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Message from the Chair

What an exciting time to be a member of the Elder Law Section ("ELS")! During this New York State budget season, we are reminded of the purpose for which we serve our membership and the clients we represent. In recent years, the budget season marked a time for our Section to rally the troops in an effort to eliminate draconian eligibility and program proposals to the Medicaid program. Six years ago, in response to these proposals, the ELS offered an alternative to these unimaginable measures through the introduction of the Compact for Long Term Care ("Compact"). The Compact provides a cost-neutral solution for New York State that balances the desires of our clients to avoid potential bankruptcy due to long-term care expenses while paying a fair share toward their care. This is particularly important for those who cannot medically qualify for long-term care insurance or afford the premiums. For the past six years, the ELS has continued to pursue passage of this major public policy initiative, which also was endorsed by the American Bar Association. During these years of political uncertainty in Albany, the ELS Compact Working Group's resolve remained steadfast as the days of the draconian budget measures remained fresh in our minds. It is my honor to report that, this year, Governor Paterson has included a Demonstration Project in the budget that is designed to test the core principles of the Compact. This is a day for us to be proud of the ELS, the NYSBA and all those who did not waiver in their support of the Compact! This is proof positive that getting actively involved in NYSBA can truly give you the opportunity to affect public policy.

Inside this Issue

NYSBA

Medicaid Managed Long-Term Care in New York: Part II

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This article is a continuation of our article on Medicaid Managed Long-Term Care (MLTC) from the Winter 2010 issue of the *Elder Law Attorney*.[1] In that article, we gave an overview of the different types of MLTC, the services covered, and the regulatory framework. This article will provide an in-depth discussion of the legal authority governing Medicaid Managed Care Organizations (MCO) in general, and the partially capitated Medicaid Managed Long-Term Care (MMLTC) plans in particular. Our focus will be the due process rights of enrollees and advocacy tips for handling disputes with these plans.

I. Introduction

With more and more clients receiving home care services from Managed Long-Term Care (MLTC) plans or Managed Care Organizations (MCOs), and a clear economic incentive for those plans and organizations to deny or reduce services, it is imperative for advocates to understand their clients' rights regarding grievances, appeals and fair hearings. This section briefly recaps the history of a consumer's due process rights when receiving services provided by a government contracted private entity, and then describes the current federal and New York State regulatory and contractual requirements for managed care organizations relating to grievance and appeals systems.

The Long-Term Care Integration and Financing Act of 1997[2] established a regulatory framework under Article 44 of the N.Y. Public Health Law (PHL)[3] for the integration of long-term care service delivery and alternative financing through the development of MLTC plans. This statute consolidated, under one legislative authority, all operational MLTC plans in New York State at the time the legislation was enacted and authorized the development of additional plans.

II. MLTC Plans Are Subject to Federal and State Regulations and Contractual Provisions Protecting Enrollees

Advocates have long fought to ensure that the Supreme Court's holding in *Goldberg v. Kelly* pervades the many nooks and crannies of the byzantine New York Medicaid system.[4] In many cases, *Goldberg*'s due process protections have been codified in statute and regulation. But when the State authorized the development of MLTC plans to provide government-funded services such as home care, advocates were concerned that there would be a significant gap in due process rights for plan participants when compared with fee-for-service cases.[5] The question is whether the actions of private health care providers can be deemed state action for the purposes of challenging their determinations.[6] However, this has not turned out to be a serious concern, given that the regulations and state contracts governing the plans require that the managed care organizations participate in the hearing process.

By contracting with the state to provide services under the statutory scheme, the MLTC plans have agreed to be subject to the due process rules and hearing and appeal rights afforded by statute and regulation. This also comports with the Second Circuit's holding in *Catanzano v. Dowling*,[7] which deems private certified home health agencies (CHHAs) state actors for the purpose of challenging their determinations to reduce, deny, or discontinue home care in contravention of treating physician's orders.

The more difficult problem is that the State has not ensured that the plans follow a uniform set of procedures for assessing care needs in the first place. This issue is discussed below in section F.

In 2002, the federal government enacted regulations pertaining to the provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health plans (PIHPs), Prepaid Ambulatory Health plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.[8] All MLTC plans (with the exception of the PACE organizations which are established pursuant to separate federal statute[9]) have been required to meet these additional federal requirements.[10] The regulations required significant changes in a number of plan policies and procedures related to an enrollee's due process rights, including grievance and appeal systems. New York State regulations governing MCOs were issued in 2005.[11] MLTC plans are also governed by the provisions of the Public Health Law gov-

erning Health Maintenance Organizations (HMOs).[12] Additional due process rights are also found in each plan's contract with the State.[13] Lastly, the application of this regulatory framework has been tested in various Fair Hearing decisions.

A. Information for Enrollees

Due process begins with adequate notice to enrollees of rights and procedures. MCOs (including MLTC plans) must provide information regarding enrollees' rights and protections, and information on grievance and Fair Hearing procedures.[14] This information must include, among other things, a list of network providers, the scope of covered services, authorization requirements, extent of out-of-network coverage, referral policy, cost-sharing, and how to access benefits available on a fee-for-service basis (i.e., "carved out" of the capitation).[15] This description must include information regarding the right to a State Fair Hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.[16] Furthermore, the description must include information regarding grievances and internal appeals, including availability of assistance in the filing process, toll-free numbers for enrollees to use to file a grievance or an appeal by phone, and the fact that an enrollee is entitled to have his or her benefits continue unchanged if the enrollee files an appeal or a request for a State Fair Hearing within the required time frames and that the enrollee may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the enrollee.[17]

New York complies with these Federal disclosure rules by requiring plans to provide handbooks to each enrollee that include the rights of the enrollees, policies and procedures regarding filing grievances, complaints and appeals, and a list of providers.[18] plans are also required to give enrollees a copy of *New York State Consumer Guide: Managed Long-Term Care*.[19] The requirements to provide enrollees with written information regarding their rights are also included in the New York State MLTC model contract.[20]

B. Disenrollment: Requirements and Limitations

The disenrollment of a member of an MLTC plan may be initiated by either the plan or the enrollee.[21] Significantly, an MLTC contract must provide that the plan may not request disenrollment because of an adverse change in the enrollee's health status, or because or the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).[22] The New York State MLTC Model Contract further provides that the plan may initiate disenrollment if the enrollee's family member or informal caregiver engages in conduct or behavior that seriously impairs the entity's ability to furnish services.[23] An enrollee may disenroll at any time, for any reason, upon oral or written notice to the plan, with such disenrollment taking effect the first day of the next month.[24]

A Fair Hearing decision from 2003, *In re E.D.*, addressed the issue of involuntary disenrollment by an MLTC plan.[25] In this case, the enrollee appealed the MLTC plan's decision to involuntarily disenroll her. The plan's basis for involuntary disenrollment was that the enrollee was no longer self-directing, was unable to direct her personal care worker regarding her medications and activities of daily living, and because her family was either unwilling or unable to provide the necessary direction of her care and had refused to approve her transfer to a nursing home.[26] Although this was not explicitly addressed by the decision, these grounds would seem to violate the Federal regulation, which provides that an MCO cannot disenroll a member due to an adverse change in health status, diminished capacity, or uncooperative or disruptive behavior.[27] In addition, the disenrollment must be approved by the social services district (in this case, NYC Human Resources Administration) to be effective.[28] In this case, the plan was unable to demonstrate that HRA approved its disenrollment request. As a result, the Commissioner's designee reversed the plan's decision to disenroll the enrollee.[29]

C. Enrollee Rights

Federal and state regulations set forth the basic rights of an MCO enrollee, including the right to: receive written explanation of his or her rights; be treated with respect and consideration for his or her dignity; receive information regarding options and alternatives in care; and the right to participate in decisions regarding the enrollee's health care, including the right to refuse treatment.[30] Additionally, this section provides that the State must ensure that the MCO complies with any other applicable Federal and State laws.[31] The model MLTC contract provides a list of enrollee rights, including the right to receive medically necessary care, the right to timely access care, the right to appoint a representative, and the right to use the Fair Hearing system, and/or the external appeal process, where appropriate.[32]

D. Availability of Services

States must ensure that all services covered under an MCO plan are available and accessible to all enrollees, and must set standards for timely access to care and services, which include consideration of an enrollee's urgent need for services.[33] The State must also require that the MCO's network providers meet these standards.[34] The Federal regulation also requires that network providers: offer hours of operation no less than are available to commercial enrollees or Medicaid fee-for-service;[35] make contract services available 24 hours a day, 7 days a week when medically necessary;[36] establish mechanisms

to ensure compliance by providers;[37] regularly monitor the providers to ensure compliance;[38] and take "action" if there is a failure to comply.[39] Additionally, State plans should provide services in a "culturally competent manner," including considerations for enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.[40]

State law and regulations specific to MLTC plans require plans to assure that all covered services are available and accessible by establishing standards for timeliness of access to care and member services, implementing a process for selection and retention of network providers, and making care management and health care services available 24/7.[41]

The Model MLTC Contract provides that the plan must maintain a sufficient and adequate network for the delivery of all covered services, and must meet the standards required by the Federal and State regulations discussed above. The Contract also provides that if an MLTC plan is unable to provide necessary services through a network provider for a particular enrollee, then it must adequately and timely furnish those services through an out-of-network provider.[42]

E. Coordination and Continuity of Care

One of the main benefits claimed by MLTC (in addition to cost savings) is care coordination—the idea that traditional fee-for-service delivery systems result in medically inappropriate care due to lack of coordination of services. Federal regulations require that every MCO implement procedures to deliver primary care to and coordinate health care service for their enrollees based upon set State standards. These procedures must ensure that enrollees have an ongoing source of primary care appropriate to his or her needs as well as provide coordination of services between any other MCOs serving the enrollee.[43]

The State law authorizing MLTC plans specifies that covered services include primary care.[44] The State regulations state that MLTC plans must promote continuity of care and integration of services through designation of a health care professional responsible for care management, coordination of covered services with non-covered services, systematic and timely communication of clinical information among providers, and maintenance of a care management record.[45]

The Model Contract contains detailed requirements about care management. The Contract defines "care management" as follows:

> Care management entails the establishment and implementation of a written care plan and assisting enrollees to access services authorized under the care plan. Care management includes referral to and coordination of other necessary medical, and social, educational, psychosocial, financial and other services of the care plan irrespective of whether such services are covered by the plan.[46]

The Contract further obligates the plan to comply with the Federal regulations cited above, but goes beyond the regulations to enumerate what services are encompassed within "care management," as well as requirements for the information systems used to facilitate care management.[47]

F. Standards for Coverage and Authorization of Services

The issue that most frequently comes up when challenging determinations of MLTC plans is a challenge to inadequacy of home care services, and a major issue in making those challenges is what type of assessment must be conducted in authorizing services. It is clear that Medicaid MCOs cannot cover fewer or less services than are covered under fee-for-service Medicaid, but as usual, the devil is in the details.

1. Services Covered

Each state contract with an MCO must identify, define and specify the amount, duration and scope of the services that it is required to provide, and requires that those services are equal in the amount, duration and scope as those services that are furnished to beneficiaries under fee-for-service Medicaid.[48] The contracts must also ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve their purpose.[49] Additionally, the contracts may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the beneficiary.[50] However, contracts may place "appropriate" limits on a service on the basis of criteria applied under the State plan, such as medical necessity or for "utilization control," as long as the services can still reasonably be expected to achieve their purpose as required by this section.[51]

Each State plan contract must specify what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the State Medicaid program and that addresses the extent to which the plan is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development, and the ability to attain, maintain or regain functional capacity. [52]

New York's MLTC plans are different than other Medicaid MCOs in that they are not intended to provide all Medicaid-covered services to the enrollee. There are some services that are included in the capitation payment, and thus must be provided by the plan through

network providers, and there are other services that are "carved out," meaning that the enrollee must access them through fee-for-service Medicaid. The State regulation governing MCOs provides that MLTC plans must cover:

> health and long term care services, including but not limited to, primary care, acute care, home and community based and institution based long term care and ancillary services that are necessary to meet the needs of [enrollees]. However, consistent with the provisions of section 4403-f of the Public Health Law, while an MLTCP may provide less than comprehensive services, it remains subject to the provisions of this Subpart.[53]

By contracting with the State to provide MLTC services, the plan "agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 C.F.R. § 438.210.… "[54] "Covered services" is defined to mean "those medical and health-related services identified in Appendix G which Enrollees are entitled to receive pursuant to Article V. A." Appendix G lists which services are included in the capitation payment, and which are not.[55]

The individual covered services listed in Appendix G are separately defined in Appendix J, subject to the qualification that "[t]he full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual.[56] Managed care organizations may not define covered services more restrictively than the Medicaid Program."[57] In most cases the Provider Manuals directly track the language in the regulations governing covered services and assessments under fee-for-service Medicaid.[58] The Model Contract further provides that services shall comply with all standards of the State Medicaid plan established pursuant to N.Y. Social Services Law § 363-a (SSL) and all applicable requirements of the PHL and SSL.[59]

2. Authorization of Services

Significantly, each State plan contract must also ensure that MCOs have in place and follow written policies and procedures regarding the initial and continuing authorization of services.[60] Furthermore, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than that requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.[61]

Each contract must also require the MCO to notify the requesting provider and the enrollee of any decision to deny a service request or to authorize a service in an amount or scope that is less than requested.[62]

The Federal regulation also provides that an MCO has 14 calendar days following receipt of the request to issue a decision on standard authorizations for services, and three working days for expedited authorizations.[63] Regardless of these timelines, the plan must consider the enrollee's health condition and his or her emergent need for the requested care when determining the appropriate time frame to render a decision.[64]

New York's Model Contract defines two different types of service authorizations, with distinct time frames. A Prior Authorization is a request by the enrollee or medical provider for a new service, or a request to change a service for a new authorization period. A Concurrent Authorization is request by the enrollee or medical provider for additional services (i.e., more of the same) that are currently authorized in the plan of care.[65] The plan must notify the enrollee of its decision on a Prior Authorization by phone and in writing as fast as the member's condition requires, but no more than within three days of receipt of necessary information, and no more than 14 days from receipt of the request. If the request is expedited, the plan has three days from the request. For Concurrent Authorizations, the plan must respond within one day of receipt of necessary information (again, no more than 14 days from receipt of the request, three days if expedited).[66] The policy regarding expedited requests and extensions of time is the same as for grievances and appeals.[67]

3. Challenging Inadequate Authorizations in Practice

Advocates report that some of the MTLC plans have not been complying with these rules and that instead they have been making case-by-case assessments of care needs following "internal policies" or seat-of-the-pants evaluations. In their defense, it appears that they have done things this way with the approval of the Department of Health. As more of these cases reach the Fair Hearing stage, advocates report that OTDA has not upheld determinations made in this fashion.

For example, in *In re T.T.*[68] the enrollee had appealed the MLTC plan's denial of her request for an increase in personal care services from 24-hour sleep-in to split-shift services. In support of the plan's decision, the plan's representative submitted at the hearing an unsigned Personal Care Assessment Tool (PCAT) based on entries on the Semi-Annual Assessment of Members (SAAM).[69] Although the plan's representative submitted several of these assessments and 72 pages of contact notes, the Commissioner's designee accorded them minimal evidentiary weight, in part because they did not state what criteria were used to evaluate whether Appellant was entitled to split-shift services.[70] The decision then evalu-

ated the Appellant's eligibility for split-shift services using the standards for fee-for-service personal care assessments.[71] Based on a finding that Appellant met the criteria for split-shift, the Commissioner's designee reversed the MLTC plan and ordered split-shift services.

In re E.D., discussed earlier in regard to disenrollment, also addressed the question of what is required from an assessment for home care services by an MLTC plan. In that case, the plan stated that its assessment process includes a conversation with the member's doctor, case conferences with the plan's medical director, an assessment by a registered nurse, and a "tool" based on the nurse's assessment which determines the appropriate number of hours.[72] The Commissioner's designee found that the plan did not in fact have a conversation with the member's doctor, nor was there any evidence of an assessment tool. In fact, the Appellant produced at the hearing two letters from her physician, pre-dating the reduction notice, indicating that he was opposed to a reduction in services.[73] Although the decision did not contain a holding as to whether this assessment complied with the law, it did reverse the determination, ordering restoration of split-shift home care services.

In addition, the decision made reference to the holding of *Mayer v. Wing* (without citation), in stating that "the notice failed to clearly identify the development that justified altering the Appellant's amount of services…."[74] The MLTC plan representative testified at the hearing that the reason for the reduction in services was not an improvement in the Appellant's condition, but rather because:

> …Appellant was a non-self-directing individual; that the Appellant's family was thus expected to be more involved as caregivers in order to keep the Appellant at home with home care; and that if the Appellant's family members were more involved as caregivers, then the authorized home care services could be reduced.[75]

Although the decision does not cite § 505.14 of the regulations (governing assessments for personal care services), the Commissioner's designee was using the concept of the *Mayer* regulation in holding that the plan's notice was defective. Under *Mayer*, the social services agency is required to state not only the reason for the action taken, but also the change to the client's "medical, mental, economic or social circumstances" that gives rise to the reduced need.[76] In light of this analysis, it appears that reductions or terminations by MLTC plans may be effectively challenged where they fail to comply with *Mayer v. Wing*.

In *In re J.T.*, the Commissioner's designee held that an MLTC plan's failure to develop and follow written policies for authorizations of services violated the Federal regulations and the plan's contract with the State.[77] The Appellant had requested an increase from 24-hour sleep-in to split-shift services (two 12-hour personal care attendant shifts). The MLTC plan denied the request. The Appellant commenced an internal appeal with the MLTC plan. In response to this appeal, the plan issued a plan of care that supplemented the sleep-in aide services with adult day care, only allowing split-shift services when the adult day center was closed. Interestingly, after the Appellant requested a Fair Hearing, the MLTC plan sought an independent external appeal by the Medical Care Ombudsman Project pursuant to Art. 49 of the Public Health Law, discussed further below.[78] The Ombudsman affirmed the plan's decision.

At the Fair Hearing, the representatives of the MLTC plan testified that they had no specific criteria to determine when an enrollee is entitled to split-shift personal care services, instead employing a medical necessity standard on a case-by-case basis, using their independent judgment.[79] The Commissioner's designee cited Federal regulations providing that for continuing authorizations for services, each state contract with a managed care organization (MCO) must require that the MCO follow written policies and procedures, and have in effect mechanisms to ensure the consistent application of review criteria.[80] The ALJ also quoted from the State's contract with the MLTC plan, including a provision that requires the plan to "develop and comply with standards and procedures approved by the Department [of Health] that satisfy the requirements of the Public Health Law and Social Services Law and implementing regulations for coverage and authorization of services, and grievance systems."[81] In addition, the plan's contract defined covered services by reference to the *Medicaid Management Information System Provider Manual*, and stated that plans "may not define covered services more restrictively than the Medicaid Program."[82] Based on the plan's failure to comply with its contract and with 42 C.F.R Part 438, the Commissioner's designee reversed the plan's determination and ordered an increase to split-shift services.

G. Appeal Rights

There are four different avenues for an MLTC enrollee to express his or her disagreement with the actions of their plan. Before we delve into the details, here is a brief summary:

- **Grievance**—an expression of dissatisfaction about care and treatment that does not amount to a change in scope, amount or duration of service. These are handled internally by the plan. If the enrollee does not like how the plan responded to their grievance, he or she may submit a "grievance appeal."[83]

- **Appeal**—a review of an "action" taken by the plan. These are also handled internally by the plan. There is no second level of internal appeal.[84]
- **External Appeal—**a review of plan's action made by an external, independent entity, after the internal appeal has been exhausted.[85] This is not required before requesting a Fair Hearing, and its result is superseded by any Fair Hearing decision.
- **Fair Hearing**—an administrative appeal before the Office of Temporary and Disability Assistance (OTDA) challenging the final action of the plan. The enrollee must exhaust the internal appeals process before requesting a Fair Hearing.

When a dispute arises with an MLTC plan, the first question is whether to file a grievance or an appeal. This depends on whether the action complained of constitutes an "action" as defined by the Federal regulation:

(1) The denial or limited authorization of a requested service, including the type or level of service;

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

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

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

(5) The failure of an MCO or PIHP to act within the time frames provided in 438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 438.52(b)(2)(ii), to obtain services outside the network.[86]

If the subject of the dispute is not an "action," then the enrollee must request a grievance, which is defined as "an expression of dissatisfaction about any matter other than an action." Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and the aspects or interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.[87] The grievance system is not exclusive of other remedies, so an enrollee should be able to appeal or disenroll without first exhausting his or her plan's grievance procedure.[88]

1. General Requirements of Grievances and Appeals

Each State plan must have a grievance process, an appeal process, and means of access to the State's Fair Hearing system for all enrollees.[89] Under these Federal regulations, an enrollee may file a grievance and an appeal, and may request a State Fair Hearing.[90] Additionally, a provider may, with the enrollee's written consent, file an appeal. A provider may also file a grievance or request a State Fair Hearing on behalf of an enrollee; however, only if the State permits the provider to act as the enrollee's authorized representative.[91] New York State has opted to require MLTC enrollees to exhaust their plans' internal appeal process before requesting a Fair Hearing.[92]

States may specify reasonable time frames by which an enrollee or provider may file an internal appeal; however, the time frame may be no less than 20 days and not to exceed 90 days from the date on the MCO's notice of action. New York has opted for a deadline of 45 days from the postmark date of the notice of action, or within 10 days if the enrollee wants aid continuing and the appeal involves the termination or reduction of previously authorized service.[93]

An enrollee may file a grievance either orally or in writing. The enrollee *or* the provider may file an appeal either orally or in writing. All oral appeal requests must be followed by filing a written, signed appeal. However, if the enrollee orally requests an expedited resolution, then he or she does not have to file a written, signed appeal.[94]

The question has arisen whether the actions of a private managed care plan are even subject to state Fair Hearing procedures, because the plan is not a government agency.

In *In re E.D.*, an MLTC plan decided to reduce the Appellant's personal care services from 24-hour split-shift to 10 hours per day, 7 days per week.[95] Three months later, the plan decided to involuntarily disenroll the Appellant. The Appellant's representative requested a Fair Hearing after the first determination, and later amended the fair hearing request to include the second determination.

The MLTC plan argued at the hearing that it was not subject to the Fair Hearing regulations, because the regulation only refers to determinations of a social services agency.[96] Although it is true that the Fair Hearing regulation defines "social services agency" to include all state actors, and does not mention managed care organizations, the Commissioner's designee did not find this argument persuasive. The decision quoted, but did not discuss, portions of the MLTC plan's contract which provide that the plan "agrees to comply with federal Medicaid law and State Social Services Law as it related to due process, Articles 44 and 49 of Public Health Law and implementing regulations governing coverage determinations, grievances, and appeals."[97] As a result, it appears that by contracting with the State, MLTC plans have essentially agreed to be deemed state actors for purposes of Fair Hearings.

2. Notice of Action

Managed care plans must issue written notices of decisions of proposed actions. Notices must be in

writing and meet the requirements of Section 438.10(c) and (d), i.e., the plan must have notices available in all languages that are spoken by a significant number or percentage of potential enrollees in the State and provide oral interpretation for any enrollee who speaks a non-prevalent language; and the written material must use easily understood format and language and take into consideration the special needs of enrollees, e.g., those who are visually limited or have limited reading proficiency.[98]

Notices of action must contain the following information:

(1) The action the MCO or its contractor has taken or intends to take;

(2) The reasons for the action;

(3) The enrollee's or the provider's right to file an internal appeal;

(4) If the State does not require the enrollee to exhaust the internal appeal procedures (New York does), the enrollee's right to request a State Fair Hearing;

(5) The procedures for exercising the rights specified in this paragraph;

(6) The circumstances under which expedited resolution is available and how to request it;

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.[99]

The Fair Hearing decision discussed previously regarding a proposed reduction from split-shift to 10x7, *In re E.D.*, also addressed the sufficiency of a plan's notice of action. The decision held that the MLTC plan's notice of reduction in services was defective, because it failed to state the reason for the action.[100]

The time frames required for notices regarding termination, suspension, or reduction of previously authorized Medicaid-covered services must conform to the time frames for Medical Assistance Programs as set forth in 42 C.F.R. §§ 431.211 (10 days before the date of action); 431.213 (provides certain exceptions from advance notice); and 431.214 (five days notice in cases involving probable fraud by the recipient).[101]

Plans are also required to issue notices of decision in response to requests for Prior Authorization or Concurrent Authorization for services. These notices must state the reason for the determination, including the clinical rationale; the procedure for requesting an internal appeal; what additional information must be obtained to decide the appeal; the opportunity to request a Fair Hearing and/or external appeal; the opportunity to present evidence and examine the case file; and the availability of the clinical review criteria relied upon in making the decision.[102]

3. Adjudication of Grievances and Appeals

The Federal regulations require that plans give enrollees reasonable assistance in completing grievance and appeal forms; assistance with language interpretation and comprehension; and acknowledgment of receipt of each grievance and appeal.[103] Furthermore, plans must ensure that the individuals making decisions on grievances and appeals are not the same individuals involved in any previous level of review or decision-making.[104] Additionally, plans are required to have health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease make decisions in the following:

- Appeals of denials that are based on lack of medical necessity;
- Any grievance regarding a denial of a request for expedited resolution; or
- A grievance or appeal that involves clinical issues.[105]

The process for appeal must meet the following special requirements:

- Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
- Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The plan must inform the enrollee of the limited time available for this in the case of expedited resolution.)
- Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- Include, as parties to the appeal, the enrollee and his or her representative; or the legal representative of a deceased enrollee's estate.[106]

4. Time Frames

(a) Grievances

A member of an MLTC plan may file a grievance at any time, orally or in writing. In determining the time frame in which the grievance must be processed, the plan must consider the enrollee's health condition

writing and meet the requirements of Section 438.10(c) and (d), i.e., the plan must have notices available in all languages that are spoken by a significant number or percentage of potential enrollees in the State and provide oral interpretation for any enrollee who speaks a non-prevalent language; and the written material must use easily understood format and language and take into consideration the special needs of enrollees, e.g., those who are visually limited or have limited reading proficiency.[98]

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(4) If the State does not require the enrollee to exhaust the internal appeal procedures (New York does), the enrollee's right to request a State Fair Hearing;

(5) The procedures for exercising the rights specified in this paragraph;

(6) The circumstances under which expedited resolution is available and how to request it;

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.[99]

The Fair Hearing decision discussed previously regarding a proposed reduction from split-shift to 10x7, *In re E.D.*, also addressed the sufficiency of a plan's notice of action. The decision held that the MLTC plan's notice of reduction in services was defective, because it failed to state the reason for the action.[100]

The time frames required for notices regarding termination, suspension, or reduction of previously authorized Medicaid-covered services must conform to the time frames for Medical Assistance Programs as set forth in 42 C.F.R. §§ 431.211 (10 days before the date of action); 431.213 (provides certain exceptions from advance notice); and 431.214 (five days notice in cases involving probable fraud by the recipient).[101]

Plans are also required to issue notices of decision in response to requests for Prior Authorization or Concurrent Authorization for services. These notices must state the reason for the determination, including the clinical rationale; the procedure for requesting an internal appeal; what additional information must be obtained to decide the appeal; the opportunity to request a Fair Hearing and/or external appeal; the opportunity to present evidence and examine the case file; and the availability of the clinical review criteria relied upon in making the decision.[102]

3. Adjudication of Grievances and Appeals

The Federal regulations require that plans give enrollees reasonable assistance in completing grievance and appeal forms; assistance with language interpretation and comprehension; and acknowledgment of receipt of each grievance and appeal.[103] Furthermore, plans must ensure that the individuals making decisions on grievances and appeals are not the same individuals involved in any previous level of review or decision-making.[104] Additionally, plans are required to have health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease make decisions in the following:

- Appeals of denials that are based on lack of medical necessity;
- Any grievance regarding a denial of a request for expedited resolution; or
- A grievance or appeal that involves clinical issues.[105]

The process for appeal must meet the following special requirements:

- Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
- Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The plan must inform the enrollee of the limited time available for this in the case of expedited resolution.)
- Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- Include, as parties to the appeal, the enrollee and his or her representative; or the legal representative of a deceased enrollee's estate.[106]

4. Time Frames

(a) Grievances

A member of an MLTC plan may file a grievance at any time, orally or in writing. In determining the time frame in which the grievance must be processed, the plan must consider the enrollee's health condition

as it relates to a determination of his or her grievance or appeal.[107] Grievances must be decided as fast as the member's condition requires, but no longer than 45 days from the receipt of all necessary information, and no more than 60 days from receipt of the grievance. Expedited grievances must be decided within 48 hours of receipt of all necessary information, and no more than seven days from receipt of the grievance. The enrollee (or the medical provider on his or her behalf) may request extensions of up to 14 days. The plan may also request an extension, but must justify the need for additional information, and only if extension is in the enrollee's interest.[108] If the enrollee disagrees with the plan's decision on a grievance, he or she may request a "grievance appeal" within 60 days. The plan must make a decision on a "grievance appeal" within 30 days of receipt of all necessary information, or within two days for expedited appeals. Grievances or appeals thereof must be expedited 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."[109] Plans must ensure that no punitive action is taken against any provider that requests an expedited appeal on behalf of an enrollee or supports an enrollee's appeal.[110]

(b) Internal Appeals

MLTC enrollees must request an internal appeal within 45 days from the postmark date of the notice of action, or within 10 days if the enrollee wants aid continuing and the appeal involves the termination or reduction of previously authorized service. The plan must send a written acknowledgement of the internal appeal within 15 days of receipt. Internal appeals must be decided as fast as the member's condition requires, but no later than 30 days of receipt of the appeal request. Expedited appeals must be decided within two days of receipt of necessary information, but no later than three days from receipt of appeal request.[111] The policy regarding extensions of time is the same as for grievances. An internal appeal must be expedited under the same circumstances as a grievance, but with the addition of circumstances where "the action was the result of a concurrent review of a service authorization request." If the plan decides to process an appeal request as a standard appeal where the enrollee believes it should have been expedited, the member's only recourse is to request a grievance.[112]

Federal law requires plans to inform enrollees of the disposition of any appeal with a written notice.[113] The Model Contract requires plans to have templates for written notices in response to grievances, grievance appeals, and internal appeals.[114]

Each notice of an appeal resolution must include the results of the resolution and the date it was completed. Additionally, for decisions not fully favorable to the Appellant, each notice must include the right to request a State Fair Hearing, and how to do so; the right to request that the benefits remained unchanged pending the final resolution of the hearing and how to make such a request; and that the Appellant may be held liable for the cost of those "aid to continue" benefits if the hearing decision upholds the plan's action.[115] The enrollee can request a Fair Hearing within 60 days of the date on the notice of decision on the internal appeal.[116]

5. Aid Continuing

Plans are required to continue an enrollee's benefits unchanged while an appeal is pending, if the following conditions are met:

(1) The enrollee or the provider files a timely appeal;

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

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

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

(5) The enrollee requests extension of benefits.[117]

An appeal is filed timely under this section if an enrollee files the appeal within 10 days of the plan's mailing of the notice of action or on or before the intended effective date of the proposed action, whichever is later.[118]

An enrollee is entitled to receive the continuation of his or her benefits while an appeal is pending until one of the following events occurs:

(1) The enrollee withdraws the appeal.

(2) Tens days pass after the plan mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day time frame, has requested a State Fair Hearing with the continuation of benefits until a State Fair Hearing decision is reached.

(3) A State Fair Hearing Office issues a hearing decision adverse to the enrollee.

(4) The time period or service limits of previously authorized services have been met.[119]

A plan may recover the cost of the continued services ("aid continuing") furnished to an enrollee while an appeal is pending if the resolution of the appeal or decision after State Fair Hearing is adverse to the enrollee.[120] The authors of this article are aware of at least one New York plan whose counsel threatened this action during negotiations to resolve a pending appeal of a reduction in services. However, the authors believe that, as a practical matter, this is not a serious problem for our clients, as these Medicaid recipients do not have funds

for the plans to recover. This rule is no different from the rule that permits local social services districts to recover under similar circumstances, and the authors know no impetus by districts to attempt such recovery.

6. Effectuation of Reversed Appeal Resolutions

If an enrollee is successful in his or her appeal to reverse a decision to deny, limit or delay services that were not furnished while the appeal was pending, then the plan must provide those services "as expeditiously as the enrollee's health condition requires." Additionally, if an enrollee is successful in his or her appeal to reverse a decision to deny the authorization of services, and the enrollee received the disputed services while the appeal was pending, then the plan or the State must pay for those services.[121]

7. External Appeals

An enrollee, his or her representative, or his or her health care provider may request an external appeal when the enrollee has lost an internal appeal on grounds of medical necessity, experimental/investigational therapy, or coverage of out-of-network services.[122] The external appeal is conducted by an independent entity under contract with the State. It must be requested within 45 days of the plan's adverse determination on the internal appeal. If the enrollee requests a State Fair Hearing, that decision will supersede any determination made by the external appeal entity.[123] To request an external appeal, you can call the State's External Appeal line at (800) 400-8882, or fill out the external appeal form, available online.[124] This level of appeal was requested in one of the Fair Hearing decisions discussed previously, *In re J.T.*[125]

III. Practice Tips in MLTC Appeals

Appealing the determinations of MLTC plans can be quite different from appeals of DSS determinations. In addition to the bewildering array of managed care regulations discussed above, there are also different logistical issues. Advocates familiar with the Fair Hearing process have probably litigated numerous hearings where the DSS representative does not mount a strong case, often having reviewed the case file only minutes before the start of the hearing. In Fair Hearings against MLTC plans, you have a private adversary who is often familiar with the underlying facts and is motivated to defend his or her employer's decision.

The first step in appealing an adverse determination of an MLTC plan is to request an internal appeal, which in New York is a prerequisite to requesting a Fair Hearing.[126] In many cases, the plan has not issued a written notice of decision (although this is required), so your first step will actually be to get a notice. Because each plan has its own internal appeal process, you will have to contact the case manager or other plan staff to find out how to request an internal appeal. Although plans are required to treat an oral inquiry as a request for an internal appeal, it is a better practice to request the appeal in writing. The plan must allow you to submit evidence in support of your appeal. However, the chances of success on the internal appeal are low, so it is probably not worthwhile to belabor this step as it will have to be repeated for the Fair Hearing.

Once a less than fully favorable decision on the internal appeal is received, you can request a Fair Hearing. The Fair Hearing can be requested in the usual way, but it is important to state in the request that the issue relates to MLTC, and to identify the plan.[127] Once you have received the confirmation of your Fair Hearing request, you should request the "evidence packet"—the administrative record of all evidence relating to the plan's determination. If you submit this request to the usual office at DSS, it will likely be ignored or forwarded on to the appropriate office of the MLTC plan. It may save some time to ask the MLTC case manager where to direct these requests.

The evidence packet from an MLTC plan is drastically different from those you might have encountered in personal care or CHHA appeals. It will likely be a much larger file, and will contain a variety of different records including assessments, contact notes, and clinical records. The main focus of your attention will be the SAAM and any supporting assessments, as these are the method by which MLTC plans conduct their home care assessments. However, do not overlook the contact notes, as these may refer to the factual issues underlying your case. At a typical MLTC plan, every phone conversation between the case manager and the client or his or her family members is recorded in a computerized case management system. These records can be useful in demonstrating facts that the plan knew but did not act upon.

If you have the chance to assist a client in initiating a request for an increase in hours, we suggest that you ask the client's physician to prepare a physician's order for personal care services (M-11q in New York City) and submit it to the agency. Try to make sure that the MTLC plan follows through with a social assessment and a nursing assessment.

If a client has already received a denial of an increase in services without a physician's order, we suggest that you ask the physician to prepare a physician's order as soon as possible and submit it while the appeal is pending. This form will be evidence of medical need for more services that can support a hearing decision in your client's favor if it turns out that the MTLC plan did not follow proper procedures.

One curious aspect of Fair Hearing strategy with MLTC plans is that you can enter into a settlement with the plan. Sometimes the plan will agree to either give you the relief you requested or to negotiate a compro-

mise. Although the authors see nothing wrong with this, it has caused confusion for some hearing officers.[128]

IV. Conclusion

In light of the State's concerns about cost containment in the Medicaid program, it is likely that MLTC will become a more central part of the delivery system for long-term care services. As more of our clientele enroll in MLTC plans, it behooves us as advocates to become familiar with the rules of the game, so that we can help ensure that these plans live up to their promise of efficiency, quality, and coordination of care.

Endnotes

1. David Kronenberg & David Silva, *Medicaid Managed Long-Term Care in New York Part I*, NYSBA Elder Law Attorney, Winter 2010, at 10.
2. 1997 N.Y. Laws ch. 659.
3. N.Y. Public Health Law § 4403-f (PHL). The other provisions of Article 44 of the Public Health Law regulating Health Maintenance Organizations (HMOs) also apply to MLTC plans. PHL § 4403-f(5).
4. *Goldberg v. Kelly*, 397 U.S. 254 (1970).
5. Mark Hannay, Nursing Home Community Coalition of N.Y. State, Improving the Option: Consumer's Perspectives on New York State's Managed Long Term Care Demonstration Project, 17–20 (February 1999), at http://www.ltccc.org/papers/ImprovingTheOption.PDF.
6. *See, e.g., Blum v. Yaretsky*, 457 U.S. 991 (1982), holding that determinations of care levels by private nursing homes were not state actions.
7. *Catanzano v. Dowling*, 60 F.3d 113 (2d Cir. 1995).
8. 42 C.F.R. pt. 438. *See also* 42 U.S.C. 1396u–2. The term "Managed Care Organization" encompasses not only Managed Long-Term Care plans, but also other Medicaid managed care plans including "mainstream" Medicaid Managed Care, Medicaid Special Needs plans, and Medicaid Advantage.
9. 42 U.S.C. 1396u–4.
10. "The Contractor agrees to operate in compliance with the requirements of this Contract, legislative and regulatory requirements including, but not limited to, 42 Code of Federal Regulation (C.F.R.) parts 434 and 438, New York State Public Health Law § 4403-f, and other applicable provisions of Article 44 and Article 49 of New York State Public Health Law and implementing regulations." N.Y. Dep't of Health, 2007 MLTC Model Contract (2007), art. II, subsection A, at p. 6, at http://tinyurl.com/YGU4QL2 [hereinafter Model Contract].
11. N.Y. Comp. Codes R. & Regs. tit. 10, subpart 98-1.
12. PHL § 4403-f(5); PHL art. 44.
13. Model Contract, *supra* note 10.
14. 42 C.F.R. § 438.10.
15. 42 C.F.R. § 438.10(f).
16. 42 C.F.R. § 438.10(g)(1)(i)(A)–(C).
17. 42 C.F.R. § 438.10(g)(1)(ii)–(vi).
18. 10 N.Y.C.R.R. § 98-1.14.
19. N.Y. State Dep't of Health, New York State Consumer Guide: Managed Long-Term Care (August 2007), at http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/mltc_consumer_guide_08.pdf.
20. Model Contract, art. V, subsection H, at 20; Appendix M.
21. 42 C.F.R. § 438.56(b) & (c).
22. 42 C.F.R. § 438.56(b)(2); Model Contract, art. V, subsection (D)(1)(c), at 13.
23. *Id.* at subsection (D)(5)(a), at 15.
24. *Id.* at subsection (D)(1)(b), (D)(2)(a), at 13.
25. *In re E.D.,* Fair Hearing No. 3915572Z (N.Y. Dep't of Health, September 25, 2003), available at http://onlineresources.wnylc.net (must register to access Fair Hearing Database).
26. *Id*. at 2.
27. 42 C.F.R. § 438.56(a)(2).
28. 42 C.F.R. § 438.56(d); Model Contract, art. V, subsection (D)(3)(b), at 14.
29. *In re E.D.* at 6.
30. 42 C.F.R. § 438.100(b)(2)(i)–(iv); 10 N.Y.C.R.R. § 98-1.14(b).
31. "[S]uch as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality." 42 C.F.R. § 438.100(d).
32. Model Contract, Appendix L.
33. 42 C.F.R. § 438.100.
34. 42 C.F.R. § 438.206(c)(1)(i).
35. 42 C.F.R. § 438.206(c)(1)(ii).
36. 42 C.F.R. § 438.206(c)(1)(iii).
37. 42 C.F.R. § 438.206(c)(1)(iv).
38. 42 C.F.R. § 438.206(c)(1)(v).
39. 42 C.F.R. § 438.206(c)(1)(vi).
40. 42 C.F.R. § 438.206(c)(2).
41. PHL § 4403-f(3)(i); 10 N.Y.C.R.R. § 98-1.13(f).
42. Model Contract, art. V, subsection (A)(4), at 10.
43. 42 C.F.R. § 438.208(b)(1) & (2).
44. PHL § 4403-f(1)(e).
45. 10 N.Y.C.R.R. § 98-1.13(g).
46. Model Contract, art. V, subsection (J)(1), at 22.
47. *Id.* art. V, subsection (J)(6), at 23.
48. 42 C.F.R. § 438.210(a)(1) & (2).
49. 42 C.F.R. § 438.210(a)(3)(i).
50. 42 C.F.R. § 438.210(a)(3)(ii).
51. 42 C.F.R. § 438.210(a)(3)(iii)(A) & (B).
52. 42 C.F.R. § 438.210(a)(4)(i) & (ii).
53. 10 N.Y.C.R.R. § 98-1.2(g)(2).
54. Model Contract, art. V, subsection (A)(1), at 10.
55. *Id.* Appendix G; excerpted in Part I of this article, *supra* note 1, at 12.
56. N.Y. State Dep't of Health & Computer Sciences Corporation, Provider Manuals, at http://www.emedny.org/ProviderManuals/index.html.
57. Model Contract, Appendix J.
58. *See, e.g.,* N.Y. State Dep't of Health, Personal Care Services Program Provider Manual 7-8 (2005), at http://tinyurl.com/YDGFQYP; 18 N.Y.C.R.R. § 505.14(a).
59. *Id*. art. V, subsection (A)(2), at 10.
60. 42 C.F.R. § 438.210(b)(1) & (2).

61. 42 C.F.R. § 438.210(b)(3).
62. 42 C.F.R. §§ 438.210(c); 438.404.
63. 42 C.F.R. § 438.210(d)(1) & (2).
64. *Id.*
65. MODEL CONTRACT, Appendix K, subsection (3).
66. *Id.*
67. *Id.* at 12.
68. *In re T.T.*, Fair Hearing No. 5136483H (N.Y. Dep't of Health, May 29, 2009), available at http://onlineresources.wnylc.net (must register to access Fair Hearing Database).
69. *Id.* at 9. The SAAM is an assessment tool approved by the N.Y. State Dep't of Health and required by the Model Contract. *See* MODEL CONTRACT, art. VIII, subsection (E)(2), at 35.
70. *Id.* at 11.
71. *Id.* at 11-12; 18 N.Y.C.R.R. § 505.14(a)(2)(ii) & (a)(3).
72. *In re E.D.* at 5.
73. *Id.* at 5.
74. *In re E.D.* at 4; *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), modified in part, unpublished Orders (May 20 and 21, 1996); Stipulation & Order of Discontinuance (Nov. 1, 1997), incorporated in 18 N.Y.C.R.R. § 505.14(b)(5)(v).
75. *Id.* at 5.
76. 18 N.Y.C.R.R. § 505.14(b)(5)(v)(c)(1).
77. *In re J.T.*, Fair Hearing No. 4295716Y (N.Y. Dep't of Health, April 4, 2005), available at http://onlineresources.wnylc.net (must register to access Fair Hearing Database).
78. PHL § 4910; 10 N.Y.C.R.R. Subpart 98-2.
79. *In re J.T.* at 6.
80. 42 C.F.R. § 438.210(b).
81. *In re J.T.* at 5, 7.
82. *Id.* at 6.
83. PHL § 4408-a.
84. PHL § 4904.
85. PHL §§ 4910 *et seq.*
86. 42 C.F.R. § 438.400(b); MODEL CONTRACT, Appendix K.
87. *Id.*
88. "The rights and remedies conferred in this article upon enrollees shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law." PHL § 4408-a(15).
89. 42 C.F.R. § 438.402(a).
90. 42 C.F.R. § 438.402(b)(1)(i).
91. 42 C.F.R. § 438.402(b)(1)(ii).
92. 10 N.Y.C.R.R. § 98-2.11(a)(1); MODEL CONTRACT, Appendix K, subsection (1)(B).
93. *Id.*
94. 42 C.F.R. § 438.402(b)(3)(i) & (ii).
95. *In re E.D.*, Fair Hearing No. 3915572Z (N.Y. Dep't of Health, September 25, 2003), available at http://onlineresources.wnylc.net (must register to access Fair Hearing Database).
96. 18 N.Y.C.R.R. § 358-3.1.
97. MLTC Version #2 (Commonwealth Contract) for Co-op Care plan, Art. III.E, quoted in *In re E.D.* at 3.
98. 42 C.F.R. § 438.10(c) & (d).
99. 42 C.F.R. § 438.404(b).
100. *In re E.D.* at 4-5; 42 C.F.R. § 438.404; 18 N.Y.C.R.R. § 358-2.2.
101. 42 C.F.R. § 438.404(c).
102. MODEL CONTRACT, Appendix K, subsection (3).
103. 42 C.F.R. § 438.406(a)(1) & (2).
104. 42 C.F.R. § 438.406(a)(3)(i).
105. 42 C.F.R. § 438.406(a)(2).
106. 42 C.F.R. § 438.406(b)(1)–(4).
107. 42 C.F.R. § 438.408(a).
108. 42 C.F.R. § 438.408(c)(i) & (ii); MODEL CONTRACT, Appendix K, subsection (1)(A).
109. 42 C.F.R. § 438.410(a); MODEL CONTRACT, Appendix K, subsection (1)(A).
110. 42 C.F.R. § 438.410(b).
111. 42 C.F.R. § 438.408(b)(1)–(3); MODEL CONTRACT, Appendix K, subsection (1)(B).
112. 42 C.F.R. § 43.410(c)(1) & (2); MODEL CONTRACT, Appendix K, subsection (1)(B).
113. 42 C.F.R. § 438.408(d)(1) & (2).
114. MODEL CONTRACT, Appendix K, subsection (1).
115. 42 C.F.R. § 438.408(e)(1) & (2); MODEL CONTRACT, Appendix K, subsection (1)(B).
116. MODEL CONTRACT, Appendix K, subsection (1)(B).
117. 42 C.F.R. § 438.420(b)(1)–(5).
118. 42 C.F.R. § 438.420(a)(1) & (2).
119. 42 C.F.R. § 438.420(c)(1)–(4); MODEL CONTRACT, Appendix K, subsection (1)(B).
120. 42 C.F.R. § 438.420(d).
121. 42 C.F.R. § 438.424(a) & (b).
122. PHL § 4910.
123. PHL § 4910(4).
124. N.Y. STATE DEP'T OF INSURANCE, EXTERNAL APPEALS, at http://www.ins.state.ny.us/extapp/extappqa.htm.
125. *See supra* note 77.
126. 10 N.Y.C.R.R. § 98-2.11(a)(1).
127. N.Y. STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE, FAIR HEARING REQUEST FORM, at http://www.otda.state.ny.us/oah/forms.asp.
128. *See In re T.T.* at 9.

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