**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** October 3, 2017
[redacted]
**AGENCY:** MAP
**FH #:** 7621304Q

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 November 28, 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, Visiting Nurse Service Choice (VNSC)

On papers only - Agency appearance waived by the Office of Administrative Hearings

## ISSUE

Was the determination by VNS Choice, a Managed Long-Term Care Plan, to deny the Appellant's request for Adult Social Day Care services at an out of network provider, 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 84, was enrolled in a partially capitated Managed Long Term Care Plan operated by Visiting Nurse Service Choice (hereinafter, the "MLTC Plan"), from which Appellant or the provider, requested Appellant to receive Adult Social Day Care services one day per week from a Social Adult Day Care (SADC) that is not in network. The Appellant also receives Personal Care Services. The Appellant's Personal Care Services Authorization is not at issue in this hearing.

2. In or about August 2017, the MLTC Plan received a request for Appellant to attend one day a week a particular SADC that is not an in network provider, Center for Long Life in Queens.

3. By notice dated September 10, 2017, the MLTC Plan advised the Appellant of its determination to deny the Appellant's SADC "request for a SADC not in our network. The plan did not decide by the due date. The request is denied…. The plan can give you names of SADC that are in our network."

4. On October 3, 2017, the Appellant requested this fair hearing.

**APPLICABLE LAW**

Social Services Law section 365-a states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

> 2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, 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 of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and 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, . . .

* * *

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.

Appendix G of the partial capitation Managed Long-Term Care Model Contract states that Social Day Care is an included benefit.

9 NYCRR § 6654.20(a) defines a Social Adult Day Care Program as a structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include, and are not limited to, maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

Section 6654.20(e)(iv)(a) requires Social Adult Day Care programs to provide the following services: socialization, supervision and monitoring, personal care (some assistance with activities of daily living); and nutrition. These programs may also offer other services consistent with participant needs, including, but not limited to: (b) Optional services. Consistent with the needs of the participant, programs may provide the following services: (1) maintenance and enhancement of daily living skills: (2) Transportation between the home and the program; (3) Caregiver assistance; and (4) Case coordination and assistance.

Socialization is defined at 9 NYCRR 6654.20(d)(1)(iv)(a)(1) as follows:

> (i) means planned and structured activities which utilize the participant's skills to the extent possible; respond to the participant's interests, capabilities, and needs; and minimize any impairments in capacity to engage in those activities;
> (ii) includes social, intellectual, cultural, educational, and physical group activities; and
> (iii) encourages and stimulates the participant to interact with others and seeks to establish, maintain, or improve the participant's sense of usefulness to self and others, the desire to use his or her physical and mental capabilities to the fullest extent, and his or her sense of self-respect.

In fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

The law of Managed Long-Term Care contemplates that enrollees will make use of in-network providers.

The Managed Long-Term Care Partial Capitation Model Contract, at Chapter 5, provides, in part:

> The Contractor shall maintain and demonstrate to the Department’s satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through a network of contracted providers that meets the requirements in section D of Article VII of this Contract. The Contractor shall meet the standards required by 42 CFR 438.206 for availability

of services; 42 CFR 438.207 for assurances of adequate capacity; and applicable sections of PHL 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.

Chapter 7 of the just-referenced Contract provides, in part, at subsection A:

Pursuant to 42 CFR 438.206, the Contractor must maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible and being physically accessible according to the ADA standards.

**DISCUSSION**

The hearing record establishes that the Appellant, age 84, was enrolled in the VNS NY (VNS Choice) Managed Long Term Care Plan, from which Appellant or the provider, requested Appellant to receive Adult Social Day Care services one day per week from a Social Adult Day Care (SADC) that is not in network.

By notice dated September 10, 2017, the MLTC Plan advised the Appellant of its determination to deny the Appellant's SADC "request for a SADC not in our network. The plan did not decide by the due date. The request is denied…. The plan can give you names of SADC that are in our network."

Adult Social Day Care is most appropriate for individuals such as the Appellant who have moderate needs for assistance with activities of daily living, but who are socially-isolated and would benefit from attendance in such program as a cost-effective measure and a means of ameliorating quality of life in a protective setting (*see* 91 LCM-198 described above and 9 NYCRR 6654.20).

The Model Contract and applicable law require a Managed Care Plan member to utilize providers that are in network with the MLTC Plan to which the member belongs. In this case the MLTC Plan has in its Initial Adverse Determination in formed Appellant that "The plan can give you names of SADCs that are in our Network", however, the Appellant must contact the MLTC Plan to ask for the names of in network SADC providers. Appellant failed to establish that the particular Day Care locale participated in the VNS-NY network, and failed to establish any reason that it would be necessary to assign her to her chosen center rather than participating with one of the Day Care locales that in fact does participate with VNS-NY.

Upon review of the hearing record in its entirety, the Plan's determination is sustained.

It should be further noted that, according to a Statewide system called EMedNY, Appellant is no longer with VNS Choice as of January 1, 2018. Instead, she has been transferred over to the Centers Plan for Healthy Living partially capitated Managed Long-Term Care Plan. From now on, she should address any requests pertaining to Adult Social Day Care or other Plan-covered services to her new MLTC Plan.

**DECISION**

The determination by VNS Choice dated September 10, 2017 to deny the Appellant an authorization to attend a Social Adult Day Care Center that is not in network was correct.

DATED: Albany, New York
02/02/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee