STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 21, 2017
[redacted]
AGENCY: MAP
FH #: 7518930Z

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 2, 2017, 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

No appearance by the Plan

ISSUE

Has the Managed Long Term Care plan, Centers Plan for Healthy Living, acted correctly with respect to its April 19, 2017, determination to reduce the Appellant's Personal Care Services from 24-hour daily "live in" services to forty-five and one half (45.5) hours per week (6.5 hours per day x 7 days), pursuant to a task-based services plan?

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 ninety-two, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long Term Care plan with Centers Plan for Healthy Living.

2. The Appellant has been in receipt of an authorization of Personal Care services in the amount of 24-hour daily "live-In" services.

3. On April 19, 2017, the Plan sent to the Appellant a written Initial Adverse Determination which advises the Appellant of the plan's intention to change the personal care services authorization in order to reduce the Appellant's personal care services from 24-hour daily "live in" services to forty-five and one half (45.5) hours per week (6.5 hours per day x 7 days), pursuant to a task-based services on the grounds that continuation of "live-in" services is not medically necessary.

4. On April 21, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

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.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

e. Terminations and Reductions…

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care

services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

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....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and,

when applicable, each PIHP and PAHP meets the requirements of this section.

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the

type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.404(b) of 42 CFR Subpart F provides in part:

(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...

DISCUSSION

The evidence in this matter establishes that the Long Term Managed Care plan in which the Appellant is enrolled, Centers Plan for Healthy Living, sent to the Appellant a written notice which is dated April 19, 2017. and which is entitled "Initial Adverse Determination. The record also establishes that this written notice advises the Appellant that the plan was changing her personal care services authorization in order to reduce her personal care services from 24-hour daily "live in" services to forty-five and one half (45.5) hours per week (6.5 hours per day x 7 days), pursuant to a task-based services and that the reason for this action is the Plan's determination that there is no medical necessity for continuation of "live-in" level of services.

Centers Plan for Healthy Living was duly notified of the date, time and location of the hearing as well as the issue (s) to be addressed at the hearing. The Plan, however, did not appear at the hearing nor did the plan request a waiver of personal appearance at the hearing in lieu of presenting written documentation (waiver packet) regarding the aforesaid April 19, 2017, determination. It is noted that this matter was originally scheduled for a fair hearing to be conducted on May 16, 2017, and that the hearing was specifically adjourned (due to need for interpreter services) and rescheduled to June 2, 2017, 9:30 am, and that the Plan's representative who appeared on May 16, 2017, had been provided with the date and time of the adjourned, rescheduled, fair hearing in this matter.

With respect to the April 19, 2017. determination by Centers Plan for Healthy Living, to reduce the Appellant's personal care services based upon a determination of lack of medical necessary, the plan failed to meet its obligations under 18 NYCRR 358-4.3(b) and failed to establish that its determination was correct pursuant to 18 NYCRR 358-5.9(a).

DECISION AND ORDER

The April 19, 2017, determination to reduce the Appellant's Personal Care Services from 24-hour daily "live in" services to forty-five and one half (45.5) hours per week (6.5 hours per day x 7 days), pursuant to a task-based services plan, on the grounds that the health care service is not medically necessary is not correct and is reversed.

Centers Plan for Healthy Living is directed to:

1. Take no further action upon its April 19, 2017, Initial Adverse Determination and to immediately restore the authorization of personal care services to 24-hour daily "live-in" services and continue same unchanged.

Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Managed Long Term Care plan, Centers Plan for Healthy Living, must comply immediately with the directives set forth above.

DATED: Albany, New York
06/06/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee