MANAGED LONG TERM CARE UPDATE

Presented By:

David Silva, Esq.
Community Service Society of New York
New York City

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David Silva, Esq.
Community Service Society of New York

Introduction

Since Governor Cuomo's Medicaid Redesign initiative began in 2011, the majority of New Yorkers needing Medicaid home care must enroll in Managed Long Term Care (MLTC) plans.[1] MLTC plans are but one variety of Medicaid Managed Care plan offered in New York State. There have been several significant changes to the MLTC program in the last year. To fully understand these changes, it is important to have a basic background on Medicaid Managed Care.

Background on Medicaid Managed Care

In New York state, the majority of Medicaid recipients are required to receive their Medicaid benefits through privately owned and operated managed care organizations (MCOs).[2]

Under fee-for-service (FFS) Medicaid, an enrolled provider submits claims directly to the Medicaid program for each service provided, sometimes subject to prior authorization by the Medicaid program. In Medicaid Managed Care, the State pays each MCO a fixed capitation payment per-member, per-month (PMPM) for each enrollee. The capitation is generally the same for all enrollees in a given plan, but varies from plan to plan. This variation is due to differences in the acuity of each plan's enrolleed population. For example, if a plan's enrollees have medical conditions that would tend to make them costlier to care for on average than the overall population, then that plan would get a higher monthly capitation. This is called "risk adjustment." Plans are expected to comply with all rules governing the Medicaid program, but have flexibility to determine their own networks of contracted medical providers and employ utilization management (e.g., prior authorization) to reduce costs.

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1 https://www.health.ny.gov/health_care/medicaid/redesign/

2 N.Y. Social Services Law § 364-j(3)(a) [Mainstream Medicaid Managed Care]; N.Y. Public Health Law § 4403-f [Managed Long Term Care].

There are about nine different varieties of MCO providing Medicaid benefits in New York. By far the most common is the Medicaid Managed Care, or "mainstream," plan, which covers 71% of all Medicaid recipients in the state.[3] The remaining managed care products are tailored for particular subsets of the Medicaid population with special healthcare needs (e.g., people living with HIV/AIDS, dual eligibles, long term care consumers, people with behavioral health needs, or people with intellectual or developmental disabilities). All together, these special Medicaid managed care products account for only around 7% of the Medicaid population.

However, there has been tremendous growth in the MLTC product, with enrollment more than doubling in the last five years (MMC enrollment grew by 25% in that same period).[4]

Medicaid Managed Care Enrollment Summary[5]

Managed Care Product	Abbrev-iation	Covers Long-Term Home Care?	Number of Enrollees	% of Recipients
Mainstream Medicaid Managed Care	MMC	Yes	4,368,967	71
Partial-Capitation Managed Long Term Care	MLTC	Yes	212,736	3
Health And Recovery Plans	HARP	Yes	129,499	2
Medicaid Advantage Plus	MAP	Yes	11,459	0
Medicaid Advantage	MA	No	6,237	0
Programs of All-inclusive Care for the Elderly	PACE	Yes	5,663	0
Fully Integrated Duals Advantage	FIDA	Yes	3,797	0
FIDA for Individuals with Intellectual or Developmental Disabilities	FIDA-IDD	Yes	1,048	0
Managed Care Total			**4,739,406**	**78**
Fee-For-Service Total			**1,371,393**	**22**
Total			**6,110,799**	

[3] N.Y. Social Services Law § 364-j(1)(b).

[4] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018 and August 2013), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm.

[5] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm; N.Y. Dep't of Health, MEDICAID PROGRAM ENROLLMENT BY MONTH: BEGINNING 2009 (January 2018), *at* https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3 (Managed Care enrollment data as of August 2018; fee-for-service data as of January 2018; most current available).

"Mainstream" Medicaid managed care plans are Health Maintenance Organizations (HMOs) or Prepaid Health Service Plans (PHSPs), licensed under Article 44 of the Public Health Law or Article 43 of the Insurance Law, to provide comprehensive health services on a full capitation basis to Medicaid recipients.[6] These entities are regulated by the NY Department of Financial Services (formerly the Department of Insurance) in the same manner as MCOs provided through employer-sponsored, marketplace, or other commercial venues.[7]

However, because they provide Medicaid benefits, Medicaid managed care plans are also subject to several other layers of regulation, from both the Federal and State governments.

The U.S. Centers for Medicare and Medicaid Services (CMS) promulgated regulations governing any state that uses managed care plans to deliver Medicaid benefits.[8] These regulations were amended in 2016, introducing several significant changes to New York's program which are only going into effect this year.

Each Medicaid Managed Care plan has a contract with the State, which is based off of a Model Contract posted on the Department of Health website.[9] These contracts obligate MCOs to comply with a number of different laws and regulatory regimes, including: 42 C.F.R. Part 438; the N.Y. Public Health Law; the N.Y. Social Services Law; and the Americans with Disabilities Act.[10]

In general, the rule is that "what's good for FFS is good for managed care." However, there are three specific applications of that rule that are worth highlighting:

- The State must require that covered services "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."[11]
- When the state delegates prior authorizations for Medicaid services to private entities, Medicaid recipients may challenge such determinations as if they were made by the Medicaid program.[12]
- The Model Contracts include a glossary of covered services, incorporating by reference the eMedNY Provider Manuals that define clinical criteria and medical necessity for FFS Medicaid.[13]

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6 Id. However, the variety of managed care plan providing the majority of home care services, MLTC, is partially capitated. This means that its benefit package only includes a subset of the services otherwise covered by Medicaid.

7 N.Y. Public Health Law § 4402(1); N.Y. Insurance Law § 4301.

8 42 C.F.R. Part 438.

9 See https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm#model and https://www.health.ny.gov/health_care/managed_care/providers/#model_contracts.

10 See e.g., N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Art. II (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

11 42 C.F.R. § 438.210.

12 N.Y. Social Services Law § 365-a(8).

From these authorities we can conclude that if a particular service were deemed medically necessary for a particular individual under FFS Medicaid, it should remain so under managed care, absent some change in the individual's condition.

In addition to the Provider Manuals, there are N.Y. State regulations defining the medical necessity criteria and assessment processes for most Medicaid-covered healthcare services.[14] Of particular importance to home care practitioners are those regulations governing the personal care,[15] consumer-directed personal assistance program,[16] certified home health agency, [17] and private duty nursing benefits.[18]

The above authorities require that the MCOs' processes for authorizing those services can be no stricter than these regulations. So while the financing and delivery systems may have changed, the underlying rules regarding covered services have not. This remains true in spite of the following recent changes.

2016 Amendments to Federal Medicaid Managed Care Regulations

In 2016, the U.S. Centers for Medicare and Medicaid Services (CMS) finalized amendments to the regulations governing Medicaid Managed Care.[19] These amendments included many changes intended to modernize the regulations in light of changes in managed care. Several of these changes relate to the process for appealing adverse determinations by managed care plans, and are therefore of particular relevence for elder law practitioners.

Exhaustion of Internal Appeals Now Mandatory

All types of Medicaid Managed Care plans have always been required to have an internal grievance and appeal system.[20] This system was required to enable enrollees to appeal certain actions by the plan and receive a written decision. However, because these plans administer Medicaid benefits, enrollees are also entitled to a Medicaid Fair Hearing.[21] Under the previous regulation, states were given flexibility to decide whether to require enrollees to exhaust the

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13 N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Appendix J (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf; N.Y. Dep't of Health, EMEDNY PROVIDER MANUALS at https://www.emedny.org/ProviderManuals/index.aspx.

14 See e.g., 18 N.Y.C.R.R. Chap. II, Subch. E, Art. 3.

15 18 N.Y.C.R.R. § 505.14.

16 18 N.Y.C.R.R. § 505.28.

17 18 N.Y.C.R.R. § 505.23.

18 18 N.Y.C.R.R. § 505.8.

19 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27497 (May 6, 2016)(codified at 42 CFR Part 438), available at https://www.federalregister.gov/d/2016-09581.

20 42 C.F.R. Part 438, Subpart F.

21 18 NYCRR Part 358.

internal plan-level appeal before they could request a Fair Hearing. Under these amendments, states no longer have that option. Exhaustion of internal appeals is now required for all kinds of Medicaid Managed Care plan, in all states.[22]

When Medicaid Managed Care was first implemented in New York, advocates successfully argued that exhaustion should not be required, because Medicaid recipients were accustomed to requesting fair hearings, and this was a new system that was likely to result in many disputes about services. As a result, exhaustion had never been required for enrollees in Mainstream MMC plans in New York (this includes HIV SNP and HARP).

However, New York *did* require exhaustion of internal appeals in MLTC plans until July 2015.[23] All other varieties of Medicaid Managed Care in New York have always required exhaustion of internal appeals (i.e., PACE, Medicaid Advantage, Medicaid Advantage Plus, FIDA, and FIDA-IDD).

From July 2015 through April 2018, MLTC enrollees were not required to exhaust internal appeals before requesting a Fair Hearing. Beginning May 1, 2018, they are.[24] This change has several important ramifications for enrollees and their advocates.

Consumers can no longer request a Fair Hearing to challenge a plan action

From July 2015 through April 2018, enrollees in MLTC and MMC plans had two non-exclusive options when challenging a plan action with which they disagreed: internal appeal and/or fair hearing. They could request an internal appeal, wait for a decision, and then request a fair hearing; or they could request both simultaneously; or they could just request a fair hearing. As a practical matter, going straight to a fair hearing usually made the most sense, because they had a more favorable reversal rate (over 70%); the decisionmaker was independent and impartial; and legal precedent was more likely to be honored. However, because fair hearings take many months and are difficult for consumers to navigate, some people would request an internal appeal concurrently and withdraw their hearing if they got a favorable decision.

Starting May 1, 2018, enrollees cannot request a fair hearing to challenge a plan action until they have received a Final Adverse Decision (FAD) after a requesting an internal plan appeal.[25] This means that enrollees no longer have a choice at their first step of the appeals process: the first

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22 42 C.F.R. § 438.408(f)(1).

23 N.Y. Department of Health, MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees (July 2, 2015), at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-03.htm.

24 Email from Hope Goldhaber, Deputy Director, Division of Health Plan Contracting and Oversight, N.Y. Dep't of Health, to Service Authorizations and Appeals Stakeholder Workgroup (February 27, 2018, 3:59 pm) (on file with author).

25 42 CFR §§ 438.402(c)(1)(i) & 438.420(b); NY Dep't of Health, NYS MMC Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations at 2 (12/15/2017).

step is always to request an internal appeal. If the plan does not issue a FAD within the timeline, or if the FAD or extension notice is defective, then the enrollee can proceed to a fair hearing under "deemed exhaustion."[26]

Practice Note: The exhaustion requirement only applies to "adverse benefit determinations" by Medicaid managed care plans.[27] There are still certain issues which an enrollee can take directly to a fair hearing without needing to request an internal appeal first. For example, involuntary disenrollments are technically not actions of the plan; they are actions of NY Medicaid Choice, the enrollment broker designated by the State. As a result, NY Medicaid Choice must send a timely and adequate notice and the individual has the right to a fair hearing and aid continuing, without needing to exhaust the internal plan appeal.

Requesting a fair hearing no longer ensures aid continuing; must request an internal appeal

Under Federal and State welfare regulations, the Medicaid program must continue services without change during the pendency of the appeal while a recipient is appealing a reduction or discontinuance of services.[28] Prior to May 1, 2018, the enrollee could only get aid continuing by requesting a fair hearing, not an internal appeal. Starting May 1, 2018, this is reversed: the enrollee must request an internal appeal by the deadline in order to get aid continuing.

If the enrollee makes a mistake and requests a fair hearing, the state agency may issue an aid continuing directive, which the managed care plan must honor.[29]

The deadline to obtain aid continuing remains the same: by the effective date of the proposed action, or within 10 calendar days of the date of the notice, whichever is later.[30] When the plan receives an enrollee's request for an internal appeal of a reduction or discontinuance, they must assume that the enrollee wants aid continuing, unless the enrollee checks the box on the appeal form indicating, or states orally, that they do not want it.[31] This "opt-out" aid continuing is an advantage for consumers who may not have known to say the "magic words" when requesting

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26 42 CFR §§ 438.402(c)(1)(i)(A) & 438.408(c)(3), (f)(1)(i).

27 42 CFR § 438.400(b).

28 42 CFR §§ 431.230, 438.420; 18 NYCRR § 358-3.6.

29 N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 11 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf; N.Y. Dep't of Health, MANAGED LONG TERM CARE PARTIAL CAPITATION CONTRACT ("MLTC Model Contract"), Art. V(R) at pp.39-40 (May 24, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

30 42 CFR § 438.420.

31 N.Y. Dep't of Health, MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) ("Model IAD Notice"), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf.

their appeal. However, it is still true that consumers may be held liable for the cost of services they receive as aid continuing if they lose their appeal.[32]

Second opportunity to get/lose aid continuing after FAD

Now that the fair hearing is the second level of appeal, the question arises of whether/when aid continue persists after receiving an unfavorable decision at the first level of appeal. Regardless of whether aid continuing was granted at the plan appeal level, the enrollee must request a fair hearing within 10 calendar days of the date the FAD was mailed (which should be the same as the notice date) in order to obtain aid continuing during the pendency of the fair hearing.[33]

If the enrollee already had aid continuing at the plan appeal level, then the plan must automatically maintain the aid continuing for 10 calendar days after the FAD in case the enrollee requests a fair hearing during that time.[34] However, the enrollee can lose their aid continuing (even though they had it during the plan appeal) if they don't request their fair hearing within 10 days of the FAD.

Even if the enrollee did not get aid continuing during the plan appeal, they have a second chance once they receive the FAD, by requesting a fair hearing within 10 days.

Adjusted timelines for service authorizations, appeals, and fair hearings

The amended Federal regulations made some adjustments to the timelines for requesting service authorizations, appeals, and fair hearings, and for managed care plans to issue decisions.[35] The modified timelines are indicated in *italics* below.

Service Authorizations

	Old Timeline	New Timeline
Prior Authorization (standard)	3 business days after all info but not > 14 days*	3 business days after all info but not > 14 days*
Prior Authorization (expedited)	3 business days*	*72 hours**
Concurrent Review (standard)	1 business day after all info but not > 14 days*	1 business day after all info but not > 14 days*

[32] 18 NYCRR § 358-3.6(d); 42 CFR § 438.420(d).

[33] 42 CFR § 438.420(c)(2); N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 10 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf

[34] Id.

[35] NY Dep't of Health, NEW YORK STATE MEDICAID MANAGED CARE SERVICE AUTHORIZATION AND APPEALS TIMEFRAME COMPARISON (February 2, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-2-2_timeframe_comparison.pdf.

	Old Timeline	New Timeline
Concurrent Review (expedited)	1 business day after all info but not > 3 business days*	1 business day after all info but not > *72 hours**
Concurrent Review (homecare post-discharge)	1 business day after all info but not > 3 business days*	1 business day after all info but not > *72 hours**

* Subject to extension of up to 14 calendar days.

Internal Appeals

	Old Timeline	New Timeline
Filing Deadline (MLTC)	60 calendar days	60 calendar days
Filing Deadline (MMC & Medicaid Advantage)	60-90 business days	*60 calendar days*
Filing Deadline (Medicaid Advantage Plus)	At least 45 business days	*60 calendar days*
Decision Deadline (standard)	30 calendar days*	30 calendar days*
Decision Deadline (expedited)	2 business days after all info but not > 3 business days*	2 business days after all info but not > *72 hours**

* Subject to extension of up to 14 calendar days.

Fair Hearings

	Old Timeline	New Timeline
Filing Deadline (aid continuing)	10 days from notice date of IAD, or by effective date	*10 days from mailing of FAD*
Filing Deadline (no aid continuing)	60 calendar days from notice date of IAD	*120 calendar days from mailing of FAD*

There have been no changes to the filing or decision timelines for external appeals to the N.Y. State Department of Financial Services.[36] The filing deadline for these remains four months from the FAD.[37] The enrollee must exhaust the plan appeal before requesting an external appeal.[38] If the enrollee requests both an external appeal and a fair hearing, the fair hearing decision will control.[39]

[36] N.Y. Insurance Law § 4910.
[37] Id. at § 4914(2)(a).
[38] Id. at § 4910(2)(a)(ii).
[39] Id. at § 4910(4).

Expedited Appeals

The regulations have long provided for a "fast-track" process in certain cases. As noted above, the regulations shortened the decision timeline for expedited appeals from 3 business days to 72 hours. However, the model notice provided by New York State contains additional grounds for expedited appeals which may make this process more accessible to enrollees.

> 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.[40]

The second reason ("your provider says the appeal needs to be faster") suggests that the doctor's request for an expedited appeal cannot be overruled by the plan. In the past, plans had complete discretion to deny requests for expedited appeals, regardless of whether a letter from the treating physician was provided in support of the request. Any request for an expedited appeal under this (or the first) prong should include a doctor's note explaining in detail how "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."[41]

The third reason ("you are asking for more of a service you are getting right now") suggests that appeals of *all* concurrent reviews must be expedited. In other words, every time a plan denies an enrollee's request for increased home care hours, the appeal must be expedited. This has always been true for one subset of concurrent reviews: requesting increased homecare hours upon discharge from a hospital or nursing home. In either case, this provision has the potential to be of great benefit for enrollees who otherwise must go without medically necessary care for many weeks while awaiting a decision on their appeal.

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[40] Model IAD Notice, supra at note 31.
[41] 42 CFR § 438.410(a).

Practice Note: Advocates are encouraged to invoke these grounds when appropriate to get a faster decision on appeals. However, one downside of expedited appeals is that 72 hours leaves very little time to obtain the case file from the plan, supplement the record with additional medical evidence, and submit any written arguments in support of the appeal. As a result, the plan will likely decide based on no better a record than they had for the initial determination, with the likely result that it will still be denied. Perhaps the best thing about an expedited appeal is that you can "get to no" faster, and proceed quickly to a fair hearing.

Changes to the process for requesting internal appeals

The amendments still preserve multiple means of requesting an internal plan appeal. However, they added the requirement that an orally-requested appeal must be confirmed in writing (unless it is expedited).[42] Furthermore, the enrollee's representative cannot request the internal appeal on their behalf unless they provide written consent of the enrollee.[43] However, if the enrollee has previously designated an authorized representative for the plan, the plan must honor that designation for subsequent appeals.[44]

All plans must include with their IAD notice a standard form that can be used to request an internal appeal.[45] The plans are expected to provide multiple means of requesting an internal appeal, including by phone, fax, email, and mail.[46]

Practice Note: The best practice is to request internal appeals by fax. This ensures that there is a paper trail and proof of delivery, to resolve any potential disputes regarding timeliness. This also means that you can use the appeal form provided by the plan, so they will be most likely to accept it and have all of the information they need to properly process it. Phone appeals are not recommended, as plan staff are sometimes unfamiliar with the appeals process and may give misinformation or process the appeal incorrectly. The one exception is to make a protective filing when the deadline to receive aid continuing is fast approaching, and there is no way to request it by fax or email. Even in that case, it is necessary to follow up in writing to confirm.

New model notices

In response to the amended regulations, the Department of Health has issued new model notices that plans must use for all Initial Adverse Determinations (IAD) and Final Adverse Determinations (FAD), effective May 1, 2018.[47]

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42 42 CFR §§ 438.402(c)(3)(ii), 438.406(b)(3).

43 42 CFR § 438.402(c)(1)(ii).

44 N.Y. Dep't of Health, 2016 FINAL RULE 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS FREQUENTLY ASKED QUESTIONS FOR MANAGED LONG TERM CARE PLANS: PARTIAL CAPITATION, BENEFIT DETERMINATIONS FOR MAP AND MEDICAID ADVANTAGE PLANS ("Part 438 FAQ") #7 at p.8 (March 14, 2018) *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_faqs.pdf.

45 N.Y. Dep't of Health, MODEL APPEAL REQUEST FORM FOR DENIAL OF SERVICES at p.8 of PDF (February 1, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

46 Model IAD Notice, supra at note 31.

Previously, plans were required to use two separate notices for most IADs: one to comply with the Federal managed care regs, and a separate one to comply with State fair hearing regs. Thankfully, these are now combined into a single notice. The Department incorporated feedback from both plans and consumer advocates in designing these notices. They are structured as a series of questions that recipients might ask about the notices, along with responses in plain language. Much of the content is determined by computerized algorithms that fill in blanks or select from alternative blocks of language. All legal precedent regarding the required content of these notices remains in effect (e.g., Mayer v. Wing).

Case files must be provided automatically

Before the amendment, consumer representatives were accustomed to requesting the evidence packet from the plan after requesting a fair hearing. Now, the plan is required to automatically send a copy of the case file to the enrollee and their representative once an internal appeal is requested.[48]

Practice Note: An enrollee has a legal right to obtain a copy of their case file or any other health information from their plan at any time under HIPAA.[49] However, the HIPAA rules give the covered entity up to 30 days to provide the requested records. If the enrollee requests an internal appeal, the plan must provide them automatically and "sufficiently in advance of the resolution timeframe for appeals," which one might expect to be less than 30 days as that is the standard resolution timeframe for internal appeals.[50] It might make sense to make an immediate internal appeal request as soon as the IAD is received, along with a request for the case file, and a request to leave the record open to permit an opportunity to review the case file and supplement with additional evidence and arguments.

The next three changes to be discussed derive from the legislation passed in April 2018 as part of New York State's budget process.[51]

Nursing Home Carve-Out

This change regards the fate of Medicaid Managed Care plan enrollees who require permanent placement in a nursing home. Prior to 2015, MMC enrollees would be involuntarily disenrolled and return to fee-for-service Medicaid after 60 days in a nursing home. While MLTC enrollees

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47 N.Y. Dep't of Health, WEBSITE: SERVICE AUTHORIZATION AND APPEALS at https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm.

48 42 CFR § 438.406(b)(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 [plan] in connection with the appeal of the adverse benefit determination."); Part 438 FAQ at #2-4 (p.7), supra at note 44.

49 45 CFR § 164.524.

50 42 CFR § 438.406(b)(5).

51 N.Y. Budget Appropriations Bill, S.7507 / A.9507, *available at* https://www.nysenate.gov/legislation/bills/2017/s7507.

were not involuntarily disenrolled, they were permitted to voluntarily disenroll, and indeed most did. Starting in 2015, the long-term nursing home benefit was carved into both MMC and MLTC.[52] As a result, plans were no longer able to shift enrollees to fee-for-service upon nursing home placement. In addition, long-term nursing home residents on fee-for-service Medicaid were auto-assigned to MLTC and MMC plans. Now New York plans to request permission from the Federal government to partially reverse this policy.[53]

Upon CMS approval, MLTC enrollees who are permanently placed in nursing homes must be involuntarily disenrolled from their MLTC plans after three calendar months. Individuals will be allowed to remain in the same nursing home throughout this transition. "The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan."[54] This change also means that nursing home residents on fee-for-service Medicaid will no longer be required to enroll in MLTC.

This change only impacts enrollees of partial-capitation MLTC plans; it does not impact enrollees of MAP, PACE, FIDA or MMC plans.

In addition, individuals who are disenrolled from their MLTC plan under this rule will be deemed eligible for Community-Based Long Term Care (CBLTC) services for six months, meaning that they can re-enroll in MLTC to return to the community without needing a Conflict-Free Evaluation and Enrollment Center (CFEEC) evaluation. However, they will require a pre-enrollment assessment by the MLTC plan of their choice.

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52 N.Y. Dep't of Health, TRANSITION OF NURSING HOME BENEFIT AND POPULATION INTO MANAGED CARE (February 2015), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf.

53 N.Y. Dep't of Health, DEAR HEALTH PLAN ADMINISTRATOR LETTER ("Dear HPA Letter") (May 23, 2018), *available at* https://hca-nys.org/wp-content/uploads/2018/04/Dear-Health-Plan-letter-budget.pdf.

54 Id.

Practice Note: This policy was intended to relieve the financial burden on MLTC plans of paying for expensive nursing home care, the monthly cost of which exceeds their monthly capitation from the state. Advocates are concerned that this creates a financial incentive to institutionalize enrollees who would otherwise need costly, high-hour home care services. MLTC plans are prohibited from disenrolling a member due to the cost of their care or the nature of their medical condition(s).[55] However, an MLTC plan can now once again use nursing home placement as a loophole to allow them to disenroll high-cost enrollees and shift their costs onto fee-for-service Medicaid. In response to concerns from the NY State Assembly, the Department gave assurances that it would "provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports."[56]

Enrollment Lock-In

Another change arising from the NY Budget process this year is a provision restricting MLTC enrollees' ability to change plans. Beginning December 1, 2018, individuals enrolling in an MLTC plan (either because they are new to care or due to a plan-to-plan transfer) will have a 90-day grace period to change plans, followed by a 9-month lock-in period during which they may not switch plans unless they can show good cause.[57] "While not an exhaustive list, the following circumstances are examples of good cause: the enrollee is moving from the plan's service area, the plan fails to furnish services, or it is determined the enrollment was non-consensual."[58]

After the 9-month lock-in period, the enrollee may once again switch plans at will. However, any subsequent enrollment starts a new 90-day grace period, followed by a new 9-month lock-in period. This policy only applies to partial-capitation MLTC plans; there is no lock-in for MAP, PACE, or FIDA. There has always been a lock-in period for MMC; that has not changed.

Cap on Number of Home Care Agencies in MLTC Network

As with the prior two changes, this one attempts to address the growth of cost in the MLTC program. It caps the number of Licensed Home Care Services Agencies (LHCSAs) with which a

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55 42 CFR § 438.56(b)(2).

56 N.Y. Dep't of Health, SIDE LETTER TO N.Y. STATE ASSEMBLY HEALTH COMMITTEE CHAIR, HON. RICHARD N. GOTTFRIED (March 30, 2018), on file with author.

57 N.Y. Dep't of Health, MEDICAID UPDATE: JUNE 2018, VOLUME 34, NUMBER 6, *available at* https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm#mltc.

58 Id.

partial-capitation MLTC plan may have contracts.[59] Beginning October 1, 2018, all MLTC plans must limit the number of LHCSAs in their networks based on the following ratios:

For Downstate: 1 LHCSA per each 75 enrollees (1:75)

For ROS: 1 LHCSA per each 45 enrollees (1:45)

These ratios will be further constricted starting October 1, 2019:

For Downstate, the ratio is 1 LHCSA per each 100 enrollees (1:100)

For ROS, the ratio is 1 LHCSA per each 60 enrollees (1:60)

The Department provided for two exceptions to this policy:

- **Continuity of Service** – A plan may request a three-month extension of its contract with a LHCSA in order to ensure continuity of service to an enrollee who would otherwise lose their aide due to termination of the LHCSA's contract. During the three-month period, the contract with that LHCSA does not count against the plan's total.
- **Adequate Access to Services** – A plan may also request an exception if they can demonstrate that additional LHCSA contracts are required to ensure adequate access to services in a geographic area. This includes "special needs services" and services that are culturally or linguistically appropriate.

Plans must email LHCSAExceptions@health.ny.gov in order to request either of the foregoing exceptions. There is no indication that enrollees have any right to challenge plans' denials of their requests for exceptions.

Practice Note: The majority of home care services covered by MLTC plans are provided by LHCSAs in the plans' provider networks. With this change, many enrollees will be presented with a difficult choice: switch to a different LHCSA (and therefore lose your current aides), or switch to a different MLTC plan (and possibly lose your hours). Many MLTC enrollees have struggled to find aides with whom they are compatible, which becomes even more important for those enrollees with dementia and other cognitive impairments, for whom stability of caregivers is critical. Because there is no legal entitlement to keep a certain aide, a change of agencies/aides is not amenable to legal remedies.

One possible solution is trying to persuade the aides to move to a different agency (one that is in-network). However, this raises the possibility that the aides may lose wage enhancements based on seniority, and other employment benefits.

[59] N.Y. Dep't of Health, LIMITATION ON NUMBER OF CONTRACTED LHCSAS IN A PARTIAL CAPITATION PLAN NETWORK (August 21, 2018), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/lhsca_contract_guidance.pdf.

In theory, there is no reason why an individual shouldn't be able to switch MLTC plans to one with whom the preferred agency remains in-network. However, for an enrollee receiving high hours of home care, it is quite common for other plans to deliberately assess the enrollee for fewer hours than they have been receiving in order to deter them from transferring. Furthermore, any such plan-to-plan transfer is treated as a voluntary one, and therefore any resulting reduction in hours is treated as a new application for services. As a result, any appeal of such a change is not eligible for aid continuing, and the enrollee (not the plan) bears the burden of proof to establish the authorization was not correct.

Increased Medicaid Cap on Physical/Occupational/Speech Therapy Visits

For many years there has been a cap on the number of rehabilitation therapy visits per year that Medicaid will pay for. One bright spot in this year's budget was to increase this cap from 20 visits per year to 40.[60]

Market Alterations

One of the oldest and largest MLTC plans in the state, Guildnet, recently announced their plans to terminate all of their health insurance products effective December 1, 2018.[61] Another large and long-time MLTC plan, Independence Care System, has been reported to be in danger of closing as well.[62] Any such plan closures are now governed by a transition process set out in state guidance.[63] This also includes any changes to a plan's service area (as happened when Guildnet pulled out of Long Island last summer) or acquisition of a plan by another company (as happened when Centerlight's and NorthShore-LIJ's members were acquired by Centers Plan for Healthy Living).

MLTC Policy 17.02 provides that the closing plan must provide written notice to all enrollees 60 days in advance of the closing date. The enrollees are given the option to choose a new plan within that 60-day period, or be autoassigned to a new plan if they take no action. If an affected enrollee wishes to choose a new plan (rather than be auto-assigned), they may contact New York

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60 Dear HPA Letter, supra at note 53.

61 Crain's New York Business, MAJOR MANHATTAN NONPROFIT'S INSURANCE ARM SHUTTING DOWN HEALTH PLAN (August 28, 2018), *available at* http://www.crainsnewyork.com/article/20180828/HEALTH_CARE/180829882/major-manhattan-nonprofit-s-insurance-arm-shutting-down-health-plan.

62 Crain's New York Business, DISABILITY ADVOCATES FEAR CLOSURE OF SPECIALIZED PLAN (July 5, 2018), *available at* http://www.crainsnewyork.com/article/20180705/HEALTH_CARE/180709962/disability-advocates-fear-closure-of-specialized-plan.

63 N.Y. Dep't of Health, MLTC POLICY 17.02: MLTC PLAN TRANSITION PROCESS – MLTC MARKET ALTERATION (September 22, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/17-02.pdf.

Medicaid Choice within the 60 days to effectuate the transfer, and no pre-enrollment assessment by the new plan is required. Most importantly, regardless of whether the enrollee selects a new plan or allows themselves to be auto-assigned, the new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for 120 days after enrollment. The only exception to the 120-day transition requirement is that the plan may change the enrollee's services earlier after conducting a new assessment, but only if the enrollee agrees to the new plan of care. Any reduction or discontinuance of services after the 120-day period is subject to timely and adequate notice (on the state-mandated IAD form), the right to an internal plan appeal, aid continuing, and plan burden of proof.

Practice Note: MLTC enrollees may be contacted by plan staff or others informing them of their plan's impending closure and urging them to start looking for a new plan. In general, the safest advice is for them to wait until they receive their 60-day written notice. The reason is that if an enrollee switches to a new plan before the 60-day notice, they will not be protected by the 120-day transition rights, because it will be considered a voluntary plan-to-plan transfer.

Furthermore, the 120-day transition rights only apply to the first plan enrollment after plan closure. So if an enrollee of terminating Plan A enrolls in Plan B at the end of the 60-day period, Plan B must continue the services they were receiving from Plan A. But if the enrollee subsequently decides they don't like Plan B and switches to Plan C (even within the 120-day period), that is considered a voluntary plan-to-plan transfer, so transition rights do not apply.

The following tables provide a snapshot of enrollment in the various types of MLTC plan.

Partial-Capitation MLTC Plans by Enrollment and Region[64]

Plan Name	NYC	Long Island	RoS	Total
Centers Plan for Healthy Living	25,718	2,832	877	29,427
Fidelis/Centene	7,942	2,259	11,425	21,626
Healthfirst	13,544	505	348	14,397
Senior Whole Health	13,653		221	13,874
Elderplan/Homefirst	10,772	793	1,378	12,943
VNSNY CHOICE	9,755	1,183	1,713	12,651
Riverspring/Elderserve	11,323	688	369	12,380
Integra	10,647	1,185	394	12,226
VillageCare	10,716			10,716
Agewell	6,318	2,711	659	9,688
Guildnet	7,316			7,316

[64] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018), *available at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

VNA Homecare Options			6,811	6,811
Aetna	4,556	1,774		6,330
Independence Care System	6,182			6,182
Wellcare	3,954	558	989	5,501
Empire BCBS Healthplus/Amerigroup	5,080			5,080
Extended	4,441	433		4,874
United Healthcare	2,748		1,463	4,211
Archcare	2,758		1,176	3,934
iCircle Care			2,691	2,691
Hamaspik Choice			2,196	2,196
Metroplus	1,857			1,857
Montefiore	1,189		331	1,520
Kalos Health			1,309	1,309
Elant			995	995
Fallon Health Weinberg			742	742
Senior Network Health			548	548
Prime Health Choice			383	383
Elderwood			328	328
Grand Total	**160,469**	**14,921**	**37,346**	**212,736**

FIDA Plans by Enrollment and Region[65]

Plan Name	NYC	Long Island	RoS	Total
VNSNY CHOICE	1,233	45		1,278
Healthfirst	912	74	12	998
Partners Health Plan (FIDA-IDD)	359	380	124	863
Elderplan/Homefirst	387	62		449
Guildnet	417			417
Agewell	35	204	10	249
Metroplus	209			209
Senior Whole Health	131			131
Centers Plan for Healthy Living	25			25
VillageCare	23			23
Riverspring/Elderserve	14	3	1	18
Total	**3,386**	**388**	**23**	**3,797**

[65] Id.

Medicaid Advantage Plus Plans by Enrollment and Region[66]

Plan Name	NYC	Long Island	RoS	Total
Healthfirst	7,193	92		7,285
VNSNY CHOICE	1,394	16	12	1,422
Elderplan/Homefirst	1,330	29	41	1,400
VillageCare	688			688
Guildnet	478			478
Fidelis/Centene	43		53	96
Senior Whole Health	86	3		89
Empire BCBS Healthplus/Amerigroup	1			1
Total	**11,213**	**140**	**106**	**11,459**

PACE Plans by Enrollment and Region[67]

Plan Name	NYC	Long Island	RoS	Total
Centerlight	2,400	178	210	2,788
Independent Living for Seniors			771	771
Archcare	709		22	731
PACE CNY			566	566
CHS Buffalo Life			240	240
Eddy Senior Care			215	215
Complete Senior Care			120	120
Fallon Health Weinberg			118	118
Total Senior Care			114	114
Grand Total	**3,109**	**178**	**2,376**	**5,663**

[66] Id.
[67] Id.

Glossary

ABD	**Adverse Benefit Determination** – "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." 42 CFR § 438.400(b).
CBLTC	**Community-Based Long Term Care** – In order to be eligible to enroll in MLTC, MAP, PACE or FIDA, a Medicaid recipient must be found in need of CBLTC for a continuous period of 120 days within a calendar year. CBLTC consists of personal care services (but not merely Level 1, aka housekeeping), home health aide (i.e., CHHA) services, private duty nursing, consumer directed personal assistance services (CDPAS), or medical-model adult day health care (ADHC). Social adult day care alone does not constitute CBLTC.
CFEEC	**Conflict-Free Evaluation and Enrollment Center** (pronounced "see-fic") – In 2013, CMS required New York State to stop allowing MLTC plans to determine whether prospective enrollees met the clinical eligibility standard for MLTC enrollment (see CBLTC above), because plans were caught (and sanctioned for) fraudulently enrolling ineligible, low-needs individuals. They also refused to enroll eligible, high-needs individuals. Since 2013, prospective MLTC enrollees must obtain an independent, conflict-free evaluation from a nurse employed by MAXIMUS (who also operates the enrollment broker, NY Medicaid Choice). The CFEEC nurse conducts a UAS-NY assessment in the individual's home, and then immediately informs them whether they have met the eligibility standard (97% do). After getting the green light from CFEEC, the individual may contact any MLTC plan to enroll. Plans may still try to dispute CFEEC's determination of eligibility, but the individual is at least entitled to notice and appeal rights.
Dual Eligible	Someone eligible for both Medicare and Medicaid.

FAD **Final Adverse Determination** – The written notice a Medicaid managed care plan must provide to the enrollee when it issues a less-than-fully-favorable decision on an internal plan appeal. Under the amended regs, this notice can be appealed to a Medicaid Fair Hearing or an External Appeal.

FIDA **Fully Integrated Duals Advantage** – FIDA is the most recent addition to the State's MLTC menagerie. As part of a Federal demonstration under the Affordable Care Act, FIDA was created to more seamlessly integrate the Medicare and Medicaid programs within a single managed care plan. Of the three fully-capitated plans in New York, FIDA has the most beneficiary-friendly features, such as simplified enrollment, across-the-board transition rights, integrated appeals, the broadest benefit package (including waiver services), and an interdisciplinary care team. In spite of these advantages, enrollment has been low, most likely due to limited participation by providers and lukewarm marketing by plans who prefer the rate structure of other product lines.

FIDA-IDD **Fully Integrated Duals Advantage for Individuals with Intellectual or Developmental Disabilities** – A new version of FIDA, offered by only one plan, Partners Health Plan, for dual eligibles in the OPWDD waiver.

IAD **Initial Adverse Determination** – This is the written notice a Medicaid managed care plan must provide to the enrollee whenever it makes an adverse benefit determination. Under the amended regs, this notice can only be appealed by an internal plan appeal, not a fair hearing.

LDSS **Local Department of Social Services** – The county governmental department responsible for local administration of state welfare programs, including (for the aged, blind and disabled) Medicaid eligibility. Assessment, authorization, and contracting for home care services was largely removed from LDSS jurisdiction when MLTC was made mandatory in 2012-2013. However, individuals may still receive home care through their LDSS if they are excluded from MLTC (e.g., OPWDD, hospice, Native American) or under immediate need personal care services.

LHCSA **Licensed Home Care Services Agency** – These are the home care agencies that provide the majority of home care workers in the state. They contract with Medicaid managed care plans such as MLTC, as well as Local Departments of Social Services for those individuals still on fee-for-service Medicaid. Unlike CHHAs, LHCSAs are not Medicaid providers, so they cannot bill Medicaid directly (unless under contract with an LDSS).

MAP **Medicaid Advantage Plus** – A fully-capitated Medicaid and Medicare managed care plan in New York. This is the least integrated of the three Medicare-

Medicaid products. It is essentially a Medicare Advantage plan connected loosely to a Medicaid managed care plan from the same company. Unlike Medicaid Advantage, it includes coverage for long-term care services such as home care and nursing home.

MLTC **Managed Long Term Care** – Somewhat confusingly, the term MLTC is used to refer both to a general category of Medicaid managed care plans that include long-term care services for dual eligibles, as well as one particular type of plan included within that category. Partially-capitated Medicaid Managed Long Term Care plans are the most common type of MLTC, and include only a subset of the Medicaid benefit package and no Medicare benefits. The other varieties of "MLTC" – FIDA, MAP and PACE – include all Medicaid and Medicare benefits as well.

MMC **Mainstream Medicaid Managed Care** – This is the type of Medicaid managed care plan that the majority of Medicaid recipients in New York State are required to enroll in. These are comprehensive HMOs that include almost all services in the Medicaid benefit package, including long-term care services like home care and nursing home. People with Medicare, spend-down, or comprehensive third-party insurance are not eligible for MMC.

PACE **Programs of All-inclusive Care for the Elderly** – These are the oldest of New York's fully-capitated managed care plans. They are site-based, and enrollees must receive most of their medical care from providers employed by the PACE center. Many enrollees participate in adult day care programs at the PACE center, but they also cover all other Medicare and Medicaid services, including home care.

APPENDIX TO MLTC UPDATE

NYSBA Elder Law Section Fall Meeting 2018

Assembled by David Silva, Esq.

Table of Contents

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

42 CFR 438 Service Authorization and Appeals

MLTC: Partial Cap, MAP, Medicaid Advantage

Bureau of Managed Long Term Care
Office of Health Insurance Programs

December 7, 2017

Welcome

- This presentation is for MLTC plans: Partial Cap and benefit determinations for MAP and Medicaid Advantage products

- Goals for today:
  - Describe implementation steps related to full compliance with 42 CFR 438 for service authorization and appeal processes
  - Highlight impacts of the 2016 Mega Rule on these processes
  - Review appropriate use of the template notices
  - Confirm the template notice approval process

Reminders

- This webinar is being recorded
- PLEASE:
  - Type any questions into the Q & A box feature
  - For plan specific or detailed questions, email MLTCmodelnotices@health.ny.gov

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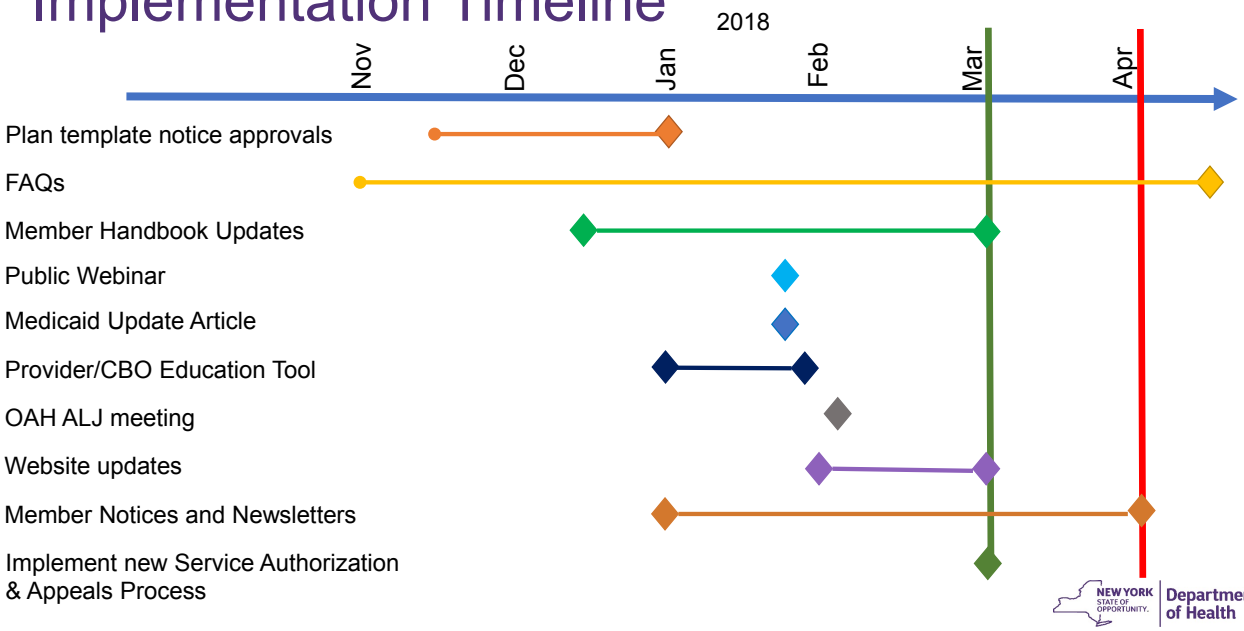
Implementation Timeline



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Questions?

Are we speaking the same language?

42 CFR 438	MLTC Model Contract	Template
Service Authorization Request	Services Authorization Request	You asked for [service]
Adverse Benefit Determination	Action	Decision to deny, reduce, suspend, stop
Notice of Adverse Benefit Determination	Notice of Action	Initial Adverse Determination
Appeal	Action Appeal	Plan Appeal
Notice of Appeal Resolution	Notice of Action Appeal Determination	Final Adverse Determination
Continuation of Benefits	Aid Continuing	Keep your services the same
External Medical Review	External Appeal	External Appeal
Grievance	Grievance	Complaint

42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.210(d)(2)(i)	Changes expedited authorization decision/notice timeframe to **72 hours** subject to extension This is a change from 3 business days
438.402(c)(1)(i) 438.408(f)(1) *Enrollee has to exhaust the internal appeal process prior to going to Fair Hearing*	Establishes the enrollees right to a Fair Hearing regarding an adverse benefit determination after receipt of notice under 438.408 (appeal resolution) that the adverse benefit determination has been upheld. • *In NYS – the right to a fair hearing is decided after adverse benefit determination* • *Enrollee still has right to NYS External Appeal in accordance with PHL 49*
438.402(c)(1)(i)(A) 438.408(c)(3) 438.408(f)(1)(i)	Defines 'deemed exhaustion' – the enrollee has exhausted the plan's appeal process if the notice and timing requirements of 438.408 (appeal resolution) have not been met and may request a fair hearing. • *Failure to respond to a service authorization request is an adverse benefit determination subject to appeal. Failure to* • *respond to an appeal is subject to fair hearing*

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.402(c)(1)(ii)	Adds requirement for enrollee's written consent for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing but may not request Aid Continuing. • *Templates use plain language, e.g., complaint* • *Plans must still have mechanism in place to accept complaints and appeals from enrollees who are unable to sign or obtain signatures* • *All notices are sent to both enrollee and their representative*
438.402(c)(2)(ii)	Requires appeals to be filed within 60 calendar days of the date on the Initial Adverse Determination
438.404(b)(2)	Notices identify the right to request and receive, free of charge, copies of all sources of information relevant to the adverse determination • *includes criteria, procedures, internally generated documents and state policy guidance relevant to the adverse benefit determination.*

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.406(b)(5) Suggestion: Send case file with acknowledgement	Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative. • *includes medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.*
438.408(b)(3) Change from 3 BD	Changes expedited appeal determination/notice timeframe to 72 hours
438.408(c)(2)	Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within 2 calendar days
438.408(f) Change from 60 days	Provides enrollees 120 calendar days from the date of an adverse appeal resolution notice to request a fair hearing.

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:

438.420
We are going back to the process that was in place prior to July 2015
 	
If member uses the Appeal form, Ac should be provided unless the member checks the box indicating they don't want it
	Provides enrollees the right to Aid Continuing upon timely filing of **an appeal -** 10 days of the notice of adverse benefit determination or by the effective date of the adverse benefit determination, whichever is later. Provides aid continuing without interruption if the enrollee requests a fair hearing within 10 days of the plan's sending the written adverse appeal resolution notice.
	• *The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:*
	  • *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*
	  • *For an enrollee in receipt of long term services and supports or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.*

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.420	*(continued)* • *The plan must immediately provide AC upon timely filing of appeals regarding these adverse benefit determinations* • *The plan must immediately provide AC if so directed by the NYS Office of Administrative Hearings*
438.424(a)	If the fair hearing decision reverses the plan's adverse benefit determination, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but **no later than 72 hours** from the date the plan receives the fair hearing decision.

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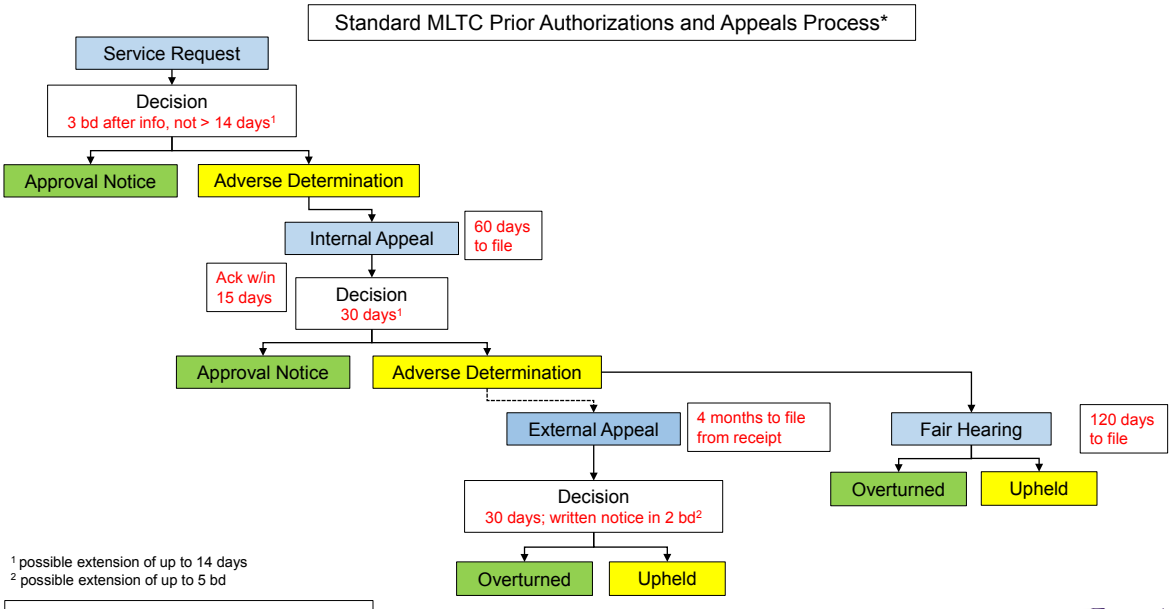

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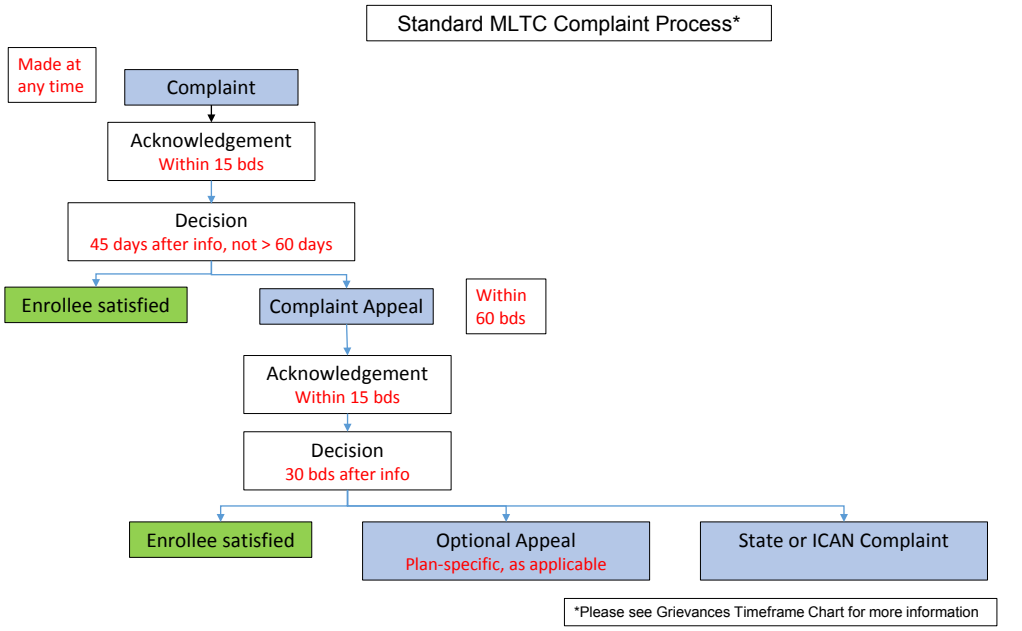

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Questions?

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Template Notices – Purpose and Use

- 42 CFR 438.10(c)(4)(ii) requires the use of model enrollee notices
- The State developed the template notices with significant input of the Service Authorization and Appeals Stakeholder Workgroup
- There are now eight model templates:
  - **Approva**l: approval of a services authorization request or whole overturn of an adverse benefit determination on appeal
  - **Extension**: extension for more information during service authorization request review or appeal
  - **Initial Adverse Determination No AC**: notice of adverse benefit determination
  - **Initial Adverse Determination With AC**
  - **Final Adverse Determination No AC**: adverse notice of appeal resolution (adverse benefit determination upheld in whole or in part)
  - **Final Adverse Determination With AC**
  - **Complaint Resolution**
  - **Complaint Appeal Resolution**

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Template Notices – Purpose and Use

- 2015 IAD combined all rights, with separate appeals attachment and fair hearing form to be used for any type of denial
- 2017 templates for IADs and FADs are split by decisions where the enrollee does or does not have a right to aid continuing.
- 2017 FADs are one notice – combined plan decision and Fair Hearing rights – no separate fair hearing form.

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Notice Process and Timeframes

- New charts have been finalized indicating the blended time frames for compliance with PHL and 42 CFR 438 for service authorization requests, appeals, complaints and complaint appeals. Which we will be forwarding after presentation
- Plan policies and procedures must be updated to comply with the new timeframes
- New notices and exhaustion/AC processes may not be utilized prior to March 1, 2018. These apply to adverse benefit determination made on March 1, 2018 and thereafter.
- For enrollees who receive an action taken notice prior to March 1, 2018 and subsequently appeals or requests a fair hearing after March 1, 2018, the appeal or fair hearing will be considered timely and handled pursuant to the rights issued in the action notice (old rules).
  - If the enrollee appeals, the plan's appeal resolution will be the new FAD and the enrollee will receive the right to request a fair hearing within 120 days (new rules).

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Template Notices – Clinical rationale/specific reason for denial

- During the stakeholder workgroup meeting 3, we reviewed poor clinical rationales and explored ways to improve noticing, including emphasis on plain language and reduction of extraneous information

- DOH restructured model notice templates placeholder language to improve the inclusion of all required elements for these decisions

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Specific Denial Reason Requirements:

For benefit denials:

- 4th-6th grade reading level
- Grounds for appeal must be easily identifiable
- Must include the ***specific*** service that is not covered
- For benefit coverage that is dependent on the enrollee's condition, must include the specific benefit criteria that is not being met (e.g., dental, personal care, etc.)

Specific Denial Reason Requirements:

- Examples:
  - Family planning services are not covered under our benefit package. You may use your Medicaid card to obtain this service from any provider that accepts Medicaid.
  - Root canals for tooth #18 (wisdom tooth) are not covered by Medicaid unless the tooth is needed to support a dental device or you need the tooth to be able to chew. You do not wear a dental device, and you have at least eight teeth in contact with each other and are able to chew without this tooth.

Out of Network (OON) IAD

For benefit denials:

- 4th-6th grade reading level
- Grounds for appeal must be easily identifiable
- OON service denials for service that are not materially different must include a description of the service available in-network, why it is not materially different, and how to access the in-network service.
- OON referral denials for services requested based on the training and experience of a provider must include contact information for in-network providers available and able to provide the requested service.

Out-of-Network Example:

- OON Denial:

You requested outpatient physical therapy from Great PT Inc. You do not need to get these services outside of our network because we have providers who can give them to you. The in-network providers listed below are available to provide outpatient physical therapy and have the correct training and experience to meet your needs.

Dr. Smith	Dr. Brown
111 Main Street	99 First Street
New York, NY 10101	New York, NY 10001
Phone: 212-555-5555	Phone: 212-555-7777

Clinical Rationale Requirements:

- 4th- 6th grade reading level
- Grounds for appeal must be easily identifiable
- Must include for service request:
  - the service requested;
  - the enrollee's condition;
  - why the service was requested or how the service was intended to treat or improve the enrollee's condition;
  - the specific criteria that must be met for the service to be approved including the identification/ name of the criteria and a description of what is actually necessary to get the service approved;
  - enrollee-specific information about why the decision was made including how the criteria was not met
- If this is a change to a service that has already been approved, the change to the enrollee's condition impacting the level of care needed and when the change occurred must be included.

Updates to Specific Denial Reason/ Clinical Rationale Placeholders for LTSS

{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE OF A CURRENT SERVICE (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}

- The request for [service] was [denied][partially approved]. This decision was based on:
  - [Insert the criteria requirements and other information relied on to make the decision.].
  - [Insert enrollee-specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.].

{*Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal*.}

Clinical Rationale for LTSS Service Request Example:

- The request for an increase in Personal Care Service from 24 hour live-in to 24 hour split shift (2x12) was denied. This decision was based on:
  - 24 hour split shift of continuous personal care means the provision of care by more than one personal aide for more than 16 hours in a calendar day for a member who because of their medical condition needs assistance with toileting, walking, transferring, turning and positioning, or feeding, and needs assistance with such frequency that a live-in 24 hour personal care aide would be unlikely to obtain, on a regular basis, 5 hours daily of uninterrupted sleep during the aide's 8 hour period of sleep.
  - A sleep study was done 11/1/17. The member fell asleep at 11pm and woke up requesting to go to the bathroom at 5am. Member did not require turning or positioning at night. Current 24 hour live-in aide reported getting at least 5 hours of uninterrupted sleep per night.
  - Therefore, the member's needs are met with 24 hour live-in personal care aide.

Updates to Specific Clinical Rationale Placeholders for LTSS

{INSERT IF THE DECISION IS ABOUT LTSS STOPPAGES, REDUCTIONS, OR SUSPENSIONS (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}

- [Insert service] will be [stopped][reduced][suspended] because:
  - [**Indicate the change** in medical condition, social, or environmental circumstances since the previous authorization was made.]
  - [**Indicate when the change occurred**. Include the information and criteria relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
  - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

Clinical Rationale LTSS Reduction Example:

- Your Level 2 Personal Care Services 4 hours per day, 5 days per week will be reduced to 2 hour per day, 5 days per week because:
  - In March 2017 you fractured your hip, and your condition has since improved. You no longer need the same level of care with personal hygiene tasks and mobility.
  - Your current services were approved based on your 3/15/17 UAS-NY results. At that time, you needed extensive assistance with both personal hygiene tasks and mobility. On 9/1/17, you had a UAS-NY completed. At this time, your needs show limited assistance with certain personal hygiene tasks and mobility.
- You no longer meet the criteria for your current level of service because:
  - Based on your 9/1/17 assessment, you now only need some hands-on help for bathing and dressing. You now only need limited assistance when walking around your home and in the community.
  - We are reducing your Personal Care Services because you do not need the level of service that was previously approved.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Questions?

NEW YORK STATE OF OPPORTUNITY. Department of Health

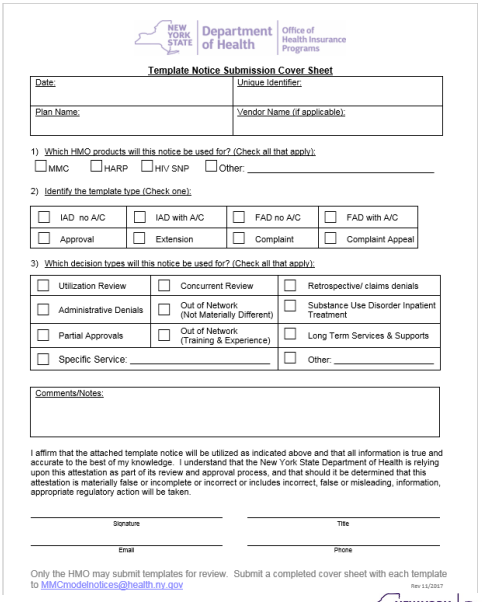
Template Approval Process

- All template notices must be submitted to the Department prior to use
  - 2017 templates may not be used prior to May 1, 2018.
- Only MLTCs may submit templates for approval.
- A Notice Submission Cover Sheet **must** be submitted for EACH template
- A plan-created unique identifier **must** appear on the cover sheet and in the footer on each page of the template
- Plans are **required** to follow the model template language

NEW YORK STATE OF OPPORTUNITY. Department of Health

Template Approval Process

- The Submission Cover Sheet identifies the intended purpose of each template
- Incomplete submissions will be returned
- Upon completion of the review, the plan will receive an approval or if revisions are needed, details highlighting needed changes.



NEW YORK STATE Department of Health | Office of Health Insurance Programs

Template Notice Submission Cover Sheet

Date:	Unique Identifier:
Plan Name:	Vendor Name (if applicable):

1) Which HMO products will this notice be used for? (Check all that apply):
☐ MMC ☐ HARP ☐ HIV SNP ☐ Other: _____

2) Identify the template type (Check one):

☐ IAD no A/C	☐ IAD with A/C	☐ FAD no A/C	☐ FAD with A/C
☐ Approval	☐ Extension	☐ Complaint	☐ Complaint Appeal

3) Which decision types will this notice be used for? (Check all that apply):

☐ Utilization Review	☐ Concurrent Review	☐ Retrospective/ claims denials
☐ Administrative Denials	☐ Out of Network (Not Materially Different)	☐ Substance Use Disorder Inpatient Treatment
☐ Partial Approvals	☐ Out of Network (Training & Experience)	☐ Long Term Services & Supports
☐ Specific Service: _____		☐ Other: _____

Comments/Notes:

I affirm that the attached template notice will be utilized as indicated above and that all information is true and accurate to the best of my knowledge. I understand that the New York State Department of Health is relying upon this attestation as part of its review and approval process, and that should it be determined that this attestation is materially false or incomplete or incorrect or includes incorrect, false or misleading, information, appropriate regulatory action will be taken.

Signature _____ Title _____

Email _____ Phone _____

Only the HMO may submit templates for review. Submit a completed cover sheet with each template to MMCmodelnotices@health.ny.gov

Rev 11/2017

NEW YORK STATE OF OPPORTUNITY. Department of Health

Questions?

Next Steps

- Submit templates no later than December 15, 2017
- Additional guidance materials and FAQs will be provided

Thank You!

Please send comments or questions to:

438reg@health.ny.gov

Submit template notices or specific MLTC questions to:

MLTCmodelnotices@health.ny.gov

NEW YORK STATE OF OPPORTUNITY. Department of Health

2016 FINAL RULE 42 CFR 438 Service Authorization and Appeals

Frequently Asked Questions for
Managed Long Term Care Plans: Partial Capitation, benefit determinations for MAP and Medicaid Advantage plans

I. General Questions:

1. What is the implementation date for changes to 42 CFR 438.210 and Subpart F?

   The effective date for the Medicaid Managed Care service authorization and appeals processes changes is 5/1/18.

2. What is the scope of use for the MMC/MLTC Model Notices?

   These notices will be used for Mainstream Medicaid Managed Care, HIV/SNP, HARP, MLTC Partial Capitation, and Medicaid benefit determinations of Medicaid Advantage and Medicaid Advantage Plus plans.

3. Will the plain language recommendations of the Services Authorizations and Appeals Workgroup be used universally within the state?

   The workgroup recommended the use of plain, easily understood language for member communications. This includes "approval," "denial," "decision," and "complaint." The Department has adopted this approach for the 8 model notices issued and strongly suggests plans utilize this language in member communications.

II. Notice Submissions:

1. Will DOH approval of templates from plans and their delegates be required prior to implementation in 2018?

   Yes, plans must submit all templates for approval prior to implementation.

2. Will approval of template submissions need to be submitted to the Bureau of Long Term Care (for MLTC and Medicaid Advantage) separately from the DHPCO?

   Yes, any templates used for Mainstream MMC, HARP, and HIV SNP notices should be sent to DHPCO; while any templates for MLTC Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus should be sent to DLTC. For submissions, use the following BMLs:
   DHPCO- MMCModelNotices@health.ny.gov
   DLTC- MLTCModelNotices@health.ny.gov

3. Can plans modify the State Model Notices?

   Segments of the model notices may be removed, as appropriate, depending on the decision type. All notice templates must be approved for use by the Department and meet all content and format requirements prior to their use.

4. Can plans use BIGA-approved 1557 Language Services and Non-Discrimination templates in the new template submissions?

   Plans may continue to use templates for non-discrimination and language services meeting 45 CFR 92 (§1557 of the ACA) requirements that have been approved by the Bureau of Program Implementation and Enrollment (BPIE). These must be updated to reflect large print content requirement as indicated in the models consistent 42 CFR 438.10(d)(3) and (6). The plan contact information must be included in these sections.

5. Do plans need to submit separate coversheets for each template individually?

   Yes.

6. Does the coversheet need to be a in a separate document from the template it applies to when submitted?

   No, a submitted template can include the coversheet in the same document. Plans must not submit a document that contains multiple notices or multiple coversheets.

7. Is there a naming convention for the unique identifier? Does the unique identifier need to be included in a specific place in the footer of the notice?

   There is no required naming convention, and no specific location. The identifier must be unique for each template, and appear in the footer on every page of the template.

8. What is the process for submitting vendor templates?

   Each plan must submit its vendors' (management contractor delegated to conduct issue coverage and/or utilization review determinations) templates; only plan representatives can sign coversheets. Templates received directly from vendors will not be reviewed. Vendor templates approved for one plan are NOT automatically approved for use by other plans. To expedite review, the unique identifier under which a vendor template has already been approved for use by another plan may be included in the comment box on the coversheet.

III. Model Notices:

1. Does the IAD need to include information about the process for requesting Fair Hearings?

   Yes, this is required under 42 CFR 438.404(b)(4).

2. When is the External Appeal Form used versus the Fair Hearing Form?

   The External Appeal Form is to be distributed with the FAD when the determination is subject to Article 49 of Public Health Law. The Fair Hearing Forms have been incorporated within the FAD notices and are always to be distributed with the FAD as included in the model notice templates.

3. Will there be a State Model Notice for the acknowledgement letter for complaints/grievances for plans to use?

   No.

4. Why does fast track "[at hour received]" language appear in the IAD without AC, but not in the IAD with AC?

   It is anticipated that the IAD with AC is only used when a plan is changing a service that has already been authorized, or in the case of long term services and supports (LTSS) or nursing home stay, that is changing the service in the subsequent authorization period. The [hour received] notation is for a response to an expedited service authorization request, subject to the 72 hour review required under 42 CFR 438.210(d)(2).

5. For all letter templates, there are both [ ] brackets and { } brackets, please clarify the meaning and when the types of bracketed text should be excluded/included. Does NYS have instructions on how to interpret these brackets like CMS (for example see https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Integrated-Denial-Notice-Instructions-CMS-10003.pdf)?

   Brackets are intended to identify placeholder information and instructions throughout these notices. The { } brackets are used for instructions, while the [ ] brackets are used as placeholders for content to be inserted. Further, instructions are highlighted in green or yellow, and static fields (for contact information that may be hard-coded in the plan's template) are highlighted in blue. The static fields should be filled in with correct contact information in the templates submitted for DOH approval.

6. What does the State expect to see in "Coverage Type" in the header? Is this the type of Medicaid Plan (i.e., Medicaid without SSI, Medicaid with SSI)?

Coverage type refers to MLTC: Partial Capitation, MAP etc. The plan may elect to indicate the plan-specific name for the coverage type or premium group within the product line.

7. On the 2nd page of the Approval Letter first paragraph, do we need to state the provider's name as well as their participating versus non-participating status with the plan?

   Yes, if a specific provider is identified include the name of the provider. If not, use the "this service will be provided by a" placeholder. In both cases, identify if the approval is for an in-network or out-of-network provider.

8. Does the IAD apply to Concurrent, Prospective, and Retrospective review determinations?

   Yes, the IAD is intended for use for all of these purposes.

9. With regards to the extension letter, the plan asks for information during the review period on pre-service and concurrent reviews. This is not a formal extension but a request for information. Can we continue to send our own letters in this phase of the process?

   Yes.

10. What is the State looking for with "UR Agent name"? Is this a plan delegate?

    The "UR Agent Name" placeholders are for any entity delegated through a management contract to issue coverage and/or utilization review determination notices on behalf of the plan.

11. Can you define the "Plan Tracking ID" number on the IAD- is this the same as our authorization number?

    This is the identifier the plan uses to track the case. This may be your plan's authorization number.

12. For all letters, does NYS expect to see the same copy that was mailed to the member also be sent to the provider (an exact duplicate)?

    The provider notice may (but is not required to) be an exact duplicate of the notice going to the enrollee. The provider notice must include all required content as per statute, regulation and the MLTC Model Contract.

13. Can you please clarify what information should be included for Service developer/manufacturer?

    Inclusion of the service developer/ manufacturer is a requirement specific to the FAD added by 10 NYCRR 98-2.9(e)(7). This information is to be included as

applicable and available under the regulation. This should be the name of a company, not a restatement of what the item or service is. This information does not have to be included if the service developer/manufacturer is unknown to the plan.

14. Will you be re-issuing the revised Fair Hearing Form to us for the latest version to consider for implementation or should we use the previous documents?

    As of May 1, 2018, the LDSS-4687 and LDSS-4688 Managed Care Action Taken Forms currently in use will not be used in connection with the IAD or FAD notices. Fair hearing rights and fair hearing request forms have been incorporated into the FAD model notice.

15. The fair hearing request form has multiple numbers at the top of it on the first line. How should these numbers be used?

    The codes included at the top of these request forms are the codes used by OTDA to process fair hearing requests and indicate MLTC or MMC, and whether the service is a home care service. Codes should be utilized as follows:
    - *General MMC/ HARP/ HIV SNP= 229*
    - *MMC/ HARP/ HIV SNP Home Care Services= 266*
    - *General MLTC= 212*
    - *MLTC Home Care Services= 211*

16. In the "Insert when extension is for an appeal" portion of the Extension Notice, what does [EXPDate] signify?

    This placeholder is the "expiration date" of the extension; the date by which a plan must make a determination and provide notice to the enrollee. Inclusion of this date is necessary to identify and inform the enrollee when deemed exhaustion applies if the enrollee does not receive timely notice of the appeal resolution following an extension.

17. For out of network referral denials, the model notice indicates plans should populate the placeholder with two in-network providers. Can the plan refer the enrollee to our website for a list of participating providers or do the provider names actually need to be merged into the notice?

    When issuing an out of network referral denial as defined at PHL 4900(7-f-1), plans must include in the notice the names and contact information of provider(s) able and available to provide the service in-network. Inclusion of at least two named providers, where possible, is recommended. See also Department of Financial Services guidance at: http://www.dfs.ny.gov/insurance/health/OON_guidance.htm *and* http://www.dfs.ny.gov/insurance/health/OON_law_supplement_qa.htm

18. Will translated templates be provided?

No.

IV. Service Authorization Determinations:

1. What is meant by "administrative denial?"

   Any Service Authorization Determination or retrospective determination (i.e., claim denial) that is not a utilization review determination subject to Public Health Law Article 49. This includes, but is not limited to adverse determinations for benefits not covered and covered benefits with service limits.

2. The implied effective date for reduction in service or stopping service in the IAD example is 10 calendar days from date of letter. The letter would be dated 1/1 and the effective date would be 1/11. The Current IAD template in use by the plan states 10 Business Days. Please clarify.

   42 CFR 431.211 requires advanced notice of an adverse determination at least 10 calendar days prior to such an action, except under circumstances identified in 42 CFR 431.213 and 431.214. Plans may elect to provide greater than 10 calendar days advanced notice.

3. Can plans continue to combine Acknowledgment and Determination Notices when a determination is made before the acknowledgement timeframe expires?

   Yes.

4. What needs to be included in the clinical rationale when the determination is there is not enough information to determine if the service is medically necessary?

   *If there is not enough information to determine medical necessity, the plan must request the needed information before making a determination. If the information is not received on time, the notice should include: the criteria for approval; a statement indicating how the information received was insufficient (or that no information was received) to make the determination; and a statement regarding the **specific** information needed to make a medical necessity determination.*

V. Appeals:

1. How do PHL 4904(5) requirements (to overturn adverse determinations when notice of an Internal Appeal determination is not provided timely) align with deemed exhaustion requirements at 42 CFR 438.408(c)(3)?

   Both requirements are applicable. Failure of the plan to respond to any Plan Appeal on time means the enrollee has exhausted the plan's internal appeal process and may request a fair hearing. The plan is required to comply with PHL

4904(5) if the decision was subject to PHL Article 49, and reverse the initial denial.

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 <u>in connection</u> 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.

5. Current FAD placeholder language does not address the enrollee's right to file a standard internal appeal after a FAD is issued on an expedited internal appeal. Do enrollee's no longer have this right?

   42 CFR 438.402(b) limits the plan to only one level of internal appeal, superseding the provision at PHL 4904(2)(c). For determinations subject to PHL 49, enrollees may file an expedited external appeal at the same time as they file an expedited internal appeal.

6. On the extension model notice, in paragraph 2, there is an explanation of how the delay is in the best interest of the enrollee. CMS has specific Medicare rules

for the MCO and when the extension can occur. Will NYS adhere to these same rules for Medicaid?

Plans must adhere to the requirements set forth in 42 CFR 438.210(d) and 438.408(c) for decisions to extend determination/resolution timeframes.

7. 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.

8. What is the state's definition of "60 working days" in: "You have 60 working days from getting this notice to ask for a Complaint Appeal?" Shouldn't this statement reference business days? (Mon – Fri are working days; however, if Christmas falls on a Monday that is a non-working business day.)

   "Working days" is used as a more reader-friendly version of the term "business days." However; if the last day to ask for a Complaint Appeal falls on a "non-working business day," the enrollee has until the next "working business day" to submit the request.

VI. Fair Hearings:

1. How will the State reconcile state regulations that allow fair hearing requests concurrent with internal appeals with 42 CFR 438 requiring exhaustion of internal appeals prior to a fair hearing request?

   As of May 1, 2018, enrollees will be required to exhaust appeals rights as provided in 42 CFR 438 Subpart F before requesting a fair hearing. The State will revise 10 NYCRR 360-10.8 to reflect the federal rule requirement.

2. Why did the Fair Hearing timeframe change to 120 days from the FAD (currently 60 from IAD)?

   Per 42 CFR 438.408(f)(2) the enrollee must request a fair hearing no later than 120 calendar days from the date of the plan's notice of appeal resolution. In the comments for the Final Rule, CMS provides that enrollees now have 120 days from the appeal resolution to request a fair hearing (see pages 27510, 27511, 27516)

3. Can an enrollee still request a Fair Hearing for services that are not covered by the Benefit Package?

   Yes, administrative denials are included in the definition of an adverse benefit determination in 42 CFR 438.400(b), to which Fair Hearing rights apply.

VII. Aid Continuing:

1. What are the timeframes for requesting Aid Continuing?

   Enrollees may request Aid Continuing subject to timeframe requirements in 42 CFR 438.420. For determinations subject to Aid Continuing, an enrollee must request a Plan Appeal within 10 days of when the plan sends the Initial Adverse Determination, or prior to the effective date of the determination, whichever is later, to receive Aid Continuing. If the Plan Appeal is upheld, the enrollee must request a state fair hearing within 10 days of when the plan sends the Final Adverse Determination to receive Aid Continuing.

2. Is Aid Continuing applicable to all concurrent review determinations?

   No. An enrollee has a right to Aid Continuing in the following circumstances:
   - *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*
   - *For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.*

3. Will plans be permitted to recuperate costs of services from beneficiaries if an adverse determination is upheld on internal appeal/fair hearing?

   When the appeal or fair hearing is adverse to the enrollee, enrollees may be held liable for the cost of services they received during the appeal or fair hearing review as provided by 42 CFR 438.420(d). Plans should not attempt to recoup such costs after an upheld Plan Appeal until after the enrollee fails to request a fair hearing within 10 days of the Final Adverse Determination, or, for enrollees requesting a fair hearing, after the adverse fair hearing decision.

VIII. Complaints:

1. In the Complaint Notice, what is the intent of the member providing information in person? What is the State's expectation of the plan once this has been received?

Enrollees have the right to present evidence in person if they choose to do so. This information must be considered when reviewing a Plan Appeal. This does not change the timeframe for making a determination.

New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations

December 15, 2017

Federal Medicaid managed care rules published in May 6, 2016 amended procedures for service authorization, appeals, fair hearings, and aid continuing. Medicaid managed care plans, including mainstream, HIV Special Needs Plans and Health and Recovery Plans, must continue to comply with requirements in NYS statute, NYS regulation, and the Medicaid Managed Care Model Contract where not superseded by federal rule, including but not limited to the provision of evidence packets, appearance at state fair hearings, and compliance with the Office of Administrative Hearings directives and decisions.

Right to Fair Hearing regarding plan services authorization determinations:

1) 42 CFR §§438.402(c)(1)(i) and 438.408(f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld.

2) 42 CFR §§438.402(c)(1)(i)(A), 438.408(c)(3), and 438.408(f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applies when:

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State-specified timeframes; or
- a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408.

3) 42 CFR §438.408(f)(2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing.

4) Pursuant to 42 CFR §438.424(a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Right to Aid Continuing

Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365-a(8), and 18 NYCRR §360-10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:

- The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or

- For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

NYS MMC plans are required to provide AC:

- **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan's appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

The MMC plan must continue the enrollee's services provided under AC until one of the following occurs:

- the enrollee withdraws the request for aid continuing, the plan appeal or the fair hearing;
- the enrollee fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (Final Adverse Determination)[1];
- OAH determines that the Enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or
- the provider order has expired, except in the case of a home bound enrollee.

Where the final resolution upon plan appeal or fair hearing is to uphold an adverse benefit determination, the enrollee may be held liable for services in accordance with 42 CFR §438.420(d).

[1] Services authorized under AC must be continued for at least 10 days from when the Final Adverse Determination is sent.

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

42 CFR 438 & 2018-19 Budget Initiatives Impacting Medicaid Managed Care

Information for ALJs

Erin Kate Calicchia, Division of Long Term Care
Hope Goldhaber, Division of Health Plan Contracting and Oversight
Patricia Sheppard, Division of Health Plan Contracting and Oversight
Office of Health Insurance Programs

April 2018

Reminders

- Participants have been muted upon entry
- Please submit questions through the Q&A function
- Submit any questions not addressed today to: 438reg@health.ny.gov

Welcome

- This presentation describes initiatives impacting:
  - Mainstream Medicaid Managed Care Plans
  - HIV Special Needs Plans
  - Health and Recovery Plans (HARP)
  - Managed Long Term Care Partial Capitation Plans
  - Medicaid benefit of Medicaid Advantage Plans; and
  - Medicaid benefit of Medicaid Advantage Plus Plans

Agenda

Part I: May 6, 2016 Final Rule by the US Health and Human Services Center for Medicare and Medicaid Services (CMS) for Medicaid and Children's Health Insurance Programs

- In Lieu of Services
- Service Authorization and Appeals
- Deemed Exhaustion
- Aid to Continue

Part II: FY 2018-19 Health and Medicaid Budget Initiatives

Chapter 57 of the Laws of 2018

- Benefit changes
- Long Term Care

Part I: May 6, 2016 Final Rule by the US Health and Human Services Center for Medicare and Medicaid Services (CMS) for Medicaid and Children's Health Insurance Programs

In Lieu of Services

42 CFR 438.3(e):In Lieu of Services

Cost-Effective Alternative Services aka "In Lieu of Services" (ILS) are alternative services or settings that are not included in the State Plan but are medically appropriate, cost-effective substitutes for covered services or settings.

- Currently only applicable to Mainstream, HIV SNP, HARP
- Plans may volunteer to provide ILS, with DOH approval, to a defined population
- Enrollees may elect to utilize ILS offered by plan

More information at:
https://www.health.ny.gov/health_care/managed_care/plans/index.htm

42 CFR 438.3(e):In Lieu of Services

- DOH approved ILS will be posted on the health.ny.gov website and be included in the MMC plan contract Appendix M.
- Web posting will include the start date, service definition, service area, provider type, and population criteria
- MMC plans may not be required to:
  - offer same ILS as another plan
  - offer ILS to all of their enrollees; may limit to enrollees that meet the ILS criteria
  - provide ILS where the enrollee does not agree to use the ILS instead of the Benefit Package service or setting
- MMC plans may be required to:
  - provide DOH approved ILS where the enrollee meets the ILS criteria, the ILS is medically necessary, and the enrollee agrees to use the ILS instead of the Benefit Package service or setting

42 CFR 438.3(e):In Lieu of Services

- If the plan is contracted to offer an ILS in their area, the enrollee has right to fair hearing if:
  - the plan denies a request for the ILS
    - the enrollee believes that they meet the criteria for the ILS
    - the enrollee meets the criteria and believes the ILS is medically necessary for them
  - the plan requires the enrollee to use or try ILS before providing a service included in the plan's Benefit Package

Medicaid Managed Care Service Authorization, Appeals and Fair Hearing Under 42 CFR 438

42 CFR 438 Regulation Changes

- Impact New York's Medicaid managed care service authorization and appeal process for enrollees
- Key changes that start **May 1, 2018** in NYS and apply to:
    - Medicaid Managed Care
    - HIV Special Needs Plan
    - Health and Recovery Plan (HARP)
    - MLTC Medicaid Plan
    - Medicaid Advantage
    - Medicaid Advantage Plus
- 42 CFR 438 provisions supersede NYS SSL, NYS PHL, 10 NYCRR 360-10.8, and the Model Contracts
- Because plans also have to follow New York State Law, 42 CFR 438 requirements are blended with State requirements for plans

42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.210(d)(2)(i)	Changes expedited authorization decision/notice timeframe to **72 hours** subject to extension
438.210(d)(3)	Refers to SSA §1927(d)(5)(A) -Requires response by phone or telecommunication device **within 24 hours** of prior authorization request for "covered outpatient drugs" (as defined in SSA §1927)
438.400(b)	Defines adverse benefit determination (replaces "action"). • *"Notice of Intent to Restrict" is not an adverse benefit determination.* • *Template notices use plain language, e.g., decision, denied.*
438.400(b)(7)	Adds denial of a request to dispute a financial liability to the definition of adverse benefit determination.
438.402(b)	Only one level of internal appeal is permitted. • *A second level appeal under PHL 4408-a(8) or 4904(2)(c) is no longer available.* • *Reconsideration under PHL 4903(6) still applies*

42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.402(c)(1)(i) 438.408(f)(1)	Establishes the enrollees right to a Fair Hearing regarding an adverse benefit determination after receipt of notice under 438.408 (appeal resolution) that the adverse benefit determination has been upheld. • *In NYS – the right to a fair hearing is decided at the hearing* • *Enrollee still has right to NYS External Appeal in accordance with PHL 49*
438.402(c)(1)(i)(A) 438.408(c)(3) 438.408(f)(1)(i)	Defines 'deemed exhaustion' – the enrollee has exhausted the plan's appeal process if the notice and timing requirements of 438.408 (appeal resolution) have not been met and may request a fair hearing. • *Failure to respond to a service authorization request is an adverse benefit determination subject to appeal. Failure to respond to an appeal is subject to fair hearing*

42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.402(c)(1)(ii)	Adds requirement for enrollee's written consent for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing but may not request Aid Continuing. • *Templates use plain language, e.g., complaint* • *Plans must still have mechanism in place to accept complaints and appeals from enrollees who are unable to sign or obtain signatures* • *All notices are sent to both enrollee and their representative*
438.402(c)(2)(ii)	Requires appeals to be filed within 60 calendar days of the date on the Initial Adverse Determination
438.404(b)(2)	Notices identify the right to request and receive, free of charge, copies of all sources of information relevant to the adverse determination • *includes criteria, procedures, internally generated documents and state policy guidance relevant to the adverse benefit determination.*

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.406(b)(5)	Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative. • *includes medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.*
438.408(b)(3)	Changes expedited appeal determination/notice timeframe to 72 hours
438.408(c)(2)	Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within 2 calendar days
438.408(f)	Provides enrollees 120 calendar days from the date of an adverse appeal resolution notice to request a fair hearing.

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:

438.420	Provides enrollees the right to Aid Continuing upon timely filing of **an appeal -** 10 days of the notice of adverse benefit determination or by the effective date of the adverse benefit determination, whichever is later. Provides aid continuing without interruption if the enrollee requests a fair hearing within 10 days of the plan's sending the written adverse appeal resolution notice.
	• *The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:*
	  • *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*
	  • *For an enrollee in receipt of long term services and supports or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.*

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42 CFR 438 Impact on Service Authorizations and Appeals

Changed Regulation:	Impact Summary:
438.420	*(continued)* • *The plan must immediately provide AC upon timely filing of enrollee appeals regarding these adverse benefit determinations* • *The plan must immediately provide AC if so directed by the NYS Office of Administrative Hearings*
438.424(a)	If the fair hearing decision reverses the plan's adverse benefit determination, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but **no later than 72 hours** from the date the plan receives the fair hearing decision.

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Implementing 42 CFR 438 changes for Medicaid Managed Care Service Authorization, Appeal and Fair Hearing Processes

MMC Template Notices

- 42 CFR 438.10(c)(4)(ii) requires the use of model enrollee notices
- DOH developed new template notices in 2017 with significant input of the Service Authorization and Appeals Stakeholder Workgroup
  - Same templates for MMC and MLTC plans
  - Separate notices for denials and reductions/suspensions/terminations
  - Initial Adverse Determinations include a standardized Plan Appeal form
  - Final Adverse Determinations integrates Fair Hearing rights and request form into one notice

MMC Template Notices

- There are now eight model templates for use with MMC/MLTC plans:
  - **Approval**: approval of a services authorization request or whole overturn of an adverse benefit determination on appeal
  - **Extension**: extension for more information during service authorization request review or appeal
  - **Initial Adverse Determination No AC**: notice of adverse benefit determination
  - **Initial Adverse Determination With AC**
  - **Final Adverse Determination No AC**: adverse notice of appeal resolution (adverse benefit determination upheld in whole or in part)
  - **Final Adverse Determination With AC**
  - **Complaint Resolution**
  - **Complaint Appeal Resolution**
- DOH model templates are posted at: https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm
- All 42 CFR 438.10 and 438.210; 438.404 notice content included – plus NYS required content

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Are we speaking the same language?

42 CFR 438	MMC Model Contract	Template
Service Authorization Request	Services Authorization Request	You asked for [service]
Adverse Benefit Determination	Action	Decision to deny, reduce, suspend, stop
Notice of Adverse Benefit Determination	Notice of Action	Initial Adverse Determination
Appeal	Action Appeal	Plan Appeal
Notice of Appeal Resolution	Notice of Action Appeal Determination	Final Adverse Determination
Continuation of Benefits	Aid Continuing	Keep your services the same
External Medical Review	External Appeal	External Appeal
Grievance	Complaint	Complaint

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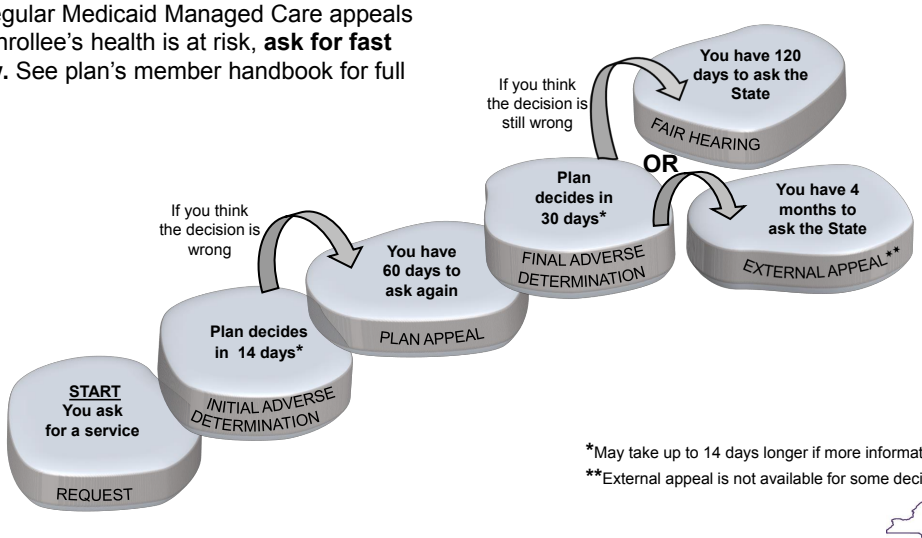
Steps to take if a service request is denied

This is the regular Medicaid Managed Care appeals process. If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



*May take up to 14 days longer if more information is needed

**External appeal is not available for some decisions

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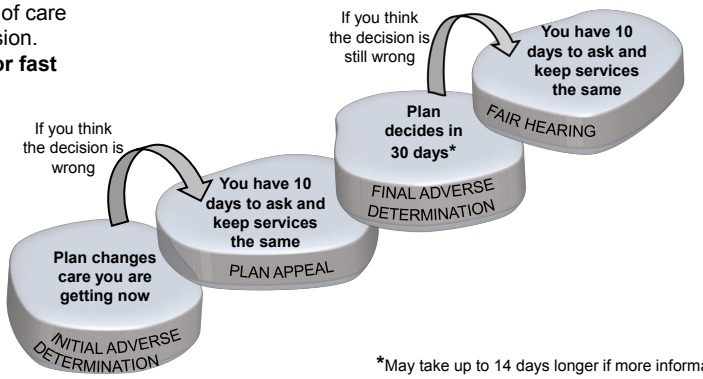
If plan decision is to reduce suspend or stop a service and enrollee wants to keep services the same during appeal

Enrollee may have to pay the cost of care received while waiting for the decision. If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



*May take up to 14 days longer if more information is needed

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Service Authorization Request

- Plans must respond to a service authorization and provide notice by phone and in writing to the enrollee within 14 days
- If the enrollee's health is at risk, the plan must Fast Track, and decide in **72 hours**
- If the request is for more of, or extension of, a service the enrollee is getting now – the plan will Fast Track these requests
- If the plan needs more information and its in the enrollee's best interest to delay, it may take up to 14 days longer to decide. The plan will notify the enrollee in writing if this happens.
- State law provides special timeframes for some requests; like home care after a hospital admission, and more inpatient substance use disorder treatment.
  - These special times are listed in the plan's member handbook
  - Review time frame chart posted here: https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-2-2_timeframe_comparison.htm
- If the plan denies or partially approves the request, the written notice is called the **Initial Adverse Determination**

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Reduction, Suspension, and Termination

- Upon review of the enrollee's services, the plan may send notice of an Initial Adverse Determination when:
  - When the plan makes a decision to reduce, suspend or stop a previously authorized service during the period for which the service was approved
  - When the plan makes a decision to partially approve, reduce, suspend or stop the level or quantity of long term services and supports (LTSS) or nursing home stay in the next authorization period

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Initial Adverse Determination

- The enrollee's appeal rights are described in the Initial Adverse Determination, including:
  - the specific reason for the decision
  - How and when to ask for a Plan Appeal, including an appeal form
  - How to get help understanding the notice and asking for an appeal
- If the enrollee thinks the plan's decision is wrong, they must first ask for a Plan Appeal, and allow time for an answer, **BEFORE asking for a Fair Hearing**
- The plan's member handbook has full information about the enrollee's appeal rights

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Plan Appeals

- The enrollee has 60 days from the date of the Initial Adverse Determination to ask for a Plan Appeal
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Initial Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Plan Appeal and keep their service the same
- The Plan Appeal can be made by: mail, phone, or fax. The plan may also take requests in-person, by email, or online.
- If the enrollee asks for a Plan Appeal by phone, the enrollee must follow up in writing, unless the appeal will be Fast Tracked.

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Plan Appeals

- The enrollee can choose someone else to ask for the Plan Appeal for them.
- This could be anybody, like a family member, doctor or representative. The enrollee and **that person must sign and date a paper saying the enrollee wants that person to ask for them**
- If the enrollee already told the plan that someone may represent them, that person may ask for the Plan Appeal

Plan Appeals

- The plan must write to the enrollee to let them know the plan received the Plan Appeal – this acknowledgement may be combined with the determination notice
- The plan must send the enrollee a copy of the enrollee's **case file.** The case file has all the information the plan looked at about the service and the Plan Appeal

Case Files – During Plan Appeal

- 42 CFR 438.406 Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative.
- The case file includes all medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.
- Case files must be automatically sent to enrollee and their representative after the request for a Plan Appeal and before the plan's appeal determination. May be combined with the acknowledgment notice

Plan Appeals

- The plan has 30 days to decide the Plan Appeal
  - Plans must send written notice within 2 business days of their decision
- Fast Track appeal are decided in **72 hours**
  - Enrollees are told the decision by phone. The written notice is sent within 24 hours of the decision.
- If the plan needs more information and its in the enrollee's best interest to delay, it may take up to 14 days longer to decide. The plan must notify the enrollee in writing if this happens.

Final Adverse Determination

- If the enrollee lost, or partially lost the Plan Appeal, the plan will send the enrollee a Final Adverse Determination notice, including:
  - the specific reason for the decision
  - **Information about the enrollee's Fair Hearing rights**
  - For some decisions, the enrollee's right to External Appeal
  - Ways for the enrollee to get help understanding the notice and their rights.
- The plan's member handbook also has information about the enrollee's Fair Hearing and External Appeal rights

External Appeals

- An **External Appeal** is a review of the enrollee's case by health professionals that do not work for the plan or the state.
- An enrollee can ask for an External Appeal if the plan said the service was:
  - not medically necessary;
  - experimental or investigational;
  - not different from care you can get in the plan's network; **or**
  - available from a participating provider who has the necessary training and experience.
- Before asking for an External Appeal:
  - An enrollee must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
  - If the enrollee asks for a fast track Plan Appeal, he or she may also ask for a fast track External Appeal at the same time; **or**
  - The enrollee and plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

External Appeals

- The enrollee has 4 months to ask for an External Appeal from getting the Final Adverse Determination, or from agreeing to skip the Plan Appeal process.
- Requesting an External Appeal does not extend timeframes to ask for a Fair Hearing.
- There are no Aid to Continue rights provided by asking for an External Appeal.
- An enrollee can ask for both a Fair Hearing and an External Appeal, but the Fair Hearing decision will be the final answer

Fair Hearings

- An enrollee can ask for a Fair Hearing about a plan decision **after** going through the Plan Appeal process. This means that the enrollee asked for a Plan Appeal and either:
  - Received a Final Adverse Determination; **or**
  - The time for the plan to decide the appeal has expired, including any extensions. If there is no response, or the response is late, the enrollee can ask for Fair Hearing. This is called **Deemed Exhaustion**

Deemed Exhaustion

The Plan's appeal process is deemed exhausted when:

- An enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- An enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State–specified timeframes; or
- A plan´s appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408

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Fair Hearings

- If the enrollee thinks the Plan Appeal decision is still wrong:
  - The enrollee has **120 days** from the date of the Final Adverse Determination to ask for a Fair Hearing
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Final Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Fair Hearing and keep their service the same

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Fair Hearings

- The Fair Hearing decision is final
- 42 CFR 438.424 provides that if the services were not furnished during the review, if the enrollee wins the Plan Appeal or Fair Hearing, the plan must provide or approve the enrollee's services within 72 hours of the decision, or sooner if the enrollee's health requires it.

Frequently Asked Questions: 42 CFR 438 Medicaid Managed Care Service Authorization, Appeal, Deemed Exhaustion and Aid to Continue

Adverse Benefit Determination

42 CFR 438.400 defines as any of the following:

- 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
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the State
- 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
- 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
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

These events are adverse benefit determinations whether or not the plan sends notice

When can an enrollee ask for a Plan Appeal of an Adverse Benefit Determination?

- An enrollee can ask for a Plan Appeal of an Adverse Benefit Determination*:
  - Up to 60 days from the date of the Initial Adverse Determination
  - When the enrollee requests a service, and the plan does not respond or response is late
  - When the plan made an adverse benefit determination without adequate notice, or notice was late
  - *MMC/HARP/HIV SNP only:* After filing a complaint that a provider denied a service (which must be handled as a service authorization request), and the plan does not respond, or the response is late

* Not an exhaustive list of appeal rights; enrollees have right to appeal other plan decisions

When can an enrollee ask for a Fair Hearing about plan adverse benefit determinations?

- An enrollee may request a state fair hearing:
  - After receiving an appeal resolution that an adverse benefit determination has been upheld (Final Adverse Determination)
  - After asking for a Plan Appeal, and the time for the plan's decision has expired, including noticed extension.
  - After asking for a Plan Appeal, and receiving an inadequate notice of the plan's appeal resolution
  - After asking for an expedited Plan Appeal, and the time for the plan's decision has expired (no notification that the request for expedited appeal was denied, and plan handled in regular time)
  - After attempting to ask for a Plan Appeal about an adverse benefit determination, and the plan refuses to accept or review the appeal

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What if the enrollee asks for a fair hearing without first exhausting the appeal process?

Does the enrollee have to exhaust the plan's appeal process if the plan denies/reduces a service before 5/1/18?

- The enrollee's right to fair hearing will be honored in accordance with the notice the enrollee received.
- For example: the plan issues the current initial adverse determination notice on 4/23/18 with Managed Care Action Taken fair hearing form.
  - If the enrollee timely requests a fair hearing on 5/15/18, the hearing will be handled in accordance with April 2018 processes.
  - If the enrollee requests a timely appeal on 5/15/18, and the plan issues a new Final Adverse Determination with the new fair hearing request form, the enrollee will have right to request a fair hearing within 120 days of the FAD.

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What if the enrollee asks for a fair hearing without first exhausting the appeal process?

What if enrollee receives an initial adverse determination (after 5/1/18) – and asks for a fair hearing without first exhausting the appeal process?

- The Office of Administrative Hearings will remind enrollees they must ask for a Plan Appeal before asking for a fair hearing.
  - However, depending on the circumstances, a fair hearing may still be scheduled.

(continued on next slide)

What if the enrollee asks for a fair hearing without first exhausting the appeal process?

What if enrollee receives an initial adverse determination (after 5/1/18) – and asks for a fair hearing without first exhausting the appeal process?

- If the plan receives a fair hearing request notification and the appeal was not exhausted:
  - In the evidence packet, the first statement should clearly indicate the enrollee received a timely initial adverse determination and did not exhaust the plan's internal appeal process
  - The plan may contact the enrollee, remind them of the need to ask for a Plan Appeal, and ask if they wish to file a Plan Appeal
  - The plan may contact the enrollee and attempt to resolve their dispute prior to the fair hearing
  - **UNDER NO CIRCUMSTANCES MAY A PLAN INTERFERE WITH THE FAIR HEARING PROCESS OR SUGGEST/DIRECT AN ENROLLEE TO WITHDRAW THEIR FAIR HEARING REQUEST**

When does the plan have to send notice of an adverse benefit determination 10 Days in advance?

10 Day Notice Requirement

- 42 CFR 438.404 requires the plan to send advance notice when reducing, suspending or terminating a previously authorized service within time frames at 42 CFR 431.211, 431.213, and 431.214

- The notice must be sent **at least** 10 days before the date of adverse benefit determination, except as permitted under §§431.213 and 431.214.

10 Day Notice Requirement - Exceptions

Notice may be sent not later than the date of adverse benefit determination if—

- The plan has factual information confirming the death of an enrollee;
- The plan receives a clear written statement signed by an enrollee that—
  - They no longer wishes services; or
  - Gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying that information;
- The enrollee has been admitted to an institution where he is ineligible for further services;
- The enrollee's whereabouts are unknown and the post office returns mail directed to them indicating no forwarding address;
- The enrollee has been accepted for Medicaid by another jurisdiction;
- A change in the level of medical care is prescribed by the enrollee's physician;
- The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i)

The plan may shorten the period of advance notice to 5 days before the date of action if—

- The plan has facts indicating that action should be taken because of probable fraud by the enrollee; and
- The facts have been verified, if possible, through secondary sources.

10 Day Notice Requirement

- DOH guidance issued December 15, 2017 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm

- 10 Day notice must be provided when the plan determines to reduce, suspend or terminate a previously authorized service during the period for which the service was approved
- 10 Day notice must be provided when the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a **subsequent** authorization period.

When does enrollee have right to Aid to Continue?

- DOH guidance issued December 15, 2017 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm

- Right to Aid to Continue exists when:
  - the plan determines to reduce, suspend or terminate a previously authorized service during the period for which the service was approved
  - when the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a subsequent authorization period.

Aid to Continue

- 42 CFR 438.420 provides that an enrollee has right to continued benefits while a Plan Appeal or Fair Hearing is pending, if the enrollee timely requests the Plan Appeal and/or Fair Hearing
- Timely filing means:
  - The enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination notice or by the effective date of the decision, whichever is later
  - The enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination, or by the effective date of the appeal decision, whichever is later

Aid to Continue on Plan Appeal

- New York provides Aid to Continue on an “opt out” basis
- Plans must provide Aid to Continue (AC):
  - **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

Aid to Continue on Plan Appeal

- Plans must provide Aid to Continue:
  - **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

Aid Continuing on Plan Appeal

- For example: it is 5/22/18 and an enrollee gets care in a nursing home. The plan initially approved nursing home services from 1/1/18 to 6/30/18. The plan receives a request to keep providing nursing home services from 7/1/18 to 8/31/18. After review, the plan decides to deny the request and issues an Initial Adverse Determination on 5/25/18; services will still end on 6/30/18. On 6/25/18 (before the effective date of the termination), the enrollee requests a Plan Appeal and does not opt out of AC. The plan must provide AC.

Aid to Continue on Plan Appeal

What if the enrollee's provider requests the Plan Appeal on behalf of the enrollee?

- 42 CFR 438.402 prohibits providers from requesting AC
- The plan must ask the enrollee if they wish to continue their services unchanged until the Appeal decision
- The plan may remind the enrollee that if they lose their appeal, they may be liable for the cost of the services they receive while waiting for the decision.

Aid to Continue on Fair Hearing

What if the enrollee requests a Fair Hearing within 10 days of the plan's Final Adverse Determination?

- As appropriate, the Office of Administrative Hearings will direct the plan to provide AC unless the enrollee indicates they do not wish their services continue

What if the enrollee has been deemed to have exhausted the plan's appeal process and there is no Final Adverse Determination?

- As appropriate, the Office of Administrative Hearings may direct the plan to provide AC

What if the enrollee did not receive AC during the Plan Appeal, but timely filed a Fair Hearing?

- As appropriate, the Office of Administrative Hearings will direct the plan to provide AC unless the enrollee indicates they do not wish their services continue

Aid to Continue on Fair Hearing

- Plans must provide Aid to Continue:
  - **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan´s appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

Aid to Continue on Fair Hearing

- Back to example: Enrollee gets care in a nursing home. The plan initially approved nursing home services from 1/1/18 to 6/30/18. The plan receives a request on 5/22/18 to keep providing nursing home services from 7/1/18 to 8/31/18. After review, the plan decides to deny the request and issues an Initial Adverse Determination on 5/25/18; services will still end on 6/30/18. On 6/25/18 (before the effective date of the termination), the enrollee requests a Plan Appeal and does not opt out of AC. The plan must provide AC.
- The plan reviews the Plan Appeal and determines to uphold their decision. On 6/30/18 the plan issues a Final Adverse Determination. The plan is required to continue services for at least 10 days; the effective date of the termination is 7/10/18.
  - this allows for 10 day advanced notice of a termination in a subsequent authorization period for a nursing home stay and
  - allows at least 10 days for the enrollee to ask for a Fair Hearing and AC
- The enrollee timely requests a Fair Hearing with AC on 7/1/18. The plan must continue to provide AC.

How long must the plan provide Aid to Continue?

- DOH guidance issued December 15, 2017 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm
- NYS Social Service Law 365-a(8) applies

- The plan must continue the enrollee's services under AC until one of the following occurs:
  - the enrollee withdraws the request for AC, the plan appeal or the fair hearing;
  - the enrollee fails to request a fair hearing within 10 days of the plan´s Final Adverse Determination or the effective date of the decision, whichever is later;
  - OAH determines that the Enrollee is not entitled to aid continuing;
  - OAH completes the administrative process and/or issues a fair hearing decision adverse to the enrollee; or
  - the provider order has expired, except in the case of a home bound enrollee.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Can the member be held liable for the cost of service received while the Plan Appeal and/or Fair Hearing was under review?

- 42 CFR 438.420 provides the enrollee may be held liable for cost of services provided while the Plan Appeal or Fair Hearing was pending
  - Plan recoveries must be consistent with the State's policies on recoveries
  - The plan may not begin recovery of these costs from the enrollee until at least 10 days have passed from the Final Adverse Determination, and the enrollee has not requested a Fair Hearing
  - If the enrollee requests a Fair Hearing within 120 days of the Final Adverse Determination, the plan must cease any collection activity pending the Fair Hearing decision

NEW YORK STATE OF OPPORTUNITY. Department of Health

Summary of Changes From 42 CFR 438

- New time frame for Fast Track initial decisions: 72 hours
  - Outpatient Pharmacy** 24 hours
- If no notice of adverse benefit determination, or the notice is late, the enrollee may file a Plan Appeal
- Enrollee must first ask for a Plan Appeal and allow time for response, BEFORE asking for a Fair Hearing
- Enrollee has 60 days from the Initial Adverse Determination to ask for a Plan Appeal
- If plan decision is to reduce, suspend or stop a service, an enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination to keep their services unchanged until the decision (aid to continue)
- The enrollee must provide written authorization to designate someone, including their provider, to ask for a Plan Appeal or complaint on their behalf

**as defined by SSA §1927

Summary of Changes From 42 CFR 438

- New time frame for Fast Track Plan Appeal decisions: 72 hours
- Enrollee has 120 days from Final Adverse Determination to ask for a Fair Hearing
- If Plan Appeal decision is to reduce, suspend or stop a service, an enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination to keep their services unchanged until the decision (aid to continue)
- If no response to Plan Appeal or if response is late, the enrollee may ask for a Fair Hearing
- If Enrollee wins Plan Appeal or Fair Hearing, plan must authorize services in 72 hours

Part II: FY 2018-19 Health and Medicaid Budget Initiatives
Chapter 57 of the Laws of 2018

Benefit Changes

Physical Therapy Cap

Effective July 1, 2018, the physical therapy cap under both Medicaid fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per year.

Telehealth

Effective July 1, 2018.

Telehealth Providers were Expanded to Include:

- Residential health care facilities serving special needs populations;
- Credentialed alcoholism and substance abuse counselors credentialed by the Office of Alcoholism and Substance Abuse Services or by a credentialing entity approved by such office, pursuant to Section 19.07 of the Mental Hygiene law;
- Providers authorized to provide services and service coordination under the Early Intervention Program, pursuant to Article 25 of Public Health law;

Telehealth

- Clinics licensed or certified under Article 16 of the Mental Hygiene law;
- Certified and non-certified day and residential programs funded or operated by the Office for People with Developmental Disabilities; and
- Any other provider as determined by the Commissioner pursuant to regulation or, in consultation with the Commissioner, by the Commissioner of the Office of Mental Health, the Commissioner of the Office of Alcoholism and Substance Abuse Services or the Commissioner of the Office for People with Developmental Disabilities.

Telehealth

Originating Sites were Expanded to Include:

- Certified and non-certified day and residential programs funded or operated by the Office for People with Developmental Disabilities.
- The patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York.

Remote Patient Monitoring (RPM) was Expanded to Include:

- Additional interaction, triggered by previous RPM transmissions, such as interactive queries conducted through communication technologies or by telephone.

Telehealth

- The Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will issue a single guidance document to assist consumers, providers and health plans in identifying and understanding any differences in telehealth regulations and policies issued by the agencies.

Long Term Care

Long Term Services and Supports (LTSS)

LTSS: facility and community based long term services and supports, including but not limited to short- and long-term nursing home stays; adult day care services; private duty nursing in the home; therapies in the home; home health aide services; personal care services; and consumer directed personal assistance services

Mainstream Managed Care

- LTSS is included in the comprehensive Benefit Package for Mainstream Managed Care Plan, HIV SNP and HARP (no long-term NH)

Managed Long Term Care Plans

- only enroll individuals who need community based LTSS

Receipt of LTSS does not automatically mean the enrollee is in an MLTC plan

2018-2019 Enacted Budget – DLTC Summary

- Limit the number of LHCSA (Licensed Home Care Services Agencies) that Contract with MLTC Plans
- Require Continuous 120 days of CBLTC for Plan Eligibility
- Restrict MLTC Members from Transitioning Plans for 12 Months After Initial Enrollment
- Authorization vs. Utilization Adjustment for MLTC

2018-2019 Enacted Budget – NH Benefit

- Limit MLTC Nursing Home Permanent Placement Benefit to Three Months (3 Prong-Approach)
  1. Closing the front door to new permanent placement NH residents (returning the exclusion)
     - — Individuals will no longer be auto assigned upon entry to the NH
  2. Limitation of the Partial Cap NH Benefit to 3 months for permanently placed enrollees once Medicare is maximized
     - — DOH is working with New York Medicaid CHOICE to get notices to all enrollees on the change
     - — DOH will provide plans with a model notice to enrollees in NH
  3. Transition of NH enrollees from MLTC to FFS
     - — Enrollees that are permanently placed as of April 1 will be disenrolled in July 2018

Questions?

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [Service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

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 **[DATE+60]. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10].** 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 [PLAN NAME] is [reducing] {or} [suspending] {or} [stopping]the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval [**changes** to:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]
From [new start date] to [new end date]] {or}
[**is suspended** from {start date} to {end date}] {or} [**ends**.]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services}*[This service will be provided by [a participating][an out of network] 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][suspend][stop] your service?

[[UR Agent/benefit manager] on behalf of] [Insert Plan Name] is taking this action because [the service is not medically necessary] {or} [*other decision*].

- Your [service] will be [reduced][suspended][stopped] because:
  - [**Indicate the change** in the enrollee's medical condition, social, or environmental circumstances since the previous authorization was made.]
  - [**State when the change occurred**.]
  - [Include the criteria requirements and other information relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
  - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

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 [date+10].**
- 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 **[date+60]**.

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: [phone number]. TTY users call [TTY number].

{Insert for MLTC/LTSS/HARP Services or Delete}[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.
- [Insert any specific information needed for the plan to render a decision on appeal.]

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.
{*If the plan has different contact information for standard and fast track appeals, plans may replace/revise the contact information below.*}
Give us your information and materials by phone, fax, [email,] mail, [online,] or in person**:**

Phone…….	[1-800 MCO number]
Fax……..	[fax number]
Email……..	[email address]
Mail……..……..	[address] [city, state zip]
On Line……..	[web portal]
In Person……...…	[address] [city, state zip]

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, [plan name] 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/FHReq.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 [plan name] at [PLAN'S TOLL FREE #]; 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.

{Insert for medical necessity denials of inpatient substance abuse treatment requested 24 hours prior to discharge}[SPECIAL NOTICE: If you asked for inpatient substance use treatment at least 24 hours before you were to leave the facility, the plan will continue to pay for your stay if:

- you ask for a Fast Track Plan Appeal within 24 hours of receipt this notice AND
- you ask for a Fast Track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your Fast Track Plan Appeal in 24 hours. The Fast Track External Appeal will be decided in 72 hours.]

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 MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

You can call [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Appeal Request Form

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representative, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}
[At your request, a copy of this notice has been sent to:

[Fname Lname]]

[PLAN NAME] APPEAL REQUEST FORM
FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To:
[Plan Name/UR AGENT]
[Address]
[City, State Zip]

Fax to: [Fax number]

Today's date: _____

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 [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 [DATE+60**]. **If you want a Plan Appeal, you must ask for it on time.**

Enrollee Information
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]
Service being reduced, suspended or stopped: [SERVICE]

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 [Plan Name] 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.

75

NOTICE OF NON-DISCRIMINATION

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

[PLAN NAME] 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 **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** 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 **[PLAN NAME]** 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 numberالبكم والصم هاتف رقم)< 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 আছে৷ ফোন করুন ১-<toll free number> <TTY/TDD>	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

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

INITIAL ADVERSE DETERMINATION
DENIAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

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 **[DATE+60].** 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?

On [date] {*for Fast Track requests insert:*} [at [hour received]], you or your provider asked for [SERVICE TYPE: HOURS/DAYS, VISITS, LEVEL, QTY, etc.] {*insert as applicable*}[provided by [provider name].

You are getting this notice because [PLAN NAME] has [partially] denied [your request for services][payment for a claim].

{*insert for partial approvals or concurrent review*}
[{*insert as applicable*}[Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
On [date] you or your provider requested approval for:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
On [EFFDATE], the plan approval [**is only for**:] [**stays** at:]
[HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
This means from [NEWSTARTDATE] to [NEWENDDATE], your service is approved for:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{*Insert as applicable*}[We will review your care again [IN TIME FRAME/ ON DATE]].

This service will be provided by [a participating][an out of network] 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 [partially] deny the [request][claim]?

On [Date], [[UR Agent] on behalf of] [Plan Name] decided to [deny] *{or}* [partially approve] this [service] *{or}* [claim] because the *{insert reason as applicable*}*

[service is not medically necessary]
[request did not have enough information to determine if the service is medically necessary]
[service is experimental/investigational]
[service is not covered by your managed care benefits]
[the benefit coverage limit has been reached]
[service can be provided by a participating provider]
[service is not very different from a service that is available from a participating provider]
[other decision].

{ INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

[Insert a detailed reason for the decision, including the specific services not covered, the plan requirement for coverage not met, and/or where benefit coverage is dependent on the enrollee's condition, a description of the benefit coverage criteria not met.]

{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST/CLAIM FOR A NEW SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

- You asked for [service] because [Insert the nature of the enrollee's condition].
- To approve this service {*Insert for partial approvals}*[in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

{Note: The clinical rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST FOR MORE OF A CURRENT SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

- You were receiving [service] because [Insert the nature of the enrollee's condition].
- [This service will stay the same] {*or*} [The request to increase this service is partially approved] because you do not meet the criteria to [fully] approve this request. To approve this service [in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet

the required criteria for service approval (necessitating a partial service approval) *or* Insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

{Note: The clinical rationale must be sufficiently specific to enable an enrollee to determine the basis for appeal.}

{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE OF A CURRENT SERVICE (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}

- The request for [service] was [denied][partially approved]. This decision was based on:
  - [Insert the criteria requirements and other information relied on to make the decision.]
  - [Insert the enrollee specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

{INSERT FOR OON SERVICE DENIALS BASED ON SERVICES NOT MATERIALLY DIFFERENT FROM SERVICES AVAILABLE IN-NETWORK, OR OON REFERRAL DENIALS IF IN-NETWORK PROVIDERS HAVE TRAINING/EXPERIENCE TO MEET ENROLLEE'S NEEDS, OR DELETE}

- You asked for [service] because [insert the nature of the enrollee's condition].
- {*Insert for denials of OON Not Materially Different services*} The following in-network service is available to treat your condition: [Insert a description of the similar service that is available in network.] We believe that this service is not very different from the service you requested because [Insert why the in-network service is not materially different than the OON service, and is adequate to meet the enrollee's clinical/social needs.] You can get this service by [insert how to access and get approval, if needed, for the in-network service].

- {*Insert for OON referral denial based in training and experience*} The in-network providers listed below are available to provide [service] and have the correct training and experience to meet your needs. You can check the provider directory or call us for other provider options. [Insert providers and contact information who are available to provide the requested service, and have training and experience to meet the enrollee's particular needs.]

[Provider 1]	[Provider 2]
[Address]	[Address]
[Phone Number]	[Phone Number]

{*Insert for denials for services not covered by the Benefit Package that are available through Fee-For-Service Medicaid*}[While this service is not covered by [Plan Name], you may be able to get it from regular Medicaid. To get this service, use your New York State Benefit card to see any provider that accepts New York Medicaid.]

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.

You have **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to file a Plan Appeal is **[date+60]**.

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: [phone number]. TTY users call [TTY number].

{*Insert for MLTC/LTSS/HARP Services or Delete*}[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.
- [Insert any specific information needed for the plan to render a decision on appeal.]

{*Insert for OON not materially different, if plan requires for UR review*} [If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

{*Insert for OON referral denial based on training/experience*} [If you think our participating provider does not have the correct training or experience to provide this service, you can ask us to check if it is

medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

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.

{*If the plan has different contact information for standard and fast track appeals, plans may replace/revise the contact information below.*}

Give us your information and materials by phone, fax, [email,] mail, [online,] or in person**:**

Phone…….	[1-800 MCO number]
Fax……..	[fax number]
Email……..	[email address]
Mail……..……..	[address] [city, state zip]
Online……..……	[web portal]
In Person……...…	[address] [city, state zip]

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, [plan name] 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 Plan 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:

- A 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/FHReq.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 the 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 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 [plan name] at [PLAN'S TOLL FREE #]; 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.

{*Insert for medical necessity denials of inpatient substance abuse treatment requested 24 hours prior to discharge*}[SPECIAL NOTICE: If you asked for inpatient substance use treatment at least 24 hours before you were to leave the facility, the plan will continue to pay for your stay if:

- you ask for a Fast Track Plan Appeal within 24 hours of receipt this notice AND
- you ask for a Fast Track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will decide your Fast Track Plan Appeal in 24 hours. The Fast Track External Appeal will be decided in 72 hours.]

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 MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

You can call [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Appeal Request Form

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:
[Fname Lname]]

[PLAN NAME] APPEAL REQUEST FORM
FOR DENIAL OF SERVICES

Mail this form to:
[Plan Name/UR AGENT]
[Address]
[City, State Zip]

Fax to: [Fax number]

Today's date: _____

Deadline: If you want a Plan Appeal, **you must ask for it on time. You have 60 days** from the date of this notice to ask for a Plan Appeal. The last day to ask for a Plan Appeal about this decision is [**DATE+60**].

Enrollee Information
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]
Service being Denied: [SERVICE]

I think the plan's decision is wrong because:

_____

_____

_____

Check all that apply:

- ☐ 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 [Plan Name] 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

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

[PLAN NAME] 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 **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** 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 **[PLAN NAME]** 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 numberرقم 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 আছে৷ ফোন করুন ১-<toll free number> <TTY/TDD>	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

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage type: [coverage type]
Plan reference number:[plan reference number]
Provider: [provider to perform the service]
Facility:[Insert Facility]
Service developer/manufacturer:[service developer/manufacturer]]

Dear [Enrollee]:

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 [**Date+120**]. **If you want to keep your services the same until your Fair Hearing is decided, you must ask for a Fair Hearing by [DATE+10].** 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 [date appeal filed] {for Fast Track appeals insert} [at [hour received]], you or your provider asked for a Plan Appeal about our decision to [reduce] [suspend] [stop] [service]. [Insert summary of appeal].

On [date of appeal determination], [[UR Agent Name/Benefit Manager] on behalf of] [Plan Name] decided we are [not changing our decision][changing our decision and will partially approve your service].

From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [DATEIAD], we decided to [reduce your [SERVICE] from [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] starting on [Date].] *{or}* [suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}* [stop your [SERVICE] on [Date].]

On [DATE FAD], we have [partially] denied your Plan Appeal and:

[On [EFFDATE] we will reduce your [SERVICE] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and new TOTAL AMOUNT].] *{or}*

[On [EFFDATE] we will suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}*

[On [EFFDATE] we will stop your [SERVICE].]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services*}[This service will be provided by [a participating][an out of network] 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][suspend][stop] your service?

We made this decision because the [service is not medically necessary][there was not enough information to determine if the service is medically necessary][other decision].

- Your [service] will be [reduced][suspended][stopped] because:
  - [**Indicate the change** in the enrollee's medical condition, social, or environmental circumstances since the previous authorization was made.]
  - [**State when the change occurred**.]
  - [Include the criteria requirements and other information relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
  - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

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[; ADD SPECIFIC BENEFIT CITATION AS APPLICABLE]

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.

- *{Insert if applicable}* [If we said your service was not medically necessary, you can **ask the State for an <u>External Appeal</u>** – this is 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 must 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 [date+10].**
- 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 **[date+120].**

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.

{insert if applicable}[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 MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

{Insert for MLTC/LTSS/HARP Services or Delete}[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 [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice. {*Insert as applicable*}[To talk to someone at [UR Agent], call [contact name] at [UR Agent number].

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:
[Fname Lname]]

{MMC}[229]{*or*}[266]{MLTC}[212]{*or*}[211] 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 [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.

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 [date]. On [date of appeal determination], [UR Agent Name/Benefit Manager] on behalf of][Plan Name] decided we are [not changing our previous decision to [reduce][suspend][stop]] [changing our previous decision and will partially approve] the service.
From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
On [DATEIAD], we decided to [reduce your [SERVICE] from [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] starting on [Date].] *{or}* [suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}* [stop your [SERVICE] on [Date].]
On [DATEFAD] we have [partially] denied your Plan Appeal and
[on [EFFDATE] we will reduce your [SERVICE] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and new TOTAL AMOUNT].]{*or*} [on [EFFDATE] we will suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}* [on [EFFDATE] we will stop your [SERVICE].]

NOTICE OF NON-DISCRIMINATION

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

[PLAN NAME] 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 **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** 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 **[PLAN NAME]** 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 আছে৷ ফোন করুন ১-<toll free number> <TTY/TDD>	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

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

FINAL ADVERSE DETERMINATION
DENIAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage type: [coverage type]
Plan reference number:[plan reference number]
Provider: [provider to perform the service]
Facility:[Facility]
Service developer/manufacturer:[service developer/manufacturer]]

Dear [Enrollee]:

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 [**Date+120**] . 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 [date appeal filed] {*for Fast Track appeals insert*}[at [hour received]], you or your provider asked for a Plan Appeal about our decision to [partially] deny [service]. [Insert summary of appeal].

On [date of appeal determination], we decided we are [not changing our decision to [partially] deny] {or} [changing our decision and will partially approve] your [request][this claim].

{INSERT FOR CONCURRENT REVIEW OR PARTIAL APPROVALS OR DELETE THIS SEGMENT}
{*Insert as applicable*}[From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
{*Insert as applicable*}[ON [Date] you or your provider requested approval for: [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]]
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT].
On [DATEFAD], the plan approval [**is only for**:] {or} [**changes** to:] {or} [**stays** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [STARTDATE] to [ENDDATE].
{*Insert as applicable*}[We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for partial approvals*}[This health care service will be provided by [a participating][an out of network] 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 [partially] deny the [request][claim]?

[[UR Agent] on behalf of] [Plan Name] decided to [deny] *{or}* [partially approve] this [service] *{or}* [claim] because the *{insert reason as applicable*}*

[service is not medically necessary]
[request did not have enough information to determine if the service is medically necessary]
[service is experimental/investigational]
[service is not covered by your managed care benefits]
[the benefit coverage limit has been reached]
[service can be provided by a participating provider]
[service is not very different from a service that is available from a participating provider]
[other decision].

{*For OON denials:}* [State if only the service is not covered or if only the out of network access is not covered or both are not covered] {insert if applicable} [You can get [requested service] [[alternate service], which is not very different the service you requested,] from one of our providers. We have confirmed [a provider][providers] in our network that are available and able to perform this service. To get this service contact:

[Provider 1]	[Provider 2]
[Mailing Address]	[Mailing Address]
[Phone Number]	[Phone Number]]

{ INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

[Insert a detailed reason for the decision, including the specific services not covered, the plan requirement for coverage not met, and/or where benefit coverage is dependent on the enrollee's condition, a description of the benefit coverage criteria not met.]

{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST/CLAIM FOR A NEW SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT ABOUT LTSS OR DELETE THIS SEGMENT}

- You asked for [service] because [Insert the nature of the enrollee's condition].
- To approve this service {*Insert for partial approvals*}[in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* insert model prescriber prevails language or case-specific information about why the service is experimental/investigational. For OON not medically necessary, clearly state if only the service is not medically necessary, or if only the out of network access is not medically necessary, or both are not medically

necessary]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

{INSERT IF THE DECISION IS CLINICAL AND FOR A CONCURRENT REVIEW INCLUDING PARTIAL APPROVALS AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

- You were receiving [service] because [Insert the nature of the enrollee's condition].
- [This service will stay the same] {*or*} [The request to increase this service is partially approved] because you do not meet the criteria to [fully] approve this request. To approve this service [in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* Insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

{Note: The clinical rationale must be sufficiently specific to enable an enrollee to determine the basis for appeal.}

{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE SERVICES (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}

- The request for [service] was [denied][partially approved] because you do not meet the criteria. This decision was based on:
    - [Insert the criteria requirements and other information relied on to make the decision.]
    - [Insert the enrollee specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

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[; ADD SPECIFIC BENEFIT CITATION AS APPLICABLE].

What if I don't agree with this decision?

If you think this decision is wrong:

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

- *{Insert if applicable}* [**You can ask the State for an External Appeal** – this is may be the best way to show how this service is medically necessary for you.

If you ask for both of these, the Fair Hearing decision will always be the final answer.]

How can I ask for a Fair Hearing?

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 **[date+120].**

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.

{Insert as applicable}[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 MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

{*Insert for MLTC/LTSS/HARP Services or Delete*}[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 [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice. {*Insert as applicable*}[To talk to someone at [UR Agent], call [insert contact name] at [UR Agent number].

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
{*Insert as applicable*}[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:
[Fname Lname]]

{MMC}[229]{*or*}[266]{MLTC}[212]{*or*}[211] **MANAGED CARE DECISION FAIR HEARING REQUEST FORM**

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

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

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 [date]. On [date of appeal determination], [UR Agent Name/Benefit Manager] on behalf of][Plan Name] decided we are [not changing our previous decision to [partially] deny] [changing our previous decision and will partially approve] the service.

[{*Include for only for partial approval, concurrent and LTSS*}
{include as applicable}From [STARTDATE] to [ENDDATE], the plan approved:[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
{include as applicable}You or your provider requested approval for:[HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT]]
On [EFFDATEFAD], the plan approval [is **only** for:] {or} [**changes** to:] {or} [**stays** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [start date] to [end date].]

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

[PLAN NAME] provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
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  - 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

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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)

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
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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 আছে৷ ফোন করুন ১-<toll free number> <TTY/TDD>	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

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Dear Health Plan Administrator:

New York State's Fiscal Year 2018-2019 Enacted Budget includes several changes that will impact Managed Long-Term Care (MLTC) Plans. Changes affecting covered benefits, plan and provider policies and procedures were scheduled for implementation as early as practicable in order to realize the greatest possible program benefits. These changes, along with implementation dates and impact to the specific products are detailed below.

In many cases, the changes in law adopted with the 2018-2019 State Budget require additional guidance from the Department to plans. This will be forthcoming. This letter will provide plans awareness of changes that will impact both plan operations and membership. Changes are summarized below and member materials are forthcoming.

The terms of the existing contracts stipulate that plans must comply with any applicable State or federal statute, plans must put policies and procedures in place to implement the following statutory changes as of the effective date indicated. Future contract amendments will be developed to address these proposals and reflect the specific product type impacts.

Until such time as changes can be made to Member Handbooks, plans may notify enrollees of these changes through member letters and handbook inserts.

I

Limit the Nursing Home Benefit in Partially Capitated MLTC Plans for Permanently Placed Enrollees to 3 months

Presuming CMS' approval of the technical amendment to the State's 1115 Demonstration Waiver, partially capitated MLTC plan enrollees who have been permanently placed in a nursing home for a period of 3 calendar months will be disenrolled from the plan and returned to fee for service (FFS) Medicaid. There will be no impact to the member, who will remain in the same nursing home. The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan. The period of 3 months will commence once any available Medicare coverage has been maximized. Generally, those who were permanently placed in the nursing home in April 2018 will be disenrolled to FFS as of July 2018. This limitation only impacts the NH benefit for Partial Capitation plans. There is no impact to the nursing home benefit for MAP, PACE, FIDA, or Medicaid Managed Care.

Limitation of the permanent nursing home benefit will be carried out as a State administrative action. Further guidance, along with template notice to affected members will be provided shortly. The State will also provide model Member Letter language to address the limitation of the NH benefit.

Effective May 3, 2018, the mandated enrollment of newly identified permanently placed Dual Eligibles moving into MLTC plans will end and those consumers will stay in FFS Medicaid. The Department is developing a model notice to members regarding this change. In addition, disenrollment notification and processes are under development.

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Please note: Consumers who are disenrolled due to 3 months of permanent placement in a nursing home will be deemed eligible for CBLTC services for a period of 6 months, should they wish to revert from permanent placement and return to a community setting with CBLTC services from a MLTC plan. Those consumers will not be subject to a CFEEC evaluation prior to plan enrollment. Consumers may elect to rejoin their previous MLTC plan or choose another plan but in either event, remain subject to the selected plan's assessment prior to approval of enrollment.

Further information regarding impact to capitation rates will be provided by the Division of Finance and Rate Setting (DFRS).

Addition of 'continuous period' of 120 days of CBLTC Services to Eligibility Criteria – *Effective 4/12/18*

The addition of 'continuous period' to the eligibility criteria of 120 days of CBLTC services is applicable to all MLTC product types: Partially Capitated, PACE, MAP and FIDA. The intent of this addition is to provide clarification of criteria's intent, as applied upon enrollment into plan. The need for a period of 120 days is to be applied on a continuous forward looking basis, not retrospectively. This should not be calculated as cumulative throughout the first year of enrollment. Plans are expected to amend all enrollee materials and policies and procedures accordingly. Model member notices and handbook notice insert as developed by the State will also reflect this clarifying statement.

Restrict MLTC Partial Capitation Members from Plan Transfers Within a 12-month Period – *Effective 10/1/2018*

Individuals who enroll in a partially capitated MLTC plan will be prohibited from transferring to another available MLTC plan more than once a year unless good cause is demonstrated. Each member will be allowed a grace period of 90 days from point of enrollment, during which time they may elect one transfer for any reason. For the remainder of a twelve-month period beginning with the effective date of their enrollment, enrollees may pursue transfer if good cause is demonstrated.

This change is intended to mirror Lock-in provisions currently in place for New York's Medicaid Managed Care plans. It is expected to provide MLTC plans with more opportunities to foster continuity of care, engage members with effective care management strategies and improve health outcomes. In addition, the change is expected to facilitate plans' participation in Value Based Payment arrangements by providing a consistent timeframe to provide services and evaluate their effectiveness.

The Department will provide guidance to plans outlining good cause exceptions to allow members to transfer between plans during the 12-month lock-in period, and describing the process for identification of enrollees that have moved and their period of lock-in. Template Model Member notices and insert for Member Handbooks will be developed.

Utilization and Authorization Adjustment – *Effective 10/1/18*

Enrollees in all MLTC products who do not use the CBLTC services or supports outlined in their plan of care during a calendar month without prior notice to the plan will be disenrolled.

While all MLTC product lines are contractually required to follow this practice presently, this change in law is intended to ensure that all MLTC plans develop or use systems to better track utilization and immediately disenroll members who are not utilizing authorized services and supports.

Members disenrolled under this change in law will be considered involuntarily disenrolled using the existing process and will receive a notice from the MLTC plan with Fair Hearing rights issued by New York Medicaid Choice (NYMC). The Department will provide plans with guidance and exceptions to the directive that members must use the services for which they are authorized each calendar month. The Department will also develop a model member notice and Member Handbook insert. Once finalized, all MLTC plans will be required to update their policies and procedures accordingly.

II

Restrict the Number of LHCSA Contracts Partially Capitated MLTC Plans May Hold -- *Effective 10/1/18*

Partially capitated MLTC plans will be limited in the number of Licensed Home Care Services Agency (LHCSA) contracts it may hold. This change will limit the number of contracts these plans may hold based on a methodology approved by the Department.

MLTC plans operating in the City of New York and/or the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per seventy-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per one hundred members enrolled in the plan within such region.

MLTC plans operating in counties other than those in the city of New York and the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per forty-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per sixty members enrolled in the plan within such region.

In instances where limits on contracts may result in the enrollee's care being transferred from one LHCSA to another, and in the event the enrollee wants to continue to be cared for by the same worker(s), the MLTC plan may contract with the enrollee's current LHCSA for the purpose of continuing the enrollee's care by that worker(s). These types of contracts shall not count towards the limits mentioned above for a period of three months.

The Department will be providing guidance to affected plans. Plans may be required to provide evidence of their compliance on an annual basis. Plans that must reduce their number of LHCSA contracts will have to consider continuity of care and adequate workforce in addition to quality and value in selecting their contracted plans.

Monitor FI Marketing – *Effective 4/1/18*

Effective April 1, 2018, Fiscal Intermediaries must submit all advertising to the Department for review and prior approval. The Department will issue guidance to Consumer Directed Personal Assistance Service (CDPAS) Fiscal Intermediaries on advertising. This change does not require member notification or inclusion in the Member Handbook insert.

Social Adult Day Benefit Efficiency Savings – *Effective 10/1/18*

Social adult day care should be carefully planned and prioritized for those who would otherwise need constant personal care coverage in their home, those who require supervision due to advanced dementia, and those who have no other opportunity to be integrated in the community (e.g.- social isolation). All MLTC products will be incentivized to more efficiently provide this service to enrollees most in need of this level of care through a rate cut in their premium.

The Department will provide further guidance to plans that distinguishes between adult day health care and social adult day care, indicates how plans can prioritize this benefit to those who need it most, and suggests characteristics of quality and value that may help plans contract with appropriate social adult day care providers through Value Based Payment arrangements.

III

The following changes were also included in the enacted 2018-2019 State Budget.

Nursing Home Transition and Diversion (NHTD)/Traumatic Brain Injury (TBI) Managed Care Carve Out

The NHTD and TBI waiver populations will continue to be exempt/excluded from mandatory enrollment into Medicaid Managed Care until January 1, 2022.

Increase the Physical Therapy Limit to 40 Visits/Year – Effective 4/12/18

The Budget increases the limit on Physical Therapy from 20 to 40 visits. The Department will be providing additional guidance on this change in the MLTC benefit package. Member notice and Member Handbook inserts will have to be updated.

Establish Report Requirement for Plans Receiving Members Due to Acquisition, Merger or Other DOH Approved Arrangement – Effective 4/1/18

Any MLTC plan that accepts members as a party to an acquisition, merger, or other similar DOH approved arrangement must submit a report to the Department within twelve months of the transaction. The report shall include, but not be limited to, enrollee information and services authorized and utilized by the enrollee before and after the transaction. The Department shall make a summary of such report available to the public.

The Department will release guidance to plans affected by the budget provision prior to any such transactions. This provision does not require member notification.

The State's contracted Enrollment Broker, New York Medicaid Choice (NYMC) has been notified of all the changes which impact those operations. Applicable processes will be altered, as will all impacted Enrollment Broker educational materials and notices. Further guidance will

be provided to MLTC plans with regard to NYMC Enrollment Broker operations in respect to these budget initiatives.

Additional information related to the implementation of these actions, along with frequently asked Questions and Answers, will be forthcoming. MLTC plans may submit questions regarding implementation to the Department at DLTCEB19@health.ny.gov.

Sincerely,

Andrew Segal

Andrew Segal, Director
Division of Long Term Care
Office of Health Insurance Programs

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 30, 2018

Hon. Richard N. Gottfried
Chair, Assembly Health Committee
New York State Assembly
Legislative Office Building, Room 822
Albany, New York 12248

Dear Assembly Member Gottfried:

The purpose of this letter is to confirm (as part of the budget dialogue) that the Office of Health Insurance Programs at the New York State Department of Health ("Department") is committed to providing the following items:

- **Limit Managed Long-Term Care (MLTC) Eligibility to Less Than 3 Months in Nursing Homes:** The Department will provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports.

- **Congestion Surcharge**: The Department will pay the Medicaid transportation fee plus the cost of congestion pricing using amounts transferred to the Department for that purpose. The Department will also issue a Medicaid Update to clarify that Medicaid transportation providers (i.e. livery, etc.) will be held harmless from congestion pricing.

- **Adult Day Health Care (ADHC)Transportation:** The Department will refrain from taking administrative actions intended to carve out the provision of Medicaid transportation from the ADHC programs reimbursed to manage their own transportation to Fee-For-Service under the administration of the State's transportation manager during State Fiscal Year 2019.

- **Medicaid Transportation Livery Reimbursement Rates in New York City**: The Department will refrain from taking administrative actions that would reduce the rate of reimbursement to New York City Medicaid livery transportation providers in State Fiscal Year 2019.

- **Indigent Care Workgroup:** The Department will establish a temporary workgroup on hospital indigent care methodology which will make recommendations regarding Disproportionate Share Hospital (DSH) and Indigent Care Pool (ICP) funding. The workgroup shall convene no later than June 1, 2018 and create a report on its findings no later than December 1, 2018.

- **Quarterly Meetings on Medicaid Managed Care Rates:** The Executive commits to providing quarterly updates to the Legislature regarding Medicaid Managed Care rates. In the spirit of transparency, the Department, in conjunction with the Division of the Budget (DOB), will hold quarterly meetings with the chairpersons of the Senate and Assembly Health Committees, the Senate Finance Committee and the Assembly Ways and Means Committee. Staff from the offices of the chairpersons are welcome to participate in these monthly meetings in lieu of the elected official. The Department will also provide the actuarial memorandum which, pursuant to statute, is provided to managed care organizations 30 days in advance of submission to CMS. This document contains information regarding components of the premium (e.g. base amounts, trend percentages, category of service splits, etc.), add-on adjustments, quality pool amounts and various other Medicaid Managed Care rate development information. Finally, the Department will continue to provide the Legislature with all presentation materials disseminated at monthly managed care plan meetings.

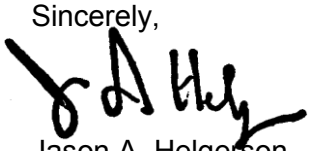
- **Monthly Meetings on the Medicaid Global Cap:** The Executive commits to monthly meetings with the Legislature during the third Wednesday of every month to provide an update on actual spending to-date and potential changes to projections for the remainder of the State Fiscal Year (May 16, June 20, July 18, August 15, September 19, October 17, November 21, December 19, January 16, February 20 and March 20). The agenda for such meetings shall be agreed upon by the Department and the Legislature. In addition, the Global Cap report will be expanded to include information on all non-Medicaid expenditures made out of Global Cap resources or any material changes on the program in the last month.

- **Separate Rate Cells or Risk Adjustments for Specific Populations:** The Department commits to exploring separate rate cells or risk adjustments for the nursing home, high cost / high need home and personal care, and Health and Recovery Plan (HARP) populations. The Department will re-engage the Centers for Medicare and Medicaid Services (CMS) regarding this reimbursement methodology with the assistance of health care industry stakeholders impacted by these changes (e.g. advocates, providers and managed care organizations).

- **Managed Long Term Care (MLTC) and Licensed Home Care Service Agency (LHCSA) Patient Protections:** The Department will issue guidance to assist both MLTC and LHCSAs in minimizing the disruption of care for Medicaid members and the impacted workforce when methodologies are enacted to limit the number of LHSCAs with MLTC Plans.

The Department is committed to ensuring that Legislative leaders have full access to vital information and commitments provided in this letter to build off previous efforts to ensure Medicaid program transparency. We look forward to working with you and your staff to make the Medicaid program more cost effective in the months and years to come.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Howard A. Zucker, M.D., J.D.
Sally Dreslin
Donna Frescatore
Dan Sheppard
Elizabeth Misa
OHIP Division Directors

Office of Health Insurance Programs

Division of Long Term Care

Managed Long Term Care Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration

Date of Issuance: September 22, 2017

Effective immediately, the Department is establishing a process applicable to Managed Long Term Care (MLTC) enrollees in Partially Capitated, Programs of the All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP) plans who are required to involuntarily transition from one MLTC plan to another MLTC plan, as the result of (a) plan closure, (b) a plan's service area reduction or withdrawal, or (c) merger, acquisition or other arrangement approved by the Department.

A. Plan Closures

1. Requests. Requests to withdraw from the market through plan closure must be formally submitted to the Department, and receive specific approval, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to withdraw.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through plan closure. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter, and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by the State's Enrollment Broker, New York Medicaid Choice (NYMC) and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for plan closure and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will

subsequently process the enrollment transaction to the receiving plan. The plan that is closing must provide the new plan of choice with detailed information on the enrollee's plan of care and network provider relationships within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select or are auto-assigned to the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

B. Service Area Reduction

1. Requests. Requests to withdraw from the market by reducing a plan's service area must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to reduce a service area.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through reduction of a plan's service area. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for reduction in service area and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process

the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will subsequently process the enrollment transaction to the receiving plan. The plan that is withdrawing must provide the new plan of choice with detailed information on the enrollee's plan of care within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

C. Mergers, Acquisitions, and Other Arrangements Approved by the Department

1. Requests. Requests to withdraw from the market by merging with, or being acquired by, another MLTC plan must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of either plan. The Department will consider for approval, and reserves the right to approve, other proposed arrangements. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. The Department must approve any request for a merger, acquisition, or other proposed arrangement with another MLTC plan.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through merger, acquisition, or other proposed arrangement with another MLTC plan. Notices shall contain an announcement notice of the upcoming change, written information on plan choice and contact information for NYMC for education on other available options. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for merger, acquisition, or other acceptable arrangement and all member notifications have been approved by the Department. Enrollees will be provided with information on plan choice and may elect to transfer to any other MLTC, within a sixty (60) day selection period. Market reduction that relates to an approved acquisition, merger, or other acceptable arrangement will result in

transfer of remaining enrollees to the designated receiving plan.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.
Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

PLEASE NOTE: MLTC enrollees will continue to have the opportunity to pursue a voluntary plan-to-plan transfer at any time.

D. Rate Adjustments

1. Plan Closures. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

2. Service Area Reduction. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

3. Mergers, Acquisitions, and Other Arrangements Approved by the Department. The Department will blend the most recent premium rates (draft or approved) of the consolidating plans. The blend will occur in the development process utilizing the community portion of the rate. The blend will utilize the most recent projected community enrollment to develop the blended community rate.

   Additionally, the Nursing Home Transition (NHT) add-on will also be recalculated based on the combined projected nursing home and community enrollment of both plans.

   The new blended rate must be actuarially sound as determined by the Department's actuary.

   Note: Different financing arrangements other than those specified above may be required for any of the member transition scenarios.