STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 9, 2016
[redacted]
AGENCY: MAP
FH #: 7377197K

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 July 3, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

On papers only- Centers Plan for Healthy Living appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 84 per week (12 hours daily, 7 days weekly) to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide, correct?

FACT FINDINGS

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

1. The Appellant, age 59, has been enrolled in a Managed Long Term Care Program and has received care and services, including Personal Care Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. The Appellant has been authorized to receive Personal Care Services in the amount of 84 hours weekly, provided under a task-based plan of care (12 hours daily, 7 days weekly).

3. The Appellant requested an increase in Personal Care Aide hours from 84 hours per week to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide.

4. By notice dated August 11, 2016, Centers Plan for Healthy Living, denied the Appellant's request for increase because, "…the health care service is not medically necessary."

5. On September 9, 2016, the Appellant requested this fair hearing to contest the Managed Long Term Care Plan's determination.

6. On February 27, 2017, Centers Plan for Healthy Living, approved Appellant's request and increased Personal Care Aide to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide.

APPLICABLE LAW

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(3) your public assistance, medical assistance, SNAP or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

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

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

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

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

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

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

(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....

DISCUSSION

The hearing record establishes that Appellant has been authorized to receive Personal Care Services in the amount of 84 hours weekly, provided under a task-based plan of care (12 hours daily, 7 days weekly). The hearing record further establishes that Appellant requested an increase in Personal Care Services from 84 hours per week to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide. By notice dated August 9, 2016, Centers Plan for Healthy Living denied the Appellant's request for increase because, "…the health care service is not medically necessary."

However, on February 27, 2017, Centers Plan for Healthy Living, approved Appellant's request and increased Personal Care Aide to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide. Accordingly, since the Appellant's request for an increase in her Personal Care Services from 84 hours weekly, (12 hours daily, 7 days weekly) has been approved, the issue of the August 9, 2016 determination to deny the Appellant's request has become moot.

DECISION

With regard to the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 84 per week (12 hours daily, 7 days weekly) to 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide, there is no issue to be decided by the Commissioner of the New York State Department of Health.

DATED: Albany, New York
07/17/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee