STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 15, 2017
[redacted]
AGENCY: MAP
FH #: 7667026L

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 January 16, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the MLTC Plan (Centers Plan for Healthy Living)

Alicia Jacobs, Fair Hearing Representative
Shari Oberstein, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, not to provide the Appellant with either live-in personal care services or continuous personal care services 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 85, has been enrolled in a Managed Long Term Care Program and has received care and services, including personal care services, through a partially capitated Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. On October 9, 2017, the Appellant's representative requested that the Appellant's personal care services be increased from 59.5 hours per week (eight and one-half hours per day, seven days per week) to 24-hour live-in personal care services.

3. By notice dated October 26, 2017, the Centers Plan for Healthy Living informed the Appellant and her representative that the Plan received the Appellant's representative's request for an increase in the Appellant's personal care services hours from 59.5 hours per week (eight and one-half hours per day, seven days per week) to 24-hour live-in personal care services along with requisite medical documentation from the Appellant's cardiologist, [redacted]. The Plan indicated that a Uniform Assessment System was conducted on August 8, 2017 as well as a tasking tool which showed that the Appellant required eight hours, seven days per week to complete activities of daily living. The Plan further indicated that another Uniform Assessment System (UAS) would be conducted and that the Appellant's representative's request would be reviewed after this UAS has been completed. The Plan stated that the Appellant's personal care services would remain at 59.5 weekly.

4. Sometime after December 14, 2017, the Appellant's representative requested that the Appellant's personal care services be increased from 59.5 hours per week (eight and one-half hours per day, seven days per week) to continuous personal care services.

5. On December 15, 2017, the Appellant requested the present hearing.

APPLICABLE LAW

Part 438 of 21 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 21 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.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 21 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 21 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 21 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.

***

Section 505.14(a) of the Regulations provides:

(2) 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.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(4) 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.

Section 505.14(a) of the Regulations provides in part that 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.

(ii)Level II shall include the performance of nutritional and environmental support functions and personal care functions.

a. Personal care functions shall 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) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

8) feeding;

9) 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;

10) providing routine skin care;

11) using medical supplies and equipment such as walkers and wheelchairs, and;

12) changing of simple dressings.

General Information System message, GIS 97 MA/033, states in pertinent part that once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by authorizing 24-hour split-shift personal care services for a recipient who is medically eligible for split-shift services, and who otherwise meets the fiscal assessment requirements, but has no informal or formal supports.

18 NYCRR 358-5.9(a) provides that, at a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, or an exemption from work activity requirements, the Appellant must establish that the Agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 states, in pertinent part, that 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**.**

1. 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 of daily on interrupted sleep during the aids eight of sleep.

2. Live-in 24 hour personal care services is a provision of care by a personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with transferring, walking, toileting, turning and positioning, or feeding, and whose needs 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 of period of sleep.

GIS 15 MA/24 further provides that the social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized.

DISCUSSION

The Appellant's representative requested the present hearing to review Centers Plan for Healthy Living's determination not to provide the Appellant with either 24-hour live-in personal care services or continuous personal care services.

At the hearing, Centers Plan for Healthy Living (also referred to as "the Plan") presented its October 20, 2017 Uniform Assessment System report that lists the Appellant's primary diagnosis as dementia. The report also lists the Appellant's other diagnoses as dizziness and giddiness, full incontinence of feces, history of falling, insomnia, fatigue, pain, cardiac pacemaker, primary generalized osteoarthritis, shortness of breath, traumatic subdural hemorrhage without loss of consciousness, unspecified abnormalities of gait and mobility, unspecified hearing loss, unspecified urinary incontinence, unsteady of feet, and vitamin deficiency. The report further states that the Appellant is totally dependent on another for meal preparation, ordinary housework, managing finances, and shopping. She requires maximal assistance with managing medications, phone use, stairs, bathing, dressing lower body, walking, locomotion, and toileting, extensive assistance with personal hygiene, bed mobility, eating, and dressing upper body. The report also states that the Appellant is frequently incontinent of bladder and bowel.

At the hearing, the Appellant's representative stated that she is requesting continuous personal care services (24-hour split-shift). However, in the Appellant's October 9, 2017 request that is discussed below, the Appellant's representative stated that she was requesting a 24-hour home attendant indicating that she was requesting one home attendant that would provide care for 24 hours, seven days per week, i.e., live-in personal care services. In her fair hearing request, she indicated that she had requested 24-hour split shift from the Agency although the record in this case does not establish that she made such request with the Plan. However, the evidence in this case has been reviewed to determine whether the Plan's determination not to provide either live-in personal care services or continuous personal care services was correct.

At the hearing, the Appellant's representative stated that she visits the Appellant daily during the evening hours after the Appellant's aide leaves at 7:30 pm. The Appellant's representative testified that she visits the Appellant during the evening because the Appellant feels lonely and scared at night, and that she was not sleeping at night. She further stated that the Appellant awakens at night and wanders outside of her apartment into the hallway. The Appellant's representative stated that she once found the Appellant wandering outside of her apartment in front of the elevators in her apartment complex. The Appellant's representative also stated that the Appellant leaves the stove on after she finishes warming milk, and that, one evening, the Appellant believed that it was morning when it was in fact evening. The Appellant's representative contended that the Appellant is at high risk of being left home alone due to these reasons.

The Appellant's representative stated that the Appellant's son, [redacted], resides with the Appellant, but that he is bipolar and consequently, he is unable to assist the Appellant with activities of daily living. The Appellant's representative presented a letter dated January 11, 2018 from [redacted] that stated that he resides with the Appellant and that he has bipolar disease and Parkinson's disease for several years and that he is unable to help the Appellant with any ADLs, assistance, or supervision of her daily need.

It is noted that the record does not establish that the Plan determined that it would not provide the Appellant with live-in personal care services or continuous personal care services because her son, [redacted], assists the Appellant during the night. The Appellant must, however, establish that she has nighttime needs that require assistance regardless of [redacted]'s inability to assist the Appellant with ADLs.

The Appellant's representative stated that the Appellant fell to the ground at her home on December 14, 2017 which resulted in pain in her lower back. She stated that the Appellant was transported to the emergency room of [redacted] on December 14, 2017 consequent to this fall, and that she was discharged approximately 10 to 12 hours later from this hospital. The Appellant's representative stated that, subsequent to the Appellant's fall on December 14, 2017, the Appellant requires assistance with toileting at night. The Appellant's representative stated that she informed the Plan that the Appellant fell on December 14, 2017 and that the Plan sent a nurse to the Appellant's home on January 13, 2018 to complete a new assessment of the Appellant's medical condition following the fall of December 14, 2017. The Appellant's representative stated that prior to the Appellant's fall on December 14, 2017, the Appellant was using a walker to ambulate in her home, and that the Appellant would ambulate to the restroom to use the toilet. The Appellant's representative stated that, since the Appellant's fall on December 2017, the Appellant has been wearing pads for her incontinence and she has been using a bed pan because she has difficulty standing and walking to the restroom. The Appellant's representative stated that the Appellant uses the bed pan four times per night. She stated that the Appellant requires assistance with changing her incontinent pads as well as assistance with changing the bed pan. She also stated that the Appellant prefers to use the bed pan than to wear adult diapers; however, she indicated that the Appellant only uses diapers "long term", indicating that the Appellant only wears diapers when no one is available for long period

of time. Moreover, the Appellant's representative contended that the Appellant became crippled after she fell on December 14, 2017; however, the Appellant's representative failed to provide medical documentation to support this contention. She also stated that she borrowed money to pay a woman to stay with the Appellant during the night from 11pm to 11 am. However, the Appellant did not present documentary evidence such as receipts to support her contention that she paid a woman to assist the Appellant at night from 11pm to 11am when she was unable to visit the Appellant in the evening.

The Appellant's representative presented the Appellant's hospital records for December 14, 2017 from [redacted] that states that the Appellant was diagnosed with lumbosacral strain; it also stated that the Appellant was treated for a compression fracture. The Appellant's representative presented a radiological report, dated December 14, 2017, that stated that the Appellant had a T11 compression fracture that she had since December 2016. She also presented a letter from [redacted]., dated January 8, 2018, that stated that the Appellant has senile dementia, sensorineural hearing loss, arthropathy, cerebral atherosclerosis, wedge compression fracture of T11 and T12 vertebrae, a history of falls, and hypertension. The letter further states that the Appellant is very confused and forgetful, and that she has had a series of falls at home when she has been alone. The letter stated that the Appellant reportedly leaves: "burners on, on the range a number of times . . . [wanders] in the hallway of the apartment unaware of where she is going . . . [the][Appellant] can not be left alone [sic] she needs constant supervision and help with her activities of daily living."

The Appellant's representative presented a letter dated January 11, 2018 which she wrote and which stated in pertinent part that the Appellant has an altered mental status due to dementia/Alzheimer's disease. She stated that there are safety concerns because the Appellant cannot be left alone. She stated that the Appellant experiences sun downing/confusion during the night, she is at high risk of falling, she requires contact guarding during ambulation, and she requires around the clock care. The Appellant's representative stated that the Appellant awakens four to eight times per night and requires assistance with ADLs and escorting outside, and that she has multiple history of falling. She stated that the Appellant was crippled after her fall on December 14, 2017 and that she was unable to walk, stand, or toilet independently. She stated that she borrowed money from a friend to pay a woman to assist the Appellant at night from 11pm to 11am when she was unable to visit the Appellant in the evening. The Appellant's representative indicated that she informed the Plan of the Appellant's fall on December 14, 2017 and subsequently, a nurse from the Plan visited the Appellant on January 13, 2018. Furthermore, the Appellant's representative stated that she visits the Appellant almost every evening, and that she informed the Appellant's physician, [redacted], that the Appellant "left the burners on, on the range several times . . . and that she found the Appellant wandering in front of the elevators of her apartment building." She further stated that she was concerned for the Appellant's safety and that the Appellant cannot be left alone because she requires constant supervision and assistance with ADLs. She further indicated that the above-mentioned activities, i.e., turning on burners and wandering in front of elevators occurred when the Appellant was left alone after the aide left at 7:30 pm.

The Plan contended that the Appellant's representative is seeking safety supervision which the Plan is not required to provide. The Plan presented a letter from the Appellant's representative dated October 9, 2017. The letter states in relevant part that the Appellant goes to sleep late every night and that she awakens and leaves her bed to make sure that her door is locked, the stove knobs are off, all the windows were closed, and the refrigerator door closed. She stated that the Appellant returns to her bed, but later leaves her bed again to inspect same things over again. The Appellant's representative indicated that, when she visits the Appellant, she assures her that her home is safe, and the Appellant then goes to sleep. The Appellant's representative stated that a few weeks before she wrote this letter, the Appellant was experiencing dizziness and that she was unable to get out of bed and go to the bathroom independently until her aide arrived at 10:30 am. The Appellant's representative stated that she visited the Appellant in the morning to ensure that she does not attempt to get out of bed and risks falling. She further stated that the Appellant needs an aide to stay with her during the night "to assure her and to enforce the things she easily forgets due to short term memory loss." She also stated that the Appellant feels scared and lonely at night and that she noticed that she was offering a bed to the daytime aid and asked her to stay overnight.

It is noted that the Appellant stated that, prior to the Appellant's fall on December 14, 2017, the Appellant wanders (walks) outside of her apartment and into the hallways, and that she was able to walk to the restroom to use the toilet which is contrary to the October 9, 2017 letter discussed above which states that the Appellant was experiencing dizziness and that she was unable to get out of bed and go to the bathroom independently until her aide arrived at 10:30 am.

The Plan presented a letter from [redacted] dated September 18, 2017 that the Appellant has a pacemaker and she has been diagnosed with dementia. [redacted] further stated that he saw the Appellant on September 14, 2017 for routine checkup and he discovered that the Appellant was suffering from weakness and dizziness, and her cognition is in decline, which puts her at high risk of falling. The Plan also presented a letter dated September 20, 2017 from [redacted] who stated that the Appellant is presently receiving help from an aide from 11 am to 7 pm. Her dementia is progressing so she would benefit from having an aide for at least 12 hours. She needs help with her activities of daily living as she is at increased risk of falling.

Safety monitoring or "supervision" as an independent or "standalone" task is not a covered task, and therefore, the Plan is not required to provide personal care services for safety supervision as an independent or standalone task. However, safety monitoring or "supervision" as an independent or "standalone" task should be distinguished from appropriately monitoring a patient while providing assistance with the performance of Level II personal care tasks, such as transferring, toileting, or walking, to assure that the task is being safely completed (see "GIS 03/MA03"). Thus, safety supervision provided while assisting a patient with the performance of such tasks as ambulating, transferring, or toileting is a covered task, and is not deemed as an independent or a standalone task.

Therefore, Centers Plan for Healthy Living are **not** required to provide the Appellant with a personal care services to supervise the Appellant to ensure her safety. In other words, the Plan is not required to provide personal care services to prevent the Appellant from turning on burners

or wandering into the hallway; the Plan is also not required to provide personal care services to give assurance to the Appellant that she is safe in her home. Therefore, the personal care aide who is being provided to assist the Appellant in connection with personal care services authorized by Centers for Healthy Living are not required to supervise the Appellant to prevent her from turning on burners or from wandering in the hallway, or to give her reassurance of safety because she checks her windows and doors to ensure that they are locked more than once per evening, as these activities are **not** Level II personal care activities.

The evidence has been considered. The evidence fails to establish that the Appellant requires continuous personal care services (24-hour split shift) or live-in personal care services (24 hour per day, seven days per week).

First, the medical evidence (January 8, 2018 letter from [redacted]) that was presented by the Appellant fails to state the Appellant requires assistance with activities of daily living at night as well as the particular activities to which the Appellant requires assistance, i.e., the medical evidence does not establish that the Appellant requires assistance with particular activities such as toileting and walking, or that the Appellant requires assistance with particular activities during the night. The medical evidence presented by the Appellant indicates that the Appellant wanders outside of her apartment at night and turns on the burners, and that consequently, the Appellant should not be left alone and she requires supervision in addition to assistance with ADLs; the medical evidence does not state that the Appellant has nighttime needs to which she requires assistance or that the Appellant requires personal care services, 24 hours per day, seven days per week, to meet her needs. In addition, the uncontroverted evidence establishes that the Appellant *is* receiving assistance with ADLs from 11am to 7:30pm, Monday through Sunday; hence, the January 8, 2018 letter is merely re-emphasizing that the Appellant requires assistance with ADLs. In the January 8, 2018 letter that was written after the Appellant fell on December 14, 2017, [redacted] does not state that the Appellant requires additional personal care services due to her condition after falling. Thus, the medical evidence fails to establish that the Appellant requires assistance with ADLs during the night or that the Appellant requires either continuous personal care services or live-in personal care services.

Next, the Appellant's representative's testimony was not persuasive. The Appellant's representative testified that the Appellant is crippled and that consequently, she cannot walk without assistance and that she requires use of a bed pan because she is crippled. However, the December 14, 2017 hospital record stated that the Appellant has a lumbosacral strain and that she had a T11 compression fracture that she had since December 2016. The record fails to establish that the Appellant is crippled. In addition, the Appellant's representative failed to present any medical evidence to establish that the Appellant has become crippled after falling on December 14, 2017 and that consequently, the Appellant requires assistance with walking and toileting during the night. The Appellant's representative's testimony was also inconsistent because she stated that, prior to the Appellant's fall on December 14, 2017, the Appellant wanders (walks) outside of her apartment and into the hallways, and that she found the Appellant in front of the elevators; also, that the Appellant was able to walk to the restroom to use the toilet at night. However, in her October 9, 2017 letter, she states that the Appellant was unable to get out of bed and go to the bathroom independently until her aide arrived at 10:30 am.

Finally, the Plan is neither required to authorize personal care services to prevent a member from wandering outside of her apartment nor to prevent a member from turning or leaving on burners on the stove. The Plan is also not required to authorize personal care services to give a person reassurance at night because his or her actions (i.e., checking and locking windows and doors) reveal that he or she express safety concerns in the home.

Accordingly, the Appellant's representative failed to establish that the Appellant requires either continuous personal care services or live-in personal care services. Therefore, Center Plan for Healthy Living's determination not to provide the Appellant with continuous personal care services or live-in personal care services must be sustained.

DECISION

Centers Plan for Healthy Living's determination not to provide the Appellant with continuous personal care services or live-in personal care services is affirmed.

DATED: Albany, New York
03/02/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee