
In the Matter of the Appeal of
[REDACTED]

from a determination by the New York City
Department of Social Services

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**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 August 17, 2012, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[REDACTED]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

For the Managed Long Term Care Plan ([REDACTED])

Dina Liberman RN, [REDACTED] Manager
Medeya Machavariani RN, [REDACTED] Witness

ISSUES

Is the issue of the correctness of a determination by the Appellant's Managed Long Term Care Provider regarding the amount of the Appellant's Personal Care Services authorization hearable?

Assuming that the issue is hearable, was the determination 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 89, has been in receipt of Medical Assistance benefits, and was receiving Certified Home Health Aide services in the amount of continuous 24 hour care by more than one personal care worker. The Appellant was informed that the Appellant's Certified Home Health Aide services would be discontinued because the Certified Home Health Aide agency was ceasing operations. The discontinuance of the Appellant's Certified Home Health Aide services was not an issue at the hearing.

2. Prior to the discontinuance of the Appellant's Certified Home Health Aide services, the Appellant requested enrollment into a Managed Long Term Care Plan, [REDACTED].

3. Prior to the enrollment of the Appellant into [REDACTED], the Appellant was verbally informed that [REDACTED]'s intended plan of care included Personal Care Services in the amount of live-in 24-hour personal care services.

4. On June 28, 2012, prior to the Appellant's enrollment in [REDACTED], and prior to issuance of a formal notice describing the Managed Long Term Care Plan's plan of care, the Appellant requested the present fair hearing.

5. The Appellant did not exhaust the Managed Long Term Care Provider's internal appeal process before she requested this fair hearing. On July 8, 2012, the Appellant signed a request to be voluntarily disenrolled from [REDACTED].

APPLICABLE LAW

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.

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

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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:

Action means-- In the case of an MCO or PIHP--

- (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 438.210 of 42 CFR Subpart D provides in 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.

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(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 Sec. 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.

(e) Compensation for utilization management activities. Each contract must provide that, consistent with Sec. 438.6(h), and Sec. 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

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; or

(ii) The legal representative of a deceased enrollee's estate.

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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.

Article V.A. of the Managed Long Term Care Contract provides in part:

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.

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.

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

1. GRIEVANCE SYSTEM REQUIREMENTS

The Grievance System regulations in Subpart F of 42 CFR Part 438 apply to both "expressions of dissatisfaction" by enrollees (grievances) and to requests for a review of an "action" (as defined in 438.400) by a managed long-term care plan (an appeal). For managed long-term care plans, the Grievance System processes identified in Subpart F have been

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combined with the grievance requirements in New York State Public Health Law (PHL) 4408-a and the utilization review and appeal requirements in Article 49 of the PHL.

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.

Grievance Appeal – Expedited and Standard

1. Plan must send written acknowledgement of grievance appeal within 15 business days of receipt of request. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with notice of decision (one notice).

2. Must be decided as fast as member’s condition requires, but no more than:

a. Expedited: 2 business days of receipt of all necessary information.

b. Standard: 30 business days receipt of necessary information.

3. Plan must provide written notice of decision. Notice must include reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

4. No further appeal.

Appendix J of the Managed Long Term Care Contract is titled “Definitions” and provides, part:

Action is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

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

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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.

Note: 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.

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

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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.

Section 358-3.1 of the Regulations provides in pertinent part:

Right to a fair hearing

- (a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

- (f) As an applicant or recipient you do not have the right to a fair hearing in all situations.

DISCUSSION

The record reveals that this case arose in the context of the ceasing of operations of the Appellant's Certified Home Health Aide agency, which caused the Appellant to seek other means for the provision of personal care. At the hearing, there was a dispute between the parties as to whether the Appellant had been informed at the time when the enrollment forms were signed in May of 2012 that the Managed Long Term Care Plan, [REDACTED], intended to provide Personal Care Services in the amount of live-in 24-hour personal care services rather than the continuous care which the Appellant had been receiving from the Certified Home Health Aide agency. It was undisputed at the hearing, however, that the Appellant requested this hearing before the enrollment in [REDACTED] actually was completed, and before the Appellant exhausted the Managed Long Term Care Provider's internal appeal process.

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."

The undisputed evidence at the hearing establishes that the Appellant did not exhaust the Managed Long Term Care Provider's internal appeal process before she requested this fair hearing. Based thereon, the application of law to uncontroverted facts establishes that the issue of the correctness of a determination by the Appellant's Managed Long Term Care Provider regarding the amount of the Appellant's Personal Care Services authorization is not hearable.

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DECISION

The determination by the Appellant's Managed Long Term Care Provider regarding the amount of the Appellant's Personal Care Services authorization is not subject to review by the Commissioner.

DATED: Albany, New York
08/29/2012

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "James J. Walter". The signature is written in a cursive style with a large initial "J".

Commissioner's Designee