STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 29, 2018
[redacted]
AGENCY: MAP
FH #: 7764850M

In the Matter of the Appeal of

[redacted]

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

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 21, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

Julia Rolffot, by telephone, Representative

ISSUE

Was the Managed Long-Term Care Plan's determination dated April 6, 2018, not to increase and to continue to provide the Appellant with a Consumer Directed Personal Assistance Service (CDPAS) authorization in the amount of 12 hours per day, 7 days per week correct?

FACT FINDING

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], has been in receipt of a Consumer Directed Personal Assistance Services (CDPAS) authorization from a Managed Long-Term Care Plan, Centers Plan for Healthy Living (hereinafter the "Plan"), in the amount of 12 hours per day, 7 days per week.

2. On November 13, 2017, and March 14, 2018, a nursing assessor completed uniform assessment system evaluations of the Appellant's personal care needs.

3. By notice dated April 6, 2018, the Plan determined not to increase and to continue to provide the Appellant with a Personal Care Services authorization in the amount of 12 hours per day, 7 days per week.

4. On April 11, 2018, the Appellant's Representative requested a standard appeal.

5. By notice dated May 14, 2018, the Plan determined to partially overturn its determination not to increase the Appellant's Personal Care Services authorization. The Plan determined to change the Appellant's Personal Care Services authorizations from 12 hours, 7 days a week to 24 hour live-in, 7 days a week.

6. On May 29, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

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

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

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

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.

MLTC Policy 16.07 provides, in part, that:

All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance.

Part 505 - MEDICAL CARE
Title: Section 505.28 - Consumer directed personal assistance program
Effective Date
07/06/2016
505.28 Consumer directed personal assistance program.
(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. The following definitions apply to this section:
(1) "consumer" means a medical assistance recipient who a social services district has determined eligible to participate in the consumer directed personal assistance program.
(2) "consumer directed personal assistance" means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.
(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.
(4) "continuous consumer directed personal assistance" means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer’s medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.
(5) "designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities specified in subdivision (g) of this section and who is willing and able to perform these responsibilities. With respect to a non self-directing consumer, a "designated representative" means the consumer's parent, legal guardian or, subject to the social

services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.
(6) "fiscal intermediary" means an entity that has a contract with a social services district to provide wage and benefit processing for consumer directed personal assistants and other fiscal intermediary responsibilities specified in subdivision (i) of this section.
(7) "home health aide services" means services within the scope of practice of a home health aide pursuant to Article 36 of the Public Health Law including simple health care tasks, personal hygiene services, housekeeping tasks essential to the consumer's health and other related supportive services. Such services may include, but are not necessarily limited to, the following: preparation of meals in accordance with modified diets or complex modified diets; administration of medications; provision of special skin care; use of medical equipment, supplies and devices; change of dressing to stable surface wounds; performance of simple measurements and tests to routinely monitor the consumer's medical condition; performance of a maintenance exercise program; and care of an ostomy after the ostomy has achieved its normal function.
(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(5) of this Part except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week.
(9) a "self-directing consumer" means a consumer who is capable of making choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands the impact of these choices; and assumes responsibility for the results of these choices.
(10) "skilled nursing tasks" means those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to Section 6908 of the Education Law.
(11) "stable medical condition" means a condition that is not expected to exhibit sudden deterioration or improvement and does not require frequent medical or nursing evaluation or judgment to determine changes in the consumer's plan of care.
(12) live-in 24-hour consumer directed personal assistance means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer’s medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

(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 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.
(1) Physician's order. (i) A physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist assistant registered in accordance with article 131-B of the Education Law or a nurse practitioner certified in accordance with article 139 of the Education Law must conduct a medical examination of the individual and complete the physician's order within 30 calendar days after conducting the medical examination.
(ii) The physician's order must be completed on a form that the department requires or approves. The physician or other medical professional who conducted the examination must complete the order form by accurately describing the individual's medical condition and regimens, including any medication regimens; the individual's need for assistance with personal care services, home health aide services and skilled nursing tasks; and provide only such other information as the physician's order form requires. The physician or other medical professional who completes the order form must not recommend the number of hours of services that the individual should be authorized to receive.
(iii) A physician must sign the physician's order form and certify that the individual can be safely cared for at home and that the information provided in the physician's order form accurately describes the individual's medical condition and regimens, including any medication regimens, and the individual's need for assistance at the time of the medical examination.
(iv) The physician's order form must be submitted to the social services district within 30 calendar days after the medical examination. The form may be submitted by the physician, other medical professional or by the individual or the individual's representative.
(v) The physician's order form is subject to the provisions of Parts 515, 516, 517 and 518 of this article, which permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers and prescribers of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed recipients' documented needs are provided or ordered.
(2) Social assessment. Upon receipt of a completed and signed physician's order, social services district professional staff must conduct a social assessment. The social assessment must include the following:
(i) a discussion with the individual or, if applicable, the individual's designated representative to determine the individual's perception of his or her circumstances and preferences;

(ii) an evaluation of the individual's ability and willingness to fulfill the consumer's responsibilities specified in subdivision (g) of this section and, if applicable, the ability and willingness of the individual's designated representative to assume these responsibilities;
(iii) an evaluation of the potential contribution of informal supports, such as family members or friends, to the individual's care, which must consider the number and kind of informal supports available to the individual; the ability and motivation of informal supports to assist in care; the extent of informal supports' potential involvement; the availability of informal supports for future assistance; and the acceptability to the individual of the informal supports' involvement in his or her care;
(iv) for cases involving continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance, the social assessment shall demonstrate that all alternative arrangements for meeting the individual’s medical needs have been explored and are infeasible including, but not limited to, the provision of consumer directed personal assistance in combination with other formal services or in combination with voluntary contributions of informal caregivers; and
(v) for cases involving live-in 24-hour consumer directed personal assistance, an evaluation whether the consumer’s home has sleeping accommodations for a consumer directed personal assistant. When the consumer’s home has no sleeping accommodations for a consumer directed personal assistant, continuous consumer directed personal assistance must be authorized for the consumer; however, should the consumer’s circumstances change and sleeping accommodations for a consumer directed personal assistant become available in the consumer’s home, the district must promptly review the case. If a reduction of the consumer’s continuous consumer directed personal assistance to live-in 24-hour consumer directed personal assistance is appropriate, the district must send the consumer a timely and adequate notice of the proposed reduction.
(3) Nursing assessment. Upon receipt of a completed and signed physician's order, the social services district must conduct or obtain a nursing assessment.
(i) The nursing assessment must be completed by a registered professional nurse who is employed by, or under contract with, the social services district or by a licensed or certified home care services agency or voluntary or proprietary agency under contract with the district.
(ii) The nursing assessment must include the following:
(a) a review and interpretation of the physician's order;
(b) the primary diagnosis code from the ICD-9-CM;
(c) an evaluation whether the individual's medical condition, as described in the physician's order, would require frequent nursing evaluation or judgment;
(d) an evaluation of the personal care services, home health aide services and skilled nursing tasks that the individual requires;
(e) an evaluation, made in conjunction with the social assessment and physician's order, whether the individual or, if applicable, the individual's designated representative, is self-directing and willing and able to instruct, supervise and direct the consumer directed personal assistant in performing any needed skilled nursing tasks, home health aide services and personal care services;
(f) an evaluation whether the individual's need for assistance can be totally or partially met through the use of adaptive or specialized medical equipment or supplies including, but not limited to, commodes, urinals, adult diapers, walkers or wheelchairs and whether the individual

would be appropriate for personal emergency response services provided in accordance with section 505.33 of this part;

(g) for continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases, documentation of the following:
(1) whether the physician's order has documented a medical condition that causes the consumer to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks;

(2) the specific functions or tasks with which the consumer requires frequent assistance during a calendar day;

(3) the frequency at which the consumer requires assistance with these functions or tasks during a calendar day;

(4) whether the consumer requires similar assistance with these functions or tasks during the consumer's waking and sleeping hours and, if not, why not; and

(5) whether, were live-in 24-hour consumer directed personal assistance to be authorized, the consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(h) development of a plan of care in collaboration with the individual or, if applicable, the individual's designated representative, that identifies the personal care services, home health aide services and skilled nursing tasks with which the individual needs assistance in the home and a recommendation for the number of hours or frequency of such assistance; and
(i) recommendations for authorization of services.
(4) Guidelines for completion of social and nursing assessment. The social services district must conduct the social assessment and conduct or obtain a nursing assessment with reasonable promptness, generally not to exceed 30 calendar days after receiving a completed and signed physician's order, except in unusual circumstances including, but not limited to, when the individual or, if applicable, the individual's designated representative has failed to participate as needed in the assessment process.
(5) Local professional director review.
(i) If there is a disagreement among the physician's order, the nursing assessment and the social assessment, or a question regarding the amount or duration of services to be authorized, or if the case involves continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance, an independent medical review of the case must be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the social services district.
(ii) The local professional director or designee must review the physician's order and the nursing and social assessments. When determining whether continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance should be authorized, the local professional director or designee must consider the information in the social and nursing

assessments. The local professional director or designee may consult with the consumer's treating physician and may conduct an additional assessment of the consumer in the home.
(iii) The local professional director or designee is responsible for the final determination regarding the amount and duration of services to be authorized. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized.
(e) Authorization process. (1)(i) When the social services district determines pursuant to the assessment process that the individual is eligible to participate in the consumer directed personal assistance program, the district must authorize consumer directed personal assistance according to the consumer's plan of care. The district must not authorize consumer directed personal assistance unless it reasonably expects that such assistance can maintain the individual's health and safety in the home or other setting in which consumer directed personal assistance may be provided.
(ii) Consumer directed personal assistance, including continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance, shall not be authorized to the extent that the consumer's need for assistance can be met by the following:

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

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

(c) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

(iii) The social services district must first determine whether the consumer, because of the consumer's medical condition, would be otherwise eligible for consumer directed personal assistance, including continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance. For consumers who would be otherwise eligible for consumer directed personal assistance, the district must then determine whether, and the extent to which, the consumer's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in clauses (ii)(a) through (ii)(c) of this paragraph.
(2) The district may authorize only the hours or frequency of services that the consumer actually requires to maintain his or her health and safety in the home. The authorization must be completed prior to the initiation of services.
(3) The duration of the authorization period must be based upon the consumer's needs as reflected in the required assessments. In determining the authorization period, the social services district must consider the consumer's prognosis and potential for recovery and the expected duration and availability of any informal supports identified in the plan of care.

(4) No authorization may exceed six months unless the social services district has requested, and the department has approved, authorization periods of up to twelve months. The department may approve district requests for authorization periods of up to twelve months provided that professional staff of the social services district or its designee conduct a home visit with the consumer and, if applicable, the consumer's designated representative every six months and evaluate whether:
(i) the plan of care continues to meet the consumer's needs;
(ii) the consumer or, if applicable, the consumer's designated representative continues to be willing and able to perform the consumer's responsibilities specified in subdivision (g) of this section; and
(iii) the fiscal intermediary is fulfilling its responsibilities specified in subdivision (i) of this section.
(5) The social services district must provide the consumer with a copy of the plan of care that specifies the consumer directed personal assistance that the district has authorized the consumer to receive and the number of hours per day or week of such assistance.
(6) Nothing in this subdivision precludes the provision of the consumer directed personal assistance program in combination with other services when a combination of services can appropriately and adequately meet the consumer's needs; provided, however, that no duplication of Medicaid-funded services would result.
(f) Reassessment and reauthorization processes. (1) Prior to the end of the authorization period, the social services district must reassess the consumer's continued eligibility for the consumer directed personal assistance program in accordance with the assessment process set forth in subdivision (d) of this section.
(i) The reassessment must evaluate whether the consumer or, if applicable, the consumer's designated representative satisfactorily fulfilled the consumer's responsibilities under the consumer directed personal assistance program. The social services district must consider whether the consumer or, if applicable, the consumer's designated representative has failed to satisfactorily fulfill the consumer's responsibilities when determining whether the consumer should be reauthorized for the consumer directed personal assistance program.
(ii) When the social services district determines, pursuant to the reassessment process, that the consumer is eligible to continue to participate in the consumer directed personal assistance program, the district must reauthorize consumer directed personal assistance in accordance with the authorization process specified in subdivision (e) of this section. When the district determines that the consumer is no longer eligible to continue to participate in the consumer directed personal assistance program, the district must send the consumer, and such consumer's designated representative, if any, a timely and adequate notice under Part 358 of this chapter of the district's intent to discontinue consumer directed personal assistance on forms required by the department.
(2) The social services district must reassess the consumer when an unexpected change in the consumer's social circumstances, mental status or medical condition occurs during the authorization or reauthorization period that would affect the type, amount or frequency of consumer directed personal assistance provided during such period. The district is responsible for making necessary changes in the authorization or reauthorization on a timely basis in accordance with the following procedures:

(i) When the change in the consumer's service needs results solely from an unexpected change in the consumer's social circumstances including, but not limited to, loss or withdrawal of informal supports or a designated representative, the social services district must review the social assessment, document the consumer's changed social circumstances and make changes in the authorization or reauthorization as needed. A new physician's order and nursing assessment are not required; or
(ii) When the change in the consumer's service needs results from a change in the consumer's medical condition, including loss of the consumer's ability to instruct, supervise or direct the consumer directed personal assistant, the social services district must obtain a new physician's order, social assessment and nursing assessment.
(g) Consumer responsibilities. A consumer or, if applicable, the consumer's designated representative has the following responsibilities under the consumer directed personal assistance program:
(1) managing the plan of care including recruiting and hiring a sufficient number of individuals who meet the definition of consumer directed personal assistant, as set forth in subdivision (b) of this section, to provide authorized services that are included on the consumer's plan of care; training, supervising and scheduling each assistant; terminating the assistant's employment; and assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included on the consumer's plan of care;
(2) timely notifying the social services district of any changes in the consumer's medical condition or social circumstances including, but not limited to, any hospitalization of the consumer or change in the consumer's address, telephone number or employment;
(3) timely notifying the fiscal intermediary of any changes in the employment status of each consumer directed personal assistant;
(4) attesting to the accuracy of each consumer directed personal assistant's time sheets;
(5) transmitting the consumer directed personal assistant's time sheets to the fiscal intermediary according to its procedures;
(6) timely distributing each consumer directed personal assistant's paycheck, if needed;
(7) arranging and scheduling substitute coverage when a consumer directed personal assistant is temporarily unavailable for any reason; and
(8) entering into a department approved memorandum of understanding with the fiscal intermediary and with the social services district that describes the parties' responsibilities under the consumer directed personal assistance program.
(h) Social services district responsibilities. Social services districts have the following responsibilities with respect to the consumer directed personal assistance program:
(1) annually notifying recipients of personal care services, long term home health care program services, AIDS home care program services or private duty nursing services of the availability of the consumer directed personal assistance program and affording them the opportunity to apply for the program;
(2) complying with the assessment, authorization, reassessment and reauthorization procedures specified in subdivisions (d) through (f) of this section;
(3) receiving and promptly reviewing, the fiscal intermediary's notification to the district pursuant to subparagraph (i)(1)(v) of this section of any circumstances that may affect the consumer's or, if applicable, the consumer's designated representative's ability to fulfill the

consumer's responsibilities under the program and making changes in the consumer's authorization or reauthorization as needed;
(4) discontinuing, after timely and adequate notice in accordance with part 358 of this chapter, the consumer's participation in the consumer directed personal assistance program and making referrals to other services that the consumer may require when the district determines that the consumer or, if applicable, the consumer's designated representative is no longer able to fulfill the consumer's responsibilities under the program or no longer desires to continue in the program;
(5) notifying consumers, on forms required by the department, of the district's decision to authorize, reauthorize, increase, reduce, discontinue or deny services under the consumer directed personal assistance program, and of the consumer's right to request a fair hearing pursuant to part 358 of this chapter. The social services district's decision to deny, reduce or discontinue consumer directed personal assistance must be stated in the notice.
(i) Appropriate reasons and notice language to be used when denying consumer directed personal assistance include but are not limited to the following:
(a) the consumer's health and safety cannot be assured with the provision of consumer directed personal assistance. The notice must identify the reason or reasons that the consumer's health and safety cannot be assured with the provision of such assistance;
(b) the consumer's medical condition is not stable. The notice must identify the consumer's medical condition that is not stable;
(c) the consumer is not self-directing and has no designated representative to assume those responsibilities;
(d) the consumer refused to cooperate in the required assessment;
(e) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
(f) the consumer resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed assistance; and
(g) the consumer or, if applicable, the consumer's designated representative is unable or unwilling to fulfill the consumer's responsibilities under the program.
(ii) Appropriate reasons and notice language to be used when reducing or discontinuing consumer directed personal assistance include but are not limited to the following:
(a) the consumer's medical or mental condition or economic or social circumstances have changed and the district determines that the consumer directed personal assistance provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the consumer's health and safety can no longer be assured with the provision of consumer directed personal assistance; the consumer's medical condition is no longer stable; or the consumer is no longer self-directing and has no designated representative to assume those responsibilities. The notice must identify the specific change in the consumer's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the assistance should be reduced or discontinued as a result of the change;
(b) a mistake occurred in the previous authorization or reauthorization for consumer directed personal assistance. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior assistance is not needed as a result of the mistake;

(c) the consumer refused to cooperate in the required reassessment;
(d) a technological development, which the notice must identify, renders certain assistance unnecessary or less time-consuming;
(e) the consumer resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed assistance; and
(f) the consumer or, if applicable, the consumer's designated representative is no longer able or willing to fulfill the consumer's responsibilities under the program or the consumer no longer desires to continue in the program.
(6) maintaining current case records on each consumer and making such records available, upon request, to the department or the department's designee;
(7) entering into contracts with each fiscal intermediary for the provision of fiscal intermediary responsibilities specified in subdivision (i) of this section and monitoring the fiscal intermediary's performance under the contract, including reviewing the fiscal intermediary's administrative and personnel policies and recordkeeping relating to the provision of consumer directed personal assistance program services and evaluating the quality of services that the fiscal intermediary provides; and
(8) entering into a department approved memorandum of understanding with the consumer that describes the parties' responsibilities under the consumer directed personal assistance program.
(i) Fiscal intermediary responsibilities. (1) Fiscal intermediaries have the following responsibilities with respect to the consumer directed personal assistance program:
(i) processing each consumer directed personal assistant's wages and benefits including establishing the amount of each assistant's wages; processing all income tax and other required wage withholdings; and complying with worker's compensation, disability and unemployment insurance requirements;
(ii) ensuring that the health status of each consumer directed personal assistant is assessed prior to service delivery pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation;
(iii) maintaining personnel records for each consumer directed personal assistant, including time sheets and other documentation needed for wages and benefit processing and a copy of the medical documentation required pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation;
(iv) maintaining records for each consumer including copies of the social services district's authorization or reauthorization;
(v) monitoring the consumer's or, if applicable, the consumer's designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the social services district of any circumstance that may affect the consumer's or, if applicable, the consumer's designated representative's ability to fulfill such responsibilities;
(vi) complying with the department's regulations at 18 NYCRR § 504.3, or any successor regulation, that specify the responsibilities of providers enrolled in the medical assistance program;
(vii) entering into a contract with the social services district for the provision of fiscal intermediary services; and
(viii) entering into a department approved memorandum of understanding with the consumer that describes the parties' responsibilities under the consumer directed personal assistance program.

(2) Fiscal intermediaries are not responsible for fulfilling responsibilities of the consumer or, if applicable, the consumer's designated representative. Nothing in this section shall diminish, however, the fiscal intermediary's failure to exercise reasonable care in properly carrying out its responsibilities under the program.
(j) Payment. (1) The department will pay fiscal intermediaries that are enrolled as Medicaid providers and have contracts with social services districts for the provision of consumer directed personal assistance services at rates that the department establishes and that the Director of the Division of the Budget approves, except as provided in paragraph (2) of this subdivision.
(2) A social services district may submit a written request to the department to use an alternative payment methodology. The request must describe the alternative payment methodology that the district will use to determine payments to fiscal intermediaries for consumer directed personal assistance services and include such other information as the department may require. The department may grant a district's exemption request when it determines that the alternative payment methodology is based on the fiscal intermediary's allowable costs of providing consumer directed personal assistance services and includes an adjustment for inflationary increases in the fiscal intermediary's costs of doing business.
(3) No payment to the fiscal intermediary will be made for authorized services unless the fiscal intermediary's claim is supported by documentation of the time spent in provision of services for each consumer.
(k) This subdivision sets forth expedited procedures for social services districts' determinations of medical assistance ("Medicaid") eligibility and consumer directed personal assistance eligibility for Medicaid applicants with an immediate need for consumer directed personal assistance.
(1) The following definitions apply to this subdivision:
(i) A Medicaid applicant with an immediate need for consumer directed personal assistance means an individual seeking Medicaid coverage who:
(a)(1) is not currently authorized for Medicaid coverage; or
(2) is currently authorized for Medicaid coverage only for community-based coverage without long-term care services; and
(b) provides to the social services district:
(1) a physician's order for consumer directed personal assistance; and
(2) a signed attestation on a form required by the Department that the applicant has an immediate need for consumer directed personal assistance ("attestation of immediate need") and that:
(i) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the applicant;
(ii) no home care services agency is providing needed assistance to the applicant;
(iii) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet, or cannot meet, the applicant's need for assistance; and
(iv) third party insurance or Medicare benefits are not available to pay for needed assistance.
(ii) A complete Medicaid application means a signed Medicaid application and all documentation necessary for the social services district to determine the applicant's Medicaid eligibility. For purposes of this subdivision, an applicant who would otherwise be required to document accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts. After the determination of Medicaid eligibility, if

the commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district must request documentation adequate to verify such resources.

(2) The social services district must determine whether the applicant has submitted a complete Medicaid application. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation.

(i) When the applicant submits the Medicaid application together with the physician's order and the signed attestation of immediate need, the district must provide such notice as soon as possible and no later than four calendar days after receipt of these documents.

(ii) When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation of immediate need, or both such documents, the district must provide such notice as soon as possible and no later than four calendar days after receipt of both the physician's order and the signed attestation of immediate need.

(3) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for consumer directed personal assistance, but no later than seven calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must determine whether the applicant is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the applicant of such determination.

(4) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for consumer directed personal assistance, but no later than twelve calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must:

(i) obtain or complete a social assessment and a nursing assessment pursuant to paragraphs (d)(2) and (d)(3) of this subdivision; and

(ii) determine whether the applicant, if determined eligible for Medicaid, would be eligible for consumer directed personal assistance and, if so, the amount and duration of the consumer directed personal assistance that would be authorized should the applicant be determined eligible for Medicaid; provided, however, that consumer directed personal assistance shall be authorized only for applicants who are determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services. In no event shall consumer directed personal assistance be authorized for a Medicaid applicant unless the applicant has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

(5) Social services districts must provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility determination and consumer directed personal assistance assessment procedures set forth in this subdivision as the Department may require.

(l) This subdivision sets forth expedited consumer directed personal assistance assessment procedures for medical assistance ("Medicaid") recipients with an immediate need for consumer directed personal assistance.

(1) A Medicaid recipient with an immediate need for consumer directed personal assistance means an individual seeking consumer directed personal assistance who:

(i)(a) is exempt or excluded from enrollment in a managed long term care plan operating pursuant to Section 4403-f of the Public Health Law or a managed care provider operating pursuant to Section 364-j of the Social Services Law; or
(b) is not exempt or excluded from enrollment in a plan or provider described in clause (i)(a) but is not yet enrolled in any such plan or provider; and
(ii)(a) was a Medicaid applicant with an immediate need for consumer directed personal assistance pursuant to subdivision (k) of this section who was determined, pursuant to such subdivision, to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who was also determined pursuant to such subdivision to be eligible for consumer directed personal assistance; or
(b) is a Medicaid recipient who has been determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district:
(1) a physician's order for consumer directed personal assistance; and
(2) a signed attestation on a form required by the Department that the recipient has an immediate need for consumer directed personal assistance ("attestation of immediate need") and that:
(i) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the recipient;
(ii) no home care services agency is providing needed assistance to the recipient;
(iii) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet, or cannot meet, the recipient's need for assistance; and
(iv) third party insurance or Medicare benefits are not available to pay for needed assistance.
(2) With regard to a Medicaid recipient with an immediate need for consumer directed personal assistance who is described in clause (1)(ii)(a) of this subdivision, the social services district must promptly notify the recipient of the amount and duration of consumer directed personal assistance to be authorized and issue an authorization for, and arrange for the provision of, such consumer directed personal assistance, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize consumer directed personal assistance to be provided until such recipients are enrolled in such a plan or provider.
(3)(i) With regard to a Medicaid recipient with an immediate need for consumer directed personal assistance who is described in clause (1)(ii)(b) of this subdivision, the social services district, as soon as possible after receipt of the physician's order and signed attestation of immediate need, but no later than twelve calendar days after receipt of such documentation, must:
(a) obtain or complete a social assessment and a nursing assessment pursuant to paragraphs (d)(2) and (d)(3) of this subdivision; and
(b) determine whether the recipient is eligible for consumer directed personal assistance and, if so, the amount and duration of consumer directed personal assistance to be authorized.
(ii) The social services district must promptly notify the recipient of the amount and duration of consumer directed personal assistance to be authorized and issue an authorization for, and arrange for the provision of, such consumer directed personal assistance, which must be provided as expeditiously as possible. With regard to those recipients who are neither exempt nor

excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize consumer directed personal assistance to be provided until such recipients are enrolled in such a plan or provider.
(4) Social services districts must provide Medicaid recipients with the required attestation of immediate need form and such other information regarding the expedited consumer directed personal assistance assessment procedures set forth in this subdivision as the Department may require.

DISCUSSION

The record in this case establishes that the Appellant, [redacted], has been in receipt of a Consumer Directed Personal Assistance Services (CDPAS) authorization from a Managed Long-Term Care Plan, Centers Plan for Healthy Living (hereinafter the "Plan"), in the amount of 12 hours per day, 7 days per week. The Appellant's Representative requested an increase in the Appellant's CDPAS authorization to 24 hour split/shift.

On November 13, 2017, and March 14, 2018, a nursing assessor completed uniform assessment system evaluations of the Appellant's personal care needs. By notice dated April 6, 2018, the Plan determined not to increase and to continue to provide the Appellant with a Personal Care Services authorization in the amount of 12 hours per day, 7 days per week. On April 11, 2018, the Appellant's Representative requested a standard appeal. By notice dated May 14, 2018, the Plan determined to partially overturn its determination not to increase the Appellant's Personal Care Services authorization. The Plan determined to change the Appellant's Personal Care Services authorizations from 12 hours, 7 days a week to 24 hour live-in, 7 days a week.

18 NYCRR 505.14(a)(2) provides a definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

At the hearing, the Appellant's Representative testified that she and her sister provide personal care services to the Appellant, their grandmother. She testified that two others, also provide personal care services for the Appellant. She testified that the Appellant is incontinent; has fallen as recently as May 14, 2018; she wanders, she cooks at night, she has fallen out of her bed; and she uses a cane. According to the Agency's records, the Appellant has been diagnosed with advanced [redacted].

The May 14, 2018 notice states in relevant part that the "UAS_NY of 3/14/18 as well as the neurological evaluation of 1/29/2018 were reviewed and the following noted: 1) you have severe cognitive impairment and you rarely make decisions. You smoke a pack of cigarettes daily, and do not smoke safely due to cognitive impairment. You were noted to have some [redacted] features and is on [redacted] twice daily. You have frequent wandering behavior; 2) you are totally dependent for meal preparation, shopping, housework, and finances; 3) you require maximal assistance for transportation, stairs, medications, bathing, hygiene, dressing upper and lower body and toilet use; 4) you are frequently [redacted]. There is no skin breakdown; 5) you walk 150-299 feet with assistance; 6) There were no falls or hospitalization in the preceding 90 days."

The evidence has been considered. The Plan agrees that the Appellant needs assistance with activities of daily living and independent activities of daily living to such an extent that they partially reversed their denial and will authorize personal care services in the amount of 24 hour live-in, 7 days a week. At the hearing, the Appellant's Representative agreed to accept personal care services authorization in the amount of 24 hour live in, 7 days a week.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination dated April 6, 2018, not to increase and to continue to provide the Appellant with a Personal Care Services authorization in the amount of 84 hours weekly (12 hours daily, 7 days weekly) is not correct and is reversed.

1. The Managed Long-Term Care Plan is directed to provide the Appellant with an increased Personal Care Services authorization in the amount of 24 hour live-in, 7 days a week.

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

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

DATED: Albany, New York
07/11/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee