STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 10, 2016
[redacted]
AGENCY: MAP
FH #: 7240934P

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 July 7, 2016, 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

Jillian Hinkson, Grievance & Appeals Manager

ISSUE

Was the Managed Long Term Care Plan's determination related to rehabilitation-related services provided to the Appellant in a Residential Health Care Facility (RHCF), and concerning a request for continued rehabilitation-related services for December 10, 2015 to January 15, 2016 correct?

FINDINGS OF FACT

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

1. The Appellant, age 53, has been in receipt of Medicaid for herself.

2. Until March 1, 2016, Appellant had been enrolled in Medicaid Managed Long Term Care with Centers Plan for Healthy Living as her designated Plan.

3. During the period from October 29, 2015 to May 27, 2016, the Appellant was a resident of a residential health care facility, [redacted], where Appellant was receiving rehabilitative treatment.

4. The residential health care facility, on behalf of Appellant, had asked the Plan for approval of a rehabilitative stay for periods when combined, lasted from October 29, 2015 through December 9, 2015, and the Plan granted the prior approval requests for Appellant.

5. By Notice of Adverse Determination dated January 15, 2016, the Plan advised the Appellant as follows, effective January 15, 2016, the date of the notice, "….your ongoing physical support needs could have been met at a lower level of care as of 12/09/15. Continuation of…care beyond 12/09/15 was not medically necessary and the request to retrospectively approve your continued…stay beyond 12/09/15 must, therefore, be denied. "

6. On February 10, 2016, this fair hearing was requested on behalf of Appellant.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

> 2. "Medical Assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized by this title or the regulations..., which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for…

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title…

Public Health Law Section 4403-f provides in pertinent part as follows concerning eligibility for managed long term care:

1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care

services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

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(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care and acute care if so authorized.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to the 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.

Federal Regulations (Title 42) state, in pertinent part:

§ 438.210 Coverage and authorization of services.

(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 § 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…

(c) ***Notice of adverse action***. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

(d) ***Timeframe for decisions.*** Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—
(i) The enrollee, or the provider, requests extension; or
(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
(2) *Expedited authorization decisions.*
(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

§438.404 Notice of action.

(a) ***Language and format requirements.*** The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.

(b) ***Content of notice.*** The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) ***Timing of notice.*** The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

§431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

§431.213 Exceptions from advance notice.

The agency may send a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a beneficiary;

(b) The agency receives a clear written statement signed by a beneficiary that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;

(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);
(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the beneficiary's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.
The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
(b) The facts have been verified, if possible, through secondary sources.

18 NYCRR 360-10.8(e)(2)(i)(f)(11) provides, in part, that:

(e) Notices
…
(2) An MMCO or its management contractor shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever a notice of action is issued. For the purposes of this paragraph, *MMCO* means an HMO, PHSP or HIV SNP. A notice of action that sets forth all of the information required by subparagraph (i) of this paragraph will be considered an adequate notice for the purposes of section 358-2.2 of this Title.

(i) The notice of action shall include:
…
(f) the enrollee's right to a fair hearing and the procedures for exercising this right, including:
…
(11) if an MMCO or its management contractor has determined to reduce, suspend, or terminate a service or benefit currently authorized: the circumstances under which the enrollee's benefits will be continued unchanged; how to request that benefits be continued; explanation that a request for an MMCO appeal is not a request for the enrollee to have benefits continue; and the circumstances under which the enrollee may be required to pay the costs of continued services. Such notice shall be issued within the timeframes required by federal regulations at 42 CFR 438.404(c)(1) and sections 358-2.23, 358-3.3(a)(1), and 358-3.3(d)(1) of this Title.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- when the agency action or proposed action is a reduction, discontinuance, restriction or suspension of public assistance, medical assistance, SNAP benefits or services, the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued; that a fair hearing must be requested separately from a conference; and a statement that when only an agency

conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services; and that participation in an agency conference does not affect the right to request a fair hearing;

- a statement that a fair hearing must be requested separately from a conference;
- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;
- a statement that participation in an agency conference does not affect the right to request a fair hearing;
- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;
- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;
- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;
- the right to present written and oral evidence at the hearing;
- the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;
- information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and
- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

18 NYCRR 360-6.5 states:

Fair hearing requirements in utilization review cases.

When a utilization review committee determines that MA payments should be reduced or discontinued, the following steps must be taken:

(a) If the recipient is in a long-term care facility (a skilled nursing facility, intermediate care facility or mental hospital) or is a chronic care patient in a general hospital facility:

(1) The recipient, his/her representative, or an appropriate relative must be notified of the action in writing by the utilization review committee. The notice must be notified of the action in writing by the utilization review committee. The notice must be both timely and adequate as defined in Part 358 of this Title. The notice and action must be consistent with both State and Federal requirements on utilization review.

(2) If the recipient requests a fair hearing before the effective date of the action, payment for the recipient's care in a long-term care facility or for long-term care in a general hospital will be continued until the fair hearing decision is rendered.

(b) If the recipient is in a general hospital, but not receiving chronic care services:

(1) The recipient, his/her representative, or an appropriate relative must be notified of the action in writing by the utilization review committee. The notice must be adequate, as defined in Part 358 of this Title. The notice and action must be consistent with both State and Federal requirements on utilization review.

(2) MA payments on behalf of the recipient will be terminated on the effective date of the utilization review committee determination.

(3) MA payments will not be continued on behalf of the recipient if the recipient requests a fair hearing to contest a determination that hospitalization is no longer necessary.

(c) All provisions of Part 358 of this Title which are not inconsistent with subdivisions (a) and (b) of this section apply to utilization review committee determinations.

Social Services Law section 365-a states, in part, that “standard coverage” under Medical Assistance shall include:

care, treatment, maintenance and nursing services in hospitals, nursing homes that qualify as providers in the medicare program pursuant to title XVIII of the federal social security act, infirmaries or other eligible medical institutions, and health-related care and services in intermediate care facilities, while operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provision thereof requiring an operating certificate or license, or where such facilities are not conveniently accessible, in hospitals located without the state.

18 NYCRR section 505.11 provides that the Medical Assistance Program includes rehabilitation services. With limited exceptions, provision of such services requires the written part of a physician that forms part of a comprehensive medical care program.

Regulation 504.1 defines a provider as:

> any person who has enrolled under the Medical Assistance program to furnish medical care, services or supplies; or to arrange for the furnishing of such care, services or supplies; or to submit claims for such care, services or supplies for or on behalf of another person.

Regulation 504.3 provides in relevant portion:

By enrolling, the provider agrees:

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> (c) to accept payment from the Medical Assistance program as payment in full for all care, services and supplies billed under the program, except where specifically provided in law to the contrary.

Regulation 515.2 is entitled "unacceptable practices under the medical assistance program."

Subsection 515.2(b) defines an "unacceptable practice" as conduct which constitutes fraud or abuse and includes the practices specifically enumerated in this subdivision [including]:

> (8) Seeking or accepting any gift, money, donation or other consideration in addition to the amount paid or payable under the program for any medical care, services or supplies for which a claim is made.

Regulation 358-5.9(a) provides:

> At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, Supplemental Nutrition Assistance Program (SNAP) benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of public assistance, medical assistance, SNAP benefits or services, the social services agency must establish that its actions were correct.

DISCUSSION

The record in this case establishes that until March 1, 2016, Appellant had been enrolled in Medicaid Managed Long Term Care with Centers Plan for Healthy Living as her designated Plan. The residential health care facility, on behalf of Appellant, had asked the Plan for approval of a rehabilitative stay for periods when combined, lasted from October 29, 2015 through December 9, 2015 and the Plan approved the prior requests for Appellant. By Notice of Adverse Determination dated January 15, 2016, the Plan advised the Appellant that, effective

January 15, 2016, the date of the notice, "….your ongoing physical support needs could have been met at a lower level of care as of 12/9/15. Continuation of…care beyond 12/09/15 was not medically necessary and the request to retrospectively approve your continued…stay beyond 12/9/15 must, therefore, be denied. " This hearing was requested on behalf of Appellant for review.

At the hearing, Appellant's attorney argued that the Agency's January 15, 2016 Notice denying continued service was, in effect, a notice to discontinue ongoing services. This implies that the notice was inadequate, since it did not properly label itself a Notice of Intent to discontinue services, and did not list an effective date at least ten days in the future, as required by timeliness regulations found at 18 NYCRR section 358-2.2.

The defects in the January 15, 2016 notice have consequences with regard to whether or not the Plan's determination can be upheld. Pursuant to State Regulations at 18 NYCRR 360-6.5, a recipient must be notified of any utilization review action to reduce or discontinue Medicaid payments and such notice must be both timely and adequate as defined in Part 358 of this Title, when the recipient is in a long-term care facility such as skilled nursing facility or intermediate care facility. Notably, this State Regulation does not differentiate between the length of stay (short-term versus long-term) at such facility and indicates that, as long as the recipient is "in" such facility at the time the determination to discontinue coverage is made, a timely and adequate notice of such action must be provided to the recipient. It is undisputed that at the time the Plan rendered the subject determination of January 15, 2016, the Appellant was "in" such facility, thus necessitating that a notice advising the Appellant of the Plan's action to discontinue coverage of the Appellant's continued stay at the facility be both timely and adequate.

Accordingly, it is found that the Plan's determination of January 15, 2016 constitutes a discontinuance of coverage of the Appellant's ongoing stay and treatment at the residential health care facility/skilled nursing facility. It is further found that the Plan's notice of such action was required to be both timely and adequate. Review of the notice demonstrates that it was not mailed at least ten days prior to the effective date of the proposed action. See Federal Regulations at §438.404 and §431.211 and State Regulations at 18 NYCRR 358-2.23 and 18 NYCRR 360-10.8. Review of the notice further demonstrates that it does not correctly identify the action taken, as it refers to the Plan's subject action as a "denial" as opposed to a "discontinuance" of the service in question. The above defects in the Plan's notice render the Plan's determination void.

It is noted that a reasonable time period should be provided for the MLTC Plan to comply with this hearing decision. Thereafter, the RHCF may bill the MLTC Plan.

It is further noted that the manner in which Medicaid pays for inpatient rehabilitation services in this situation is to pay the MLTC Plan a capitation payment, which has been done, and for the MLTC Plan to thereafter pay the provider of medical care and services. The RHCF having been advised that Appellant is a Medicaid recipient, it is not permitted to recover the cost

of care directly from the Appellant. See, e.g., 18 NYCRR section 515.2; July 2007 "Medicaid Update" publication of the New York State Department of Health.

DECISION AND ORDER

The Managed Long Term Care Plan's determination related to rehabilitation-related services provided to the Appellant in a Residential Health Care Facility (RHCF), and concerning a request for continued rehabilitation-related services for December 10, 2015 through January 15, 2016 was not correct and is reversed.

1. The Managed Long-Term Care Plan in which Appellant was enrolled during the period in question is directed to authorize rehabilitation-related services for the Appellant in the RHCF for the period December 10, 2015 to January 15, 2016.

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

DATED: Albany, New York
08/24/2016

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee