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New "exhaustion" requirement for MANAGED CARE APPEALS

- The Obama Administration revised the federal regulations that govern Medicaid "managed care" plans. 42 CFR Part 438 (App. p. 1). They had not been revised since 2002.
- Many changes in regs – appeals is just one. See NHELP summaries. http://www.healthlaw.org/issues/medicaid/managed-care
- **General new rule-- After May 1, 2018,** a managed care or MLTC member may not request a Fair Hearing against the plan until **AFTER BOTH OF THESE OCCUR:**
  1. Member has requested a **plan appeal** (internal appeal) of an adverse plan determination, and
  2. The plan has issued a **decision**. 42 CFR 438.402(c).
- There is a small exception where exhaustion is "deemed" – discussed later.

What this training will cover

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**

Why Did CMS Require Exhaustion?

- To align Medicaid appeals with those enrollees experience in private health insurance with employers, Qualified Health Plans and Medicare Advantage.
- CMS thought this approach would be less confusing if similar process, but ignored fact that private insurance doesn't have **Aid Continuing** or **Fair Hearings**! And that Medicaid eligibility issues other than managed care services STILL have direct access to Fair Hearings
- CMS responded to concerns **about extra delay in waiting for a plan appeal** by:
  - shortening deadline for plan to decide plan appeal (30 calendar days, shortened from 45 days) and by
  - "**deemed exhaustion**," which allows a consumer to request a fair hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 FR 88 at 27510.

Concerns: 5 million members & their advocates don't know about the change!!!

Exhaustion is a Massive Change to the Appeals Process

- In 20 years of mandatory "mainstream" managed care, 4.5 million "mainstream" managed care members (those without Medicare, mostly < 65) were never **required** to request an internal appeal (now called a Plan Appeal) before requesting a fair hearing. It's been OPTIONAL.
- When MLTC became mandatory in 2012-14, exhaustion was required, but effective July 1, 2015 the State lifted that requirement. Requesting an internal appeal remained an option after that, but one still had to request a FH to get Aid Continuing. (**MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees).**

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 webinar of plan training held 4/13/18
  - *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)

More Needed To Implement Exhaustion!

- OTDA Fair Hearing Request webpage should inform of changes. All people requesting fair hearings should be educated by OTDA staff and correspondence on changes.
- State regulations not yet updated 18 NYCRR 360-10
- **Have Managed Care Plans set up new procedures and trained their staff?**
  - Systems to make sure all appeals are logged in, processed, and Aid Continuing is directed and provided.
  - Plans will now have the responsibility to determine whether member entitled to Aid Continuing – which requires them to objectively review the adequacy and timeliness of their own notices – a job normally done by OTDA.
  - Plans' 1-800 numbers are hard to navigate to request appeals.
  - Plan appeal fax and email addresses must be shared.

WHO IS AFFECTED AND FOR WHAT TYPES OF APPEALS?

Types of managed care plans

Managed care actions vs. DSS actions

Appeals vs. Complaints/Grievances

Exhaustion applies to ALL Medicaid Managed Care Plans

1. **Managed Long Term Care** (MLTC) - **206,000 members** mostly Dual Eligibles = have Medicaid and Medicare)
2. **"Mainstream" plans** - **4.39 million members**
   a. For people who have Medicaid but not Medicare and do not have a "spend-down" – income under Medicaid limit
      - Mostly < 65 and not on Medicare for disability, eligible for Medicaid through Affordable Care Act – kids, families, singles
      - Some > 65 and receive SSI and not Medicare (usually because of immigration status)
   b. Include specialized "mainstream" plans–
      HARP (**Health & Recovery Plans**) –if have Behavioral Health history **14,000 members**
      HIV Special Needs Plans **9,500 members**
3. **Medicaid Advantage Plus** – hybrid MLTC + Medicare Advantage – **9,500 members**
4. **Medicaid Advantage Plans –** **7,070 members**

TOTAL **4,613,000**

Which PLAN actions now require Exhaustion?

APPEAL vs. COMPLAINT/ GRIEVANCE

Appeal = A request to review an **adverse determination** made by a plan. The plan's original determination is called an

"Initial Adverse Determination" **(IAD)**

Two basic types of **IAD**'s --

- **REDUCTIONS – Plan reduces or stops** personal care, adult day care, or any other services, or
- **DENIALS – plan**
  - **Denies request for a new service, such as** Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing
  - **Denies request to increase the amount of an existing service, such as an increase in hours** of personal care services (sometimes called a "concurrent review")
  - **Authorizes services or hours that are less than requested**

Appeals now require EXHAUSTION.

Which types of services will now require a Plan Appeal?
If plan denies, reduces, or inadequately authorizes--

- **In MLTC and Mainstream Medicaid managed care**–
  - **HOME CARE** - Personal care, CDPAP, private duty nursing, home health aide, visiting nurse, Adult Day Care (medical model)
  - **Dental, vision, podiatry, audiology** services
  - **Durable Medical Equipment** (wheelchairs, etc.), **medical supplies** like Depends, Chux, gloves, orthotics, prostheses, respiratory therapy, hearing aids, eyeglasses, syringes
  - **Physical therapy**, Speech therapy, and Occupational therapy (NYS law now has 40-visit cap/year for PT, increased from 20-visit cap in State Budget 4/1/18. ST and OT still have 20 visit caps)
  - **Nursing Home** care/ **rehabilitation**
- **In MLTC only** -
  - Social Adult day care, environmental modifications, home delivered meals
  - Non-emergency **transportation** to medical appoint-ments

Which types of services now require a Plan Appeal?
If plan denies, reduces, or inadequately authorizes--

In Mainstream Managed Care only --

- **Prescription drugs** – denial of prior approval, denial of off-formulary drugs
- **Orthodontic** services
- **Out of network service** if not materially different than that available in network, in-network service is adequate to meet needs
- **Out of Network provider** if not necessary because in-network providers available with training and experience needed
- **Restricted Recipient Program** changes by plan
- All **Behavioral Health** services by HARP or MMC plans – including inpatient or outpatient substance abuse treatment
- All services if plan finds it is not medically necessary, or is experimental or investigational
- **Children's** as well as adult services – **EPSDT**
- MRIs and other **lab or radiology tests**

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) MEDICAL ASSISTANCE.
3424 KOSSUTH AVE (1ST FL.-RM.1A-05)
BRONX, NY 10467

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

PROGRAM CODE - 544

NOTICE NUMBER:	DATE:	CASE NUMBER:
N0342M4231	May 24, 2013	

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
544		NCBDE	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

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 | Client I.D. #

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.

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.

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Which PLAN actions do not lead to APPEALS?

Complaints/Grievances

A "Complaint" (formerly called a "grievance") is made directly with the MLTC plan about anything NOT an adverse benefit determination –

- the quality of care, services or treatment you received,
- delays in services, or
- poor communications with the plan.

- **EXAMPLES**:
  - Aide or transportation is late or doesn't show, aide isn't trained well
  - Can't reach care manager by phone or you were treated rudely, or
  - Dispute extension of time for plan to decide request for new or increased services (make authorization decision).
- **NO Fair Hearing rights with Complaints/ Grievances**
- May request **Complaint Appeal** in 30 days. Plan must resolve in 30 business days after plan has necessary info, or 2 days if delay will harm health(Fed reg allows State to set deadline up to 90 days) §438.408(b)(1)
- New NYS Complaint resolution notice templates at https://www.health.ny.gov/health_care/managed_care/plans/appeals/

MORE ON **INITIAL ADVERSE DETERMINATIONS** (IAD)

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

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NEW Appeals Process and Vocabulary

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**

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

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

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

- **"Service Authorization Request" –** Request by Member or provider to increase an existing service or provide a new service. 42 C.F.R § 438.210 (NY Insurance law calls request for more of an existing service a "concurrent review.")
- **HOW**: Make request **in writing** – or confirm an oral request with WRITTEN request. This way you have proof that you requested it and when – *starting clock for plan to decide.*
  - Letter from member's doctor helpful. Use detail.
  - Specifically request plan to **EXPEDITE** if urgent.

- **WHEN to Request** –
  - At in-home reassessment conducted every 6 months
  - OR any time – by calling Member Services or care manager or by FAX or certified mail.

TIP: If requesting 24-hour care, show how meets reg definitions

2015 amendments to regs defining two types of 24-hour care for those who, because of medical condition, need assistance daily with toileting, walking, transferring, turning or positioning. No longer require that need "total" assistance.

1. **Split Shift** – "uninterrupted care, by **more than one personal care aide**, for more than 16 hours in a calendar day for a patient who …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."
2. **Live-in** – "care by **one personal care aide** for a patient …whose 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.**"
   - Home must have adequate sleeping accommodations for aide.

GIS 15 MA/024 (12/2015), 18 NYCRR 505.14(a), (b)(3)(ii)(b), MLTC Policy 15.09
https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm

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TIP: Use DOH MLTC Policy 16.07

- MLTC Policy 16.07: 11/16/2016 - *Guidance on **Task–based Assessment Tools** for Personal Care Services and Consumer Directed Personal Assistance Services*- clarifies standards such as:
- Task-based assessment tools cannot be used to set "one size fits all" limits on hours. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs – to assess the individual time needed and frequency for client.
- Must reflect sufficient time for such **safety monitoring, supervision or cognitive prompting** for the performance of those particular IADLs or ADLs for those with dementia etc.....
  - *Gives helpful example of supervision and cognitive prompting* -"A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly."
- Must consider "frequent or recurring needs for assistance during the day or night" and any unscheduled needs.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/index.htm
Click on MLTC Policies

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Initial Adverse Determination (IAD)

- Plan must send consumer Initial Adverse Determination notice (IAD) if denies or partially denies the service authorization 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
- NOTICE must go PROVIDER as well as member if PROVIDER made the request. 42 CFR 438.210(c).

When must Plan send "Initial Adverse Determination" notice denying request for service authorization?

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

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

42 C.F.R. 438.210(d)
** posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_ext_notice.htm

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

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

42 CFR 438.210

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

1. After May 1st, Member will have **60 calendar days** to request a Plan Appeal (internal appeal) from the date of the IAD notice. This is an increase from 45 days under the old rules.
2. **If plan fails to send IAD notice by the deadline** (14 calendar days/ 72 hours from receipt if expedited/ + extension up to 14 days)-- This is a "denial." 42 CF.R. 438.404(c)(5)
   - Member **may request a plan appeal** on or after the date plan SHOULD have sent written notice.
   - Check to see if Plan extended the deadline by up to 14 days. Should have sent written notice of the extension.
   - This is why it is important to request increase/new service in writing – to start clock for plan to decide. And keep proof that requested.
   - May you request Fair Hearing if no notice? No. Must request plan appeal. Discussed later in "Deemed Exhaustion."

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

Initial Adverse Determination to reduce services

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Aid Continuing (AC)

- **Aid continuing** is a key due process right when a plan proposes to **reduce or stop** a service that was previously authorized.
  - SOURCE: ***Goldberg v. Kelly***, 397 U.S. 254 (1970) – Right to Pre-Termination Hearing – Right to have a hearing held and decided BEFORE a proposed reduction or discontinuance can take effect, because Medicaid is an ENTITLEMENT based on financial need.
- Unchanged --Plan must still send written IAD notice 10 days before the EFFECTIVE DATE of the proposed reduction/discontinuance.
  - 10 days includes weekends and mailing time!
- If member requests plan appeal before the EFFECTIVE DATE, services will not be reduced or stopped until after appeal is decided.
- **Now, member must meet that short AC deadline TWICE –**

1. File PLAN APPEAL before effective date in IAD, and then, if she loses plan appeal,
2. File HEARING REQUEST before effective date of Final Adverse Determination (FAD).

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Aid Continuing & Authorization Periods

Old federal regulation did NOT require Aid Continuing ("AC") if "authorization period" for service expired while FH was pending. NY SSL 365-a, subd. 8 enacted in 2014 to protect consumers – they are entitled to Aid Continuing "without regard to expiration of the prior service authorization." EXAMPLE:

- Nov. 1, 2017 through April 30 2018 - Ann has 24-hour live-in care, authorized for a 6 month period.
- April 20th - Plans sends an IAD notice that new authorization is 10 hours daily, effective May 1st 2018 – Oct. 31, 2018.
- This is a **reduction** effective May 1st. Ann will still get aid continuing if she requests a **Plan Appeal** before May 1st.

Amended federal reg* DOES require AC if Auth'n period expires while FH is pending, but not if Auth'n Period expired before FH requested! *QUESTION*: What if plan failed to give timely notice of reduction before end of authorization period? We'd say AC required.

*42 C.F.R. §438.420(b)-(c).

Member Liability for Services Provided as Aid Continuing

- Both the IAD and FAD Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 CFR 438.404(b)(6).
- State DOH FAQ** says plans may recoup cost of services during Aid Continuing period, but only:
  - after FAD is issued and member fails to request a hearing within the 10-day Aid Continuing period.
  - 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.
- NOTE: The vast majority of Fair Hearings on reductions of services are in FAVOR OF THE MEMBER (> 90%). See MMNY report. Appendix TOC. The potential liability should not deter member from appealing.

**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

Initial Adverse Determination Notice has 3 Dates

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

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

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

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

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

Initial Adverse Determination Notice - Appendix Page 10

Look for 3 KEY DATES if Reduction

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

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

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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Content of Notice – Reasons for reduction

- Take time to read the new Notice Templates online.
- 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 not only indicate the change in condition or circumstances, but "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."
- WARNING: Uses vague language for "If you want Aid Continuing" – instead says "if you want to keep your services the same…" .
- More on how and to request appeals later.

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DOH MLTC Policy 16.06 - Notices

MLTC Policy 16.06 (11/17/2016): *Guidance on **Notices Proposing to Reduce or Discontinue** Personal Care Services or Consumer Directed Personal Assistance Services*

- Defines what changes or mistakes may justify plan reducing services
- Describes when plan can claim that it made a "**mistake**" in a past authorization, as a justification for reducing hours now.
  - "MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than … previous .. [tools], and then reduce services … on the basis that a "mistake" occurred in the previous authorization.
- If claiming **medical condition improved**, "Notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change..."

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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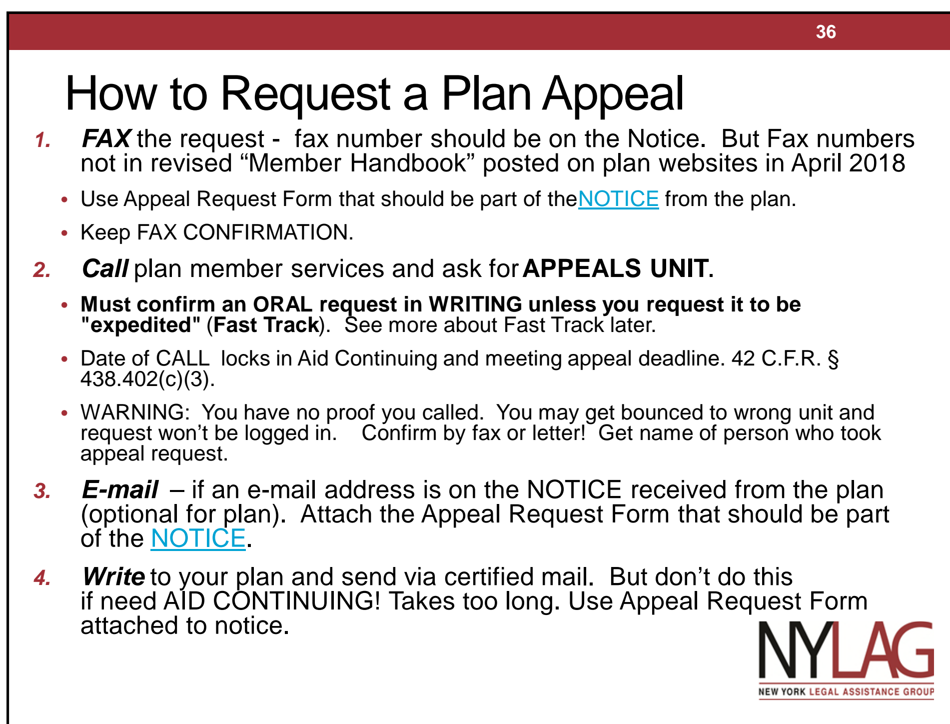

Confirming ORAL appeal in writing

- 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 to Mainstream plans 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**"

Tho FAQ not directed to MLTCs, should apply.

*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)

Request Expedited or "Fast Track" Appeal

- Member or her provider have the right to request an **expedited or "Fast Track" appeal**. The plan must expedite its appeal decision "…if 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).
- If need "fast track" – best if PROVIDER requests it or supports the enrollee's request because:
  - If *enrollee* requests expedited appeal – then PLAN decides if meets criteria;
  - If *Provider* indicates that taking time of standard appeal would meet criteria above, then plan must expedite – reg language implies plan may not disagree
- The **Appeal Request Form** that is part of the Initial Adverse Determination **has a check-off** for requesting a **Fast Track Appeal**. 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 new federal regulations require the member to **SIGN** the appeal request, or to give **written consent for a health care** provider or an authorized representative to request an appeal or file a grievance, or to request a State fair hearing." § 438.402(c)(1)(ii).
- Getting client's signature could delay filing an appeal request --with disastrous consequences. The client could miss the deadline to request Aid Continuing and have home care hours cut.
- Tip: The State Notice template says, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal;" 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** on which client can 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/ Not a retainer for a specific plan action – no end date. Allows specifying that the listed people may REQUEST an appeal and/or REPRESENT. Is not a "retainer" – doesn't commit your org to representing.
- Have all current and new clients sign (or if can't sign, make an "x" on) it. If client can't sign, she can make any mark.
- When you assist/counsel clients in enrolling in a plan, have them sign the form and file with plan, keep proof filed.
- Keep it on file & give a copy to family AND send to plan for client's file return receipt requested (or give to care manager and get her signature of receipt).
- Attach a copy of the signed authorization to the appeal request. Even if you will not REPRESENT in appeal, you can REQUEST it. 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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Appendix P. 25

Who may request appeal?

***Provider* May Not Request Aid Continuing without 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 without written authorization by member**.. § 438.402(c)(1)(ii).
- 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

Who may request appeal?

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

- Per the same FAQ # IV.2 on the previous slide, *"…Plans should have policies and procedures for… establishing designation of a representative* ***where the enrollee cannot provide written authorization due to an impairment****"*
- In a different 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 responded, "**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

If Plan Extends its time to Decide Appeal

If the plan has extended the time to decide-- it must

- make reasonable efforts to give enrollee prompt **oral** notice of the delay, and
- within 2 calendar 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

What to Look for in Notice

Next Step – Fair Hearing and/or External Appeal

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

- The word "Final" on the notice means that this is the decision after the Plan's plan appeal / internal appeal.
- First page of notice involving a REDUCTION is on next slide. Notice templates posted here https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.
- 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.

Page 1 of 7

(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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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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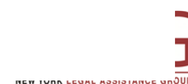
DEEMED EXHAUSTION

When can you request a Fair Hearing without either REQUESTING a PLAN APPEAL or waiting for the Plans' appeal decision?

"Deemed Exhaustion"

Deemed Exhaustion – Federal regulations provide a narrow exception to the general rule requiring member to BOTH request a Plan Appeal and wait for the plan's Final Adverse Determination *before* requesting a Fair Hearing.

Federal regs allow a request for a FH without a "Final Adverse Determination" **if plan "fails to adhere to the notice and timing requirements of § 438.408."** These are the requirements for when the plan must give notice of its Final Adverse Determination on the appeal. These are on the next slide.



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When Must Plan Decide Appeal? §438.408

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

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

- If plan does not send FAD by deadline (30 days for standard/ 72 hours for expedited, OR
- 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
- If plan denied request for expedited appeal without giving prompt oral notice and written notice in 2 calendar days➔
- **Member may request FAIR HEARING even though the plan has not made a decision on the Internal Appeal** This is called "Deemed Exhaustion." 42 CFR 438.402(c)(1)(A).
- This is the ONE ground for Deemed Exhaustion required by federal regulation. CMS in preamble permits states to define Deemed Exhaustion more broadly. NYS has not done so.

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Other grounds for deemed exhaustion?

In preamble to federal regs, CMS allows states to deem exhaustion on a broader basis. 81 Fed. Reg. 88 p. 27510. NY has not. We asked DOH to deem exhaustion if plan gave:

- **No** initial written IAD notice for a reduction or denial
- **Late (untimely)** IAD notice (not dated & mailed 10 days in advance)
- **Defective** IAD **notice** (not in client's language, illegal reason for reduction)
- Or if **Plan fails to order/provide Aid Continuing** where client is entitled to it.

"Deemed Exhaustion" *con'd.*

On April 16, 2018, NYS DOH told consumer advocates that it had trained plans on 4/13/18 that if plan sends:

1. **No** initial written IAD notice for a reduction or denial OR
2. **Late (untimely)** notice (not dated & mailed 10 days in advance – check postmark)

-- the consumer **MUST STILL request a plan appeal**, but **if the plan fails to process the appeal, or does not order Aid Continuing**, consumer may request a Fair Hearing and **exhaustion will be deemed**. Unclear if "defective notice" is in this category (notice not in client's language, illegal reason for reduction).

- However, the 4/13/18 DOH training for Plans on this policy posted on 4/13/18 does not clearly say this. Posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-04-13_appeals.pdf

OTDA Role in "Deemed Exhaustion"

Will OTDA have a front-end system to determine if "deemed exhaustion" applies; i.e. Did the plan decide the Plan appeal in time? Is the IAD notice defective? Was the IAD notice late?

- So far, DOH/OTDA have said it will be up to the ALJ to decide this issue
- Because this is not yet clear, cannot assume that exhaustion will be deemed. **Must also:**
  1. request a plan appeal,
  2. wait for Final Adverse Determination (FAD),
  3. then call OTDA back to request new FH or amend FH request.

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 – who in plan will review timeliness & adequacy of notices, etc.?
- **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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Strategy: What if **No** Written IAD Notice from Plan?

- It is not uncommon for MLTC members to say they were told by a plan rep or by the home care agency that provides aide under contract with the plan, that the hours are being cut, but with no written notice.
- In the past, clients could request a Fair Hearing and Aid Continuing, based on lack of written notice.
- Now, client **must request Plan Appeal** with plan, and ask Plan to give Aid Continuing, which means recognizing its own notice was defective.
- **If plan does not accept the appeal request or provide Aid Continuing --**
  1. **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.
  2. **Complain to DOH MLTC or mainstream Complaint lines**(last slide)
  3. **Call ICAN** (last slide)

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Strategy: What if **Late or Inadequate** Written IAD Notice from Plan?

- On 4/16/18 DOH advised NYLAG that client**must still request Plan Appeal** with MLTC or other managed care plan, and ask Plan to give Aid Continuing (which means recognizing its own notice was defective).
- **If plan does not accept the appeal request or provide Aid Continuing --**
  1. 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.
  2. Complain to DOH MLTC or mainstream Complaint lines (last slide)
  3. Call ICAN (last slide)

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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. Exact scripts not available.
- **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. Unclear now how OTDA will interpret the regulations.
- 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

- In the training DOH conducted for Plans on 4/13/18*, 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)*
- Members do not waive their right to notice of an adverse decision with appeal rights if the matter is "resolved" less than fully favorably with the plan.

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

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

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

Get Help From ICAN!

Call

844-614-8800

TTY Relay Service 711

Email

ican@cssny.org

Website:

http://icannys.org

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