STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 22, 2019
[redacted]
AGENCY: MAP
FH #: 8049962P

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 December 3, 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 Health Living, by: Debra Ferguson, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination authorizing Appellant to receive Consumer Directed Personal Assistance Services of 73.5 hours weekly, 10.5 hours daily, 7 days weekly, 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[redacted], resides with her father[redacted], her step-mother, [redacted] and her sister[redacted].

2. The Appellant has been authorized to receive Personal Care Services of 73.5 hours weekly, provided 10.5 hours daily, 7 days weekly with a Personal Care Aide under Consumer

Directed Personal Assistance Services ("CDPAP,") through Centers Plan for Healthy Living, a Managed Long-Term Care Plan, partially capitated, hereinafter, "MLTCP."

3. On June 20, 2019, the Appellant's family and/or provider, requested an increase in Appellant's CDPAP service hours from 73.5 hours weekly, 10.5 hours daily, 7 days weekly to 98 hours weekly, 14 hours daily, 7 days weekly.

4. On March 13, 2019 the MLTCP obtained a "Client Task Sheet," hereinafter, "Client Task Sheet of March 13, 2019."

5. On March 13, 2019 the MLTCP obtained a "Uniform Assessment System – New York Community Assessment Comparison Report," hereinafter, "UAS of March 13, 2019."

6. On March 13, 2019, the MLTCP obtained a "Uniform Assessment System – New York Comprehensive Community Assessment Report," hereinafter, "UAS Comprehensive of March 13, 2019."

7. On March 13, 2019, the MLTCP obtained a "Person Centered Service Plan."

8. On June 20, 2019, the MLTCP obtained a "Client Task Sheet," hereinafter, "Client Task Sheet of June 20, 2019."

9. On June 20, 2019, the MLTCP obtained a "Uniform Assessment System – New York Community Assessment Comments Report," hereinafter, "UAS Comments of June 20, 2019.

10. On June 20, 2019, the MLTCP obtained a Uniform Assessment System – New York Comprehensive Community Assessment Report," hereinafter, "UAS Comprehensive of June 20, 2019."

10. On June 28, 2019, by "Initial Adverse Determination Denial Notice," hereinafter, the "Determination," the MLTCP informed Appellant of their denial of Appellant's request for an authorization to increase Appellant's CDPAP service hours to 98 hours weekly, 14 hours, daily, 7 days weekly.

11. On July 2, 2019, the Appellant's step-mother made an internal appeal of the Determination on Appellant's behalf and by "Final Adverse Determination Denial Notice," dated July 5, 2019, hereinafter, "Final Adverse Determination," the MLTCP upheld the Determination.

12. On October 22, 2019, this fair hearing was requested on the adequacy of Appellant's CDPAP Services.

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 ser vices 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 42 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 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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative;

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.

The Medicaid Advantage and Advantage Plus Model Contract provides, in part:

10.1 Contractor Responsibilities

The Contractor agrees to provide the Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package, as described in Appendix K-1 of this Agreement, to Enrollees of the Contractor's Medicaid Advantage Plus Product subject to any exclusions or limitations imposed by Federal or State law during the period of this Agreement. Such services and supplies shall be provided in compliance with the requirements of the Contractor's Medicare Advantage Coordinated Care Plan contract with CMS, the State Medicaid Plan established pursuant to § 363-a of the State Social Services Law, and all other applicable federal and state statutes, regulations and policies.

21.2

d) The Contractor's Medicaid Advantage Plus Product network must contain all of the provider types necessary to furnish the Medicaid Services identified in Appendix K-2.

14.2 Filing and Modification of Medicaid Advantage Plus Action Appeals and/or Grievance Procedures

a) The Contractor's Action and Grievance System Procedures governing services determined by the Contractor to be a Medicaid only benefit and services determined by the Contractor to be a benefit under both Medicare and Medicaid shall be approved by the SDOH and kept on file with the Contractor and SDOH.

b) The Contractor shall not modify its Action and Grievance System Procedures without the prior written approval of SDOH.

14.3 Medicaid Advantage Plus Action and Grievance System Additional Provisions

a) The Contractor must have in place effective mechanisms to ensure consistent application of review criteria for Service Authorization Determinations and consult with the requesting provider when appropriate.

b) If the Contractor subcontracts for Service Authorization Determinations and utilization review, the Contractor must ensure that its subcontractors have in place and follow written policies and procedures for delegated activities regarding processing requests for initial and continuing authorization of services consistent with Article 49 of the PHL, 10 NYCRR Part 98, 42 CFR Part 438, Appendix F of this Agreement, and the Contractor's policies and procedures.

c) The Contractor must ensure that compensation to individuals or entities that perform Service Authorization and utilization management activities is not structured to include incentives that would result in the denial, limiting, or discontinuance of Medically Necessary services to Enrollees.

d) The Contractor or its subcontractors may not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, Enrollee's condition, or cost of services. The Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity or utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

e) The Contractor shall ensure that its Medicaid Advantage Plus Grievance System includes methods for prompt internal adjudication of Enrollee Complaints, Complaint Appeals and Action Appeals and provides for the maintenance of a written record of all Complaints, Complaint Appeals and Action Appeals received and reviewed and their disposition, as specified in Appendix F of this Agreement.

f) The Contractor shall ensure that persons with authority to require corrective action participate in the Medicaid Advantage Plus Grievance System.

g) The Contractor's Grievance System Procedures for services determined by the Contractor to be a Medicaid only benefit and services determined by the Contractor to be a benefit under both Medicare and Medicaid shall be described in the Contractor's Medicaid Advantage Plus member handbook and shall be made available to all Medicaid Advantage Plus Enrollees.

h) When the Contractor makes a final adverse determination about an Action it has taken, the Contractor will advise Enrollees of their right to a fair hearing as appropriate and comply with the procedures established by SDOH for the Contractor to participate in the fair hearing process, as set forth in Section 24 of this Agreement. Such procedures shall include the provision of a Medicaid notice in accordance with 42 CFR 438.210 and 438.404.

i) When the Contractor makes a final adverse determination about an Action it has taken, the Contractor will also advise Enrollees of their right to an External Appeal, related to services determined by the Contractor to be a Medicaid only benefit or services determined by the Contractor to be a benefit under both Medicare and Medicaid, in accordance with Section 25 of this Agreement.

MLTC policy memo 13.09(a) reminds Plans of MLTC Policy 13.09: *Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York* which indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM).

As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013;** the SAAM assessment must **not** be used

for these new enrollees. Additionally, the UAS-NY must be used for *all* reassessments beginning **October 1, 2013**.

All SAAM assessments conducted from June 16, 2013 through September 30, 2013 must be submitted to the Department of Health by October 31, 2013 via the regular SAAM submission process.

MLTC policy memo 13.09(b) advises in part:

1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.

No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

Section 505.14(a)(1) of the Regulations, as amended effective December 23, 2015, defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

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

(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.

(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.

(5) 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(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section….
monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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I. Accessing the benefit

a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request…

b. Nursing and Social Assessment:
   i. Initial assessment
   Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
   ii. Social Assessment
   In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated , whether the member's home has adequate sleeping accommodations for a personal care aide.

   This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139…

c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period, the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion

about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.

d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

II. Authorization and Notice Requirements for Personal Care Services

a. Standards for review. Requests for PCS 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.

b. Timing of authorization review.
   i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
   ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

c. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v) and must contain all required information as per Appendix F.1(5)(a)(iii).

d. Level and Hours of Service. 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.

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living functional potential;
- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental Care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

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4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

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.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

GIS 03 MA/03 was released 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. In relevant portion, this GIS Message states:

> 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**.**

18 NYCRR Section 360-10.8 provides, in part, that, at a fair hearing concerning any type of Managed Care issue, the Plan must prepare evidence to justify its challenged determinations. The same Regulation provides that the Plan may present the evidence at the hearing or submit written evidence. If the Plan will not be making a personal appearance at the fair hearing, the

written material must be submitted at least three business days prior to the scheduled hearing: to the office of administrative hearings (OAH); and to the enrollee or enrollee's representative, unless the material was previously provided to the enrollee or the enrollee's authorized representative in accordance with paragraph (3) of this subdivision. If the hearing is scheduled fewer than three business days after the request, the Plan must deliver the evidence to the hearing site no later than one business day prior to the hearing; otherwise it must appear in person. If the Plan has reversed its initial determination and provided the service to the enrollee, the Plan may request a waiver of personal appearance and submit papers explaining that it has withdrawn the initial determination and is providing the services or treatment. Only the enrollee or the enrollee's authorized representative may withdraw his or her request for a fair hearing.

18 NYCRR section 505.28 concerns the Consumer Directed Personal Assistance Program and states, in part:

(a) Purpose. The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

(b) Definitions:

(3) "consumer directed personal assistant" means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. A consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary.

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(c) Eligibility requirements. To participate in the consumer directed personal assistance program, an individual must meet the following eligibility requirements:

(1) be eligible for medical assistance;

(2) be eligible for long term care and services provided by a certified home health agency, long term home health care program or an AIDS home care program authorized pursuant to Article 36 of the Public Health Law; or for personal care services or private duty nursing services;

(3) have a stable medical condition;

(4) be self-directing or, if non self-directing, have a designated representative;

(5) need some or total assistance with one or more personal care services, home health aide services or skilled nursing tasks;

(6) be willing and able to fulfill the consumer's responsibilities specified in subdivision (g) of this section or have a designated representative who is willing and able to fulfill such responsibilities; and

(7) participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes specified in subdivisions (d) and (f) of this section.

(d) Assessment process. When the social services district receives a request to participate in the consumer directed personal assistance program, the social service district must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.

18 NYCRR section 505.14(h) states, in part:

(2) Payment for personal care services shall not be made to a patient's spouse, parent, son, son-in-law, daughter or daughter-in-law, but may be made to another relative if that other relative:

(i) is not residing in the patient's home; or

(ii) is residing in the patient's home because the amount of care required by the patient makes his presence necessary.

New York State Department of Health
Guidelines for Consumer Directed Personal Assistance Services

Overview

The inclusion of Consumer Directed Personal Assistance Services (CDPAS) into the Medicaid Managed Care and Managed Long Term Care (MCO) benefit package occurred on November 1, 2012. This paper provides guidelines for the administration of this benefit.

I. Scope of Services

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee’s

designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

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II. Authorization and Notice Requirements for CDPAS

a. The MCO determines the need for personal care, home health aide and/or skilled nursing tasks and if the enrollee is eligible for CDPAS. Authorization of CDPAS occurs after the MCO has received the medical request for services; completion of the nursing and social assessments and the plan of care; and the enrollee has signed an acknowledgement about the roles and responsibilities of the enrollee and the MCO.

c. The duration of the authorization must not exceed six (6) months. The duration for the authorization period must be based on the enrollee's needs as reflected in the required assessments. The MCO must consider the enrollee's prognosis, potential for recovery, and the expected duration and availability of any informal supports identified in the plan of care. See 18 NYCRR § 505.28(e)(3) & (4).

e. Level of Service:

i. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.
ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.
iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).
iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. The FI is not responsible for assuring that the member is managing the plan of care.

v. **NOTE**: As in the personal care services benefit, authorization for housekeeping-only tasks are limited to eight (8) hours per week.

The Model Contract for partially capitated managed long-term care plans provides in relevant part that: Person centered service planning and care management entails the establishment and implementation of a written care plan and assisting Enrollees to access services authorized under the care plan. Person centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Enrollee, as well as the Enrollee's functional level and support systems. Care management includes referral to and coordination of other necessary medical, social, educational, financial and other services of the person-centered service plan that support the Enrollee's psychosocial needs irrespective of whether such services are covered by the MLTCP. The Contractor's care management system shall ensure that care provided is adequate to meet the needs of individual Enrollees and is appropriately coordinated and shall consist of both automated information systems and operational policies and procedures.

General Information System message GIS 02 MA/024, dated September 3, 2002, describes the scope of services under the consumer directed program and advises that the Consumer Directed Personal Assistance Program authorized by Social Services Law section 365-f, enables Medicaid recipients who are eligible for home care services to have greater flexibility and freedom of choice in obtaining needed services. CDPAP participants may hire, train, supervise and discharge their aides and, in particular, may exercise greater control regarding the manner in which their aides complete the various personal care tasks and other services for which the CDPAP participant has agreed to accept responsibility under the program.

Medicaid recipients eligible to participate in the CDPAP may need assistance with personal care services and/or other home care services. The CDPAP aide may perform home health aide and skilled nursing services when a registered professional nurse has determined that the individual who will instruct the CDPAP aide is self-directing and capable of providing such instruction. [Education Law § 6908(1)(a)(iii)]. The scope of services that a CDPAP aide may provide thus includes all services provided by a personal care services aide as well as all services provided by a home health aide, registered nurse, licensed practical nurse, physical therapist, occupational therapist or speech pathologist.

Accordingly, social services districts' CDPAP assessments and authorizations should include the full scope of home care services that the Medicaid recipient may require and for which he or she, or his self-directing representative, agrees to be responsible under the CDPAP program. When issuing an authorization, districts must include not only the personal care or home health aide services tasks with which the recipient needs assistance but also any skilled tasks that the CDPAP aide will provide such as nursing services, physical therapy, occupational therapy or speech pathology services. The social services district should determine the amount of time required to complete a task by evaluating the task to be performed and discussing with the Medicaid recipient, or representative, the steps needed to complete the task. Tasks that are needed, but for which the Medicaid recipient or his or her representative is unwilling or unable to assume responsibility under the CDPAP, may be provided through another source, such as a

licensed home care services agency, CHHA, LTHHCP or a private duty nurse. Social services districts' authorizations and reauthorizations of CDPAP services should be based upon their comprehensive nursing and social assessments as well as upon the guidance in this GIS message.

General Information Services Message GIS 04 MA/10 provides in relevant portion:

The purpose of this GIS is to clarify the scope of services that an aide in the Consumer Directed Personal Assistance Program ("CDPAP") may provide, particularly with regard to occupational therapy, physical therapy, and speech therapy services.

The scope of services that a CDPAP aide may provide includes all services provided by a personal care services aide, home health aide, registered nurse, or licensed practical nurse. A CDPAP aide is able to provide nursing services because the Education Law specifically exempts CDPAP aides from having to be licensed under Article 139 of the Education Law, otherwise known as the Nurse Practice Act.

The Education Law provisions governing physical therapists (Article 136), occupational therapists (Article 156) and speech therapists (Article 159) do not exempt CDPAP aides from their licensure requirements. CDPAP aides may not perform skilled services that may be performed only by these professionals or any other health care professional subject to the Education Law's licensure provisions. A CDPAP aide may not evaluate the recipient, plan a therapy program, or provide other skilled therapy services unless the aide is also licensed under the appropriate Education Law provision. Any required skilled therapy services must be provided through another source, such as a licensed home care services agency, CHHA, LTHHCP, or a licensed therapist in private practice. Although a CDPAP aide may not provide skilled therapy services directly, an aide may, under the direction of the consumer, assist with the performance of therapy programs that a licensed therapist has planned for that CDPAP recipient.

An attachment to Local Commissioners Memorandum 06 OMM/LCM-1 contains questions and answers relating to the CDPAP. Question and Answer sequences 1, 4 and 8 are as follows:

1. Q. What is the scope of tasks allowed under the CDPAP?
A. Under the CDPAP, the personal assistant's scope of tasks includes only those tasks that may be performed by a personal care aide, home health aide, licensed practical nurse or registered professional nurse. See GIS 04 MA/010, issued April 27, 2004.

4. Q. May family members be CDPAP providers?

A. CDPAP is funded under the Personal Care Services Program (PCSP) benefit in the State's Medicaid Plan. As such, it must operate in accordance with all applicable Federal and State Medicaid statutes and regulations. Personal Care Services regulation 18 NYCRR § 505.14 (h)(2) states that payment for personal care services shall not be made to a consumer's spouse, parent, son, son-in-law, daughter, or daughter-in-law. However, payment may be made to another relative who is not residing in the consumer's home; or, is residing in the consumer's home because the amount of care required by the consumer makes his/her presence necessary.

8. Q. Can a CDPAP personal assistant perform medical procedures? Is nurse monitoring/supervision of the personal assistant/consumer required?

A. The CDPAP personal assistant may perform any personal care aide, home health aide, or nursing task that the consumer has been assessed as needing and has been prior authorized to receive; provided, however, that the personal assistant has been trained to perform the task and is supervised and directed while performing the task. Nurse supervision/monitoring is not required as the determination that the consumer (or his/her self-directing other) has the ability to direct his or her own care and train his/her assistants in needed tasks is made during the assessment process and before the prior authorization of service. Social Services Law § 365-f requires the vendor agency (fiscal intermediary) to monitor the consumer's continuing ability to fulfill his/her responsibilities in CDPAP. The LDSS must ask the fiscal intermediary how it will fulfill that responsibility.

An attachment to Local Commissioners Memorandum 06 OMM/LCM-2 contains questions and answers relating to the CDPAP. Question and Answer sequences 1, 5, 7 and 8 are as follows:

1. Q. Can a legal guardian or "self-directing other" function as a CDPAP personal assistant?
A. No. A consumer's legal guardian or "self-directing other" may not serve as a CDPAP personal assistant.

5. Q. What tasks may a CDPAP personal assistant perform and what are the imitations?
A. The CDPAP personal assistant's tasks include those which may be provided by a personal care aide, home health aide or a nurse:
♦ Personal care services tasks include the Level I tasks of assistance with certain nutritional and environmental support functions and the additional Level II tasks of assistance with certain personal care functions. See 18 NYCRR 505.14(a)(6) for a comprehensive listing of tasks.
♦ Home health aide tasks include personal care services tasks, as well as, some health-related tasks, e.g. preparation of meals for modified or complex modified diets; special skin care; use of medical equipment, supplies and devices; dressing change to stable surface wounds; performance of simple measurements and tests to routinely monitor the medical condition; performance of a maintenance exercise program; and care of an ostomy when the ostomy has reached its normal function.
♦ Nursing tasks including, but not limited to, wound care, taking vital signs, administration of medication (including administration of eye drops and injections), intermittent catheterization and bowel regime.
(Also see response to Q. #7)

7. Q. Is safety monitoring available in CDPAP?
A. Safety monitoring as a discrete task in and of itself, is not an available CDPAP service. Prior authorization of hours for the sole purpose of safety monitoring is not appropriate. Safety monitoring can and should only be provided in CDPAP as part of the personal assistant's performance of medically necessary tasks authorized or listed on the plan of care.

Social services districts should authorize assistance with recognized, medically necessary tasks. As previously advised, (See GIS 03 MA/003 Rodriguez v. Novello, issued January 24, 2003) social services districts are not required to allot time for safety monitoring as a separate task as part of the total hours authorized.
Districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no task is being performed, and the authorization of adequate time to allow for the appropriate monitoring of the consumer while providing assistance with the performance of a task, such as transferring, toileting or walking, to assure the task is safely completed.

8. Q. What is the definition of non-self-directing?
A. As defined in 92 ADM-49, a non-self-directing consumer lacks the capability to make choices about the activities of daily living, **does not** understand the implications of these choices, and **does not** assume responsibility for the results of these choices. A non-self-directing individual may exhibit one or more of the following characteristics:
♦ May be delusional, disoriented at times, have periods of agitation, or demonstrate other behaviors, which are inconsistent and unpredictable;
♦ May have a tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home;
♦ May not understand what to do in an emergency situation or how to summon emergency assistance; or
♦ May not understand the consequences of other harmful behaviors such as, but not limited to, not following medication regimes, refusing to seek assistance in a medical emergency, or leaving gas stoves unattended.

Section 358-5.9 of the Social Services Law provides, in pertinent part, 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 was not correct or that the appellant is eligible for a greater amount of assistance or benefits or is exempt from work requirements pursuant to Part 385 of this Title.

Section 358-5.9 of the Regulations provide in part:

(a) 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.
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.

DISCUSSION

The record establishes that the Appellant [redacted], resides with her father [redacted], her step-mother, [redacted] and her sister [redacted].

The record establishes that the Appellant has been authorized to receive Personal Care Services of 73.5 hours weekly, provided 10.5 hours daily, 7 days weekly with a Personal Care Aide under CDPAP, through the MLTCP.

The record establishes that on June 20, 2019, the Appellant's family and/or provider, requested an increase in Appellant's CDPAP service hours from 73.5 hours weekly, 10.5 hours daily, 7 days weekly to 98 hours weekly, 14 hours daily, 7 days weekly.

The record establishes that on March 13, 2019 the MLTCP obtained the Client Task Sheet of March 13, 2019.

The record establishes that on March 13, 2019 the MLTCP obtained the UAS of March 13, 2019.

The record establishes that on March 13, 2019, the MLTCP obtained the UAS Comprehensive of March 13, 2019.

The record establishes that on March 13, 2019, the MLTCP obtained a Person-Centered Service Plan.

The record establishes that on June 20, 2019, the MLTCP obtained the Client Task Sheet of June 20, 2019.

The record establishes that on June 20, 2019, the MLTCP obtained a UAS Comments of June 20, 2019.

The record establishes that on June 20, 2019, the MLTCP obtained the UAS Comprehensive of June 20, 2019.

The record establishes that on June 28, 2019, by the Determination, the MLTCP informed Appellant of their denial of Appellant's request for an authorization to increase Appellant's CDPAP service hours to 98 hours weekly, 14 hours, daily, 7 days weekly stating, in pertinent part:

> "…You recently underwent a follow-up face-to-face clinical assessment on June 20, 2019, utilizing the New York State Department of Health's Uniform Assessment System (UAS) Tool that showed many of your abilities to perform physical functioning stayed the same and some improved since your prior

> assessment that was completed by Centers Plan for Healthy Living on March 13, 2019.
> Your abilities to perform physical functioning (daily activities) stayed the same for dressing lower body, walking, bathing, toilet use, meal preparation, medication management, and ordinary housework.
> Your abilities to perform physical functioning (daily activities) improved for dressing upper body, personal hygiene (cleaning yourself), bed mobility (moving on the bed), transfer toilet (getting on and off the toilet) and eating.
>
> In summary, many of your abilities to perform physical functioning stayed the same and some improved; therefore, your hours stay the same…"

The record establishes that on July 2, 2019, the Appellant's step-mother made an internal appeal of the Determination on Appellant's behalf and by the Final Adverse Determination, the MLTCP upheld the Determination stating, in part:

> A Registered Nurse from Centers Plan for Health Living (CPHL) visited you in your home on 6/20/2019 and completed a face-to-face assessment, using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.
> Based on this assessment, it was identified that:
>
> You require safety monitoring and supervision as a standalone task.
> You do not require repositioning every two hours.
> You have had no recent falls….your Consumer Directed Personal Assistance Program Services will remain the same…"

It is noted that neither the Determination nor the Final Adverse Determination properly identifies a reason for the denial of Appellant's request. There is insufficient supporting evidence of improvements in Appellant's ability to carry out ADLs. There is no evidence in the record that Appellant requires safety monitoring as a stand-alone task. Lack of need for repositioning and lack of falls are not the sole criteria for denying an increase in services. The respective determinations fail to adequately address Appellant's needs and ability to perform ADLs and do not provide an adequate basis for denying the request for an increase in services.

It is noted that Appellant's step-mother is erroneously referred to in the Determination and the Final Adverse Determination as her daughter.

The UAS Comprehensive of June 20, 2019 states Appellant's diagnoses to be as follows:

Quadriplegia
Aphasia
Cerebral palsy, unspecified
Constipation, unspecified

Dependence on wheelchair
Dizziness and giddiness
Dysphagia, unspecified
Other abnormalities of gait and monility
Pain, unspecified
Unspecified acquired deformity of hand, unspecified hand
Unspecified urinary incontinence
Vitamin deficiency, unspecified

(See UAS Comprehensive of June 20, 2019, pgs. 20, 21.)

Appellant submitted a letter from her physician adding the following:

Mental disorder due to brain damage because of Hx or anoxic encephalopathy due to prolong cardiac arrest at age 5 month old.
Patient is Wheel chair bound, is unable to take care of herself (dressing, feeding herself, using toilet and etc.) Patient is mute, unable to express herself. Has partial understanding what is going on around her and conversation.

(See letter of [redacted], M.D. of October 16, 2019.)

At the hearing, the Appellant's father testified that the Appellant cannot do anything for herself and it is noted that the 30-year old Appellant sat in her wheelchair throughout the hearing, immobile and silent. He testified that the Appellant cannot feed herself, that she is unable to move herself forward or backward in her wheelchair, unable to get into bed or get out of bed. The UAS Comprehensive of June 20, 2019 reports that Appellant is incontinent of bladder. Appellant's father testified that they must carry the Appellant to the toilet and that although she is mute, she is able to make a sound to let them know when she needs to go in the night-time. He testified that his wife, Appellant's step-mother, is the CDPAP aide. He testified that Appellant used to be able to move her hands but that they have become spastic and that her condition has not improved; it has worsened. The spastic condition of Appellant's hands was made visible at the hearing. Appellant's father denied that the Appellant needs constant safety monitoring, testifying that she has never fallen out of her wheelchair or tried to rise from it on her own.

It is noted that the most recent UAS is almost 6 months old and needs to be updated particularly in light of the Appellant's father's testimony that Appellant's condition has deteriorated. It is also noted that the Appellant appeared to be following the testimony at the hearing, which was translated from Russian into English.

It is undisputed that the Appellant is incontinent of bladder and "totally dependent" for toileting and locomotion. Although the MLTCP's Determination and Final Adverse Determination conclude that Appellant's condition has improved, the UAS Comprehensive of June 20, 2019 states on page 5: "Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago: No change Overall self-sufficiency has changed

significantly as compared to status 90 days ago, or since last assessment if less than 90 days: No change." The MLTCP contends that Appellant's condition has improved with respect to her ability to perform the following ADLs: dressing upper body, personal hygiene (cleaning yourself) bed mobility (moving on the bed), transfer toilet (getting on and off the toilet) and eating." However, the evidence of functional improvement is so scant it may be deemed negligible at best. For example, per the UAS Comments Report of June 20, 2019, p. 1: "As per member's father, member is able to reposition herself very slightly in bed." Even assuming this statement to be true, this slight ability would not impact on the necessity to turn the Appellant during the night. The MLTCP's contention that Appellant's ability to perform personal hygiene and feed herself is outdated by the apparent inability due to hand spasticity. There is no explanation in the record for the MLTCP's contention that Appellant's ability to "transfer toilet" has improved.

Pursuant to Section 505.14(b) of the Regulations. *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.

The credible evidence at the hearing is that Appellant is totally dependent for most ADLs, is totally dependent for toileting and for locomotion, that she needs to be turned during the night, and has unscheduled night-time toileting needs sufficiently infrequent that a live-in 24-hour CDPAP 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. The credible evidence at the hearing is that the Appellant is in need of live in 24-hour CDPAP Services. The MLTCP's contention that Appellant's Personal Care needs are met with the provision of 73.5 hours of CDPAP services weekly is not supported by the credible evidence at the hearing and is not sustained.

DECISION AND ORDER

The MLTCP's determination authorizing the Appellant to receive 73.5 hours of CDPAP Services, provided 10.5 hours daily, 7 days weekly is not correct and is reversed.

1. The MLTCP is directed to increase Appellant's Personal Care Services to 24-hour CDPAP Services, provided on a "live-in" basis.

Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant, and her representative, promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the MLTCP promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the MLTCP must comply immediately with the directives set forth above.

DATED: Albany, New York
01/10/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By H. Cooper Gregory

Commissioner's Designee