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NEW YORK LEGAL ASSISTANCE GROUP

MLTC Update: 2018-19 NYS Budget Changes and New MLTC Appeals Rules

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Topics

1. Growth in MLTC Leads to 2018-19 NYS Budget Changes Affecting Managed Long Term Care
2. Plan Closings – Guildnet and other plans
3. 24-Hour Live in Care - in Flux
4. New Rules for Appealing an Adverse Action by an MLTC Plan or other Medicaid Managed Care Plan – the Requirement to "EXHAUST" Plan Appeals.

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Growth in NYS Home Care population

	Late 2011	9/2018
MLTC	43,400	215,292
MAP (11,832) PACE (5,718), FIDA (3,774)	5,700	21,324
NYC (Home Attendant (2,418) Housekeeping (828) (7/2018)	35,500	3,246
Lombardi NYC	15,500	0
Personal care, Lombardi upstate (estimated)	20,000	unknown
TOTAL	**119,700**	**239,862**

Is growth solely due to aging of population?

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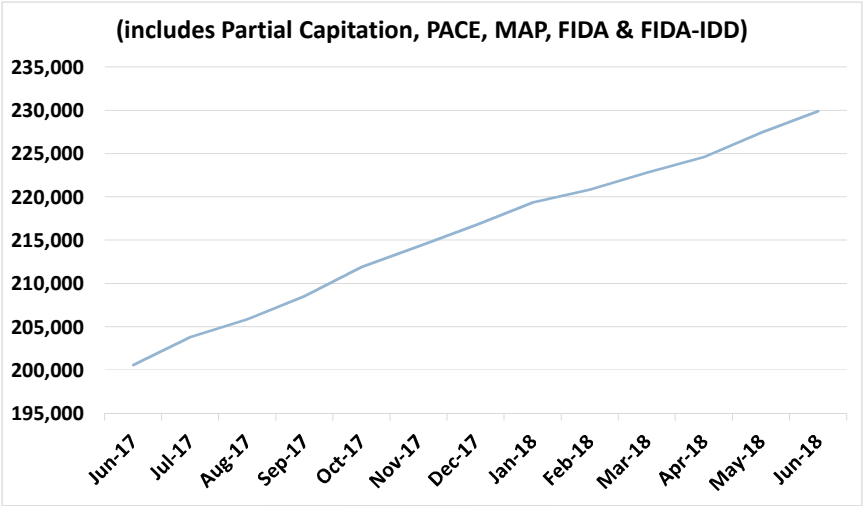
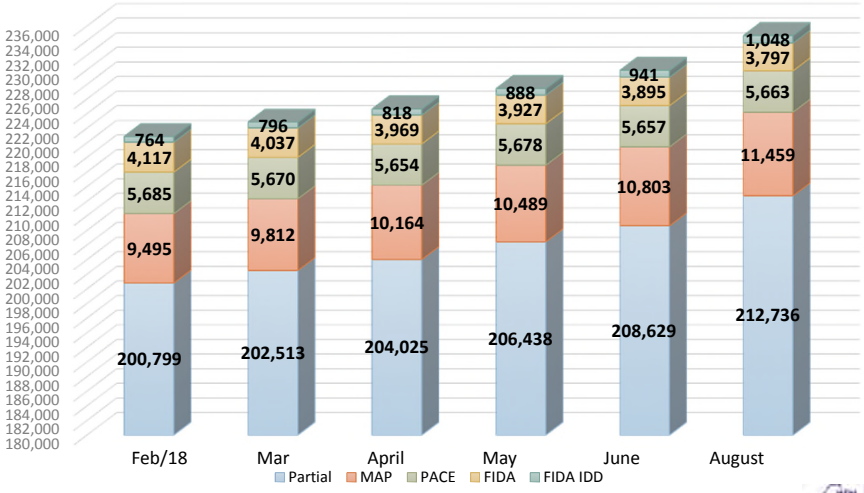
MLTC Statewide Enrollment



Department of Health

Current MLTC Statewide Enrollment

Total Enrollees in MLTC: 234,703(As of 8/1/2018)



*Based on 2018 enrollment report s - August 2018 data added by NYLAG from DOH data

Gov's State Budget – Proposed Cuts:

Trying to Slow MLTC Enrollment Growth

- After several years of promotion of MLTC growth, the State is now trying to put on the brakes.
- **Previous slides shows growth in home care since MLTC started.** The growth is more than State expected. Not just from moving consumers from Fee for Service or from "baby boomers." Possible causes:
  - **Marketing – Plans, LHCSAs*, CDPAP FI's,** and
  - **Expansion of CDPAP – Consumer Directed Personal Assistance**.- addresses shortage of aides upstate. Plus now parents may be aides for adult children and adult children for their parents. CDPAP agencies must be certified to meet standards under 2017-18 State Budget.

*Licensed Home Care Services Agency = LHCSA

Final NYS 2018-19 Budget Changes

a. LHCSA Cap
b. Lock-in
c. Disenrolled if no services for 30 days
d. CDPAP restrictions
e. Nursing Home "Carve-out"

CAP on number of LHCSAs per MLTC Plan

- **Downstate** – MLTC plan may contract with only:
  - one LHCSA per 75 members, eff. Oct. 2018, and
  - one LHCSA per 100 members as of Oct. 2019 (ICS said would have to cut from 150 to 65 agencies)*
- **Upstate** – MLTC Plan may contract with only:
  - One LHCSA per 45 enrollees as of Oct. 2018 and
  - One LHCSA per 60 members as of Oct. 2019.
- Requires plans to provide evidence annually of compliance and provides flexibility to DOH to allow exceptions where needed and to ensure continuity of care.
- New LHCSAs will go through stricter Certificate of Need approval process. Before, all were reportedly approved.

*https://www.crainsnewyork.com/article/20180410/HEALTH_CARE/180419994/new-home-care-rules-could-hurt-small-agencies

Public Health Law § 4403-f (7)(j)(x):

LHCSA CAP - DOH Guidance to plans Aug. 17, 2018:

- If the MLTC plan terminates any LHCSA contracts, it must send **written notice of termination to all enrollees receiving care from the terminated LHCSA** within LATER OF 15 days of the notice of termination to the LHCSA, or by 9/1/18.
- The notice must inform the enrollee of available options to stay with current home care worker, which may include:
  - **changing to a different LHCSA** if aide is moving to a new LHCSA;
  - enrolling in a **different MLTC plan** if aide employed with a LHCSA that is contracted with another plan; or, if applicable,
  - **requesting a *three–month exception* for continuity of care** purposes (next slide)
  - The notice must include contact information for the New York Medicaid Choice (Phone: 1–888–401–6582) to switch plans to keep home care worker.

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https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/lhsca_contract_guidance.htm

LHCSA CAP - DOH Guidance to plans Aug. 17, 2018

- **NETWORK CAPACITY** must still be maintained.
- MLTC plan must have 2 LHCSAs accepting new enrollees in each county in service area.
- If an MLTC plan is unable to provide covered services through its network, the plan must arrange with **out–of–network providers** until plan can provide them within the network.
- If an MLTC plan terminates 25% or more of its LHCSA contracts during any period of 6 or fewer months, plan must document to DOH its continued capacity to serve the enrollees in its service area, pursuant to 42 C.F.R. § 438.207, including:
  - number of MLTC enrollees impacted by the reduction in LHCSA contracts
  - plan for ensuring that services will remain available to its enrollees.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/lhsca_contract_guidance.htm

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LHCSA CAP – Exceptions to Cap

MLTC plan may request an exception to the cap from DOH targeted to specific patient needs including:

1. ***Continuity of Service up to THREE MONTHS***

- If termination of a contract with a LHCSA will require an enrollee´s care to be transferred to another LHCSA, and the enrollee wishes to be cared for by home care workers employed by the current LHCSA, MLTC plan may continue contracting with current LHCSA 3 months
  - MLTC plans must notify DOH at LHCSAExceptions@health.ny.gov of 3-month extension. Won't count toward cap until after 3-month extension expires

2. ***Additional LHCSAs Needed to Ensure Adequate Access to Services in geographic hard to serve area, or to ensure cultural or linguistic competency***

- Includes **special needs services** and **services that are culturally or linguistically appropriate**.
- Cultural and linguistic competency is the ability of organizations and practitioners to recognize an individual´s cultural beliefs, values, attitudes, traditions, language practices and health practices and apply this knowledge to influence positive health outcomes.

LHCSA CAP – Exceptions to Cap

- A plan's request for an exception must:
  - Identify potential effect on the enrollee´s care if the exception is not granted;
  - Analyze the frequency or occurrence of the service; and include plan to alleviate the issue, with timeline
  - Demonstrate that no other LHCSA in the plan´s network can meet the enrollee´s needs, and that adding the LHCSA would exceed cap
  - **Document that the enrollee desires to stay with, or be serviced by, an aide due to a cultural or linguistic concern;**
  - Inability to transfer the aide with their client to another LHCSA; and
  - No in-network LHCSA has such cultural and/or linguistic competency and/or provides specialized services.
- Compliance – Plan must certify compliance annually
- **Enrollee – Must request plan to request exception! No procedure for enrollee to do so.**

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MLTC Lock-In

- **LOCK-IN –**After Dec. 1, 2018, anyone who joins an MLTC plan for the 1st time, or switches plans after that date, has:
  - May change plans ONCE within 1st 90 days;
  - After that, they are locked into that plan for the next 9 months (the rest of the 12-month year) unless they have good cause.
- **Good cause** may include:
  - 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.
  - Not an exhaustive list – member can show other good cause - poor quality of care, lack of access to covered services or to providers experienced in dealing with the enrollee's care needs

Public Health Law § 4403-F (b)(7)(vii)

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MLTC Lock-In *con'd/*

- After the 12 months, individual may change plans any time, but then after a 3-month grace period in new plan – again locked in for 9 months.
  - WARNING: In a "voluntary" transfer, new plan not required to give same hours! Don't transfer without written plan of care that is adequate!
- Does not apply to Medicaid Advantage Plus, FIDA, or PACE. Only regular MLTC.
- What is not likely to be good cause:
  - Not enough hours
  - MLTC plan no longer contracts with client's LHCSA so client will lose her aide.
- PROCEDURE NOT CLEAR to request good cause

https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm#mltc

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MLTC Lock-In con'd

Though MEMBER locked in to a plan for 9 months, Plans retain the ability to **involuntarily disenroll** a member for the reasons specified in their contract, which includes:

1. failure to pay spend-down,
2. hospitalization for greater than 45 days, or
3. the enrollee was absent from the service area for more than 30 consecutive days.
4. NEW DOH POLICY – requires plan to disenroll a member who hasn't received services in plan of care for one calendar month if member didn't notify the plan. May harm those "difficult to serve" with LHCSAs and aides turning over.

LIMIT on Marketing by CDPAP Agencies

- CDPAP Fiscal Intermediaries must submit any ads or marketing materials to DOH for approval.
- If publish 2+ ads that are "false or misleading "or not approved by DOH," license will be **revoked**. Harsh!
  - QUERY: What is false or misleading advertising? CDPAANYS – the trade association of CDPAP agencies – gave an example of an ad saying "Take control of your home care. No more eating meals at awkward times." Is that false or misleading? Some FI's promising workers guaranteed high income – is that misleading?
- No other providers had marketing limitations enacted in the state budget – LHCSAs, MLTC plans, nursing homes.
- SSL 365-f(4)(c)

LIMIT on Marketing by CDPAP Agencies – Lawsuit by Trade Org for CDPAPs

- CDPAANYS – the Consumer Directed Personal Assistance Association of NYS, sued DOH in July 2018 to Stop Implementation of the Law
- Claim is that law violates the 1st Amendment of the U.S. Constitution (free speech, prior restraint)
- No injunction, but NYS agreed in lawsuit not to enforce the law until it circulates guidance or regulation interpreting the law and opportunity for plaintiffs to review and go back to court if not OK.
- Guidance should hopefully define what is "false and misleading" advertising

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NYS 2018-19 BUDGET CHANGE NURSING HOMES & MLTC

Carving Out Nursing Home from MLTC

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"Managed Care for All" -2015 Nursing Home Care 'Carved In" to the MLTC Service Package

- In 2015, the MLTC program was expanded to require all adult "dual eligible"* nursing home residents to enroll in an MLTC plan, once they are approved for Institutional Medicaid after the "lookback."
- If they did not pick an MLTC plan in 60 days of receiving notice from NY Medicaid Choice, they were auto-assigned to an MLTC plan that contracts with that nursing home.
- The MLTC plan became responsible for paying the Nursing Home and for collecting the NAMI from the resident.
- If the consumer was already in an MLTC plan when they entered the NH, they would remain in that plan – or could change plans. But they had to be in a plan.

***Dual Eligible = Has Medicare and Medicaid**

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Competing Interests Push State to Change Policy and "Carve Out Nursing Home Care from MLTC Services

- **NHs** want to be paid same rate they received from State pre-managed care/MLTC ("benchmark rate"). Nursing homes won law requiring plans to pay this rate until end of 2020.(Average rate in NYC $8600/mo)
- **Plans** say they can't absorb high NH cost in their capitation rate (Ave. $4000-$5500). Guildnet & other plans are closing or reducing service area, citing high NH costs. Plans want the cost of nursing home care off their plate, either:
  - "**Carve out"** nursing home care from the MLTC service package, so NH bills Medicaid Fee for Service like before 2015.
  - Or if still in service package, they want it paid by DOH to NH through a separate **"NH rate cell."**
- **Consumers** concerns – see next slide

Competing Interests Push State to Change Policy and "Carve Out Nursing Home Care from MLTC Services

- **Consumers** fear that removing the cost of NH care from MLTC plans would incentivize plans to put members in NHs rather than give them high hours of home care they need.
- Consumers oppose a "**NH rate cell"** that would pay plan more for NH care, but not for high-hour home care. Consumers want a **high need "rate cell" for community care** to give plans incentive to keep out of NH. Otherwise will never approve 24-hour care. (Split shift costs $14,000/mo).
- Consumers fear harder to leave a NH if not already in an MLTC plan. No MLTC plan wants to enroll someone who needs high-hour care. Plus practical barriers - difficulty of aligning discharge dates with the MLTC enrollment process; conversion of eligibility codes.

2018 NYS Budget - Nursing Home residents excluded from MLTC after 3 months of "permanent placement"

In the budget enacted April 1, 2018**,** those **"**permanently placed in nursing homes for 3 consecutive months or more" will no longer be eligible for MLTC enrollment**.** This impacts 3 groups – each discussed further below.

1. **New Nursing Home residents who were not previously in an MLTC plan** will no longer be required to enroll in MLTC. No more auto-assignment to an MLTC plan.
2. **23,000 current NH residents are in MLTC plans**. Will they be disenrolled? What if they hope to return home?
3. MLTC members in community – what happens to them if placed in a NH, even temporarily? Are they more at risk of being placed in NH's if plans deny adequate hours?

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DOH Guidance needed on implementation --

- **What does it mean to be "**permanently placed in nursing home for 3 consecutive months or more?" Such persons will no longer be eligible for MLTC enrollment**.**
- **What is the definition of "permanent placement**"?
  - That NH filed DOH-3559 Form (2159i in NYC) with DSS/HRA? (notice of NH placement)
  - Is it enough that applied for – or approved for -- Institutional Medicaid (5-year lookback)?
  - Anyone in a NH > 29 days must apply for Institutional Medicaid, even if just to pay Medicare SNF Coinsurance thru Day 100.
- **What notice and appeal rights are required to disenroll member** from plan after permanently placed for 3 months?
  - Who sends the notice – NH? DSS/HRA? Plan? NY Medicaid Choice?

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Questions about implementation
Group 1 – NH residents not in an MLTC plan

1. If individual has been "permanently placed" for more than 3 months, are they barred from enrolling in an MLTC plan? If so, could violate the ADA by creating barrier to discharge home.
2. Will Maximus be required to conduct a CFEEC in the NH?
3. Assuming individual may enroll in the MLTC plan from the NH, in order to return home -- it is often difficult to arrange discharge for the 1st day of the month. Now, if enrollment begins on the 1st, ideally the MLTC plan pays the NH rate for a few days until discharge is arranged. Will this still be possible? May plan refuse to pay NH care temporarily?
   - Can Capitation be pro-rated so enrollment can start any day of month? Assembly One-House bill had proposed this.

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Questions about implementation
Group 2 – 23,000 NH residents in MLTC plans

- Once CMS approves the amendment to the MLTC "waiver," will they all be disenrolled automatically?
  - Presumably some are "permanently placed" but others are not.
  - What notice and appeal rights are required to disenroll member from plan after permanently placed for the 3 months?
  - Can member contest disenrollment if intends to return to community?
  - DOH has said it may extend enrollment past 3 months in NH if consumer intends to return to community. But unclear – and what is procedure to extend the enrollment?
- DOH has proposed policy that if disenrolled after 3 months in NH, and later wants to re-enroll to return home with home care, CFEEC not required if last CFEEC done < 6 months ago, or if disenrolled < 6 mos ago.

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Questions about implementation
Group 3 – MLTC plan members in community

- If a member requests an increase in hours, may plan decide that consumer needs to be "permanently placed in NH" and deny increase? What are consumer's appeal rights?
- If a member admitted to NH for short-term rehab, and then plan refuses to reinstate home care, claiming member needs to be "permanently placed in NH" – what are consumer's rights?
  - *Granato* case says failure to reinstate home care in same amount received prior to a hospital stay is a "discontinuance" of home care, requiring Notice and Aid Continuing rights. Isn't this the same?
  - What are appeal rights for determination of "permanent placement?" Plan is really DENYING increase in home care which is appealable.

What happens to Special Income Standard for People Discharged from Nursing Homes?

- People who return to the community after >30 days in a nursing home or adult home, and enroll in or stay in an MLTC plan upon discharge, may keep more of their income to pay for housing, decreasing the spend-down by $1305/mo in NYC! (2018)
- Medicaid had to pay for at least part of their NH stay.
- Access to this benefit will diminish because it will be faster for a nursing home resident to be discharged with "Immediate need" services under SSL 366-a(12) than to an MLTC plan.
- Those who access "immediate need" services when leaving the nursing home should be eligible for the "housing disregard, since, after 120 days they will be transitioned to an MLTC plan.

NY Social Services Law 366.14; NYS DOH 12- ADM-05 - Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into MLTC Plan; MLTC Policy 13.02; GIS 18 MA/12 (9/2018)
see http://www.wnylc.com/health/entry/212*/*

High-need rate cell in the future?

- To counter the financial incentive that carving out NH care gives plans to deny high-hour home care, and instead place members in NHs, consumers advocate for a **community-based High Need rate cell.** This was not enacted in the budget.
- The "Side Letter" entered between NYS DOH and Assembly Health Chair Richard Gottfried states this:
  - "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 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)."

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UAS Scores

- **Disqualifying the lowest need individuals from MLTC**, under a UAS score of 9. They would access personal care or CDPAP from local DSS as pre-MLTC, like Housekeeping recipients. Concerns about DSS staffing capacity, resources, contracts with home care agencies to meet the demand.
- **REJECTED in FINAL BUDGET**

FINAL 2018-19 NYS BUDGET – OTHER CHANGES

Cap on Physical, Speech, & Occupational Therapy – GOOD NEWS

- Cap on PHYSICAL THERAPY visits per year increased from 20 to 40 visits.
- Speech and Occupational Therapy REMAIN capped at 20 visits/year each.
- No exceptions to caps, which also apply to Mainstream MMC and MLTC plans, though MLTC members also receive Medicare therapies.
- EXCEPTION: As before, caps do not apply to people with DD or TBI diagnoses, but note – recent case where mainstream plan only authorized PT 2 sessions at a time, requiring repeated requests for reauth by MD/PT clinic.

Spousal Refusal, Impoverishment – Good News

- Proposed Repeal of Spousal Refusal REJECTED.
- Proposed Reduction of Spousal Impoverishment Resource Allowance REJECTED.
  - Proposal would have reduced NYS to the MINIMUM allowed by federal law – $24,180 – rather than $74,820 allowed currently. NYS still far under the MAXIMUM allowed by federal law, which in 2018 is $123,600.

MLTC PLANS CLOSING!

2-3 plans closing in early 2019

- **GUILDNET** – DOH confirmed that Guildnet closing January 2019; 8,228 members will receive notices mid-October that they must select and enroll in another plan or they will be auto-assigned to another plan Jan. 2019:
  - Guildnet Medicaid Advantage Plus - 478 members
  - Guildnet Gold Plus (FIDA) 418 members
  - Guildnet MLTC 7,332 members
- **UNITEDHEALTH MLTC** – closing in UPSTATE counties Feb. 2019. Will remain in NYC.
- **ICS** has been rumored to close for months. Not official. 6100 members all in NYC.

Fully Integrated Duals Advantage (FIDA)

- Four FIDA plans are non-renewing for Calendar Year 2019:
  - AgeWell New York FIDA
  - GuildNet Gold Plus FIDA Plan
  - MetroPlus FIDA Plan
  - VillageCareMax Full Advantage FIDA Plan
- Written Communication Plan – The non-renewing plans mailed approved DOH/CMS member notices, which included options available to continue their Medicare/Medicaid services in 2019
- Remaining FIDA plans for 2019:
  - Centers Plan, Elderplan, Healthfirst, RiverSpring, Senior Whole Health, VNSNY plans
- Please direct any comments or questions to FIDA@health.ny.gov

FIDA CLOSINGS 2019

County	Plan Name (Numbered ones remain in 2019)	Total Enrolled Sept. '18	# in closing plans	% in closing plan
Nassau	Total	**281**	**98**	**34.9%**
	Agewell New York	98	x	
	1. ElderPlan FIDA Total Care	61		
	2. HealthFirst Absolute Care	74		
	3. River Spring	4		
	4. VNSNY Choice FIDA Complete	44		
Suffolk	Total	**106**	**106**	**100%**
	Agewell New York	106		
Westchester	Total	**25**	**10**	**40%**
	Agewell New York	10	x	
	1. HealthFirst Absolute Care	14		
	2. River Spring	1		
New York	Total	**3,362**	**679**	**20.2%**
	1. VNSNY Choice FIDA Complete	1,224		
	2. HealthFirst Absolute Care	903		
	GuildNet Gold Plus	418	x	
	3. ElderPlan FIDA Total Care	386		
	MetroPlus	205	x	
	4. SWH Whole Health	129		
	Agewell New York	33	x	
	5. FIDA Care Complete (Centers Plan)	26		
	Village Care Max Full Advantage	23	x	
	6. River Spring	15		
	NYC TOTAL	3,362	679	20.2%
	REST OF STATE TOTAL	412	214	51.9%
	STATE TOTAL	3,774	893	23.7%

Consumer protections when plan closes - background

- When MLTC started, if a plan closed, consumer had to try to enroll in a new plan on her own. If prospective plans refused or delayed in coming to assess, or consumer lacked the wherewithal to find a new plan.. Services just stopped.
- Plus, new plan could give FEWER HOURS than closing MLTC gave.
  - 9/2015 HomeFirst (ElderPlan) ceased taking new members in 7 upstate counties
  - March, 2017- Guildnet letter to 4000+ members in Nassau, Suffolk & Westchester that would close in those counties June 2017 –
- It was better if the closing plan merged with another plan or arranged to transfer its members to a new plan – so consumers had continuity.
  - Jan 2016 - **EmblemHealth** MLTC closed - –1300 members → Guildnet unless picked another plan. (NYC, Long Island, Westchester)
  - 2/2017 – **Centerlight** MLTC closed, 5000 members → Centers Plan
  - 9/2017 – **AlphaCare** merged into Senior Whole Partners – 4460 members
  - Jan 2018 – **North Shore LIJ** closed, 5600 members ⟶ Centers Plan for Healthy Living (about ½ of the members in NYC)

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Plans closing or reducing service area

- 2015 – 2017 - Consumer advocates advocated with DOH to adopt “transition protections” to ensure continuity of care when a plan closes.
- 2017 - NYLAG brought a lawsuit when Guildnet announced closing in Long Island & Westchester because of lack of transition rights.
- **9/22/2017 – DOH ISSUES POLICY 17.02 (next slide)**

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MLTC Plan Closings – Transition Rights

- **MLTC Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration**." NYMC will send notice to members of closing plan that they should select a new plan within 60 days.
- If they do not, they will be auto–assigned to a new MLTC plan (partial capitation – not to MAP, PACE, or FIDA).
- **New plan – whether client picks plan or is auto-assigned -- must continue existing plan of care with same providers** "for the earlier of …:

i. 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.

WARNING- could allow cajoling member to accept reduction.

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MLTC Plan Closings – Transition Rights – Concerns

1. **What if member transfers before official notice of closing?** Transition rights are only triggered when the plan closure is approved by State Department of Health and official notice sent to members. But closures are highly publicized in press or thru the grapevine before official notice. Anxious members fear losing services so may change plans out of fear. No transition rights!
   - Guildnet announced closing in letter to its employees 8/28/18, which had press coverage in Crain's. That trickled down to members - who may have transferred for Oct. 2018. Are they protected? Does new plan have to keep same hours? So far DOH has not said so.

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MLTC Plan Closings – More Concerns

2. **Policy allows new plan to reduce hours before 120 days after enrollment if enrollee "agrees."** Does not require notice to member confirming "agreement" – with appeal rights. Members may feel pressured to "agree."

3. **What happens After 120 Days?** MLTC Policy 17.02 - Does not address whether plan can reduce services at end of 120 day transition period. Advocates say MLTC Policy 16.06 allows plans to reduce service only if there is a change since the hours were approved --medical improvement, change in social circumstances. Not enough that a new plan did a new assessment.

24-HOUR LIVE-IN CARE

Court decisions and regulations – Status in flux

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State Definitions 24-hour Care - 12/2015

- All 24 – hour care - because of the patient's medical condition, must needs assistance during such calendar day with toileting, walking, transferring, turning or positioning
- **Split Shift** – "uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day needs assistance with such frequency that a live-in 24-hour PCA would be unlikely to obtain, on a regular basis**, 5 hours daily of uninterrupted sleep during the aide's eight hour period of sleep**.
- **Live-in** -- "care by one personal care aide where need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be **likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.**"
  - Live –in ADL needs also list feeding
  - Takes into account if home has adequate sleeping accommodations for a live-in personal care aide.

GIS 15 MA/024, 18 NYCRR 505.14(a), at https://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm

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More about 24-hour care

- Changes binding on MLTC and Mainstream managed care plans.
- "Turning and positioning" was added in 2015 to the definition.
- Before, only need for TOTAL assistance with ADLS, not SOME assistance, merited split-shift care. Now, Total/Some distinction is eliminated. If one needs ANY assistance, FREQUENCY is the key factor.
- If client has 24-hour needs, even if family covers some hours, the plan may NOT use "task based assessment" to calculate the number of hours. They must cover the full **span of time** family is not available. **"Mayer-3" rule. Spelled out in MLTC Policy 16.07**

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Paying for 24 –hour Care -- Overtime

- Federal labor regulations used to exempt home care aides from the Fair Labor Standards Act overtime requirements.
- Eff. Oct. 13, 2015 -- Aides must be paid overtime if work over 40 hours/week or Live-In aides working over 4 days in a work week. Overtime is 1.5 "base wage" in previous slide
- **Travel time** between different clients of the same employer/ home care agency must be paid. Travel to and from aide's home is not paid.
- **Live-in** – Federal regs allow them to be paid 13 hours for a 24-hour day (no pay for 8 hours of sleep, 3 hours for 3 meals). But if they show they actually worked more than 13 hours/day must be paid.
- See http://www.nelp.org/campaign/implementing-home-care-reforms/

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Court Decisions Reject paying live-in 13 hours for a 24-hour day

- 24-hour case home care workers must be paid for all 24 hours if they are "nonresidential," meaning they do not live with the client as their exclusive residence. *Tokhtaman v. Human Care, LLC,* 52 N.Y.S.3d 89 (1st Dept. April 2017) (appeal denied to NY Court of Appeals Nov. 2017); *Andreyeva v. NY Home Att. Agency & Moreno v Future Care Health Serv.* (2nd Dept. 2017)
  - State's interpretation of minimum wage laws is unreasonable, not entitled to deference
  - The court decisions threw out the State policy allowing live-in pay @ 13 hours/day in part on a technicality – that the State policy was not properly issued as a formal regulation. It was just an informal policy of the Dept. of Labor.
- Conflicting federal cases – *Severin v Project OHR*, e.g.

But – State Tries to Defeat Court Cases

- The court decisions on the previous slide threw out the State policy allowing live-in pay @ 13 hours/day in part because it was not issued as a formal regulation,
- So the State started the process of issuing a formal regulation, but since this takes time to adopt, it issued an "emergency" regulation.
- A state court threw out the "emergency" regulation, saying that the State did not prove a valid "emergency" existed – that the home care industry would collapse if they had to pay hourly rate x 24 hours for live in cases. *Chinese Staff Assn. v. Reardon (Supreme Ct. N.Y. Co. 9/25/18 2018 NY Slip Op 32391(U).*
- Now status of law in flux. Expected State Labor Dept will issue a permanent regulation, and more litigation.

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Who will pay for the overtime??

- Has the state increased the monthly capitation paid to plans enough to allow for that increase?
- Even if the answer is yes, are plans passing through the rates to the LHCSAs and CDPAP agencies to pay the aides?
- MLTC plans must certify to DOH that home care agencies pay overtime but what proof is required?
- Overtime requirements have resulted in plans reducing aide schedules to max out at 40 hours per week.
- Do LHCSAs and plans have to approve SOME overtime so that clients can keep longtime aides, and avoid having too many aides to cover shifts? Not clear.

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Overtime for Aides

- Overtime requirements have resulted in plans reducing aide schedules to max out at 40 hours per week.
- National advocacy organizations say there must be an **Exceptions Process** so that aides can work > 40 hours for short-term emergency needs or for long-term to ensure continuity of care and prevent institutionalization – especially in places like upstate NYS with shortage of aides. See "*Key Considerations for Developing an Exceptions Process" (*Natl. Employment Law Project, Bazelon Center, PHI, etc.) (4/26/16)
  http://www.bazelon.org/LinkClick.aspx?fileticket=qFkSrIu15xw%3d&tabid=135
- And Fact Sheet http://www.nelp.org/content/uploads/Fact-Sheet-USDOL-Home-Care-Rules-Good-Implementation.pdf

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Minimum wage/ wage parity 2018-19

	NYC- Large employer 11+ employees	NYC – small Employer < 11	Westchester, Long Island	Rest of State
Jan 1 2018				
Base wage	$13.00	$12.00	$11.00	$10.40
Supplemental	$4.09	$ 4.09	$3.22	
Total	$17.09	$16.09	$14.22	
Jan 1, 2019				
Base wage	$15.00	$13.50	$12.00	$11.10
Supplemental	$4.09	$4.09	$3.22	
Total	$19.09	$17.59	$15.22	

https://www.health.ny.gov/health_care/medicaid/redesign/mrt61/2017-10-31_ww_parity_min_nyc.htm ; https://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm

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NEW APPEAL RULES FOR MLTC ADVERSE ACTIONS

New "Exhaustion" Rules – Must Request a Plan Appeal – and Wait for Decision -- before Requesting a Fair Hearing

New "exhaustion" requirement for MANAGED CARE APPEALS

- **After May 1, 2018,** a managed care or MLTC member may not request a Fair Hearing against a plan until **AFTER BOTH OF THESE OCCUR:**
  1. Member has requested a **plan appeal** (internal appeal) of an ***Initial Adverse Determination*** to reduce or deny hours or services, and
  2. The plan has EITHER
     a. issued a ***Final Adverse Determination*** (appeal **decision)**. 42 CFR 438.402(c) OR
     b. has **failed to make *Final Adverse Determination* in the required time** (**30 days** or **72 hours if "Fast Tracked**"), or failed to give required notice that it was extending its time to decide up to 14 days. (This is "Deemed Exhaustion)

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Summary of Topics

1. **Basics on the new rule and why it changed** , general concerns
2. **WHO is affected and WHAT types of issues** and appeals require exhaustion?
3. **Two Types of appeals – Spotlight on New Notices**
   - DENIALS of services
   - REDUCTIONS of services
4. **Nuts and Bolts of Requesting Plan Appeals** –
   - How to Request Appeals, Who may request appeals
   - Requesting an Expedited Appeal
   - When must Plan Decide Appeal
6. **Plan's Final Adverse Determination Notice** after appeal and request for Fair Hearing or External Appeals
7. **"Deemed Exhaustion"**
8. **Member Rights in a Plan Appeal**
9. **Contacts**

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NYS DOH Implementation of Exhaustion

- **New Plan Notices of Adverse Determinations -** Developed by DOH meeting with a "Service Authorizations and Appeals Stakeholder Workgroup" with plan and consumer reps Fall 2017
- **New DOH webpages for plans**, with **Model NOTICEs, webinars, and FAQs**. Include **plan trainings & ALJ training**
  - *Mainstream Medicaid Managed Care, HARP, and HIV SNP plans* https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm (posted Feb. 2018)
  - *MLTC plans* (posted 4/2018) https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm
- "**Medicaid Update**" for providers – issued 3/2018 https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc Appendix p. 50
- **Plans sent letter with 2-page DOH Fact Sheet to consumers** April 2018 (App. pp 36-38), referring them to plan websites for insert to Member Handbook section on Appeals (App. pp. 39-49) (Consumer advocates version of fact sheet in Appendix p. 51-52)
- **OTDA Fair Hearing request website – NOT updated**

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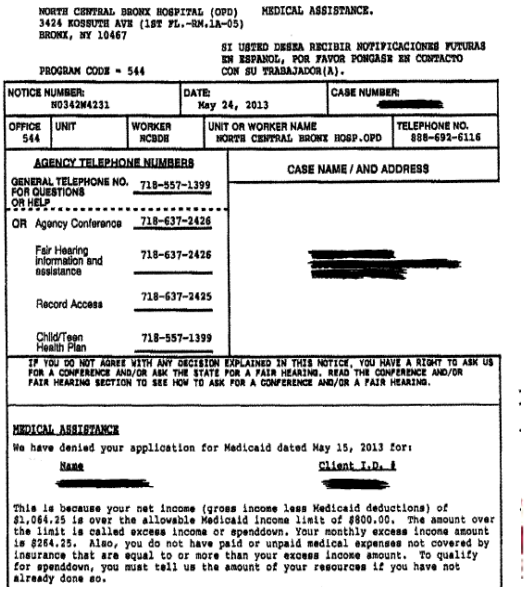
Which Medicaid actions do not require exhaustion?

- Local DSS/ HRA/ NYSofHealth actions re financial eligibility for Medicaid.
- Recipient may request Fair Hearing without a Plan Appeal (i.e., no exhaustion required).
- Must request a Fair Hearing before the effective date of a reduction or termination fo services to remain the same ("Aid Continuing").



NORTH CENTRAL BRONX HOSPITAL (OPD)
3424 KOSSUTH AVE (1ST FL.-RM.1A-05)
BRONX, NY 10467

PROGRAM CODE = 544

MEDICAL ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

NOTICE NUMBER:	DATE:	CASE NUMBER:
N0342W4231	May 24, 2013	[redacted]

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
544		NCBDH	NORTH CENTRAL BRONX HOSP.OPD	888-692-6116

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP 718-557-1399

OR Agency Conference 718-637-2426

Fair Hearing information and assistance 718-637-2426

Record Access 718-637-2425

Child/Teen Health Plan 718-557-1399

CASE NAME / AND ADDRESS

[redacted]

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

MEDICAL ASSISTANCE

We have denied your application for Medicaid dated May 15, 2013 for:

Name [redacted] Client I.D. # [redacted]

This is because your net income (gross income less Medicaid deductions) of $1,064.25 is over the allowable Medicaid income limit of $800.00. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $264.25. Also, you do not have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income amount. To qualify for spenddown, you must tell us the amount of your resources if you have not already done so.

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Warning: May not be how it appears!!

DSS/HRA Discontinuance of Medicaid Leading to MLTC Plan Disenrollment

If home care stops, it *might* be an action by the MLTC plan.

But often this chain reaction happens –

1. Medicaid is discontinued by LDSS/HRA because of a Medicaid renewal problem
2. Client is automatically DISENROLLED from the plan
3. Home care stops.

► **REQUEST Fair Hearing against LDSS/HRA for Medicaid discontinuance** (investigate if notice provided, etc). If merited (no notice, late notice, etc.)

► Request **Aid Continuing** with "relinking" or reinstatement of enrollment with MLTC plan. Must advocate with DSS/HRA for relinking.

► ALSO may request Plan Appeal and ask for "Aid Continuing," especially if plan assisted with the renewal.

NEW Appeals Process and Vocabulary

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Red equals change from previous deadlines

1. • *Plan* "**INITIAL Adverse Determination" notice (IAD)**
   • Deadline (if member requested new or increased service): 14 calendar days/ 72 hours fast track*
2. • *Member* Requests **Plan Appeal**
   • Deadline: 10 days for Aid Continuing; 60 days other
3. • *Plan* "**FINAL Adverse Determination" notice (FAD)**
   • Deadline: **30 calendar days (was 45)**/ 72 hours Fast Track*
4. • *Member* Requests **Fair Hearing**
   • Deadline: 10 days for Aid Continuing; **120 days (was 60)** other
   • Optional: External Appeal request if medical necessity but no Aid Continuing

*** Plan may extend 14 days if need more info & in member's interest**

Look at the TITLE of the Notice!!

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.

INITIAL ADVERSE DETERMINATION (IAD)
→ Must Request Plan Appeal
60 days to request appeal

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

FINAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

May 1, 2018

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

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

Dear Jane Doe:

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

Why am I getting this notice?

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

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

From April 1, 2017 to April 11, 2018, the plan approved:

FINAL ADVERSE DETERMINATION (FAD)
→ Request Fair Hearing
120 days to request

For both – if REDUCTION – only 10 Days to File Appeal!

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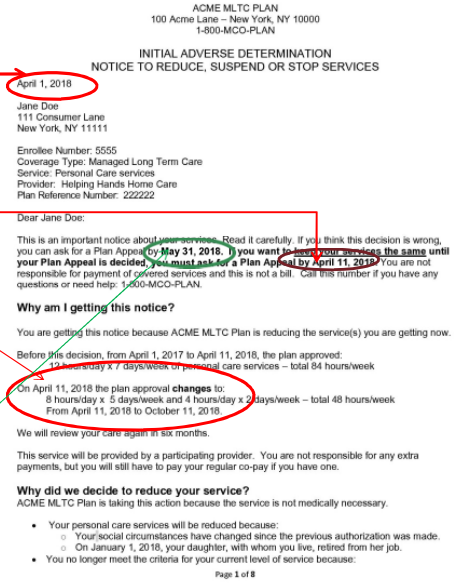
Initial Adverse Determination (IAD) – Denials of Increases

- Plan sends Initial Adverse Determination notice (IAD) if denies or partially denies a service authorization request (request for increase or new service), or REDUCES or STOPS a service.
- Also send to provider if provider made request.
- Must use new IAD Notice template. See "Denial Notice" https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_denial_notice.htm
- **Plan must send IAD notice 14 calendar days from receipt of request.**
- **Fast Track -** 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- must decide in 72 hours.** 42 CFR 438.210
- Either way plan may **extend up to 14 calendar days** if plan can justify that it needs additional info and the extension is in enrollee's interest. Plan should send Extension Notice

Initial Adverse Determination Reduction Notice - Appendix Page 10

Look for 3 KEY DATES in Reduction IAD Notice

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)**



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).

Warning Re Reductions – Deadline to get Aid Continuing Buried in IAD Notice!

IAD Notice template language says --

"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 notice mentions the APPEAL DEADLINE first (May 31st) before the EFFECTIVE DATE (April 11th) – the deadline for requesting appeal to get AID CONTINUING!
- Doesn't say "If you want Aid Continuing" – instead says "if you want to keep your services the same…"
- The real deadline is April 11th to get Aid Continuing – to keep same services had before the proposed reduction.

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REDUCTIONS: What if **No** Written IAD Notice from Plan – or notice sent < 10 days before reduction?

- IMLTC member may say they were told by a plan rep or by the home care agency that the hours are being cut, but with no written notice – or notice postmarked < 10 days before reduction.
- In the past, clients could request a Fair Hearing and Aid Continuing, based on lack of written notice or late notice.

1. Now, client **must request Plan Appeal**, and ask Plan to give Aid Continuing, which means recognizing its own notice was defective.
2. **If plan does not accept the appeal request or does not provide Aid Continuing --**
   a. **Immediately Request a Fair Hearing with Aid Continuing**. DOH said in meeting on 4/16/18 that MUST still request plan appeal but do not have to wait for appeal decision. Deemed exhausted.
   b. **Complain to DOH MLTC or mainstream Complaint lines** (last slide)
   c. **Call ICAN** (last slide)

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Strategy: If Miss Aid Continuing Deadline for Plan Appeal or Hearing - **Get Copy of Notice & Envelope**

- **Get a copy** of the complete IAD or FAD notice from client. All pages. One page has the Appeal Request Form. 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. But – Plans are new to deciding if AC applies – so strategy is:
- **Request Plan Appeal** - **If Plan does not give AID CONTINUING –**
  1. **Request a Fair Hearing**– exhaustion should be deemed and aid continuing ordered.
  2. **CALL MLTC or Mainstream DOH Complaint lines** (last slide)
  3. **Call ICAN** (see last slide)

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DENIALS OF Increased or NEW SERVICES: WHAT IF PLAN DOESN'T SEND AN IAD at all - or by Deadline?

1. **If requested an increase, or a new service, and plan fails to send IAD notice by the deadline This is a "denial."** 42 CF.R. 438.404(c)(5)
2. **Member may request a plan appeal on or after the date plan SHOULD have sent written notice.**
3. Plan's deadline to decide is 14 calendar days/ 72 hours from receipt if expedited request. Plus plan may extent time up to 14 days but must give notice extending time .
4. This is why it is important to request increase/new service **in writing** – to start clock for plan to decide. And keep proof that requested.
5. May you request Fair Hearing if no IAD notice denying request for increase? NO! Must request plan appeal.

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Member Liability for Services Provided as Aid Continuing

- Plans may ask member to repay cost of services during Aid Continuing period, 42 CFR 438.404(b)(6), but only:
  - **after FAD is issued** and member **fails to request a hearing** within the 10-day Aid Continuing period.
  - NYLAG asked to bar recoupment until after 120-day time limit to request FH. DOH says plan can start recovery if FH not requested in 10 days, but must stop if requests FH within 120 days.
- If member wins, plan can't recover! Most Fair Hearings on reductions of services are in FAVOR OF THE MEMBER (> 90%). See Medicaid Matters NY report* and NYT. The potential liability should not deter member from appealing.

* https://tinyurl.com/NYTimes-MLTCcuts and https://tinyurl.com/MMNY-report
**See DOH I 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-jan.htm

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Content of Notice – Reasons for reduction

DOH has stressed that plans must be specific about justification for reductions, as stated in MLTC Policy 16.06: *Guidance on Notices … to Reduce or Discontinue Personal Care or CDPAP.***

- Must specify a change in condition or circumstances, and "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." Can't just say their task assessment results in x hours.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

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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 (Appendix p. 15)**.

Use this form if possible.

It includes a lot of pre-filled information (**Blank on App. 27**).

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. But Fax numbers not in revised "Member Handbook" posted on plan websites in April 2018 NYLAG informal list fax numbers at http://www.wnylc.com/health/entry/179/
   - 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**.
   - **Must confirm an ORAL request in WRITING unless you request it to be "expedited"** (**Fast Track**). See more about Fast Track later.
   - Date of CALL locks in Aid Continuing and meets appeal deadline. 42 C.F.R. § 438.402(c)(3).
   - 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! Get name of person who took appeal request.
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 plan and send via certified mail. But don't do this if need AID CONTINUING! Takes too long. Use Appeal Request Form attached to notice.

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Confirming ORAL appeal in writing

- Must confirm an ORAL request in WRITING unless you request it to be "expedited." 42 C.F.R. § 438.402(c)(3).
- An FAQ asked DOH, "How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?"* DOH Response was:

  "... Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. **Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return.** The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the **plan must make a determination even if a written Plan Appeal is not received**."

*FAQ # V. 5, revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v)

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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** – plan must decide **in 72 hours instead of 30 calendar days** "…if :
  - the [plan] determines (for a request from the enrollee) or
  - the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request)

  …that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function." 42 CFR 438.410(a).
- best if PROVIDER requests it or supports the enrollee's request
- Check-off box on **Appeal Request Form** for requesting a **Fast Track Appeal (**included in IAD notice). May attach provider letter in support.
- If request Expedited Appeal, do not have to confirm ORAL appeal request in writing.

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ALERT: WHO may request Plan Appeal?

- The member must **SIGN** the appeal request, or 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." 42 CFR § 438.402(c)(1)(ii).
- Getting client's signature could delay filing appeal request. The client could miss the deadline to request Aid Continuing and could 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**;" and Appeal Request Form asks, "Have you authorized this person with [Plan Name] before?"
- No particular form should be required.

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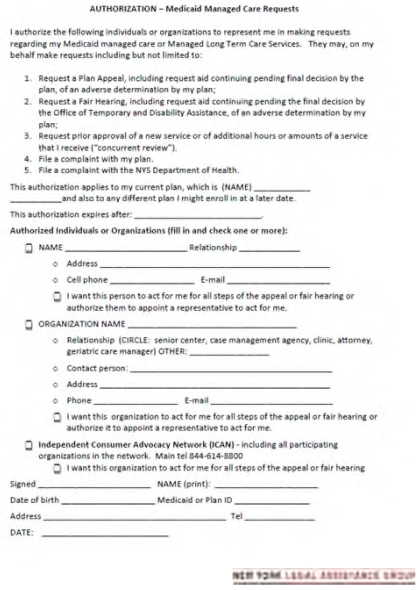
WHO may request Plan Appeal?
Get Signed Authorization!

- **NYLAG created an Authorization form** for client to authorize a legal or social service organization, law firm, ICAN, and/or specific family member(s) to request appeals and hearings. Can list many people! http://www.wnylc.com/health/download/646/. Form Is not a "retainer" – doesn't commit your org to representing.
- When you assist/counsel clients in enrolling in a plan, have them sign the form (or make an "x" if can't sign).
- Keep it on file & give a copy to family AND send to plan for client's file (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. Non-legal org's can contact ICAN for representation.

Prevent Problems!



AUTHORIZATION – Medicaid Managed Care Requests

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

1. Request a Plan Appeal, including request aid continuing pending final decision by the plan, of an adverse determination by my plan;
2. Request a Fair Hearing, including request aid continuing pending the final decision by the Office of Temporary and Disability Assistance, of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review").
4. File a complaint with my plan.
5. File a complaint with the NYS Department of Health.

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

This authorization expires after: _____.

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

☐ NAME _____ Relationship _____
- Address _____
- Cell phone _____ E-mail _____
- ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.

☐ ORGANIZATION NAME _____
- Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
- Contact person: _____
- Address _____
- Phone _____ E-mail _____
- ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.

☐ **Independent Consumer Advocacy Network (ICAN)** - including all participating organizations in the network. Main tel 844-614-8800
- ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____

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Who may request appeal?

Provider May Request Aid Continuing with Member's Authorization

- The federal regulation says that a provider or authorized rep MAY request an appeal or hearing for the member with member's consent.
- **EXCEPT that a provider may not request Aid Continuing**. § 438.402(c)(1)(ii). But may if has written authorization by member.
- See DOH Supplemental FAQ-"*…Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their representative for the Plan Appeal and the Aid Continuing request…"*

**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

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Who may request appeal?

What if client can't sign? Or not submit signed authorization?

- Per FAQ # IV.2, *"…Plans should have policies and procedures for… designation of a representative* ***where the enrollee cannot provide written authorization due to an impairment****."*
- In FAQ V. 8* *If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?*
  - DOH response: "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 [to] the decision under dispute and such authorization has not expired*."*

*DOH FAQ # V.8, https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm

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If Plan Extends its time to Decide Appeal

If the plan has extended the time to decide by up to 14 days -- it must

- make reasonable efforts to give enrollee prompt **oral** notice of the delay, and
- within 2 calendar days, give **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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PLAN MAKES "FINAL ADVERSE DETERMINATION" (FAD) -- IF DENIES PLAN APPEAL

30 Day Deadline, unless Fast Tracked or Extended

What to Look for in Notice

Next Step – Fair Hearing and/or External Appeal

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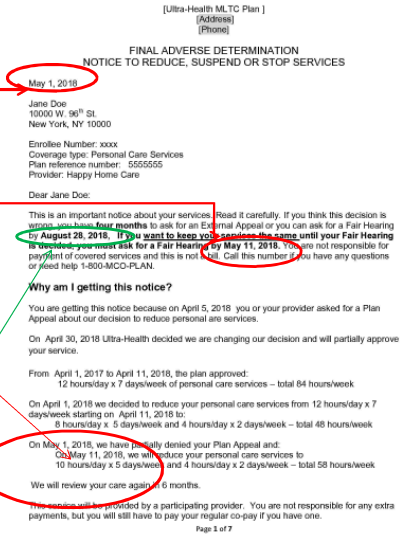
Plan must decide appeal in 30 days -- "Final Adverse Determination" Notice

- Plan has 30 days to decide standard appeal, unless Fast Tracked (72 hours) **or extended up to 14 days with Notice of Extension,** if additional info is needed and the delay is in the enrollee's interest.
  - Plan must make a reasonable effort to give oral notice of extension first, then give written notice within 2 calendar days.
- Must use "Final Adverse Termination" template posted here https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. See 1st page on next slide.
- Even though this is a *decision* on the plan appeal, it is ALSO a Notice of Reduction, and must be given 10 days in advance of the effective date of reduction.
- 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.

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)(irrelevant 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.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help 1-800-MCO-PLAN.

Why am I getting this notice?

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

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

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

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

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

We will review your care again in 6 months.

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

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

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 give written authorization for a representative to do so. See slides 26-29 above suggesting all clients sign "authorization" to request appeal or hearing in advance to have on file. Attach to hearing request.

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

Member may request FAIR HEARING if the plan has not made a decision on the Internal Appeal on time = "Deemed Exhaustion." 42 CFR 438.402(c)(1)(A).

1. If plan does not process appeal or at all or send FAD notice by deadline (30 days for standard/ 72 hours for fast-track/expedited), OR
2. If plan extends time to decide by up to 14 days without giving prompt ***oral notice of extension*** with **written notice** in 2 calendar days, OR
3. If plan denied request for expedited appeal without giving prompt oral notice and written notice in 2 calendar days ➔

CMS in preamble to regulations permits states to define Deemed Exhaustion more broadly. NYS has not yet done so.

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What if Member Requests Fair Hearing instead of Plan Appeal? OTDA role

- Undoubtedly, consumers & their families and rep's will, by habit, and unaware of change, request FHs when they receive an IAD.
- OTDA says it will accept FH request and order Aid Continuing – and plan must comply. OTDA will also advise caller to request a Plan Appeal.
- **WARNING** - **member must STILL request a Plan Appeal**! If they don't, may ultimately LOSE the FH for failure to exhaust, unless "deemed exhaustion" applies.
- So – while FH pending, consumer requests a Plan Appeal and a Final Adverse Determination received ➔ consumer should call back OTDA to request NEW FH or amend original FH to appeal the FAD, If don't, may lose FH because FH requested BEFORE appeal decided, unless "deemed exhaustion" applies.
- OTDA webpage for FH requests & FH request forms –---not yet updated to alert requesters to new rules. http://otda.ny.gov/hearings/request/

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What if Member Requests Fair Hearing instead of Plan Appeal? Plan role

- DOH told plans that when they are notified by OTDA that a Fair Hearing was requested, if no Plan Appeal was requested,
  - "…**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." (Slide 19)*
- If the matter is "resolved" less than fully favorably with the plan, plan must still send notice with appeal rights.

https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-04-13_appeals.pdf

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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 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).
- See DOH FAQs on producing file - https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm (V. #2-4)
  - Unless other requested, plan must send by regular mail
  - Differentiates "evidence packet" provided for fair hearing
- Must be provided "sufficiently in advance of resolution timeframe."
- Plan must provide file even if not requested.
- Unclear if HIPPA required for plan to send file directly to the representative - 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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Online info & Contacts

- NYLAG Article on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/
  - News updates on same http://www.wnylc.com/health/news/80/
- **Fax, phone and email contact info** to request appeals for MLTC plans- 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 managedcarecomplaint@health.ny.gov
- **NYS DOH Managed care webpage for plans on appeals**

https://www.health.ny.gov/health_care/managed_care/plans/appeals/ (has model notices, webinars, etc.)

- **NYS MLTC POLICIES** https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/ click on MLTC policies

Get Help From ICAN!

Call

844-614-8800

TTY Relay Service 711

Email

ican@cssny.org

Website:

http://icannys.org