The New Exhaustion Rules for Appeals in Medicaid Managed Care and MLTC
CLE - Implementation in NYS

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APPENDIX

Revised Federal Regulations

1. 42 C.F.R. Part 438 – Appeals and Grievances 1
2. 42 C.F. R. §210 – Authorizations 2
3. Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015) https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf .....--
4. Notice of Final Rule – with CMS preamble reviewing comments submitted; 81 Federal Register 88 at p. 27498 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf ....--

Form Notices and Appeal Request Forms -- Exhaustion of Internal Appeals

1. INTERNAL APPEAL DETERMINATION (IAD) With Appeal Request Form (Reduction of Home Care Services) (Sample in hypothetical case. Based on Model notice template at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm 10
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2. National Health Law Program comments on proposed regulations, at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>--..... --
3. National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs describing different sections of revised Managed Care regulations at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg

NYS Policy / Public & Professional Education documents

1. MLTC Plan Letter to Members about changes -- April 2018 with: 36
   - DOH Fact Sheet on Exhaustion 37-38
   - DOH revised Member Handbook section on Appeals & Grievances (MLTC) 39- 49
2. NYS Webpage on Exhaustion - *Service Authorization and Appeals for Mainstream Medicaid Managed Care Plans, HARP, and HIV SNP, at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm - oriented to training mainstream plans. Includes FAQs, PowerPoints, policy, notice templates. .....
3. DOH MLTC Webpage MRT 90 – links to model contracts, MLTC policies, etc. https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/index.htm
   - https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm - Webinars, FAQs, notice templates on Exhaustion .....
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   https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc

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Other Online Resources

1. *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf)
2. *Article on Managed Care Appeal Procedures* –http://www.wnylc.com/health/entry/184/
3. **Fax, phone and email contact info** to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

HOTLINES/ COMPLAINTS

1. **NYS DOH MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
2. **NYS DOH Mainstream managed care complaints --** 1-800-206-8125 managedcarecomplaint@health.ny.gov
3. **ICAN – Independent Consumer Advocacy Network –** Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org

Article on Exhaustion Submitted to NYSBA Elder Law & Special Needs Journal

1. "Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing – Starts April 1, 2018," Article Draft, by Valerie Bogart 57

SEE OUR http://nyhealthaccess.org Health Care Advocacy Webpage

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Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart F

Title 42: Public Health
PART 438—MANAGED CARE

Subpart F—Grievance and Appeal System

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SOURCE: 81 FR 27853, May 6, 2016, unless otherwise noted.

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§438.400 Statutory basis, definitions, and applicability.

(a) *Statutory basis.* This subpart is based on the following statutory sections:

(1) Section 1902(a)(3) of the Act 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) of the Act 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) of the Act 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:

Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

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

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

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

State fair hearing means the process set forth in subpart E of part 431 of this chapter.

(c) *Applicability.* This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

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§438.402 General requirements.

(a) *The grievance and appeal system.* Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F.

(b) *Level of appeals.* Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c) *Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.

(A) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(B) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(*1*) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(*2*) The review must be independent of both the State and MCO, PIHP, or PAHP.

(*3*) The review must be offered without any cost to the enrollee.

(*4*) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5).

(2) *Timing*—(i) *Grievance.* An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.

(ii) *Appeal.* Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) *Procedures*—(i) *Grievance.* The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.

(ii) *Appeal.* The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

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§438.404 Timely and adequate notice of adverse benefit determination.

(a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.

(b) *Content of notice.* The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210 (d)(1).

(4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).

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§438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals 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.

(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination 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.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).

(6) 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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§438.408 Resolution and notification: Grievances and appeals.

(a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(d) *Format of notice*—(1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.

(2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(B) The review must be independent of both the State and MCO, PIHP, or PAHP.

(C) The review must be offered without any cost to the enrollee.

(D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(2) *State fair hearing.* The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

(3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

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§438.410 Expedited resolution of appeals.

(a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2).

(2) Follow the requirements in §438.408(c)(2).

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§438.414 Information about the grievance and appeal system to providers and subcontractors.

The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

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§438.416 Recordkeeping requirements.

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:

(1) A general description of the reason for the appeal or grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the appeal or grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

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§438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.

(a) *Definition.* As used in this section—

Timely files means files for continuation of benefits on or before the later of the following:

(i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.

(ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.

(b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:

(1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii);

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The enrollee timely files for continuation of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal or request for state fair hearing.

(2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2).

(3) A State fair hearing office issues a hearing decision adverse to the enrollee.

(d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

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§438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.

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Need assistance?

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of June 23, 2017

Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart D → §438.210

Title 42: Public Health
PART 438—MANAGED CARE
Subpart D—MCO, PIHP and PAHP Standards

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§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract between a State and 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 FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably 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.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.

(5) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, 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 that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for an enrollee to achieve age-appropriate growth and development.

(C) The ability for an enrollee to attain, maintain, or regain functional capacity.

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(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.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* 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, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.

(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 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 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour 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.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.

(e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 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.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

[81 FR 27853, May 6, 2016, as amended at 82 FR 39, Jan. 3, 2017]

Need assistance?

ACME MLTC PLAN
100 Acme Lane – New York, NY 10000
1-800-MCO-PLAN

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

April 1, 2018

Jane Doe
111 Consumer Lane
New York, NY 11111

Enrollee Number: 5555
Coverage Type: Managed Long Term Care
Service: Personal Care services
Provider: Helping Hands Home Care
Plan Reference Number: 222222

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

Why am I getting this notice?

You are getting this notice because ACME MLTC Plan is reducing the service(s) you are getting now.

Before this decision, from April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 11, 2018 the plan approval **changes** to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week
From April 11, 2018 to October 11, 2018.

We will review your care again in six months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

Why did we decide to reduce your service?

ACME MLTC Plan is taking this action because the service is not medically necessary.

- Your personal care services will be reduced because:
  - Your social circumstances have changed since the previous authorization was made.
  - On January 1, 2018, your daughter, with whom you live, retired from her job.
- You no longer meet the criteria for your current level of service because:

- Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

If you want to keep your services the same

- **You must ask for a Plan Appeal within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Plan Appeal and keep your services the same is April 11, 2018,**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services you got while waiting for the decision.

You have a total of **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to ask for a Plan Appeal is **May 31, 2018.**

Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: 1-800-MCO-PLAN. TTY users call TTY.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at 1-800-MCO-PLAN.**

Step 1 – Gather your information.

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number

- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling 1-800-MCO-PLAN.

Step 2 – Send us your Plan Appeal.
Give us your information and materials by phone, fax, email, mail, online, or in person**:**

Phone…….. 1-800-MCO-PLAN
Fax…….. 1-800-MCO-EFAX
Email…….. appeals@acme.com
Mail or In Person …..…….. ACME MLTC PLAN, 100 Acme Lane, New York, NY 10000 ATTENTION: APPEALS
On Line…….. [web portal]

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, ACME MLTC Plan will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your appeal, you may request a Fair hearing and, in some cases, an External Appeal.

When will my Plan Appeal be decided?

Standard– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

Fast Track –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:
- Delay will seriously risk your health, life, or ability to function;

- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

For both Standard and Fast Track - If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision, **after** you ask for a Plan Appeal **and:**

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

OR

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing**. To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReg.asp.

Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan's network, or 4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may also be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call ACME MLTC Plan at1-800-MCO-PLAN; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

Other help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC complaints 1-866-712-7197.

You can call ACME MLTC PLAN at 1-800-MCO-PLAN if you have any questions about this notice.

Sincerely,

ACME MLTC Plan

Enclosure: Appeal Request Form

cc: Requesting Provider

At your request, a copy of this notice has been sent to:

John Doe –Authorized Representative
Chris Roe – Legal Guardian

ACME MLTC PLAN APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To:
ACME MLTC Plan
[Address]
[City, State Zip]

Fax to: 1-800-MCO-EFAX

Today's date: April 1, 2018

DEADLINE:

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is April 11, 2018**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is May 31, 2018. If you want a Plan Appeal, you must ask for it on time.**

Enrollee Information
Name: Jane Doe]
Enrollee ID: 5555
Address: 111 Consumer Lane, New York, NY 11111
Home Phone: 1-212-111-1111 Cell Phone: [Cell Phone]
Plan Reference Number: 222222
Service being reduced, suspended or stopped: Personal Care Services

I think the plan's decision is wrong because:

_____

_____

_____

Check all that apply:

☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.

☐ I request a Fast Track Appeal because a delay could harm my health.

☐ I enclosed additional documents for review during the appeal.

☐ I would like to give information in person.

☐ I want someone to ask for a Plan Appeal for me:
- Have you authorized this person with ACME MLTC Plan before? ☐ YES ☐ NO
- Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me):

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____

Requester Signature: _____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

NOTICE OF NON-DISCRIMINATION

ACME MLTC PLAN complies with Federal civil rights laws. **ACME MLTC PLAN** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ACME MLTC PLAN provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **ACME MLTC PLAN** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[ACME MLTC PLAN]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[ACME MLTC PLAN]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم toll free number>(رقم هاتف الصم والبكم< TTY/TDD	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-MCO-PLAN TTY: TTY	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں <toll free number> <TTY:.	Urdu

FINAL

APPEAL

DETERMINATION

(FAD)

With Appeal Request Form

Reduction of Home Care Services

[Ultra-Health MLTC Plan]
[Address]
[Phone]

FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

May 1, 2018

Jane Doe
10000 W. 96th St.
New York, NY 10000

Enrollee Number: xxxx
Coverage type: Personal Care Services
Plan reference number: 5555555
Provider: Happy Home Care

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you have **four months** to ask for an External Appeal or you can ask for a Fair Hearing by **August 28, 2018, If you want to keep your services the same until your Fair Hearing is decided, you must ask for a Fair Hearing by May 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help 1-800-MCO-PLAN.

Why am I getting this notice?

You are getting this notice because on April 5, 2018 you or your provider asked for a Plan Appeal about our decision to reduce personal are services.

On April 30, 2018 Ultra-Health decided we are changing our decision and will partially approve your service.

From April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week

On May 1, 2018, we have partially denied your Plan Appeal and:
On May 11, 2018, we will reduce your personal care services to
10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week

We will review your care again in 6 months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

Why did we reduce your service?

We made this decision because the service is not medically necessary

- Your personal care services will be reduced because:
  - Your personal care services will be reduced because:
    - Your social circumstances have changed since the previous authorization was made.
    - On January 1, 2018, your daughter, with whom you live, retired from her job.
  - You no longer meet the criteria for your current level of service because:
    - Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8.

What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a <u>Fair Hearing</u>** – and an Administrative Law Judge will decide your case.

- If we said your service was not medically necessary, you can **ask the State for an <u>External Appeal</u>** – this may be the best way to show how this service is medically necessary for you. Your services may change while you are waiting for an External Appeal decision.

If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will be the final answer about your benefits.

<u>If you want to keep your services the same</u>

- **You <u>must</u> ask for a Fair Hearing within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Fair Hearing and keep your services the same is May 11, 2018**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services provided while waiting for the decision.

You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **August 28, 2018.**

How Can I Ask for a Fair Hearing?

To ask for a Fair Hearing, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)

- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp

- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

  MAIL FAIR HEARING REQUEST FORM TO:
  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Unit
  P.O. Box 22023
  Albany, New York 12201-2023

  FAX FAIR HEARING REQUEST FORM TO: 518-473-6735

OR

- **WALK IN – New York City Only:**
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  14 Boerum Place - 1st Floor
  Brooklyn, New York 11201

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

After the hearing, you will be sent a written decision about your case.

How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC [1-866-712-7197].

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

You can call [CONTACT PERSON NAME] at Ultra-Health MLTC Plan at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
External Appeal Standard Description and Application

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[DAUGHTER]]

[266] MLTC MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC

MAIL TO: *NYS Office of Temporary and Disability Assistance*
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

FAX TO: *518-473-6735*

DEADLINE:

- ***If you want to keep your services the same*** *until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.*
- ***The last day to ask to keep your services the same is May 11, 2018***
- *You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing.* ***The last day to ask for a Fair Hearing is August 28, 2018. If you want a Fair Hearing, you must ask for it on time.***

☐ ***I want a Fair Hearing. This decision is wrong because:***

Enrollee	*Name*	*Signature*	*Phone*
Representative (if any)	*Name*	*Signature*	
	Relationship	*Phone*	

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by May 11, 2018 If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you ***do not want*** *to keep your health care the same:*

☐ *I* ***DO NOT want*** *to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.*

FOR NYS OTDA ONLY *MANAGED CARE DECISION FAIR HEARING REQUEST FORM*		
Notice Date [DATE]	*Effective [DATE]*	*Service Type:[Service]*
Case Name (c/o, if present) and Address: *[ENROLLEE NAME* *ENROLLEE ADDRESS]* *CIN: [MEDICAID CIN]*		*[MCO/URA NAME* *MCO/URA ADDRESS]* *Reference No.: [MCO REFERENCE NUMBER]*

A Plan Appeal was filed on April 5, 2018. On May 1,2018, [Plan Name] decided we are changing our previous decision and will partially approve the service.

From April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week

On May 1, 2018, we have partially denied your Plan Appeal and:
On May 11, 2018, we will reduce your personal care services to
10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week

Authorization to Request Appeal or Hearing

AUTHORIZATION – Medicaid Managed Care Requests

I authorize the following individuals or organizations to represent me in making requests regarding my Medicaid managed care or Managed Long Term Care Services. They may, on my behalf make requests including but not limited to:

1. Request an Internal Appeal of an adverse determination by my plan;
2. Request a Fair Hearing of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review").
4. File a grievance with my plan.
5. File a complaint with the NYS Department of Health.

This authorization applies to my current plan, which is (NAME) _____ _____and also to any different plan I might enroll in at a later date.

Authorized Individuals or Organizations (fill in and check one or more):

- ☐ NAME _____ Relationship _____
  - Address _____
  - Cell phone _____ E-mail _____
  - ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.
- ☐ ORGANIZATION NAME _____
  - Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
  - Contact person: _____
  - Address _____
  - Phone _____ E-mail _____
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.
- ☐ **Independent Consumer Advocacy Network (ICAN)** - including all participating organizations in the network. Main tel 844-614-8800
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____

BLANKS for

1. Requesting Plan Appeal (Internal Appeal Request)
2. Requesting Fair Hearing after Final Adverse Determination (FAD)

These are generic versions of the requests that SHOULD be attached to the Plan's IAD and FAD notices, pre-filled with client's information. If client did not receive any notice, or not this part of notice, use these

These are oriented for reductions in hours. Can adapt for other types of issues.

MLTC APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To: **Date**: _____
Plan Name/UR AGENT] _____ **Fax:** _____

Address _____City, State Zip _____

DEADLINE:

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Notice Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [Notice DATE+60**]. **If you want a Plan Appeal, you must ask for it on time.**

Enrollee Information

First Name _____ Last Name_____

Enrollee ID: _____Plan Reference Number _____
Address: _____City, State, Zip _____
Home Phone: _____ Cell Phone: _____

Type of Service being reduced, suspended or stopped: _____

I think the plan's decision is wrong because:

_____

_____

_____

Check all that apply:

- ☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with this plan before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me):

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____

Requester Signature: _____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC

MAIL TO: NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

FAX TO: 518-473-6735

DEADLINE:

- **If you want to keep your services the same** until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.
- **The last day to ask to keep your services the same is [Notice Date+10].**
- You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120**]. **If you want a Fair Hearing, you must ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

Enrollee	Name	Signature	Phone
Representative (if any)	Name	Signature	
	Relationship	Phone	

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by [date+10]**.** If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you **do not want** to keep your health care the same:

☐ I **DO NOT want** to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.

MANAGED CARE DECISION FAIR HEARING REQUEST FORM

Notice Date	Effective date	Service Type:
Case Name (c/o, if present) and Address: ENROLLEE ADDRESS CIN:		MLTC/Managed Care Plan Name: Plan Reference No.:

A Plan Appeal was filed on DATE: _____ Plan decided appeal by Final Adverse Determination dated: : _____

Amount/type of service plan provided before:

On DATE OF Initial Adverse Determination Notice _____, Plan proposed to reduce services to (Amount) _____ starting on DATE _____.

After the Appeal, by Final Adverse Determination NOTICE dated _____ Plan decided to reduce services to _____ starting on

DATE _____

NEW YORK LEGAL ASSISTANCE GROUP

Consumer Concerns on Implementation of New Exhaustion Requirement April 1, 2018

February 7, 2018

I. Regarding OTDA implementation –

1. **Intake of fair hearing (FH) requests** – I'm pleased to hear that OTDA and DOH are working to add a question at intake about whether the caller requested an internal appeal. It is critical that intake call center staff be trained to ask this question and explain the internal appeal requirements.

   A. **Revising online, paper and fax forms for requesting hearings** to include questions about the status of the internal appeal request and decision, if any and to inform the requester of the internal appeal requirement.

      - The templates developed by DOH for requests for internal appeal and for fair hearing could be adapted as generic templates and posted on the OTDA website. However, the existing FH request forms also need to be revised because people are already familiar with them.
      - A list of all plans, with their appeals contact info (phone, fax, email, mail) should be printed on the back of these forms, as well as be posted on the OTDA and DOH websites.
      - The forms must elicit facts that show whether "deemed exhaustion" is warranted – date of the internal appeal request, date of the final adverse decision, etc.

   B. **Front-end screening of requests for "deemed exhaustion."** If I understand your email correctly, OTDA will make no inquiry or determination about whether "deemed exhaustion" applies until the hearing is held. Respectfully, in most cases this will be too late. Especially where the issue is a reduction or termination, the appellant is entitled to request the FH and receive Aid Continuing without exhausting the internal appeal, if certain circumstances apply. In order to determine whether to order Aid Continuing, OTDA will need to review the notice, or lack of notice, and determine, where an internal appeal was requested, whether the time limit for the plan to make a final decision has passed, warranting deemed exhaustion. While we realize that this imposes a demand on OTDA staff and legal resources, we just don't see how this change can be implemented without having a front-end process for screening for "deemed exhaustion."

- **OTDA should issue policy guidance defining when "deemed exhaustion" applies, so that plans, consumers, ALJs, all know the standards. At a minimum, deemed exhaustion should apply when:**

    a. No written notice of initial adverse determination (IAD) was provided by the plan, or

    b. The IAD does not include the requisite information regarding the right to Aid Continuing, how to request an appeal, how to obtain representation, how to submit evidence, and other information in the DOH notice templates and otherwise required by law and regulation.

    c. The IAD did not incorporate necessary translation or alternative formats, was not on the required template, or did not offer auxiliary aids and services, free of cost, during the appeal, thus impeding the enrollee's time to appeal or request Aid Continuing.

    d. The IAD does not comply with other applicable requirements, ie. MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services;*

    e. The Plan did not decide the internal appeal within 30 days from member's appeal request, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless extended pursuant to the regulations by up to 14 calendar days. 42 CFR § 438.408.

C. Special protections, at least for an initial transition period, for FH requests that involve a reduction or termination of a service - At least during a transition period while millions of people are being educated on the new procedures:

- **The filing of the fair hearing request should be deemed the filing date of the internal appeal, for purposes of triggering Aid Continuing.** OTDA would then either assist the appellant in requesting the internal appeal, as discussed below, or, when OTDA notifies the plan through its normal procedures that the fair hearing was requested, the plan would be required to commence processing the internal appeal, as if the appellant requested it. The date of the "request" for the internal appeal would be the date of OTDA's notification to the plan, for purposes of the plan's time limit to decide the appeal. For purposes of Aid Continuing, the date of the request would be the date of the fair hearing request.

- **Alternatively, the time limit to request internal appeal should be tolled, if the hearing was requested within the aid continuing deadline for an internal appeal request**. At least for a transition period, the statute of limitations for requesting the internal appeal should be tolled from the

date of the FH request until a reasonable time after OTDA has contacted the appellant to advise them of the internal appeal requirement.

- **OTDA staff should assist with internal appeal request in these cases where the Aid Continuing time limit is imminent**. If the FH request is made by phone, the OTDA staff should do a 3-way call with the plan and the appellant as a "warm transfer" of the request to the plan for the internal appeal. (see #4 below about improved communications lines between OTDA and plan appeal units).
    - If the FH request is made by other formats, and the Aid Continuing clock is ticking, OTDA should contact the appellant within 24 hours to advise of the internal appeal requirement and assist with filing of the appeal.
- All of these requests need to be screened for "deemed exhaustion."

D. Communications must be established between OTDA and all of the plans for OTDA to quickly ascertain whether an internal appeal was requested, when, and the status of that appeal. The consumer cannot be told simply to call their plan. Nor can OTDA be required to call the plan member services numbers, which can take time to be routed to the appeals unit. Nor can OTDA simply ask the member for the status of their internal appeal. Some members or their representatives will know if they requested an internal appeal. But others will not understand or know the answer.

2. Other Systems Actions That are Needed by OTDA –

A. Making changes to the OTDA fair hearing request web pages - Instructions posted on the site must explain the new requirements in clear language.

- A list of all plans, with their appeals contact info (phone, fax, email, mail) should be posted on this page. This is very difficult information to obtain. Even though I've now represented consumers in MLTC for 5 years, I still don't have a good working list of appeals contacts or fax numbers for each plan. This needs to be public information accessible on DOH and OTDA websites.

B. Revision of FH request "acknowledgement letters" and other form letters – If a fair hearing is requested against a managed care plan, this letter is a critical opportunity to inform the requester and appellant that their fair hearing request may be dismissed if they did not request an internal appeal from the plan. If the case involves a reduction or termination of benefits, then, as discussed above, more affirmative steps should be taken by OTDA staff to ensure Aid Continuing is provided.

C. Training ALJs on all of the above.

II. Regarding DOH Systems -

1. **Educating plans** - I'm pleased to see that webinars have been conducted for mainstream MMC plans and that materials, notice templates, FAQ's and more have been posted for MMC plans on the DOH website. I do not see anything yet for **MLTC plans** on the website and would like to know if comparable materials will be posted and webinars conducted. Also, while top-level plan managers may attend these webinars, what is to ensure that all pertinent plan staff are trained, from care managers and grievance and appeal staff to call center staff. See issues re plan surveillance and readiness review below.

2. **DOH Website updates** – The implementation timeline indicates these are being done Feb – March. Will this include DOH/MLTC websites as well as the MMC? We urge that the consumer-oriented webpages be updated along with the plan-oriented webpages, including but not limited to these –

   https://www.health.ny.gov/health_care/managed_care/complaints/index.htm ,

   https://www.health.ny.gov/health_care/managed_care/mltc/mltcomplaint.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/enrollee_information.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/

   - **Post Plan Appeals Contacts** – DOH Websites must include information on each MCO's appeal phone number, fax, email and online portal if available. In order to have access to the appeal procedures as set out in the new federal regulations, DOH must maintain and provide this appeal contact list for the public. This list should be maintained on the DOH and OTDA websites. We suggest that Maximus also include this information on NYMedicaidChoice.com. Appeals contacts could be added to their existing lists of plan contacts.

   - **Post consumer-friendly information on the new appeal procedures**, and include samples of the plan notices, the **internal appeal and fair hearing request forms**. (below we suggest a downloadable fact sheet for consumers) We are glad to see the webpage oriented to MMC plans includes copies of the **notice templates**, but consumers won't see those. Also, would be more helpful for consumers to post samples of the forms completed in a hypothetical case, rather than the templates with all of the alternate language, which can be confusing. We posted one sample that we created for a reduction notice.

3. **DOH Policy and Guidance --**

    a. **MLTC Policy Guidance** - We strongly urge DOH to prepare a new MLTC policy to be posted on the MRT 90 website detailing the MLTC plan obligations under the new appeal process. This guidance should include requirements for using the new notices properly, timely logging in and tracking internal appeals, and providing AID CONTINUING as required. This document should set clear standards for MLTC plans regarding compliance with the federal regulations. The FAQs posted for mainstream plans provides useful guidance on issues such as requirements for sending the enrollee's case file prior to an appeal or fair hearing. MLTC policy guidance is needed to provide clear guidance to plans on their responsibilities in the hearing process.

    b. **New MMC and MLTC model contract language** regarding the exhaustion requirement must be drafted and executed. Advocates would like to know DOH's timeframe for the revisions to the model contracts and would be interested in reviewing any model language.

    c. **DOH Policy needed on reasonable accommodations required to assist members in understanding notices and requesting appeals.**

4. **Plan Readiness Review and Compliance** -- As discussed at the workgroup meetings, we were pleased to hear that DOH's surveillance unit intends to monitor MCO implementation of the new appeals process. We would like to know more about the surveillance and monitoring plan.

    a. **Specifically, what testing of MCO systems is planned before April 1st** to ensure that appeal requests are timely logged in and processed? Consumers reported to the Workgroup difficulties in navigating plan call centers, and being routed to care managers or other departments, which can all delay or even prevent logging in an appeal request. Of course where the issue is a reduction or termination, the right to Aid Continuing is threatened with any barriers or delays to filing the request, whether by phone, fax, or otherwise.

    b. Do MCOs have sufficient staff in their appeal departments to meet this obligation?

    c. Have care managers and other plan staff been trained to forward any appeal request to the correct department within the MCO to process the appeal request, so that there is "no wrong door" for a member seeking to appeal?

    d. **Systems to ensure that AID CONTINUING is ordered and implemented are particularly critical.** Before this change, plans have only had to implement an Aid Continuing directive given by OTDA. Even during the short time that exhaustion was required for MLTC, the appellant had to request a FH simultaneously with the internal appeal in order to obtain Aid Continuing. For this reason, both MMC and MLTC plans have not had the need to develop systems to INTERNALLY make a determination of whether a member is entitled

to Aid Continuing, and then implement that directive. This requires that plans develop procedures, designate staff responsible for determining when Aid Continuing applies, developing systems to ensure that a reduction or termination is not automatically implemented, merely by the passage of time (10 days from the notice), without ensuring that an internal appeal request was not filed. DOH will need to ensure that these systems are set up and ready for implementation.

e. **Is DOH checking to see that plans have implemented their new systems to allow filing appeal requests by fax, email, mail, and in some cases online?** This will need to ensure that these requests are logged in and read on a timely basis, so that Aid Continuing is directed and implemented in the short time frame required, and that requests are otherwise processed on a timely basis.

f. **Systems for sending the enrollee's case file in advance of the appeal and hearing** - Since there are new requirements for this aspect of appeal procedures, DOH should ascertain the plan's readiness to timely comply. Does the plan have adequate procedures and designated personnel for this task?

g. **Plan website updates –** We assume that plans will be **posting the revised member handbooks online** as soon as they are completed. In addition, plans need to post accessible information for members on how to request internal appeals, with downloadable forms, and complete information on how to file – fax numbers, e-mail and mail addresses, phone numbers, and online portal, if available. .

5. **Provider education -- Medicaid Update** – We're pleased to see you are planning to publish a Medicaid Update article; the timeline shows March. We would appreciate reviewing a draft and an opportunity for comments. Are there other plans to ensure that providers are up-to-date with this change? The Implementation timeline shows a "Provider/CBO Education Tool," which we'd like to learn more about, and would welcome the opportunity to review a draft.

6. **Consumer and Public education –**

   a. **Member handbook –**The implementation timeline states that updates have been in process since December and will be until March. We would very much appreciate the opportunity to review and comment on the latest drafts. (Can you confirm that this is both the mainstream and MLTC member handbooks that are being revised?). Please advise us of the timeframe for mailing these to members.

   b. **Cover letter to be mailed with handbook –** Will DOH be issuing a standardized letter to be mailed to members with the revised member handbook? We would welcome the opportunity to review a draft and provide feedback. On the letters to MLTC members, and those MMC members receiving long term care services and supports, ICAN contact information should be listed.

c. **We also encourage DOH to develop a brief fact sheet for consumers to include in the plan's mailing to members, to post on the DOH website and to distribute via list-serv**. This document should explain the appeals process in simple terms, and also define new terms such as FAD and IAD for consumers. We urge DOH to solicit advocate input in reviewing these documents before they are finalized and to include **ICAN Ombudsman program** contact information where applicable.

d. **Public Webinar** – We see that this is planned for March, according to the Implementation Timeline. Will this be oriented to mainstream or MLTC or both?

e. **Member newsletters –we see this on the implementation timeline.** Which newsletters does this reference? Is DOH releasing an article that could be completed in newsletters of CBOs and other networks that educate consumers, their families and advocates?

February 7, 2018

Submitted by:

Valerie Bogart and Rebecca Wallach, NYLAG
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Susan Dooha, Center for Independence for the Disabled, New York
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[redacted]

FIDELIS CARE™

April 1, 2018

[redacted]

Dear Member:

This mailing is letting you know about an important update to your member handbook. A copy of the update is enclosed. Please keep this with your Member Handbook. This update is also available on our website at: www.fideliscare.org. Please read this update carefully. Federal regulations have changed the way you can ask for an appeal and State Fair Hearing. A quick reference guide about these changes is attached. These changes take effect May 1, 2018.

This member handbook update tells you about:

- How long we will take to review your request for services that need prior approval.
- If your request is denied, how to ask for a Plan Appeal asking us to look at your case again.
- If your Plan Appeal is denied, your right to ask for a State Fair Hearing. In most cases, you will need to ask for a Plan Appeal first, **before** you can ask the State for a Fair Hearing.
- Your rights if we decide to change, stop or reduce services that you are getting now, and how you can keep your care the same until your Plan Appeal or Fair Hearing is decided.

Please call member services at 1-888-FIDELIS (1-888-343-3547) TTY: 1-800-421-1220 if you:

- have any questions about this information;

Please keep this update with your member handbook.

This fax was received by GFI FaxMaker fax server. For more information, visit: http://www.gfi.com

[redacted]

[redacted]

Important Change for Medicaid Managed Care Enrollees
Appeals and Fair Hearing Rights

What is changing on May 1, 2018?

New federal Medicaid managed care rules take effect in New York State. These rules change the way Medicaid managed care plans make decisions about health care services and Plan Appeals.

These rules change how you can ask the State for a Fair Hearing about plan decisions. Starting May 1, 2018, if you think a plan decision is wrong, you must first ask for a Plan Appeal **before** asking for a Fair Hearing. If your care is changing, and you want to keep your services the same while your case is reviewed, you must first ask for a Plan Appeal **before** asking for a Fair Hearing.

How does this change affect me?

For some services, you have to ask the plan for approval before you get them. This change means that the plan will make some of these approval decisions faster than they did before. If you think your plan's decision about your health care is wrong, you can ask the plan to look at your case again. This is called a Plan Appeal. This change means **you must first ask for Plan Appeal before you ask for a Fair Hearing.** You will have 60 days to ask for a Plan Appeal.

What if the plan's decision is changing a service I am getting now?

If you want to keep your services the same, this change means **you must first ask for a Plan Appeal** within 10 days or by the date the decision takes effect, whichever is later. Your services will stay the same until there is a decision. If you lose your Plan Appeal, you may have to pay for the services you got while waiting for the decision.

Can someone ask for a Plan Appeal for me?

If you want someone, like your provider, to ask for the Plan Appeal for you, this change means you and that person must sign and date a statement saying this is what you want.

What happens after I ask for a Plan Appeal?

After you ask for a Plan Appeal, this change means the plan will send you your case file, with all the information they have about your request. The plan will then send you their decision about your appeal. This change means if you do not receive a response to your Plan Appeal or the decision is late, you can ask for a Fair Hearing without waiting for the plan's decision.

What if I think the Plan Appeal decision is still wrong?

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for Fair Hearing. If the plan said the service is not medically necessary, you can still ask the State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both, the Fair Hearing decision will always be the final answer.

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If the plan is changing care you are getting right now, and you want your services to stay the same, you must ask for a Fair Hearing within 10 calendar days from the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

How long can the plan take to decide?

If you request approval for a service, your plan has 14 days to make a decision. If your health is at risk, your plan must fast track your request and decide in 72 hours. The decision may take longer if the plan needs more information. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If you ask for a Plan Appeal, the plan has 30 days to make a decision. If your health is at risk, your plan must fast track your appeal and decide in 72 hours. The decision may take longer if the plan needs more information.

Where can I get more information?

Call member services at 1-888-FIDELIS (1-888-343-3547) TTY: 1-800-421-1220. See your member handbook for full information about your appeal rights.

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email:** ican@cssny.org]

This fax was received by GFI FaxMaker fax server. For more information, visit: http://www.gfi.com

MODEL MEMBER HANDBOOK COMPLAINT AND APPEAL LANGUAGE

The following language relating to the managed long term care demonstration complaint and appeal process must appear in the Contractor's Member Handbook.

UnitedHealthcare Personal Assist™ will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by (insert plan name) staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: 1-877-512-9354 TTY711 or write to:

UnitedHealthcare Personal Assist
Att: MLTC Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When UnitedHealthcare Personal Assist denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

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 restricting, 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.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-877-512-9354 TTY711 or writing to:

UnitedHealthcare Personal Assist
Att: MLTC Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

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 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing 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 restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp

- Mail a Printable Request Form:

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit: http://otda.ny.gov/hearings/request/

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

3. SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request

b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

    a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

4. Enrollee or provider may appeal decision – see Appeal Procedures.

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

    a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

    a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
    b. the Contractor may mail notice not later than date of the Action for the following:

        i. the death of the Enrollee;
        ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where

the Enrollee understands that this must be the result of supplying the information);

iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;

iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or

vi. the Enrollee's physician prescribes a change in the level of medical care.

c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

a. the date the restriction will begin;
b. the effect and scope of the restriction;
c. the reason for the restriction;
d. the recipient's right to an appeal;

e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
f. the right of Contractor to designate a primary provider for recipient;
g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
k. the name and telephone number of the person to contact to arrange a conference;
l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
n. the right of the recipient to examine his/her case record; and
o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.

Medicaid Managed Care Enrollees Service Authorization and Appeals Procedure Changes

The State will implement several changes related to Medicaid managed care service authorization, appeals, fair hearings and grievances (complaints) as required by the Center for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance (CHIP) Programs Final Rule published May 6, 2016, amending federal rules at 42 CFR Part 438. These changes apply to mainstream Medicaid managed care, Health and Recovery Plans (HARPs), HIV Special Needs Plans, Managed Long-Term Care Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus. These managed care plans are certified under Public Health Law Article 44, and therefore must also continue to comply with the service authorization, appeals and grievance requirements in State statutes. The Department has issued guidance to the health plans for compliance with these changes (including the use of new model enrollee notices) at: https://www.health.ny.gov/health_care/managed_care/plans/index.htm and https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm.

Enrollees will receive notice of these changes on or before April 1, 2018. Health plans will begin handling service authorization requests, appeals and grievances (complaints) under these new rules on May 1, 2018, and thereafter. Starting May 1, 2018, plans will be required to complete review of service authorization requests under different time frames, issue revised enrollee notices, and, for adverse determinations made on May 1, 2018 and thereafter, follow revised appeal processes. Although there are several changes, two key provisions are:

- Starting with plan service determinations made on May 1, 2018 and thereafter, enrollees wishing to dispute a plan's adverse determination regarding their services must exhaust the plan's internal appeal process **before** requesting a State Fair Hearing. This means the enrollee must request a plan appeal, which may be expedited, and receive a Final Adverse Determination upholding the plan's decision prior to requesting a State Fair Hearing. Enrollees will have 120 days from the Final Adverse Determination to request a State Fair Hearing. If the plan does not respond to the Plan Appeal or the response is late, the appeal process will be deemed exhausted and the enrollee may request a State Fair Hearing.

- Upon review, health plans may determine to reduce, suspend or terminate authorized services. The enrollee will be able to have their aid continue from the plan upon filing a plan appeal within 10 days of the Initial Adverse Determination notice, or before the effective date of the decision, whichever is later. If the plan upholds its decision and issues a Final Adverse Determination, the enrollee may have their aid continue by requesting a State Fair Hearing within 10 days of the Final Adverse Determination notice, or before the effective date of the decision, whichever is later. If the enrollee loses their plan appeal or Fair Hearing, they may have to pay for the services they received while their appeal/fair hearing was being decided.

Complete information on these appeal processes will be posted on to the Department and health plan websites.

The federal rules changes do not impact the processes for providers to file plan appeals or complaints on their own behalf. However, providers often assist enrollees in filing appeals of plan service denials. Federal regulations now require the enrollee to sign an agreement that they wish the provider to represent them during the appeal and complaint processes prior to the provider filing an appeal or complaint with the health plan on the enrollee's behalf. Providers may still request a reconsideration of a medical necessity denial, otherwise known as "peer-to-peer," if such decision was made by the plan without prior consultation with the provider. The federal rules also limit enrollees to only one level of internal appeal for plan adverse benefit determinations. Otherwise, Independent External Appeal processes for disputing medical necessity decisions as provided by Public Health Law Article 49 remain unchanged.

Please contact 438reg@health.ny.gov if you have any questions regarding these regulation changes. Questions regarding a health plan's authorization, appeals or complaint procedures should be directed to the health plan.

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Important Change for Medicaid Managed Care and MLTC Enrollees Appeals and Fair Hearing Rights

What is changing on May 1, 2018?

New rules change how and when you can ask the State for a Fair Hearing to appeal a decision by your Medicaid managed care plan, HARP plan, or Managed Long Term Care (MLTC) plan. Starting May 1, 2018, if your plan denies, reduces or stops a service, and you think the decision is wrong, **you must first ask your plan to look at your case again. This is called a Plan Appeal**. You must then wait for the plan's decision **before** asking for a Fair Hearing.

This is a big change. Before May 1, 2018, you could request a Fair Hearing right away if you thought your plan's decision about your services was wrong. **Now you must first request a Plan Appeal before you can ask for a Fair Hearing.**

What happens if the plan decides to reduce or stop a service I am getting now?

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan says that it will reduce or stop any of your services. You have 60 days from the date of the plan's notice to ask for a Plan Appeal, **but if you want to keep your services the same while your case is appealed, you must ask for a Plan Appeal within 10 days** of the date of the plan's notice or by the date the notice says the change will take effect, whichever is later. If you request the Plan Appeal within 60 days but after the effective date of the reduction, you can ask the plan to "fast track" your Plan Appeal. If you lose your Plan Appeal, you may ask for a Fair Hearing. If you don't request a Fair Hearing, or if you don't win your Fair Hearing, and you received your services unchanged while waiting for the decision, you may have to pay for those services

What happens if the plan denies my request to approve a new service or to provide more services?

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a notice of its decision. If your health is at risk, you or your provider may request that approval be "fast tracked." This requires the plan to decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information, and why the delay needed to obtain this information is in your interest. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If the plan denies your request for approval, the decision is called an "Initial Adverse Determination." If you think your plan's decision is wrong, you can ask for a Plan Appeal. After May 1, 2018, **you must first ask for a Plan Appeal and wait for a plan appeal decision before you may ask for a Fair Hearing.** You have 60 days to ask for a Plan Appeal. If you disagree with the Plan Appeal decision, you may ask for a Fair Hearing.

How do I request a Plan Appeal?

You can request a Plan Appeal by completing and faxing or mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. Some plans allow you to e-mail the request. The plan's contact information for requesting the appeal should be printed on the Appeal Request Form. You can also call the plan to request the appeal, but you will then also need to mail or fax confirmation of a request made by phone, unless you ask your Plan Appeal to be "fast tracked."

Can someone ask for a Plan Appeal for me?

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must both sign and date the appeal request. Or you must give written permission to that person to request an appeal for you, unless you gave them permission in the past.

What happens in a Plan Appeal and How Long Does it Take?

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk and you or your provider request a "fast track" appeal, your plan must decide it within 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information to decide, and why the delay needed to obtain this information is in your interest. If the plan's appeal decision denies you all or some of the services you are seeking, the plan must send you a "Final Adverse Determination."

What if the Plan does not decide my Plan Appeal on time?

If you do not receive a "Final Adverse Determination" – a decision for your Plan Appeal -- by the time limits in the question above, you can ask for a Fair Hearing without waiting for the plan's decision.

What if I think the Plan Appeal decision is wrong?

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for a Fair Hearing, but if the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, **you must ask for a Fair Hearing within 10 calendar days** from the date of the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same as they were before, until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. Your services may be reduced while awaiting an External Appeal, unless you also requested a Fair Hearing in time to prevent a reduction.

You can ask for a Fair Hearing or an External Appeal or both. If you ask for both, the Fair Hearing decision will always be the final answer.

Where can I get more information?

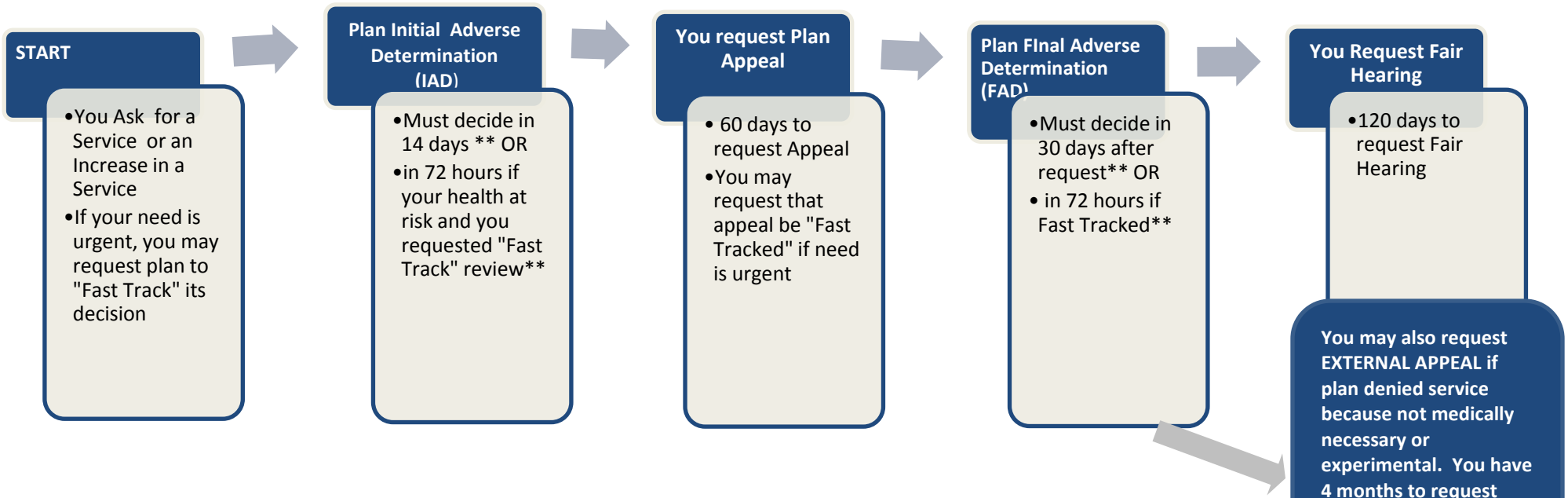
You can call your plan at the number on your plan ID card. See your plan's member handbook for full information about your appeal rights.

For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN –Independent Consumer Advocacy Network** Phone: **844-614-8800**

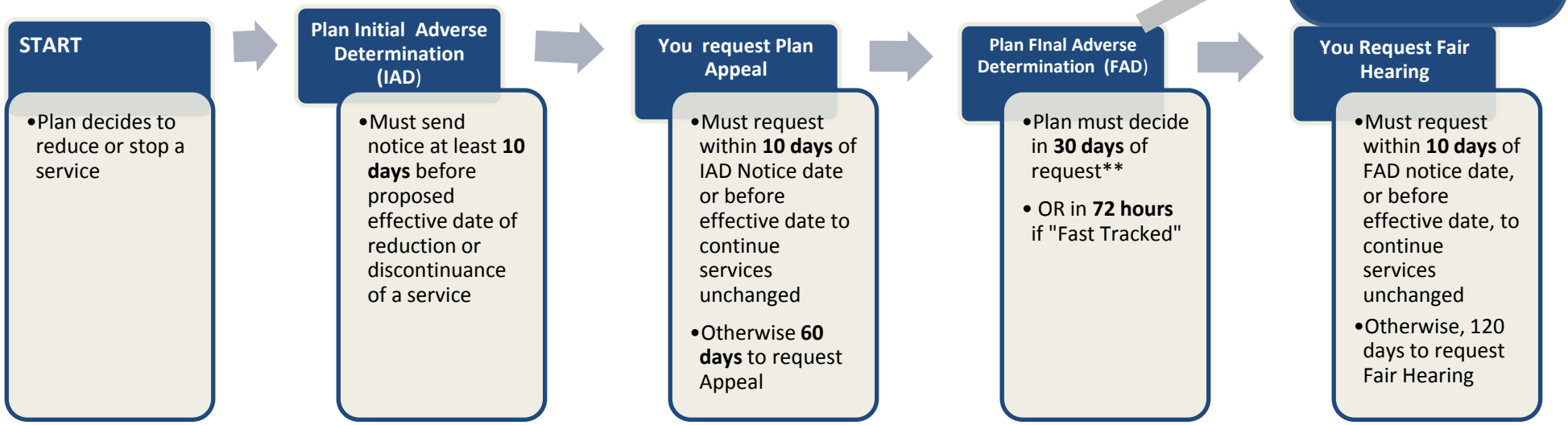
TTY Relay Service: 711 Website: icannys.org E-Mail: ican@cssny.org

By NYLAG – EFLRP contact eflrp@nylag.org April 2018

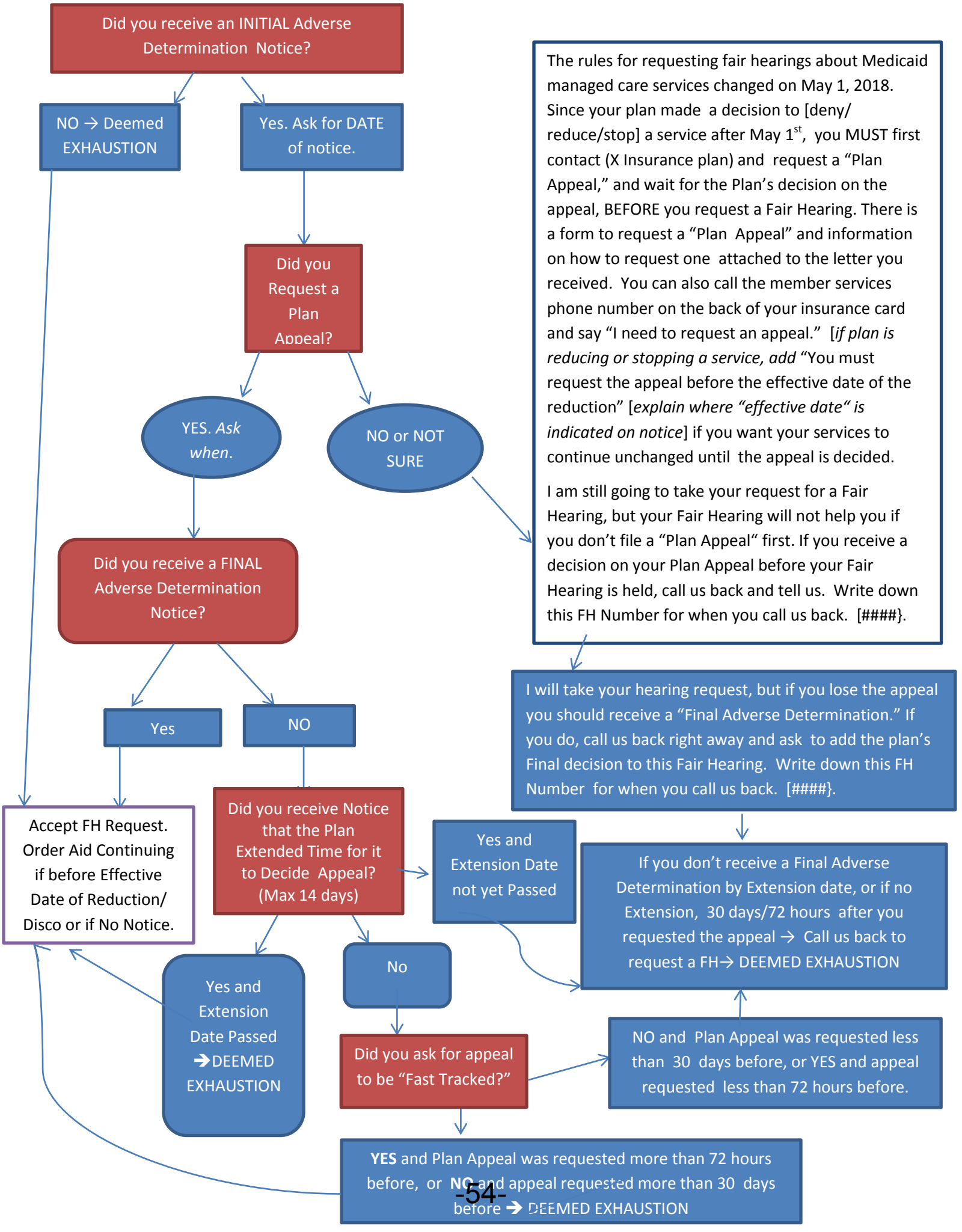
1. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN DENIES YOUR REQUEST FOR A SERVICE



2. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN REDUCES OR STOPS A SERVICE



** Plan may extend deadline up to 14 days if it needs more information, and if delay is in your interest. Plan must send you notice of why it needs more time.


Did you receive an INITIAL Adverse Determination Notice?
NO → Deemed EXHAUSTION
Yes. Ask for DATE of notice.
Did you Request a Plan Appeal?
YES. *Ask when.*
NO or NOT SURE
Did you receive a FINAL Adverse Determination Notice?
Yes
NO
Accept FH Request. Order Aid Continuing if before Effective Date of Reduction/ Disco or if No Notice.
Did you receive Notice that the Plan Extended Time for it to Decide Appeal? (Max 14 days)
Yes and Extension Date not yet Passed
Yes and Extension Date Passed ➔DEEMED EXHAUSTION
No
Did you ask for appeal to be "Fast Tracked?"
YES and Plan Appeal was requested more than 72 hours before, or **NO** and appeal requested more than 30 days before ➔ DEEMED EXHAUSTION
NO and Plan Appeal was requested less than 30 days before, or YES and appeal requested less than 72 hours before.
If you don't receive a Final Adverse Determination by Extension date, or if no Extension, 30 days/72 hours after you requested the appeal → Call us back to request a FH→ DEEMED EXHAUSTION
I will take your hearing request, but if you lose the appeal you should receive a "Final Adverse Determination." If you do, call us back right away and ask to add the plan's Final decision to this Fair Hearing. Write down this FH Number for when you call us back. [####}.
The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is reducing or stopping a service, add* "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.
I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

Information to be Obtained and Provided by OTDA in FH Requests

	DATE	Received? Or Requested?		NOTICE/EVENT
		YES	NO	
1				**Initial Adverse Determination Notice received?** If YES, enter date of notice If NO – oral notice only ➔ accept FH request. Deemed Exhaustion.
2				• Effective Date of Notice (if reduction)
3				Was Plan Appeal Requested? If YES, Enter date of request. If NO, give **Script A** below.
If Plan Appeal Requested ➔ Identify if Past Deadline for Plan to Decide Plan Appeal				
4				- Was Fast Track Requested? If YES, enter Fast Track Deadline (Line 3 + 72 hours). If YES, GO TO LINE 6. SKIP LINE 5.
5				- Standard (Line 3 + 30)
6				- Was Extension Notice Received from Plan? If YES, enter date to which review extended. (See "Review Extended" notice.)
7				**Final Adverse Determination (FAD) Notice received?** IF YES, enter Date of notice
8				• Effective Date of Notice (if reduction)
				-- If NO, and Latest of DATES in Lines 4, 5, or 6 have passed, Exhaustion is Deemed. Accept FH request. -- If NO, and Latest of DATES in Lines 4, 5, or 6 have not passed, accept FH request and give **Script B.**

SCRIPT A

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received from your plan. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is*

reducing or stopping a service, add "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.

I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

SCRIPT B

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Now, you must wait to receive the Plan's decision on your appeal before you request a Fair Hearing. I will take your Fair Hearing request, but if you lose the appeal you should receive a notice called a "Final Adverse Determination." If you receive this notice, call us back right away and ask to add the plan's Final Adverse Determination to this Fair Hearing. Write down this FH Number for when you call us back. [####}.

If you don't receive a Final Adverse Determination by [*Extension date – Line 6 in Chart or if no Extension, Line 4 or 5 in Chart*] → Call us back after that date and tell us you did not receive a final decision from your plan. Write down this FH Number [####] for when you call us back.

"Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing – Starts April 1, 2018

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New York Legal Assistance Group

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INTRODUCTION

Beginning April 1, 2018, members of Medicaid managed care plans in New York State, which include Managed Long Term Care (MLTC) plans, who wish to appeal an adverse determination by the plan, must first request an internal "plan appeal" within their plan, and wait until the plan issues a decision on that appeal, before they may request a Fair Hearing. This is called the "exhaustion" requirement, because the member must first "exhaust" the internal appeal available within the plan before requesting a State administrative fair hearing. 42 C.F.R. §438.402(c). This article explains the new requirement, and an exception, called "deemed exhaustion," which allows a request for a fair hearing before the plan decides an internal appeal.

WHO IS AFFECTED: This massive change in appeal rights affects 4.7 million Medicaid recipients in New York, 200,000 of whom are members of MLTC plans. When MLTC became mandatory in 2012 and rolled out statewide gradually over the next few years, exhaustion of internal appeals was required. In July 2015, the State lifted the exhaustion requirement entirely, allowing members to seek a fair hearing immediately to appeal an adverse plan determination.[1]

The vast majority of Medicaid managed care members in New York -- 4.5 million people -- are members of "Mainstream" Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARP), or HIV Special Needs Plans (HIV SNP). Enrollment in these MMC plans is mandatory for most Medicaid recipients who do not have Medicare or other primary insurance. While most people in these plans are under 65 and have Medicaid through the Affordable Care Act, some plan members are seniors or people with disabilities who either receive SSI or have no income at all, and who are not eligible for Medicare, usually because of immigration status. These seniors and people with disabilities obtain all medical care through the MMC plan, including personal care and other Long Term Services & Supports, They will also be required to request an internal plan appeal first to contest a proposed reduction or discontinuance of any long term care services.[2] Notably, "exhaustion" has never been required in the over twenty years that managed care has been mandatory for the non-Medicare population.

[1] See NYS Dept. of Health MLTC Policy 15.03: *End of Exhaustion Requirement for MLTC Partial Plan Enrollees,* dated July 2, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

[2] The law and regulations applying to "mainstream" managed care are at N.Y. Soc. Serv. Law . § 364-j; 18 NYCRR Subpart 360-10. All managed care plans, including MLTC plans, are also regulated as Managed Care Organizations (MCO) at NYS Public Health Law Article 44 and Article 49. Federal Medicaid requirements pre-empt those under

PRIMARY CONCERNS:

Educating Millions of Plan Members, their Families and Representatives. As New York implements this new requirement, there are concerns that 4.7 million people will not be adequately informed of this huge change. While plans' notices of adverse determinations have been modified to explain the new requirement, despite attempts to make the long, dense notices understandable to consumers in English and other languages, many will not read or understand the entire notice. Many will not show the complete notice to their family or representative – or will show the representative the notice in a foreign language that the representative does not understand.

Just educating the elder law bar, legal services advocates, and private geriatric care managers is a daunting task, let alone the huge network of social workers in hospitals, senior centers, and other community-based organizations. Lawyers and other professionals in the habit of requesting a fair hearing immediately must learn to request an internal plan appeal first instead of a fair hearing.

Barriers to Filing Appeals –Risk of Denial of Aid Continuing. The stakes are especially high when the plan proposes to reduce or discontinue personal care or other long term care services. The right to Aid Continuing has been a key element of due process since the seminal case of *Goldberg v. Kelly*. 397 U.S. 254 (1970). It has always been a challenge to file the appeal request within the short 10-day window between the date of the notice and the effective date of the reduction. Now, the appeal must be filed with a managed care or MLTC plan that may not have trained its call center staff to route these requests to ensure timely filing. Anyone who has tried to call the member services 800 number of an insurance plan knows a call may easily be mis-routed. To date, the NYS Office of Temporary Disability Assistance [OTDA] has not pledged to educate people who mistakenly request hearings adequately about the new requirements, or assist them in requesting a plan appeal. As a result, it is likely that home care will be reduced – with no Aid Continuing – for MLTC members, whose hearing requests will ultimately be dismissed, months after they requested them, for failure to "exhaust."

There are four additional barriers to filing the appeals, putting Aid Continuing at risk, all discussed at length below.

First, requests made orally must be confirmed in writing, unless an "expedited" appeal is requested. Fortunately, the regulations provide that the date of the oral request locks in Aid Continuing. 42 C.F.R. . § 438.402(c)(3)(ii).

Second, the consumer must either sign the appeal or hearing request or designate, in writing, a representative to request the appeal or hearing. 42 C.F.R. §438.402(c)(ii). This burdensome requirement is a departure from the NYS OTDA practice of allowing anyone to request a fair hearing on an individual's behalf, whether as a "representative," or as a mere "requester." See OTDA request form at http://otda.ny.gov/hearings/forms/request.pdf.

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state Public Health Law, if the federal Medicaid requirements are more strict. For example, state law allows plans to have more than one level of internal appeal. The federal regulation allows only one internal appeal for Medicaid plans, and this controls. 42 C.F.R. § 408.402(b). .

Third, plans – and not OTDA -- are now the arbiter of whether Aid Continuing applies, at least at the initial level of the plan appeal. Will MLTC plans provide Aid Continuing where, for example, the plan's adverse notice is defective or was untimely – as OTDA has historically ruled in such cases? The federal regulations define at least one circumstances which warrant "deemed exhaustion," allowing a fair hearing request without exhausting the plan appeal. 42 C.F.R. § 438.408. That is where the plan failed to decide the internal plan appeal by the deadline. However, CMS permits states to deem exhaustion on a broader basis than does the final regulation, but the State has not done so to date. See n 5, *infra*, at p. 27510 and discussion in next section below.

Fourth, if the decision after the internal Plan Appeal decision is adverse, then the consumer must *again* appeal in the short time limit to get Aid Continuing. While the second appeal is a request for a fair hearing, which is familiar to the elder law bar, this is now a second hurdle for the consumer, requiring them to respond quickly to request appeals *two times.* Also, this request must comply with the new requirement that the consumer make or sign the hearing request or give written consent to a representative to sign it.

1. BACKGROUND – REVISION OF FEDERAL REGULATIONS in 2015-2016

This change in appeal rights is required by federal Medicaid regulations, as amended in 2016. In 2015, the Obama Administration initiated a formal rulemaking process to amend the Medicaid managed care regulations, which had last been amended in 2002.[3] After hundreds of comments were filed, by organizations including the National Health Law Program[4] and the New York Legal Assistance Group, the final regulations were adopted in 2016.[5] The regulations on grievances and appeals are at 42 C.F.R. Part 438. The regulations are effective on various dates in 2017. The effective date for the exhaustion requirement in New York's appeal system was extended to April 1, 2018.

The impetus for the revision was the expansion of Medicaid managed care from being a small demonstration program covering limited primary care services for families and children in the 1990's, to the principal model for delivering all Medicaid services for all populations, including Long Term Services and Supports (LTSS) for the elderly and disabled. Grievance and appeals systems are just one of many aspects of managed care affected by the amendments to the regulations. For summaries of the other changes, see the National Health Law Program series of seven issue briefs on the revisions.[6]

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[3] Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015)

[4] NHELP comments filed in July 2015 are available at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>

[5] Notice of Final Rule, 81 Federal Register 88 at p. 27498 (May 6, 2016)

[6] National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs, available at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>

In its explanation of requiring "exhaustion" in the final regulation, CMS described its desire to align Medicaid appeals with those enrollees will experience in private health insurance as well as in Medicare Advantage.

> While we understand commenters' concerns and recommendations regarding direct access to a state fair hearing for vulnerable populations, we also have concerns regarding inconsistent and unstructured processes. We believe that a nationally consistent and uniform appeals process (particularly one consistent with how other health benefit coverage works) benefits enrollees and will better lead to an expedited resolution of their appeal.

81 Federal Register 88 at p. 27509 (May 6, 2016). The notion that Medicaid recipients flow back and forth from Medicaid to employer-based insurance to Qualified Health Plans through the ACA underlies many of the changes made, including the exhaustion requirement. Advocacy groups, including NYLAG, had opposed the exhaustion requirement, arguing that it would cause delay in accessing fair hearings, would put Aid Continuing rights at risk, and would confuse beneficiaries accustomed to requesting hearings directly on Medicaid eligibility issues. NYLAG comments pointed out that exhaustion had been confusing and harmful when it was required in New York briefly for MLTC until 2015.

CMS claimed that any delay in accessing fair hearings caused by the exhaustion requirement was mitigated by shorter deadlines for plans to decide appeals (30 calendar days, shortened from 45 days) and by "deemed exhaustion," which allows a consumer to request a fair hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 Federal Register 88 at 27510. CMS' preamble to the final regulations states, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." Id. As of February 12, 2018, the State has not responded to advocates' request to apply deemed exhaustion in other circumstances, such as when the plan fails to send any written notice, or a notice that is timely and adequate, complying with all requirements including language access and State DOH guidance specifying notice requirements in MLTC.[7]

2. New York State Rulemaking and Policy Guidance on New Exhaustion Requirement

State regulations on managed care appeals have not yet been amended to incorporate the federal changes, so should not be relied upon. 18 NYCRR Part 360-10. The New York State Department of Health [DOH] convened a Service Authorizations and Appeals Stakeholder Workgroup in 2017 to elicit stakeholder input on implementing the exhaustion requirement and other federal changes. Stakeholders included representatives of the MLTC and mainstream managed care plans and consumer advocates, including NYLAG. The Workgroup was led by administrators in two different divisions of DOH – one that oversees mainstream plans, and one that oversees MLTC plans.

The Workgroup focused on revising the adverse notice templates, which are now posted on a new webpage called "Service Authorizations and Appeals," available at

[7] See MLTC Policy 16.06, *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services (*available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. These templates must be used by both mainstream managed care and MLTC plans for Initial Adverse Determinations, which must be appealed to a plan appeal, and Final Adverse Determinations, which state the plan's decision after the plan appeal, which may be appealed to a Fair Hearing. New Appeal Request Form and Fair Hearing Request Forms for MLTC and other managed care appeals are included in the new model adverse notices. Since these forms will be pre-populated with information about the client's appeal, it is recommended that they be obtained from the client and used to file the appeal request.

Beside the notice templates, other policy guidance is apparently being issued separately by the two DOH divisions that oversee the two types of Medicaid managed care plans– one for MLTC plans and one for plans for Medicaid recipients who do not also have Medicare --Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP). As of February 20, 2018, only the division overseeing mainstream Medicaid managed care has conducted webinars and posted policy guidance and Frequently Asked Questions for plans. These are all available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

Policy guidance from the MLTC division is expected to be posted on the MRT 90 webpage at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/ - presumably under the link on that webpage for MLTC Policies. As of February 20, 2018, no guidance has been posted. However, the guidance posted for Mainstream MMC plans should be binding for MLTC plans since it is issued by the same State agency, which is the Single State Agency that administers the NY Medicaid program. 42 U.S.C. §1396a(a)(5).

Health care providers should stay tuned for a Medicaid Update article on the change, which will be posted at https://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

In March 2018, members of all managed care plans should receive by mail from their plans a letter with a revised Member Handbook. DOH must revise the standardized language for this handbook, which most plans post on their websites, and which is incorporated in the Contract by which plans contract with the NYS DOH.[8]

NYLAG's article on appeals in MLTC Plans will be updated to include links to any guidance issued by NYS DOH, available at http://www.wnylc.com/health/entry/184/.

3. **Definitions and Types of Notices; Appeal vs. Grievance**

[8] The Model MLTC contract is posted on the MRT 90 Webpage cited above. Click on Health Plans, Providers and Professionals at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm. Click on Model Contracts and select Partial Capitation Contract. Direct link is https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf (Contract 1/1/2015 - 12/31/16 is most current available). The Member Handbook is in Appendix K.

The exhaustion requirement specifically states, "An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld." 42 C.F.R. § 438.402(c). These terms are defined below. Appeals and grievances are also distinguished.

An **Appeal** is a request to review an **adverse benefit determination** made by a plan.[9] In New York, the notice of a plan's adverse benefit determination is called an **"Initial Adverse Determination" (IAD).** The plan must use the new notice templates issued by DOH.[10] *Adverse benefit determination* means, any of the following:

> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of a plan to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one plan, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
>
> (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities**.**

42 C.F.R. § 438.400(b). Thus an MLTC plan must issue a Notice of Initial Adverse Determination when it proposes to:

(1) Reduce or stop personal care, adult day care, or other services, or
(2) Deny a request for a new service, such as Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing
(3) Deny or partly deny a request to increase hours of personal care services or other services

If the plan decides the appeal in whole or in part adversely to the consumer, it must issue a notice of **"Final Adverse Determination" (FAD),** which explains the reason for the decision and explains the right to request a fair hearing. 42 C.F.R. § 438.408.

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[9] 42 C.F.R. . § 438.400(b).

[10] Model notices posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. Though this webpage is directed to mainstream managed care plans, the same model notices are required for MLTC plans.

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Grievance – which DOH is calling a "**complaint**" --means "an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by [the plan] to make an authorization decision." 42 C.F.R. §438.400(b). EXAMPLES of grievances that may be filed with MLTC plans as complaints include:

(1) The aide or transportation is late or does not show,
(2) The aide is poorly trained or otherwise does not provide quality care,
(3) Member cannot reach care manager by phone, or care manager does not respond or was rude.
(4) Member disagrees with plan's decision to extend time to decide a request for new or increased services.

Grievances/Complaints may not be appealed to a fair hearing, but may be appealed internally in a Complaint Appeal. DOH has posted a model template for a Complaint Appeal Resolution Notice and for a Complaint Resolution Notice. See https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

4. MORE ON INITIAL ADVERSE DETERMINATIONS – Reductions and Denials

Because Aid Continuing requires special notice content, timing and procedures, Initial Adverse Determinations (IAD) for plan REDUCTIONS or discontinuance of services will be discussed separately than for DENIALS of new or increased services.

A. FOCUS ON REDUCTIONS IN HOURS or SERVICES

After a plan sends an Initial Adverse Determination (IAD) to reduce or discontinue a service, Aid Continuing is only granted when the Plan appeal is requested before the effective date of the IAD. As has been true since *Goldberg v. Kelly*, *supra*, the plan need only mail the notice 10 days in advance of the effective date.[11] With mailing time and weekends, the consumer may well only receive the notice a day or two before the deadline to request the internal appeal. Clients should be advised to always keep the envelope in which notices are mailed. If the postmark is dated later than the mailing date, this can be a ground to obtain Aid Continuing based on untimely notice.[12] In the past, advocates successfully made that argument to OTDA. Now, the argument must be made to the plan itself – the same one that mailed the notice late.

[11] 42 C.F.R. § 438.404(c)(1) cross-references the long-standing regulations that establish timeliness of notices and other Medicaid fair hearing rights outside of managed care, 42 C.F.R. §§ 431.211 - 431.214.

[12] See, e.g. Fair Hearing No. 7182969J, dated Feb. 17, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-2/Redacted_7182969J.pdf (notice not mailed at least 10 days before effective date, citing 42 C.F.R. §§438.404, 431.211; 18 N.Y.C.R.R. §§ 358-2.23, 360-10.8).

i. Aid Continuing required even if the latest Authorization Period has expired

Managed care plans authorize services for specific authorization periods, which for MLTC plans may range up to six months. If a plan has authorized 24-hour x 7 day personal care services for a period that expires on December 31st, the prior federal regulations arguably allowed the plan to end or reduce that service authorization effective December 31st, precluding the consumer from receiving Aid Continuing because the authorization period expired. The amended regulations end this practice, entitling the consumer to Aid Continuing regardless of whether the authorization period for the contested service ends during the course of the appeal, as long as it had not expired at the time the appeal or hearing was requested. 42 C.F.R. §438.420(b)-(c). Additionally, to protect New York Medicaid recipients from the harshness of the former version of the federal regulations, the legislature amended the Social Services Law in 2015, to guarantee that Aid Continuing is required regardless of whether the authorization period expired. N. Y. Social Serv. L. 365-a, subd. 8.

ii. Practitioners Should Become Familiar with the new Initial Adverse Determination (IAD) notices

The DOH templates for the IAD notices, while adopting many recommendations made by NYLAG and other advocates, may still be confusing to consumers, their families and representatives.[13] The notices are in a form of a letter, rather than as a traditional notice. Here is the first paragraph of a hypothetical reduction notice dated April 1, 2018:

> This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

In this example, April 11th is the effective date of the proposed action and the deadline to request the appeal to secure Aid Continuing, yet appears in the notice only *after* the plan appeal deadline – 60 days from the date of the notice or May 31st. This may mislead consumers into thinking they have plenty of time to appeal, obscuring the 10-day time limit to secure Aid Continuing. Also, the language explaining the deadline to get Aid Continuing (April 11th) is subtle – "If you want to keep your services the same until your Plan Appeal is decided…" The language may not be clear to members.

The content of a notice to reduce services must comply with other precedent that requires a change in the consumer's medical condition or other circumstances that justify the reduction. A key authority is NYS DOH MLTC Policy 16.06, see note 7, supra. This is an important directive for practitioners opposing a proposed reduction. The directive clarifies the limited reasons why a plan may reduce personal care services, and requires very specific facts in the notice justifying the reduction. Permitted reasons

[13] See template posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf; see sample of completed reduction notice in hypothetical case posted at http://www.wnylc.com/health/download/644/.

include a change in the medical condition or social circumstances that result in needing fewer hours, not merely the fact that the plan conducted a new assessment that determined fewer hours are needed. The directive also clarifies that "mistake" may only rarely justify a reduction. The directive is rooted in a lawsuit brought against the New York City Medicaid program in the 1990's, challenging a pattern of arbitrary reductions in personal care hours. *Mayer v. Wing,* 922 F. Supp. 902 (S.D.N.Y. 1996). That decision was codified in state regulation, which applies to MLTC plans. 18 NYCRR § 505.14(b)(5)(c).

The lack of an adequate justification for reducing services, and lack of specificity of an alleged justification in the plan's notice, has been a frequent basis for reversal of proposed reductions in fair hearings.[14] Will a plan, reviewing its own proposed reduction and notice, critically review the content of the notices against the applicable standards? It seems doubtful, even though the plan employee conducting the plan appeal must have been "neither involved in any previous level of review or decision-making nor a subordinate of any such individual." 42 C.F.R. §438.406(b)(2). NYLAG and other advocates have asked the State DOH and OTDA to include an inadequate IAD as a ground for waiving exhaustion through the "deemed exhaustion" mechanism.

Plans also may fail to send any notice at all, giving only oral notice, or may send the notice less than 10 days in advance of the proposed effective date, making the notice untimely and defective. Practitioners should advise clients to keep all envelopes in which plan correspondence is mailed. The postmark may show that the notice was not mailed until days after the date of the notice. If the right to Aid Continuing is not recognized by the plan, this postmark should convince them that the notice was untimely. In such cases, if the plan will not authorize Aid Continuing, advocates should request a Fair Hearing and ask OTDA to apply "deemed exhaustion" and order Aid Continuing because the initial IAD notice was untimely. Also, complaints can be made in such cases to the NYS DOH MLTC Complaint Line: 1-866-712-7197 or e-mail mltctac@health.ny.gov. NYLAG is interested in hearing about these cases.

B. Initial Adverse Determinations - Denial of a New Service or of an Increase in A Service

If a plan member has requested a new service, or an increase in services, such as an increase in hours of personal care services, the federal regulations specify deadlines for the plan to issue determinations on these requests, which the consumer may then appeal in a "plan appeal.'

i. Background- how to request an increase or a new service – "Service Authorization Request"

A "Service Authorization Request" is a request by or on behalf of a member to increase an existing service or to authorize a new service. 18 N.Y.C.R.R. §360-10.3(o). The federal regulation for managed care service authorizations was also amended in 2016. 42 C.F.R. §438.210.

[14] See V. Bogart, R. Novick, A. Lowenstein, et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf) [hereafter "Medicaid Matters NY Report on MLTC Reductions"]

The deadline for the plan to issue a written Initial Adverse Determination notice on these requests depends on whether "expedited" review was requested. For standard requests, the plan decision must be issued within 14 calendar days from the date of the receipt of the request, but plan may extend that time for another 14 calendar days on the member's request or if the plan "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." § 438.210(d). The member, or her provider, may request that the plan expedite a decision.

> For cases in which a provider indicates, or the [plan] 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 [plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

42 C.F.R. § 438.210(d)(2). The plan may extend the time to decide an expedited decision by up to 14 calendar days, on the same basis as extending the time for a standard request.

ADVOCACY TIP – A request for an increase in hours or other services or for a new service should be made in writing, or if made orally, should be confirmed in writing. This would start the clock for the plan to make a decision following the deadlines above. Additionally, a statement from a physician or other medical professional is recommended to substantiate the increase or need for the service. The request can be made by calling Member Services or by FAX or certified mail. If the request is made in person with the care manager or at the in-home bi-annual nursing reassessment, ask the nurse or care manager to acknowledge receipt on the member's copy.

ii. Initial Adverse Determination of Service Authorization and Plan Appeal

The plan must use the State-required template for the IAD notice.[15] Under the new rules effective April 1, 2018, the member will have 60 calendar days to request a Plan Appeal (internal appeal) from the date of the notice. This is an increase from 45 days under the old rules before April 1, 2018.

If the plan fails to decide whether to grant a Service Authorizations, above, this constitutes a "denial," and the plan is required to send a notice "on the date that the timeframes expire." 42 C.F.R. § 438.404(c)(5). The member or her representative should check to see if the Plan extended the deadline by up to 14 days. If so, the Plan should have sent written notice of the extension. 42 C.F.R. § 438.408(c)(2). The regulation is unclear on the member's recourse if the plan sends no IAD notice and no extension notice. However, the regulation does state that failure to decide a service authorization within the timeframes "constitutes a denial and is thus an adverse benefit determination." Id. Therefore, presumably the member may request a plan appeal on or after the timeframes expired.

C. Nuts & Bolts of Filing PLAN APPEALS of an Initial Adverse Determination (IAD)

[15] Since it does not include the Aid Continuing provisions of a reduction notice, DOH devised a separate template, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

DOH is requiring plans to accept appeal requests by phone, fax, or mail. Plans have the option of also accepting appeal requests by e-mail or online. The phone and fax number mailing address, and at plan option, email address and online portal, should all be on the plan's IAD notice. The IAD Notice template includes a Plan Appeal Request Form, which is pre-populated with information about the member and the issue. This Appeal Request Form should be used if available. However, two new strict requirements for filing appeals must be heeded in order to ensure timely filing and, in cases of reductions, ensure Aid Continuing. First, an oral request must be confirmed in writing, unless it requests an expedited appeal. Second, the consumer must sign the written request, or authorize a representative in writing to request the appeal. Both of these new requirements are described below.

i. Oral appeal must be confirmed in writing unless it requests expedited appeal

"Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal." 42 C.F.R. § 438.402(c)(3). In other words, if a request is made by phone, unless the member, her provider or representative requests that the appeal be expedited or "fast tracked," (defined below) the phone request must be followed up by a written appeal request. Providing some relief, the regulation provides that "…oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." 42 C.F.R. § 438.402(c)(3). The phone call requesting the appeal, therefore, if made before the effective date of a reduction, locks in Aid Continuing.

An FAQ issued by State DOH regarding this regulation provides guidance as to the consequence of not confirming an oral appeal in writing:

> *FAQ 5. How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?*
>
> *Enrollees must follow verbal requests in writing unless the request is for an expedited Plan Appeal. Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return. The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the plan must make a determination even if a written Plan Appeal is not received.*

NYS DOH FAQ No. V. 5, dated Feb. 7, 2018.[16] Note that the sole FAQs posted on the NYS DOH website were specifically issued for Mainstream Medicaid Managed Care (MMC) by the division of State DOH that has oversight over those plans. A separate division has oversight over MLTC plans, which has, as of Feb. 18, 2018, not issued any policy guidance. Since the FAQ was issued by the same state agency

[16] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v) [hereafter referred to as "DOH 42 C.F.R. 438 FAQ"}

that oversees MLTC, and under general principles of administrative law requiring consistency of state policy, they should be binding on MLTC plans. 42 C.F.R. § 431.10.

The federal regulation does not require written confirmation of an oral appeal request if an expedited appeal is requested. An appeal is expedited (fast-tracked) if:

> …the [plan] determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function.

42 C.F.R. § 438.410(a). The language implies that a *provider's* request that the appeal be expedited is binding on the plan, while the plan must determine whether it agrees that a the appeal must be expedited when requested by the *member.*

ii. Client must Sign the Appeal Request Or Give Written Authorization for a Representative to File Request

The new federal regulations require the member to file the appeal request directly, and only allows a health care provider or an authorized representative to request an appeal , grievance, or a State fair hearing on the enrollee's behalf "with the written consent of the enrollee." §438.402(c)(1)(i) and (ii). Additionally, "providers cannot request continuation of benefits as specified in §438.420(b)(5)" – referencing Aid Continuing. Id. A legal practitioner, geriatric care manager, or even a family member must obtain the client's signature to show her consent for the representative to request the appeal or fair hearing, which will likely delay filing an appeal request. The model Appeal Request Form asks for the signature of both the enrolled and the "requester." As a result, the client could miss the deadline to request Aid Continuing and her home care hours could be reduced.

However, the DOH model Notice template states, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal."[17] The model Appeal Request Form has a checkbox to indicate "yes" or "no" to the question, "Have you authorized this person with [Plan Name] before?" If the practitioner or a family member had been authorized before, attach any written authorization or explain when and how the authorization was made on an attachment to the request.

NYLAG has created an Authorization form on which client can authorize her attorney, a family member, a neighborhood organization, the ICAN Ombudsprogram (www.icannys.org), or all of the above, to request plan appeals and fair hearings and, if applicable, represent her in such appeals. Form is available at http://www.wnylc.com/health/download/646/. The practitioner should have all clients sign the form before there is a crisis, and keep the signed copy on file, and give a copy to client and the family member. The form should be sent to the plan return receipt requested, or given to the care

[17] DOH Notice to Suspend, Reduce or Stop Services, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm, under heading "Who May Ask for a Plan Appeal."

manager, with the care manager asked to sign the client's copy to acknowledge receipt. Attach a copy of the signed authorization to the appeal request, and check YES to the question, "Have you authorized this person with [Plan Name] before?"

NYS DOH has issued two FAQ's regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. These FAQs do not expressly apply to MLTC plans, since they were issued by a separate division within DOH that oversees Mainstream Medicaid Managed Care (MMC) and not MLTC plans. However, as stated above, the policy should be binding on MLTC plans as well.

In the original FAQ issued by DOH to managed care plans, Question V. 8 provides:

> *FAQ V. 8. If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?*
>
> *Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment. The plan should have a process to recognize and include an enrollee´s representative when an enrollee has authorized the representative for services authorization and appeal activities prior the decision under dispute and such authorization has not expired.*[18]

This FAQ is important for several reasons. First, the plan must process the appeal request – and presumably comply with Aid Continuing – even if it has not received the member's written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, NYS DOH acknowledges the plans' duty to provide reasonable accommodations of such disabilities. These must include policies and procedures to recognize "previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment." Id. The model Appeal Request Form incorporates this policy by stating, "If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal."

A Supplemental FAQ, also issued by the DOH division that oversees "mainstream" Medicaid managed care plans, states that Aid Continuing will not be provided if the appeal is requested by a health care provider, unless the enrollee has authorized the provider as their representative.

> *FAQ IV. 2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?*
>
> *42 C.F.R. § 438.402(c)(1)(ii) requires the enrollee´s written consent for the provider or authorized representative to file a Plan Appeal on the enrollee´s behalf. Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their*

[18] DOH 42 C.F.R. 438 FAQ, *supra*, n. 15, Question V.8

representative for the Plan Appeal and the Aid Continuing request, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.[19]

The prohibition on a health care provider requesting Aid Continuing, unless specifically authorized by the plan member, reflects a suspicion that providers are acting in their own interests in receiving payment for services and not in the interests of the member.

iii. Appellant's Potential Liability to Repay Cost of Services Received as Aid Continuing – and Appeal Request Form Checkbox to indicate that Aid Continuing is not requested

It has always been true that a Medicaid recipient may be held liable to pay for services received as Aid Continuing, if the recipient is ultimately found, after a hearing, not eligible for those services. As before, the revised federal managed care regulations provide:

> (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the [plan's] adverse benefit determination, the [plan] may, consistent with the state's usual policy on recoveries under 431.230(b) of this chapter and as specified in the [plan's] contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

42 C.F.R. § 438.420(d). New York's model contract for MLTC plans has language in the Member Handbook advising the member that, "if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing."[20] Both the Initial and Final Adverse Determination Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 C.F.R. § 438.404(b)(6).

The federal regulations arguably allow states to limit Aid Continuing to those appellants who specifically request Aid Continuing when they file the appeal. New York continues to take a more liberal view, and presumes that the appellant is requesting Aid Continuing unless they indicate otherwise. Hence, the

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[19] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; SUPPLEMENTAL FINAL RULE FAQ's -- *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), Question IV.2. revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#iv [hereafter "Supplemental NYS DOH FAQ"]

[20] See Model Contract for Partial Capitation Plans, *supra* n. 8, Appendix K (pp. 145 and 147 of PDF)

model Appeal Request Form has a checkbox to indicate, "I do not want my services to stay the same while my Plan Appeal is being decided."

Though clients should be advised about the potential liability to repay services provided with Aid Continuing if they ultimately lose the Fair Hearing, they should also be advised about the high probability that they will win their appeal of a reduction, at least for personal care or CDPAP services. In a study analyzing all fair hearing decisions posted on the OTDA online archive involving reductions of home care hours by MLTC plans in the last seven months of 2015, MLTC plans prevailed in only 1.2% (13 out of 1,027) of the hearings.[21] The report explains the law and policies governing plan reductions, including the plan's burden of proof that a reduction is justified by a change in the medical condition or other circumstances. Since that Report was issued, the client's ability to defeat a proposed reduction in hours has been strengthened by additional State policy directives.[22]

DOH has also clarified that if members lose the initial Plan Appeal, plans may not recoup the cost unless and until a member fails to request a fair hearing within the statute of limitations.[23]

D. When Must Plan Decide Standard Appeals and Expedited Appeals – and Member's Right to Request Fair Hearing if Plan Does Not Meet Deadlines (Deemed Exhaustion)

Where delay is harmful to the client, such as where the client is seeking an increase in home care hours or a new service, or does not have Aid Continuing on a reduction, the practitioner will need to monitor the plan's compliance with the regulatory deadlines for deciding the plan appeal, and oppose any extension of the deadline that does not comply with the regulations described below. Importantly, the plan's failure to comply with the deadlines set forth below constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i).

The Deadlines. A standard appeal must be decided by the plan within - within **30 calendar days** of receipt of the appeal request, subject to an extension of up to **14 calendar days** described below. 42 C.F.R. § 438.408(b). The member or her provider or representative have the right to request an expedited or "Fast Track" appeal, if "taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum

[21] See Medicaid Matters NY Report on MLTC Reductions, supra at n. 14.

[22] See NYS DOH MLTC Policy 16.06, *supra* , n 7, and MLTC Policy 16.07: *Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services,* both dated Nov. 17,2016 (both available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm *)*

[23] DOH 42 C.F.R. 438 FAQ*, supra,* n. 16, at Section VII, Question 3 FAQ (The FAQ says plan cannot recoup losses until member "fails to request a fair hearing within 10 days of the Final Adverse Determination, which appears to be an error and is presumably meant to say within 120 days of the FAD. NYLAG has requested a correction).

function." 42 C.F.R. § 438.410. An expedited appeal must be decided within **72 hours** after the plan receives the appeal, subject to the same 14-day extension as for standard appeals. 42 C.F.R. § 438.408(b).

Extension of the Deadline. The Plan may extend its time to decide a standard or expedited appeal by up to 14 calendar days if the enrollee requests the extension, or if the plan "shows (to the satisfaction of the State agency, upon request)that there is need for additional information and how the delay is in the enrollee's interest." 42 C.F.R § 438.408(c). The regulation does not explain by what procedure the extension would be approved to the State agency's (State DOH) satisfaction, but presumably the enrollee would utilize the existing DOH MLTC Complaint Line – 1-866-712-7197 or email mltctac@health.ny.gov**.**

If the "… plan extends the timeframes not at the request of the enrollee, it must complete all of the following:

> (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.
>
> (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
>
> (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

42 C.F.R §438.408(c)(2). NYS DOH has issued a model Notice of Extension for plans to use to fulfill the requirement above.[24]

If a member or her representative wishes to dispute an extension, from the regulations above, the member may file a grievance with the plan and/or file a complaint with the State DOH at 1-866-712-7197 or e-mail mltctac@health.ny.gov.

The plan's failure to comply with the deadlines set forth above constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i). The hearing request could be requested either 72 hours after a request for expedited review was filed, or 30 days after a standard appeal was filed, subject to the 14 day extension if warranted.

5. Member Rights in Plan Appeal

While practitioners may not have utilized the internal Plan Appeal process when it was optional, going instead directly to a fair hearing, now there is no choice but to use it. At best, the client will win the plan appeal and no fair hearing will be necessary. Even if not favorably decided, the plan appeal provides an opportunity to obtain the plan's case file, and provide additional documentation in support

[24] Extension notice available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf

of the claim to the plan, with no harm to the client if there is Aid Continuing. At worst, the plan appeal can cause great harm to the client, adding extra delay until a Fair Hearing is held and decided, which can be harmful when an increase is being requested or services are reduced without Aid Continuing.

i. Plan Must Provide Case File to Enrollee and Representative without Request

In the past, the plan only had to provide the case file upon request. Under the new regulation, the plan must:

> 5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by … (or at the direction of the [plan] in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §§438.408(b) and (c).

42 C.F.R. §438.406(b)(5). NYS DOH has issued several FAQ's to clarify the plan's duty to provide the case file while the plan appeal is pending. See *Supplemental NYS DOH FAQ*, supra, n. 19.

> *2. Is it the State´s expectation that Health Plans will send a case file upon every request for a Plan Appeal (standard and expedited) requests?*
>
> > *Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.*
>
> *3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?*
>
> > *42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.*
>
> *4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical fair hearing evidence packet?*
>
> > *The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal. Upon receiving a Plan Appeal, the plan must automatically send the enrollee´s case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally–generated documents but does not necessarily generally include all medical records that may be in the plan´s possession. The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the fair hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the fair hearing request from OAH.*

If you want the file to be provided directly to the representative, submit a signed HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA , available at http://www.nycourts.gov/forms/Hipaa_fillable.pdf.

ii. Right to present new evidence in person or in writing

Plan must consider new evidence submitted in support of the appeal "…without regard to whether such information was submitted or considered in the initial adverse benefit determination." 42 C.F.R. § 438.406(b)(2)(iii).

The plan must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 42 C.F.R. § 438.406(b)(4)

TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if the appellant or her representative wants to include additional documents with the appeal request, or to give information in person. The member or representative could also write on the form that they request time to submit additional written documentation.

iii. Reasonable Accommodations to help with appeal

The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 C.F.R. § 438.406(a).

iv. Appeal Must be Decided by Individuals who were Not Involved in Initial Decision

The plan appeal must be decided by individuals:

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
(ii) Who, if deciding any of the following, are individuals 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.

42 C.F.R. §§ 438.406(b)(2)(i) and (ii).

6. Plan's "Final Adverse Determination" (FAD) after the Plan Appeal and Request for Fair Hearing

State DOH has issued a model notice template for a Final Adverse Determination (FAD), which is a Plan's decision after the plan appeal that is wholly or partially adverse to the member. Practitioners should note that the word "Final" on the notice means that this is the decision after the Plan's plan, meaning that the member has met the exhaustion requirement and may request a Fair hearing.

Where the appeal involves a reduction in home care hours or other services, the FAD Notice is both a decision explaining the reason for denying the appeal AND a new Notice of Reduction, which again must be provided 10 days before the effective date of the proposed reduction. A Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action, in order to secure Aid Continuing. In the state's model FAD notice template,[25] note that the "effective date" is listed *after* the statute of limitations for requesting a fair hearing, which is now 120 calendar days. 42 C.F.R. §438.408(f)(2). This placement may cause members to delay seeking representation or requesting a fair hearing. Of course, it is crucial to request a fair hearing within 10 days of the notice date, and not wait for the 120 day statute of limitations.

Where the effective date has already lapsed by the time the member has consulted an attorney, one strategy is to obtain the postmarked envelope in which the notice was mailed. If it was not mailed 10 days in advance of the effective date, Aid Continuing should be awarded. See fn. 11, *supra*. Another strategy is to look for other defects in the notice content. See, e.g. the Medicaid Matters NY Report on MLTC Reductions, supra, n. 14 for more information.

The next step is to request a FAIR HEARING. While hearings may be requested by the same modes as in the past, see http://otda.ny.gov/hearings/request/, Just like for Plan Appeals, the new regulations require the member to SIGN the request, or authorize a representative to do so. See above recommendation to have all clients sign "authorization" to request appeal or hearing in advance to have on file, and to attach to hearing request.

It is recommended to use the new Fair Hearing Request Form that should be part of the FAD Notice from the plan, since it has pre-populated information that is useful to OTDA.

If plan does not send the FAD notice by the deadline (30 days for standard appeals / 72 hours for expedited appeals, both subject to 14 day extension) then the member may request the FAIR HEARING even though the plan has not made a decision on the Internal Appeal. This is called "Deemed Exhaustion." 42 C.F.R. § 438.402(c)(1)(A).

7. Optional External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an External Appeal, if the reason for the denial is because the plan determines the service is not medically necessary or is experimental or investigational. An external appeal, like Fair Hearings, requires exhaustion of the internal plan appeal and may only be requested after receipt of the FAD.

[25] Model FAD Notice of Reduction available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_reduce_services.htm.

One may request an External Appeal even if one also requests a Fair Hearing, but the decision from the Fair Hearing supersedes the External Appeal decision. NY Public Health Law § 4910.

If the issue involves a plan's proposal to reduce or stop a service, the member MUST request a Fair Hearing before the effective date of the FAD in order to receive Aid Continuing.

For more information about External Appeals see
http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

8. Additional information and Contacts

For updates on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/

Fax, phone and email contact info to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197 mltctac@health.ny.gov

NYS DOH Mainstream managed care complaints --1-800-206-8125

NYS DOH Managed care webpage on appeals
https://www.health.ny.gov/health_care/managed_care/plans/appeals/

ICAN – Independent Consumer Advocacy Network – Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org
ican@cssny.org

Jane Perkins*, Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems*, (National Health Law Program, May 12, 2016), available at
http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WoGveSXwa2w

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