STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 10, 2019
[redacted]
AGENCY: MAP
FH #: 7959878K

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 11, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Debora Ferguson, Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination to deny the Appellant's request for an increase in Consumer Directed Personal Assistance Program (CDPAP) correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 89, has been enrolled in a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (The Plan) and has been in receipt of a CDPAP authorization in the amount of 6.5 hours a day, 7 days a week, for a total of 45.5 hours per week.

2. On March 18, 2019, the Appellant requested an increase of CDPAP to 24 hour-live in, 7 days a week.

3. By Initial Adverse Determination dated March 28, 2019, The Plan determined to partially deny the Appellant's request and to increase the Appellant's CDPAP to 7 hours a day, 7 days a week, for a total of 49 hours per week.

4. On March 28, 2019, the Appellant requested an internal appeal.

5. By Final Adverse Determination notice dated April 1, 2019, The Plan upheld its partial denial of the Appellant's request for an increase in CDPAP and determined to keep the Appellant's CDPAP authorization at 7 hours a day, 7 days a week, for a total of 49 hours per week.

6. On May 10, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

> (a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
>
> (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
>
> (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.
>
> (3) Provide that the MCO, PIHP, or PAHP--
>
> (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
>
> (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or

condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees,

or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively. 18 NYCRR § 505.14(a)(3)(iii)(a)

Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside

the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings. 18 NYCRR § 505.14(a)(5)

The purpose of GIS message GIS 03 MA/003 is to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patient's appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R.§ 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the

nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

Completion of accurate and comprehensive assessments are essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

The Department's personal care services managed care guidelines dated May 2013 advise that Managed Care Organizations should authorize some or total assistance with the recognized medically necessary personal care services tasks. Allotment of time separate and apart from the personal care tasks authorized is not required for safety monitoring. However, there is a clear and legitimate distinction between safety monitoring as a non-required stand alone function while no CDPAP is being provided and the appropriate level of safety monitoring while the enrollee is receiving assistance with CDPAP tasks such as transferring, toileting, or walking. As an example, if a member requires assistance with getting in and out of the tub and also has a condition that limits the ability to discern temperature the CDPAP worker would monitor the water temperature for the member as a safety measure. As another example, if a member requires assistance with walking, the CDPAP worker takes appropriate measures to guard the member's safety while assisting the member with the task of walking. These are but two examples of the appropriate safety monitoring that must be provided to assure that the particular Level I or Level II task is safely completed. Safety monitoring under CDPAP does not, however, include monitoring an individual with dementia, for example, when no other Level I or Level II personal care services task is being provided, to assure that the individual a does not wander away from home or engage in unsafe behavior. This type of safety monitoring is covered as a discrete service in the Nursing Home Transition and Diversion Waiver.

Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. [18 NYCRR § 505.14(a)(2)]

Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. [18 NYCRR § 505.14(a)(4)]

The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24 hour personal care, including continuous personal care services, live-in 24 hour personal care services or the equivalent provided by formal services or informal caregivers. 18 NYCRR 505.14(d)

The Department's managed care personal care services guidelines dated May 2013 advise that the MCO may not authorize or reauthorize personal care services based upon a *task-based* assessment when the member has been determined by the MCO to be in need of 24 hour personal care services, including continuous (split-shift or multi-shift) care, 24 hour live-in care or the equivalent provided by a formal or informal caregivers. The determination of the need for 24 hour personal care, including continuous (split-shift or multi-shift) care, shall be made without regard to the availability of formal or informal caregivers to assist in the provision of such care.

GIS message GIS 96 MA/019 advises of a federal court decision that applies to social services districts' reductions or discontinuations of personal care services. [Mayer et al. v. Wing, (S.D.N.Y.)] In general, the Mayer decision holds that a social services district must have a legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.

The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title. 18 NYCRR 505.14(b)(5)(v)(b)

The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice. Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

(i) the client's health and safety cannot be assured with the provision of personal care services.

The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;

(iii) the client is not self-directing and has no one to assume those responsibilities;

(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(iii) the client refused to cooperate in the required reassessment;

(iv) a technological development, which the notice must identify, renders certain services

unnecessary or less time-consuming;

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(b)

The Department's Managed Care Personal Care Services Guidelines dated May 2013 advise that requests for CDPAP must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;
ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
iii. that are authorized for the new authorization period; and
iv. the original authorization period and the new authorization period, as applicable.

All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for CDPAP. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice

Reasons to deny personal care services must be reflected in the notices and include but are not limited to: :

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
(iii) the client is not self-directing and has no one to assume those responsibilities;
(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;
(v) the client refused to cooperate in the required assessment;
(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming 18 NYCRR 505.14(b)(5)(v)(c)(1)

Reasons to reduce or discontinue personal care services must be reflected in the notices and include but are not limited to: :

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;
(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;
(iii) the client refused to cooperate in the required reassessment;
(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(c)(2)

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, the appellant must establish

that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The hearing record establishes that the Appellant, age 89, has been enrolled in a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (The Plan) and has been in receipt of a CDPAP authorization in the amount of 6.5 hours a day, 7 days a week, for a total of 45.5 hours per week. On March 18, 2019, the Appellant requested an increase of CDPAP to 24 hour-live in, 7 days a week. By Initial Adverse Determination dated March 28, 2019, The Plan determined to partially deny the Appellant's request and to increase the Appellant's CDPAP to 7 hours a day, 7 days a week, for a total of 49 hours per week. On March 28, 2019, the Appellant requested an internal appeal. By Final Adverse Determination notice dated April 1, 2019, The Plan upheld its partial denial of the Appellant's request for an increase in CDPAP and determined to keep the Appellant's CDPAP authorization at 7 hours a day, 7 days a week, for a total of 49 hours per week.

The Final Adverse Determination denied the Appellant's request for 24 hour-live in, 7 days a week CDPAP because the service is "not medically necessary." It stated that the Appellant has had a recent clinical assessment on March 14, 2019 which showed that many of the Appellant's abilities to perform physical functioning stayed the same and some declined since the prior assessment on December 7, 2018. The notice stated that the Appellant showed no changes in the ability to perform functions including, dressing upper body, personal hygiene, bed mobility, walking, toilet transfer, eating, meal preparation, medication management and ordinary housework. It further stated that the Appellant's performance declined for dressing lower body, bathing and toilet use. The notice concluded that because many of the Appellant's abilities to perform functions stayed the same and some declined, The Plan had increased the Appellant's hours to 7 hours a day, 7 days a week, for a total of 49 hours per week.

An examination of the Appellant's previous UAS assessment done on December 7, 2018, shows that the Appellant's did not require as much assistance then as she does now. In that earlier assessment, for example, she required extensive assistance with bathing, dressing lower body, walking and toilet use. The most recent UAS assessment of the Appellant done on March 14, 2019 shows that the Appellant now needs maximal assistance for bathing, dressing lower body, walking and toilet transfer and use.

The hearing record further establishes that Appellant lives alone in an apartment. Her daughter, who works and does not live in New York City, is an informal care-giver and stays with the Appellant at night. At the hearing, the Appellant's representative, her daughter, emphasized the Appellant's risk of falling when alone. Her mother suffer from syncope and blacks out, she explained. The representative stated that she is "terrified" that she might find her mother in the same situation as on the morning of March 5, 2019 when she fell and had to be

admitted to the hospital for 6 days due to her serious injuries. Her mother has fallen three times in the past three months, the representative explained. At the hearing, the Appellant's representative disagreed with The Plan assessment that her mother's functionality has mostly stayed the same. Since the March fall when her mother hit her head, her mother has been even more dizzy and light-headed. Her balance and her short term memory have declined, as has her ability to toilet herself, the representative explained. "She definitely went downhill as a result of the fall," the representative stated. Her mother is also scheduled for an operation in early July 2019 for a possibly cancerous tumor that has returned, she stated. Furthermore, the Appellant is incontinent of bladder and has bowel accidents.

The record shows that the Appellant has medical conditions, including COPD, diabetes with diabetic neuropathy, heart failure and stroke/CVA, osteoarthritis, fatigue and shortness of breath, hypertension and hyperlipidemia, major depressive disorder and a history of falls.

Currently, the aide arrives approximately at 8:30 - 9:00 am each day and leaves at 4:00 pm, after putting out food for the Appellant to eat, according to the Appellant's representative. The Appellant is alone and without assistance with her ADLs from 4:00 pm to about 7:30 pm when her daughter arrives after work.

The above law explains that that Managed Care Organizations should authorize some or total assistance with the recognized medically necessary personal care services tasks. Allotment of time separate and apart from the personal care tasks authorized is not required for safety monitoring. However, there is a clear and legitimate distinction between safety monitoring as a non-required stand alone function while no CDPAP is being provided and the appropriate level of safety monitoring while the enrollee is receiving assistance with CDPAP tasks such as transferring, toileting, or walking. As an example, if a member requires assistance with walking, the CDPAP worker takes appropriate measures to guard the member's safety while assisting the member with the task of walking. Social services districts are not required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036).

Furthermore, regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

A judge can and should direct the authorization of the amount of CDPAP needed, not necessarily what was requested. The evidence in this case was carefully considered. Based on the evidence presented, it has been established that The Plan's determination to allot 7 hours a day, 7 days a week, for a total of 49 hours per week was not correct and additional hours should be allotted to the Appellant's CDPAP authorization to adequately address the Appellant's needs. However, the Appellant's representative did not establish that the Appellant is eligible for the requested increase of 24 hour-live in, 7 days a week CDPAP.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan to deny Appellant's request for an increase in authorized Personal Care Services is not correct and is reversed.

1. The Plan is directed to authorize the increase of the Appellant's CDPAP hours from of 7 hours per days, 7 days per week (49 total hours) to 11 hours per day, 7 days per week (77 total hours), and to notify Appellant in writing upon compliance with this decision after fair hearing.

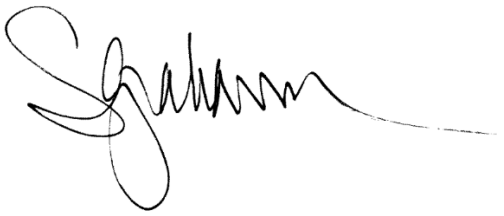
Should the Managed Long Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to the Managed Long Term Care Plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the Managed Long Term Care Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
06/20/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee