STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 18, 2017
[redacted]
AGENCY: MAP
FH #: 7516912Y

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 29, 2017, 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)

No appearance by Centers Plan For Healthy Living

ISSUE

Was Centers Plan For Healthy Living determination to reduce the Appellant's hours of Personal Care Services without notice 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, who is [redacted], receives Personal Care Services from Centers Plan For Healthy Living.

2. Effective May 2017, Centers Plan For Healthy Living reduced the Appellant's hours of Personal Care Services without notice.

3. On April 18, 2017, 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.

(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...

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.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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i. Personal care services includes some or total assistance with:
    1. Level I functions as follows:
        a. Making and changing beds ;
        b. Dusting and vacuuming the rooms which the member uses;
        c. Light cleaning of the kitchen, bedroom and bathroom;
        d. Dishwashing;
        e. Listing needed supplies;
        f. Shopping for the member if no other arrangements are possible;
        g. Member's laundering, including necessary ironing and mending;
        h. Payment of bills and other essential errands; and
        i. Preparing meals, including simple modified diets.
    2. Level II personal care services include Level I functions listed above and the following personal care functions:
        a. Bathing of the member in the bed, the tub or the shower;
        b. Dressing;
        c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
f. Transferring from bed to chair or wheelchair;
g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
h. Feeding
i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
j. Providing routine skin care;
k. Using medical supplies and equipment such as walkers and wheelchairs; and
l. Changing of simple dressings.

Regulations at 18 NYCRR 358-3.3(a) provide that a recipient of Public Assistance, Medical Assistance or services has a right to notice when the agency:

(i) proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance authorization or services; or

(iv) determines to restrict a Medical Assistance authorization.

(viii) denies an application for an exemption from or an increase in a Medical Assistance utilization threshold and the recipient has reached such utilization threshold.

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. The Centers Plan For Healthy Living must provide complete copies of its documentary evidence to the hearing officer at the hearing and also to the Appellant or representative where such documents were not otherwise provided in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). Unless a waiver of appearance is approved by the Office of Administrative Hearings, a representative of the Centers Plan For Healthy Living 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. If a waiver has been approved, the hearing officer may require the Centers Plan For Healthy Living's appearance if necessary to protect the appellant's due process rights. 18 NYCRR 358-4.3(b) and (c). In fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical

Assistance, SNAP benefits or services, the Centers Plan For Healthy Living must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The uncontroverted evidence establishes that effective May 2017 Centers Plan For Healthy Living, without sending any notice, reduced the Appellant's hours of Personal Care Services.

Centers Plan For Healthy Living' failure to give timely and adequate notice of its proposed actions violates State Regulations at 18 NYCRR 358-3.3(a).

DECISION AND ORDER

The determination of Centers Plan For Healthy Living to reduce the Appellant's hours of Personal Care Services without notice is not correct and is reversed.

1. Centers Plan For Healthy Living is directed to restore the Appellant's hours of Personal Care Services retroactive to the date the Appellant's Personal Care Services were reduced

Should Centers Plan For Healthy Living in the future determine to implement its previous action, it is directed to procure and review the Appellant's case record with respect to a determination relating to the Appellant's Medical Assistance benefits, to issue a new Notice of Intent and to produce the required case record(s) 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 to Centers Plan For Healthy Living 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.

FH# 7516912Y

DATED: Albany, New York
07/28/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee