

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 12, 2017

AGENCY: MAP
FH #: 7513094N

In the Matter of the Appeal of	:
	: 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 October 16, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



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

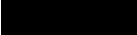
Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the April 3, 2017 determination by the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to discontinue the Appellant's home delivered meals, 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 79, has been in receipt of authorization for Medical Assistance and is enrolled in Medicaid managed long term care plan operated by Centers Plan for Healthy Living ("Centers Plan").
2. By notice dated April 3, 2017, Centers Plan notified Appellant that it would no longer pay for home delivered meals provided by "'s Restaurant," because restaurant

FH# 7513094N

meals are not a covered benefit, and because the Appellant is in receipt of personal care services of 12 hours per day, seven days per week, during which time the personal care assistant could provide meals for the Appellant.

3. On April 12, the Appellant requested this fair hearing to review the April 3, 2017 determination.

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 Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

A recipient of Public Assistance, Medical Assistance or 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). .

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:

- o for reductions, the previous and new amounts of assistance or benefits provided;
- o the effective date of the action;
- o the specific reasons for the action;
- o the specific laws and/or regulations upon which the action is based;
- o the recipient's right to request an agency conference and fair hearing;

FH# 7513094N

- o 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;
- o 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;
- o 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;
- o the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued;
- o a statement that a fair hearing must be requested separately from a conference;
- o 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;
- o a statement that participation in an agency conference does not affect the right to request a fair hearing;
- o 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;
- o 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;
- o 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;
- o the right to present written and oral evidence at the hearing;
- o the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;
- o information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and
- o 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.

FH# 7513094N

18 NYCRR 358-2.2

Appendix G of the New York State Managed Long-Term Care Partial Capitation Model Contract (the “Model Contract”) notes that home-delivered or congregate meals, when provided by a Managed Long-Term Care Plan, are covered by the Plan’s capitation payment, as a service provided through an enrollee’s plan of care devised by Care Management based upon the individual enrollee’s needs.

Pursuant to Appendix G, Social and environmental supports may be provided through care management. Care management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

- (1) All patients receiving personal care services must be provided with case management services according to this subdivision...
- (3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section....

monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

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....

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

- (a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.
- (b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
 - (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.
 - (3) Are adopted in consultation with contracting health care professionals.
 - (4) Are reviewed and updated periodically as appropriate.
- (c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
- (d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

- (a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
 - (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not

acted upon promptly.

- (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
 - (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- (b) Definitions. As used in this subpart, the following terms have the indicated meanings:
- In the case of an MCO or PIHP-“Action” means--
- (1) The denial or limited authorization of a requested service, including the type or level of service;
 - (2) The reduction, suspension, or termination of a previously authorized service;
 - (3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 438.406 of 42 CFR Subpart F provides in part:

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

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

(2) Acknowledge receipt of each grievance and appeal.

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

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

and

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

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

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

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

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

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

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

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

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

(i) The enrollee and his or her representative;

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

FH# 7513094N

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.
3. The Contractor agrees to allow each Enrollee the Choice of Participating Provider of covered service to the extent possible and appropriate.
4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.

FH# 7513094N

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

This Section further provides:

Contents of the Notice of Action

Any notice we send to you about an action will:

- ☐ Explain the action we have taken or intend to take;
- ☐ Cite the reasons for the action, including the clinical rationale, if any;
- ☐ Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- ☐ Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- ☐ Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- ☐ Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

Appendix K of the Managed Long Term Care Contract discusses grievance procedures, appeals, and fair hearing rights.

A. Grievances

Grievance – An expression of dissatisfaction by the member or provider on member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service.

A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

Grievances that can be immediately (same day) decided to the member's satisfaction do not need to be responded to in writing. Plans are required to document the grievance and decision, and log and track the grievance and decision for quality improvement purposes. If the grievance cannot be decided immediately (same day), the plan must decide if grievance is expedited or standard. Expedited Grievance – the plan determines or the provider indicates that a delay would seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function. A member may also request an expedited review of a grievance.

Expedited and Standard Grievances

1. Plan must send written acknowledgement of grievance within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with the notice of decision (one notice).
2. Must be decided as fast as member's condition requires, but no more than:
 - a. Expedited: 48 hours from receipt of all necessary information, but no more than 7 calendar days from the receipt of the grievance.
 - b. Standard: 45 calendar days from receipt of all necessary information, but no more than 60 calendar days from receipt of the grievance.
3. Up to 14 calendar day extension. Extension may be requested by member or provider on member's behalf (written or verbal). Plan may also initiate extension if it can justify need for additional information and if extension is in member's interest. In all cases, extensions must be well documented.
4. Plan must notify the member of decision by phone for expedited grievances and provide written notice of decision within 3 business days of decision (expedited and standard).

DISCUSSION

The record establishes that the Appellant requested this hearing to review an April 3, 2017 determination by her Medicaid managed long term care plan, Centers Plan for Healthy Living ("Centers Plan") to no longer pay for home delivered meals provided by "[REDACTED]". The April 3, 2017 notice indicated that restaurant meals are not a covered benefit, and because the Appellant is in receipt of personal care services of 12 hours per day, seven days per week, the personal care assistant could provide meals for the Appellant.

There is no dispute between the parties that the Appellant had previously been enrolled in a Medicaid managed long term care plan operated by "[REDACTED]", where she was authorized to receive meals delivered by "[REDACTED]". Center Plan's representative stated that they continued to authorize meal delivery from this source after Appellant's transition from "[REDACTED]", however, as this restaurant is not one of their vendors, they notified Appellant that they would no longer pay for meals from this restaurant. Thus, the record reflects this is a "discontinuance" of services, rather than a "denial," as indicated in the April 3, 2017 notice.

The Regulations provide that a recipient of Medical Assistance or 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). Further, pursuant to 18 NYCRR 358-2.2, an adequate notice sets forth the specific action to be taken, and should include, among other things, the specific laws and/or regulations upon which the action is based. In this case, however, Centers Plan has mis-characterized a "discontinuance" of services as a "denial", and the notice does not contain the specific laws and/or regulations upon which the action is based. These defects render the notice fatally defective. In addition, the April 3, 2017 notice is retroactively effective as of February 1, 2017, in violation of timely notice requirements pursuant to 18 NYCRR 358-2.23. Based on the foregoing, the April 3, 2017 notice cannot be sustained.

It is noted that the Centers Plan representative stated that meal delivery from "[REDACTED]" would no longer be authorized, but that the Appellant is still authorized to receive 14 home delivered meals per week from one of its vendors, which to this point, the Appellant has refused (The representative's testimony and the content of the notice at issue are not totally consistent). In response, the Appellant stated that she did not like the food provided by Centers Plan's vendors, and stated the food was not delivered hot; she stated that she likes the food from "[REDACTED]" and that they deliver hot food. The Appellant stated that she does not use microwave ovens to heat food, expressing food safety concerns. The Appellant is advised that dissatisfaction with administration of an authorized service constitutes a "grievance", as described in the Managed Long-Term Care Model Contract, rather than a "denial" or "discontinuance" of services. As noted further in the Model Contract, no fair hearing rights are attached to dissatisfaction with a grievance or a grievance appeal.

DECISION AND ORDER

The April 3, 2017 determination by the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to discontinue the Appellant's home delivered meals was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Cancel the notice dated April 3, 2017 and take no action thereon.
2. Notify the Appellant, in writing, of compliance with this Decision.

In the event Centers Plan for Healthy Living determines to implement its previously contemplated action, it is directed to issue a new Notice of Intent that meets regulatory requirements and to produce the required case record at any subsequent fair hearing.

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 promptly to facilitate such compliance.

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

DATED: Albany, New York
11/09/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee