

Important Change for Medicaid Managed Care and MLTC Enrollees Appeals and Fair Hearing Rights

1. What is changing on May 1, 2018?

New rules change how and when you can ask the State for a Fair Hearing to appeal a decision by your Medicaid managed care plan, HARP plan, or Managed Long Term Care (MLTC) plan. Starting May 1, 2018, if your plan denies, reduces or stops a service, and you think the decision is wrong, **you must first ask your plan to look at your case again. This is called a Plan Appeal.** You must then wait for the plan's decision **before** asking for a Fair Hearing.

This is a big change. Before May 1, 2018, you could request a Fair Hearing right away if you thought your plan's decision about your services was wrong. **Now you must first request a Plan Appeal before you can ask for a Fair Hearing.**

2. What happens if the plan decides to reduce or stop a service I am getting now?

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan says that it will reduce or stop any of your services. You have 60 days from the date of the plan's notice to ask for a Plan Appeal, **but if you want to keep your services the same while your case is appealed, you must ask for a Plan Appeal within 10 days** of the date of the plan's notice or by the date the notice says the change will take effect, whichever is later. If you request the Plan Appeal within 60 days but after the effective date of the reduction, you can ask the plan to "fast track" your Plan Appeal. If you lose your Plan Appeal, you may ask for a Fair Hearing. If you don't request a Fair Hearing, or if you don't win your Fair Hearing, and you received your services unchanged while waiting for the decision, you may have to pay for those services.

3. What happens if the plan denies my request to approve a new service or more services?

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a notice of its decision. If your health is at risk, you or your provider may request that approval be "fast tracked." This requires the plan to decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information, and why the delay needed to obtain this information is in your interest. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If the plan denies your request for approval, the decision is called an "Initial Adverse Determination." If you think your plan's decision is wrong, you can ask for a Plan Appeal. After May 1, 2018, **you must first ask for a Plan Appeal and wait for a plan appeal decision before you may ask for a Fair Hearing.** You have 60 days to ask for a Plan Appeal. If you disagree with the Plan Appeal decision, you may ask for a Fair Hearing.

4. How do I request a Plan Appeal?

You can request a Plan Appeal by completing and faxing or mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. Some plans allow you to e-mail the request. The plan's contact information for requesting the appeal should be printed on the Appeal Request Form. You can also call the plan to request the appeal, but you will then also need to mail or fax confirmation of the request, unless you ask your Plan Appeal to be "fast tracked."

5. Can someone ask for a Plan Appeal for me?

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must both sign and date the appeal request. Or you must give written permission to that person to request an appeal for you, unless you gave them permission in the past.

6. What happens in a Plan Appeal and How Long Does it Take?

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk and you or your provider request a “fast track” appeal, your plan must decide it within 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information to decide, and why the delay needed to obtain this information is in your interest. If the plan’s appeal decision denies you all or some of the services you are seeking, the plan must send you a “Final Adverse Determination.”

7. What if the Plan does not decide my Plan Appeal on time?

If you do not receive a “Final Adverse Determination” – a decision for your Plan Appeal -- by the time limits in the question above, you can ask for a Fair Hearing without waiting for the plan’s decision.

8. What if I think the Plan Appeal decision is wrong?

If you think the plan’s decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for a Fair Hearing, but if the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, **you must ask for a Fair Hearing within 10 calendar days** from the date of the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same as they were before, until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. Your services may be reduced while awaiting an External Appeal, unless you also requested a Fair Hearing in time to prevent a reduction.

You can ask for a Fair Hearing or an External Appeal or both. If you ask for both, the Fair Hearing decision will always be the final answer.

9. Where can I get more information?

For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN –Independent Consumer Advocacy Network** Phone: **844-614-8800**

TTY Relay Service: 711 Website: icannys.org E-Mail: ican@cssny.org

Call **NYLAG – EFLRP** contact eflrp@nylag.org **212-613-7310**

See <http://www.wnylc.com/health/entry/184/> for more information.