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The New MLTC Appeal Requirements – "Exhaustion" of Plan Appeals

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New "exhaustion" requirement for MANAGED CARE APPEALS

- The Obama Administration revised the federal regulations that govern Medicaid "managed care" plans. 42 CFR Part 438. They had not been revised since 2002.
- **One of the big changes is in fair hearing rights.**
- **Beginning April 1, 2018**, members must first request a plan appeal within their plan, and wait until the plan decides the appeal, BEFORE they may request a Fair Hearing. This is called "exhausting" the internal appeal.
- **WHO – all Medicaid managed care plans including**:
  - MLTC plans – 200,000 NYS residents
  - "Mainstream" plans (for people not on Medicare, mostly < 65 but some >65 if on SSI-only or not on Medicare (usually because of immigration status) – 4.4 million NYS residents

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All who work with this population must help educate & help people affected!!

- This affects nearly 5 million New Yorkers, but they may only receive one letter from their plans in March telling them about this change. That's not enough!
- State Dept of Health recently set up one webpage with info for PLANS but not CONSUMERS. https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm
- Even if you as a social worker or provider don't REPRESENT clients in appeals, it's important that you educate them about the change and help them REQUEST appeals.
- If services are being REDUCED by the plan, client may have just a day or two after receiving the notice to request **plan appeal** and ensure AID CONTINUING – that services are not cut until appeals are held and decided. If they request a Fair Hearing by mistake, they will not get Aid Continuing.

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Concerns about "Exhaustion"

- **This is a huge change in NYS.**
  - 4 million "mainstream" Medicaid managed care members (those without Medicare, mostly < 65) were never required to request an internal appeal before requesting a fair hearing.
  - When MLTC became mandatory in 2012-14, exhaustion was required, but in 2015 the State lifted that requirement.
- **AID CONTINUING in jeopardy**: If plan is reducing hours or other services, member must request the Internal Appeal quickly to get Aid Continuing. But calling Plan's 800 numbers -- and ensuring that the call is logged in – can be difficult.
  - If Internal Appeal decision is adverse, then client must AGAIN request a hearing in time to get Aid Continuing.
- **Advocates are concerned that plans have not set up new procedures and trained their staff** to make sure all appeals are logged in, processed, and Aid Continuing is provided
- OTDA must redirect people who request Fair Hearings to their plans. But will they? If not, they won't get Aid Continuing.

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Appeal vs. Grievance

What is an APPEAL?

- **Appeal -** is a request to review an **adverse determination** made by a plan. The plan's original determination is called an **"Initial Adverse Determination."**

  For example, the plan:
  - **Reduces or stops** personal care, adult day care, or other services, or
  - **denies request for a new service, such as** Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing
  - **denies request to increase your hours** of personal care services or other services

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Appeal vs. Grievance

What is a Grievance?

- **A grievance** is a complaint you make directly with the MLTC plan about anything NOT an adverse benefit determination –
  - the quality of care, services or treatment you received,
  - delays in services, or
  - poor communications with the plan.
- **EXAMPLES**:
  - Aide or transportation is late or doesn't show,
  - aide isn't trained well,
  - can't reach your care manager by phone,
  - you were treated rudely, or
  - disagree with plan's decision to extend time to decide your request for new or increased services.

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What kind of MLTC decisions must you first appeal to PLAN?

Plan gives "**Notice of Initial Adverse Determination**" (**IAD**) that it will:

- REDUCE hours of home care, adult day care, etc.
- DENY a request for an increase in hours, or for a new service, such as a wheelchair, etc.
- APPROVE hours of home care that are not enough.

After April 1, 2018, a managed care or MLTC member may not request a Fair Hearing for any of the above actions until AFTER BOTH OF THESE OCCUR:

1. Member has requested a **plan appeal** a/k/a internal appeal of an adverse plan determination, and
2. The plan has issued a decision. 42 CFR 438.402(c).

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New Extra Step in All Appeals

1. PLAN mails Notice of "**Initial Adverse Determination" (IAD)** to member. New templates for notices include form to request internal appeal.
2. Member MUST request "Internal appeal" or "**Plan appeal"** to plan directly.
3. Plan mails "**Final Adverse Determination" (FAD**) notice. If this is adverse – partly or totally,
4. Member requests **FAIR HEARING**
   - Member may request EXTERNAL APPEAL instead of or in addition to FAIR HEARING if issue involves Medical Necessity. But if plan is REDUCING services, may only get AID CONTINUING if request FAIR HEARING.

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TWO TYPES OF INITIAL ADVERSE DETERMINATIONS (IAD)

1. **REDUCTIONS** of services
2. **DENIALS** of new or increased services

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1. FOCUS ON **REDUCTIONS** IN HOURS OR SERVICES

Initial Adverse Determination to reduce services

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Aid Continuing

- **Aid continuing** is a key right when a plan proposes to reduce or stop a service. If Aid Continuing is granted, your services will not be reduced or stopped until after your appeal is decided.
  - If you win the appeal, services will not reduced.
  - If you lose, you will get a 2nd notice called a Final Adverse Termination, with the right to request a Fair Hearing, and receive Aid Continuing again.
- Aid continuing is only granted when:
  - The Plan appeal is **requested before the effective date of the** Notice of Initial Adverse Determination.
- You get Aid Continuing even if the latest Authorization Period has expired, SSL 365-a, subd. 8

  EX: Ann has 24-hour live-in care, authorized through March 31st. She gets a notice dated March 17th that she will have 12 hours daily, as of April 1st. This is a **reduction** effective April 1st. Ann will still get aid continuing if she requests **Plan Appeal** before April 1st.

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Initial Adverse Determination – 3 Key Dates

If Notice is Reducing or Terminating a Service -- watch for 3 dates on notice

1. **Date of Notice**
2. **Effective Date**: date proposed action takes effect. Must be at **least 10 days after date** of notice or date notice is mailed, if later.
3. **Time Limit to Request Plan Appeal** - 60 days from date of notice

When plan is reducing or stopping a service, the **Effective Date** - #2 above is much more important than the #3. But the IAD notice mentions the 3rd date first (in green below & next slide)!!

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

The real deadline is April 11th to get Aid Continuing.

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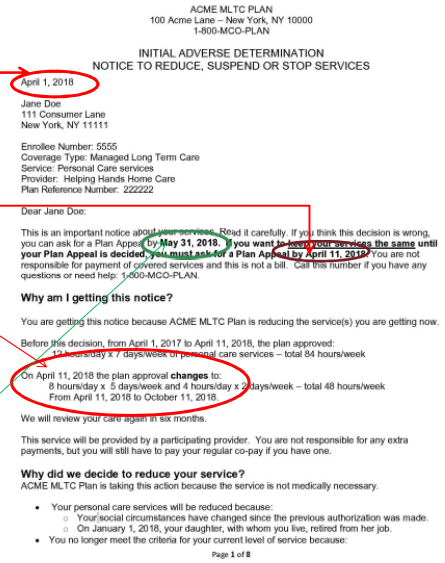
Initial Adverse Determination Notice

Look for TWO KEY DATES if Reduction

1. **Notice Date**
   - This is the date the plan printed the notice and, hopefully, mailed it to the member
2. **Effective Date**[1]
   - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, this is a Defective Notice.
   - Get Postmarked envelope!
3. Appeal deadline (60 days) (ignore!)



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

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

April 1, 2018

Jane Doe
111 Consumer Lane
New York, NY 11111

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

Dear Jane Doe:

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

Why am I getting this notice?

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

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

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

We will review your care again in six months.

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

Why did we decide to reduce your service?
ACME MLTC Plan is taking this action because the service is not medically necessary.

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

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(1) 42 CFR § §438.404(c)(1) & 431.211;
(2) 18 NYCRR §358-2.2(a)(2).

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Aid Continuing Alert --

If Plan is REDUCING Services

- **Must act QUICKLY TWO TIMES in order to receive AID CONTINUING!**

1. **After IAD Notice mailed --**
   - **Must request Plan Appeal** within **10-day period** from date of notice to date of proposed reduction to get Aid Continuing. May only have 1-2 days because of mailing time, weekends!!!!
   - AID CONTINUING will postpone the reduction until after the Plan Appeal is decided and Plan issues Notice of Final Adverse Determination (FAD).
2. **After Plan Appeal decided and Final Adverse Determination** notice mailed --
   - **Must request Fair Hearing** within **10-day period** from date of notice to date of proposed reduction to get Aid Continuing

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Reductions of Services

Get Copy of Notice & Envelope

- **Get a copy** of the complete notice from client. All pages. 1st 2 pages are most important. Cell phone pictures work!
- Tell clients to **KEEP THE ENVELOPES** the NOTICES are mailed in.
- Must be POSTMARKED 10 Days before the EFFECTIVE DATE OF THE REDUCTION.
- If postmarked LESS than 10 days before the EFFECTIVE DATE – Client should receive AID CONTINUING.
- If Plan does not give AID CONTINUING – Request a Fair Hearing right away and call ICAN (see last slide)

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What if No Written IAD Notice?

- It is not uncommon for MLTC members to say they were told by a plan rep or by the home care agency that provides their aide, under contract with the plan, that their hours are being cut, but with no written notice.
- In the past, we advised clients to request a Fair Hearing and Aid Continuing, based on lack of written notice.
- Now, client **must request Plan Appeal** with MLTC or other managed care plan, with Aid Continuing.
- **If plan does not provide Aid Continuing, immediately Request a Fair Hearing and contact ICAN**.
- Advocates have asked the State to allow fair hearings in this situation without the plan appeal, as "deemed exhaustion." The State has not yet agreed to adopt this policy.

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2. DENIAL OF A NEW SERVICE, OR AN INCREASE IN A SERVICE

- Background- how to request an increase or a new service – "Service Authorization Request"
- What to look for in the Notice of Initial Adverse Determination
- When and How to Appeal

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How to ask for Increased or New Services – Service Authorization Request

- **"Service Authorization Request" –** Request by Member or provider to increase an existing service or provide a new service
- **HOW**: Make request **in writing** – or confirm an oral request with WRITTEN request. This way you have proof that you requested it and when – *starting clock for plan to decide.*

  - Letter from member's doctor helpful. Use detail.
  - **Specifically request plan to EXPEDITE if urgent**.
- **WHEN to Request** –
  - At in-home reassessment conducted every 6 months
  - OR any time – by calling Member Services or care manager or by FAX or certified mail.

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Deadlines for Plan to make decision on request and issue "Initial Adverse Determination" notice

Type of Request	Maximum time for Plan to Decide
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info*.
Expedited	**72 hours from receipt of request,** though plan may extend up to 14 calendar days if needs more info.*

14 day extension applies if the plan can justify that it needs additional information and the extension is in enrollee's interest. Plan should send Extension Notice giving deadline to submit additional info and explaining reason for extension. Member can request grievance to oppose extension. 438.404(c)(4). Extensin Notice posted at:

https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf

42 C.F.R. 438.210(d)

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When must plan Expedite Request for Increase or a New Service?

- If the plan determines or the provider indicates that a delay would **seriously jeopardize** the enrollee's **life or health or ability to attain, maintain, or regain maximum function.**
- **Member or provider must specifically ASK that request be expedited** and explain why criteria apply in this case.

42 CFR 438.210

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If Plan denies "Service Authorization" request -- WHAT IS TIME LIMIT TO APPEAL?

1. **If plan sends the required Initial Adverse Determination Notice** --
   - After April 1st, Member will have **60 calendar days** to request a Plan Appeal (internal appeal) from the date of the notice.
   - This is an increase from 45 days under the old rules before April 1, 2018.
2. **If plan fails to send IAD notice by the deadline** (see earlier slide 14 calendar days/ 72 hours from receipt if expedited/ + extension up to 14 days)-- This is a "denial."* Member may request a plan appeal on or after the date plan SHOULD have sent written notice.
   - Check to see if Plan extended the deadline by up to 14 days.. Should have sent written notice of the extension.
   - This is why it is important to request increase/new service in writing – to start clock for plan to decide. And keep proof that you made it.

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* 42 CF.R. 438.404(c)(5)

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NUTS & BOLTS OF PLAN APPEALS: APPEALING AN INITIAL ADVERSE DETERMINATION (IAD)

- How to Request appeals?
- Who may request appeals?
- Requesting an Expedited Appeal
- When must Plan Decide Appeal?
- **Plan's Final Adverse Determination Notice (FAD)**

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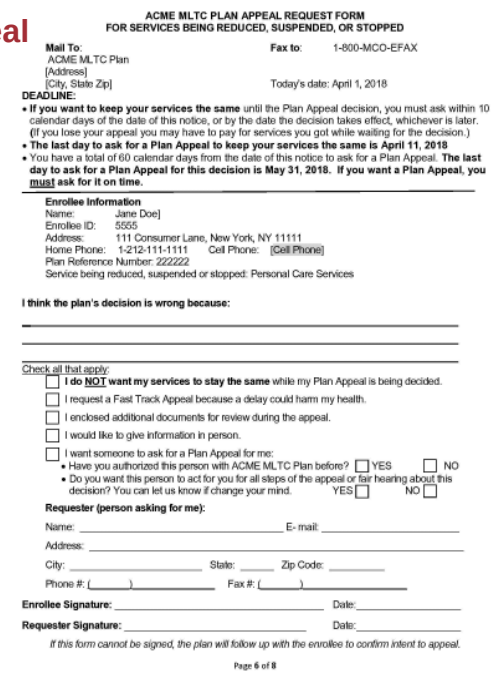
How to request Plan Appeal

Notice of Initial Adverse Determination should include a **Plan Appeal Request Form**.

Use this form if possible.

It includes a lot of pre-filled information.



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

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

Fax to: 1-800-MCO-EFAX

Today's date: April 1, 2018

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

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

I think the plan's decision is wrong because:

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

Requester (person asking for me):
Name: _____ E- mail: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____
Requester Signature: _____ Date:_____

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

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How to Request a Plan Appeal

1. ***FAX*** the request - fax number should be on the Notice.
   - Use Appeal Request Form that should be part of the NOTICE from the plan.
   - Keep FAX CONFIRMATION.
2. ***Call*** plan member services and ask for APPEALS UNIT. **But must confirm an ORAL request in WRITING unless you request it to be "expedited"** (**Fast Track**). See more about Fast Track below.
   - Date of CALL locks in Aid Continuing and meeting appeal deadline.
   - WARNING: You have no proof you called. You may get bounced to wrong unit and request won't be logged in. Confirm by fax or letter!
3. ***E-mail*** – if an e-mail address is on the NOTICE received from the plan (optional for plan). Attach the Appeal Request Form that should be part of the NOTICE.
4. ***Write*** to your plan, mail Certified. But don't do this if need AID CONTINUING! Takes too long. Use Appeal Request Form attached to notice.

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ALERT: WHO may request Plan Appeal?

- The new federal regulations require the member to **SIGN** the appeal request, or to give **written consent for a health care** provider or an authorized representative to request an appeal or file a grievance, or to request a State fair hearing." § 438.402(c)(1)(ii).
- Getting client's signature could delay filing an appeal request --with disastrous consequences. The client could miss the deadline to request Aid Continuing and have home care hours cut.
- Tip: The State Notice template says, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal." So – see next slide for a tip -

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WHO may request Plan Appeal?

Prevent Problems! Get Signed Authorization!

- Getting client's (or POA's) signature on appeal request form may take too much time if Aid Continuing is needed!
- Have all current and new clients sign (or if can't sign, make an "x" on) this **Authorization form**, designed by NYLAG - If client can't sign, she can make any mark.
- http://www.wnylc.com/health/download/646/
- On the form, client can authorize you, your organization, and/or specific family member(s) to request appeals and hearings. Can list many people!
- Keep it on file & give a copy to family AND send to plan for client's file return receipt requested (or give to care manager and get her signature of receipt).
- Attach a copy of the signed authorization to the appeal request. Even if you will not REPRESENT in appeal, you can REQUEST it. Then contact ICAN for representation. See end.

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Who may request appeal?

What if client can't sign? Or delay in getting signature?

- The federal regulation seems to say that a provider or authorized rep MAY request an appeal or hearing for the member, even without it also being signed by the member, EXCEPT that they must not request Aid Continuing. Only the member can request Aid Continuing. § 438.402(c)(1)(ii).
- Per DOH FAQ, *"Plans should have policies and procedures for… ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment."*

**See DOH Supplemental FAQ# IV. 2. 2/7/18 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#v

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Request Expedited or "Fast Track" Appeal

- Member or her provider have the right to request an **expedited or "Fast Track" appeal**. The plan must expedite its appeal decision if "taking the time for a standard resolution could **seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function**." 42 CFR 438.410.
- Who decides that "fast track" is merited:
  - Plan decides -- if appeal request made by the member or
  - If Provider says needs expedited appeal, plan must expedite (if the provider is requesting the appeal or supporting the enrollee's appeal)
- The **Appeal Request Form** that is part of the Initial Adverse Determination **has a check-off** for requesting a **Fast Track Appeal**.
- If request Expedited Appeal, do not have to confirm ORAL appeal request in writing.

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When Must Plan Decide Appeal?

- Plan must send written notice within 2 business days of decision for all appeals, but no later than:
- **STANDARD APPEAL** - within **30 calendar days** of receipt of the appeal request, subject to extension described below.
- **FAST TRACK or EXPEDITED APPEAL** - within **72 hours** after the plan receives the appeal, subject to extension.
  - Plan must make a reasonable effort to give oral notice first
- **EXTENSION** – Plan may extend its time to decide standard OR expedited appeal by up to **14 calendar days** if additional info is needed and the delay is in the enrollee's interest.
  - Member can ask State DOH to require plan to show extension justified. 42 CFR 438.408(c). Procedure unclear. Probably file complaint **1-866-712-7197**
  - Member may request plan grievance to dispute extension**.**

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If Plan Extends its time to Decide Appeal

If the plan has extended the time to decide -- it must make reasonable efforts to give enrollee:

- prompt **oral** notice of the delay, and
- within 2 calendar delays **written notice of the reason for the delay** and of the right to file a grievance about the delay. Plan should send extension notice at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf
- Plan must resolve appeal "as expeditiously as the enrollee's health condition requires and no later than date the extension expires." 42 CFR 438.408(c)(2).

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MEMBER RIGHTS IN PLAN APPEAL

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Plan must provide case file to enrollee and rep even without request

- **Plan must provide the enrollee and his or her representative the enrollee's case file**, including medical records, other documents, and any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal. This information must be provided free of charge. 42 CFR 438.406(b)(5).
- Must be provided "sufficiently in advance of resolution timeframe."
- Plan must provide this even if not requested.
- If you want the file to be provided directly to the representative, submit a signed HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA .

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Right to present new evidence

- Plan must consider new evidence submitted in appeal. 42 CFR 438.406(b)(2)(iii)
- **Must provide enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony** and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 438.406(b)(4)
- TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a **checkbox** if you want to include additional documents with the appeal request, or if you want to give information in person. You could also write in that you would like time to submit additional documentation.

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Reasonable Accommodations to help with appeal

- **IF YOU NEED HELP REQUESTING or taking other Procedural Steps Relating to the APPEAL -** The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 CFR 438.406(a).

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PLAN MAKES "FINAL ADVERSE DETERMINATION" (FAD) -- IF DENIES PLAN APPEAL

What to Look for in Notice

Next Step – Fair Hearing and/or External Appeal

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When Plan decides appeal – should send "Final Adverse Determination" Notice

- The word "Final" on the notice means that this is the decision after the Plan's plan appeal / internal appeal.
- First page of notice involving a REDUCTION is on next slide. Notice templates posted here https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.
- The next step is to request a FAIR HEARING.
- If the action is to REDUCE services, Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action. See next slide.

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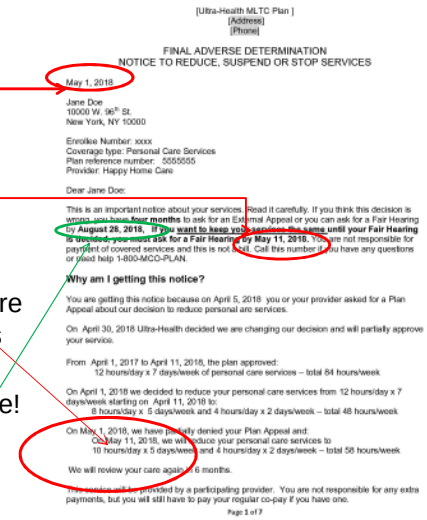
Final Adverse Determination Notice (FAD)

LOOK FOR TWO KEY DATES if REDUCTION

1. Notice Date
   - This is the date the plan printed the notice and, hopefully, mailed it to the member
2. Effective Date (May 11th) [1]
   - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, then this is a Defective Notice.
     - Get Postmarked envelope!
3. Appeal Time Limit (120 Days)(ignore if reduction!)



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

FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

May 1, 2018

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

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

Dear Jane Doe:

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

Why am I getting this notice?

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

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

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

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

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

We will review your care again in 6 months.

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

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(1) 42 CFR § §438.404(c)(1) & 431.211;
(2) 18 NYCRR §358-2.2(a)(2).

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Requesting a Fair Hearing

- **How to Request a Fair Hearing –** request still made to NYS OTDA– can do by phone, fax, online, or in writing. See http://otda.ny.gov/hearings/request/,
  - TIP: Use new Fair Hearing Request Form that should be part of the FAD Notice from the plan – has pre-filled info.
  - TIMING: If plan is REDUCING hours, make sure to call or fax OTDA before the EFFECTIVE DATE.
- **WHO may request FH** – Just like Plan Appeals (internal appeal), the new regulations require the member to SIGN the request, or authorize a representative to do so. See slides 25-26 above suggesting you have all clients sign "authorization" to request appeal or hearing in advance to have on file. Attach to hearing request.

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Aid Continuing Alert --

If Plan is REDUCING Services

- **Must act QUICKLY TWO TIMES for AID CONTINUING!**

1. **After IAD Notice mailed --**
   - **Must request Plan Appeal** within **10-day period** from date of notice to date of proposed reduction to get Aid Continuing. May only have 1-2 days because of mailing time, weekends!!!!
   - AID CONTINUING will postpone the reduction until after the Plan Appeal is decided and Plan issues Notice of Final Adverse Determination (FAD).
2. **After FAD** notice mailed --
   - **Must request Fair Hearing** within **10-day period** from date of notice to date of proposed reduction to get Aid Continuing. Even if don't get Aid Continuing after IAD, will get it pending hearing if timely request the hearing.**

**See DOH Supplemental FAQ VI. 1. 2/7/18 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#v

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If Plan Does Not Send FAD by Deadline – May Request Hearing!

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

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Optional – External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an **External Appeal**, if the reason for the denial is because they determine the service is not medically necessary or is experimental or investigational.

- You may request an External Appeal even if you also request a Fair Hearing. External Appeals are reviewed by a different State agency than Fair Hearings.
- BUT – if plan is REDUCING or STOPPING a service you MUST request a Fair Hearing to get Aid Continuing.
- If you request both an External Appeal and a Fair Hearing, the decision from your Fair Hearing will be the one that is followed by your plan. NY Public Health Law 4910
- For more info go to http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

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Member Liability for Services Provided as Aid Continuing

- Both the IAD and FAD Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 CFR 438.404(b)(6).
- A State DOH FAQ to plans clarifies that plans may recoup cost of services during Aid Continuing period, but only after FAD is issued and member fails to request a hearing within the 10-day Aid Continuing period.
- NOTE: The vast majority of Fair Hearings on reductions of services are in FAVOR OF THE MEMBER. The potential liability should not deter member from appealing.

**See DOH Supplemental FAQ #VII. 3, 1. 2/7/18 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#v

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Online info & Contacts

- Article on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/
  - News updates on same http://www.wnylc.com/health/news/80/
- We hope to post **fax, phone and email contact info** to request appeals for all MLTC plans here - http://www.wnylc.com/health/entry/179/
- **NYS Dept. of Health MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
- **NYS DOH Mainstream managed care complaints** 1-800-206-8125
- NYS DOH Managed care webpage for plans on appeals

https://www.health.ny.gov/health_care/managed_care/plans/appeals/

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