NYLAG
New York Legal Assistance Group

September 8, 2020

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Re: Comments on Notice of Revised Rulemaking - Medicaid Managed Care State Fair Hearings & External Appeals Processes and Standards
I.D. No. HLT-27-00006-P (State Register, July 8, 2020)

Dear Ms. Ceroalo:

New York Legal Assistance Group submits these comments to the Department of Health's proposed regulations implementing the federal regulatory authority (42 CFR 438 Subpart F) requiring Medicaid recipients receiving services through a Managed Care Organization (MCO) to exhaust an appeal with the MCO prior to requesting a State Fair Hearing. These federal regulations have been implemented in New York State since the spring of 2018.

NYLAG is a leading non-profit that provides free civil legal services and financial counseling, and engages in policy advocacy efforts, including health care advocacy, to help people experiencing poverty.

NYLAG commends the Department for working with stakeholders to implement the exhaustion requirement. NYLAG participated in the workgroup that is described in the preamble of the proposed regulations. Beginning in the summer of 2017, this workgroup met regularly with the Department and other stakeholders to provide feedback on the Department's policies and proposed notices. NYLAG attorneys and legal advocates have practical knowledge of exhaustion as implemented, having assisted hundreds of New Yorkers in navigating Plan Appeals and Fair Hearings to access or maintain critical medical services.

Our comments review the proposed regulation broadly and recommend that the regulation:

1. Employ the same terminology used in the Department's policy and practice instead of developing new terms (Point 1); and

2. Correct the omission of the Service Authorization and Plan Appeal processes, including MCO obligations regarding notice and timing requirements. (Point 2)

NYLAG also provides comments to guard and strengthen consumer protections in the now mandatory two-level appeal process by recommending that the final regulation:

3. Clarify and expand the definition of deemed exhaustion (Point 3);

4. Guard consumer protections when a fair hearing is requested (Point 4);
5. Align federal and state contractual requirements with the production of the case file at the Plan Appeal and Fair Hearing levels (Point 5);
6. Develop a jurisdictional review process that improves efficiency while safeguarding access to a Fair Hearing (Point 6);
7. Codify New York State's longstanding policy that entitles an enrollee to Aid Continuing upon a timely appeal request unless enrollee opts out (Point 7);
8. Does not limit hearing officer's discretion to order medical assistance to the amount or duration the Plan claims was at issue during the Plan Appeal (Point 8); and
9. Miscellaneous procedural issues (Point 9).

It is NYLAG's position that these amendments would substantially revise the proposed amendment that a second round of notice and comment should be issued before the regulations are finalized.

1. Previously Adopted Exhaustion Terminology Should be Used for the Appeal Process and Titles of the Adverse Notices -18 NYCRR § 360-10.3.

Through collaboration with stakeholders at the Department's "Part 438" Exhaustion Workgroup, terminology defining the exhaustion procedure was developed. This terminology has been in use for over two years by MCOs, OTDA hearing officers, advocates, and recipients. The Department uses these terms in the mandatory model notices and in myriad polices and procedures.[1] However, these terms are not reflected in the proposed changes to 18 NYCRR § 360-10.3 (pp. 3-5).[2] NYLAG urges the Department to use the adopted terminology in the proposed regulation to align it with the terms currently used by stakeholders. We further recommend that DOH work with OTDA to propose amendments to 18 NYCRR 358 to reflect mandatory exhaustion as CMS did by amending 42 CFR Part 431 when it undertook revisions to 42 CFR 438 Part F.

By using different terminology in the regulations, it is unclear if the Department intends to revise its notice templates so that the titles of the notices conform to the new titles. This would be unproductive, unnecessary and cause great confusion. Yet having different titles for the notices in the regulations than those in actual use modeled on Department templates is also confusing. A hearing officer reviewing the notice adequacy must be able

[1] The Department's model notices can be found here: https://www.health.ny.gov/health_care/managed_care/plans/appeals/.

[2] Page references are to the proposed regulations posted at https://regs.health.ny.gov/regulations/proposed-rule-making Direct link: https://regs.health.ny.gov/sites/default/files/proposed-regulations/Medicaid%20Managed%20Care%20State%20Fair%20Hearings%20and%20External%20Appeals%20Processes%20and%20Standards.pdf

to rely on the terminology in the regulations. Accordingly, NYLAG recommends the adoption of following terms in the regulation:

- **18 NYCRR § 360-10.3(a)-** Term "**Action**" should be re-named as **"adverse benefit determination"** to align with federal regulation. Of the seven subparagraphs (1) – (7) under that definition**,** all but two would appropriately be categorized as "adverse benefit determinations" under this definition. The only two that would not be are (4) and (5), which we recommend be added to the "plan appeal" definition, which is suggested new term for "action appeal process," below.
- **18 NYCRR § 360-10.3(b) – Proposed: Action appeal process**.
    - CMS term: "Appeal" – 42 CFR § 438.400(b)
    - NYLAG recommends: DOH Term since 2017 "***Plan Appeal***" with suggested amended definition:

      Plan Appeal means the process established by an MMCO or its management contractor through which an enrollee may appeal an Initial Adverse Determination, as defined in **§ 360-10.3(i),** or appeal the plan's

        1. [the] failure to provide services in a timely manner, as set forth in the guidelines established by the commissioner; or
        2. [the] failure to act to resolve service authorization requests, complaints, grievances, and appeals with reasonable promptness. Reasonable promptness shall mean compliance with the timeframes established by Public Health Law, Social Services Law, **Insurance Law,** and applicable Federal regulations, as set forth in the guidelines established by the commissioner

      These sections (1) and (2) we suggest moving from the definition of the term "action."
- **Proposed 18 NYCRR § 360-10.3(c) – Proposed Action Appeal Determination,**
    - CMS term: No specific term. Regulations describe required content and timing for issuance of "notice of appeal resolution." Id. at § 438.408(e)
    - NYLAG recommends: DOH Term since 2017 ***Final Adverse Determination (FAD).***
- **Proposed 18 NYCRR § 360-10.3(i) – Proposed "Notice of Action"**
    - CMS term: Notice of Adverse Benefit Determination. Id. at §§ 438.10(c); 438.400(b); 438.404
    - NYLAG Recommends: DOH Term since 2017 ***Initial Adverse Determination (IAD)***.

Perhaps the decision to continue using the word "**action**" throughout the various notices stems from the fact that this term has been used in Part 360 for some time, as in "Notice

of Action." 18 NYCRR § 360-10.3(a), 18 NYCRR § 360-10.3(i). However, those terms were defined before the exhaustion requirement was instituted. With exhaustion, a plan "action" may be either the initial denial or reduction of a service by an MCO, or the plan's later decision after a plan appeal to affirm its earlier adverse "action." Therefore the word is confusing and not specific enough in the era of exhaustion.

Alternately, the Department may want to retain use of the word "action" because that term is used in Part 358 of the regulations which are the Fair Hearing procedures for all Medicaid hearings. Section 360-10.8 (a) specifically incorporates Part 358 "…by reference as if set forth fully herein and is applicable to enrollees…" These concerns can be addressed in other ways while still making the regulations consistent with the terminology that the Department has incorporated into its contracts, guidance and notice templates since 2017.

In fact, CMS confronted the same issue with the work "action" when it amended the Medicaid managed care regulations in 2016 and introduced new terms for "actions" by managed care plans. It redefined "action" in the context of the fair hearing regulations in Part 431 to include "adverse benefit determinations" by MCO's in § 438.228(b) of the federal regulations. This way, the more specific term applicable in the MCO context could be used.[3] Since Part 358 of Title 18 of the New York regulations is the equivalent of subpart E of Part 431 of the federal regulations, we recommend that the State take CMS' lead, and work with OTDA to do rulemaking to update the terminology used in Part 358 to make these regulations consistent as they are to be read together. See 360-10.8(a) ("Part 358 of this Title by reference is set forth fully herein" unless "a provision in this section is inconsistent with Part 358 . . ."). Amendments to Part 358 should reflect that Medicaid beneficiaries enrolled in MCO's must exhaust before proceeding to a fair hearing. A few regulations in Part 358 that need to be amended in light of exhaustion include, but are not limited to:

- § 358-3.1 "Right to a Fair Hearing" should clarify the requirement to exhaust the plan appeal for MCO enrollees, and describe when "deemed exhaustion" applies.

- § 358-2.15- term "notice of action" in could be amended to reference a "Final Adverse Determination" (or "action appeal determination as proposed)

- § 358-1.3 defining "social services agencies" to which the fair hearing regulations apply should be amended to include MCO's.

Since New York has implemented exhaustion, the state has used a slightly different terminology than CMS. To minimize disruption of systems already in place for over two

[3] CMS explained, "We clarify for commenters that § 438.228(b) refers to the ''action'' specified under subpart E of part 431. It would not be appropriate to revise the term ''action,'' as this term is used in subpart E of part 431 and was not proposed to be changed. However, during our review of these public comments, we identified a needed revision in § 431.200 to update the terminology from ''takes action'' to ''adverse benefit determination'' when referring to subpart F of part 438 of this chapter**.** We have revised the term ''action'' to ''adverse benefit determination'' in subpart F of part 438 and revised the phrase ''takes action'' to ''adverse benefit determination'' in § 431.200 when referring to subpart F of part 438 of this chapter." 81 Fed. Reg. No. 88, May 6, 2016, p. 27506.

years, the terms used in New York for the "notice of action" should the Initial Adverse Determination," defined as a notice of adverse benefit determination. (See recommended definition above).

2. Notices and Timing Requirements for Determinations on Service Authorization Requests and Plan Appeals, in addition to Fair Hearings, Must be Included in the Regulation

The Department's proposed amendments to 18 NYCRR §§ 360-10.3 and 360-10.8 neglect to fully develop the Service Authorization and Plan Appeal processes as set out in the federal regulation. This missed opportunity undermines the Department's efforts to align the state and federal regulations to reflect mandatory exhaustion. It also weakens the overall aim of the amendments as in several places the state and federal regulations must still be read together to fully understand the Service Authorization, Plan Appeal and Fair Hearing procedures. The proposed draft regulation confusingly conflates the Plan Appeal with Fair Hearings, when they are separate stages, and omits the initial request for a Service Authorization entirely, even though this request results in the MCO's denial that triggers the Plan Appeal. In the preamble to the proposed regulations, the Department explains these deletions from § 360-10.8:

> In updating the State's regulations, the Department has decided to retain the regulation's primary focus on the fair hearing process and rights afforded to enrollees. Because federal rules now require exhaustion of the action appeal process in most cases before an enrollee may avail themselves of the fair hearings process, many provisions concerning or related to MMCO "notices of action" were moved or removed as not being pertinent. See, e.g., 18 NYCRR 360-10.8(e)(2)(i)(e) of the current regulation regarding procedures for requesting an appeal, which would be moot in any action appeal determination notice. However, the underlying requirements on notices of actions are still present under federal regulation and State contracts with MMCOs. As such, the removal of these provisions should not, in and of itself, be construed as changing the notice of action requirements; as such requirements may still be applicable pursuant to other sources of authority.

NYS Register, July 8, 2020, p. 2. The fact that these requirements are in the federal regulations and state MCO contracts does not obviate the need to include them in the state regulations. Consumers, advocates, ALJs, the Department of Financial Services that administers external appeals, and courts, not just MCO's, rely on State Medicaid regulations to clarify the policy and procedures by which the state is implementing federal regulations. By describing only the fair hearing requirements while omitting the earlier stages of the process–the Service Authorization requests and Plan Appeal–the regulation is incomplete and will lead to more confusion. This information must be somewhere in Section 360-10, whether in section 10.8 or elsewhere.

NYLAG recommends that the Department retitle section 360-10.8 as "Service Authorizations, Plan Appeals, and Fair Hearings" and comprehensively address the MCO obligations for each of these stages, including deadlines, notices, and review requirements. Making these changes would be a substantial revision, requiring a second round of public notice and on the revised text. NY SAPA § 202 4-a.

A. Section 360-10.8 should be renamed "Service Authorization Requests, Plan Appeals and Fair Hearings" and include MCO obligations and Consumer Rights at each Level

There is no subdivision of Part 360-10 that specifies the procedures for requesting Service Authorizations or for conducting Plan Appeals. NYLAG recommends expanding Section 360-10.8 from being limited to Fair Hearings to include all three stages, from the service authorization to the Plan Appeal to the Fair Hearing. These new sections should be added so that they are in sequential order, which can be achieved by renumbering of subsections.

i. Service Authorizations

42 CFR § 438.210 presents the obligations of an MCO in making Service Authorization determinations. The Service Authorization request by an enrollee and the subsequent processing of the request is the foundational step in the appeals procedure. If an enrollee's request is denied she must initiate a Plan Appeal and, if necessary, a Fair Hearing. The failure to include the MCO procedure and time limits for processing a service authorization request in the proposed amendment makes it exceedingly difficult to understand exhaustion and fair hearing procedures. NYLAG proposes adding at least the following MCO obligations for service authorization requests, to 18 NYCRR § 360-10.8.

- The service authorization procedure must be consistent for all enrollees. 42 CFR § 438.210(b).
- Reductions, denials, and partial approvals must be reviewed by a medical professional with relevant expertise. 42 CFR § 438.210(b).
- Where an MCO service authorization decision is unfavorable, adequate notice as set out in 42 CFR § 438.404, must be issued to the enrollee. Id. at § 210(c).
- The federal regulation further sets out time frames by which the MCO must decide service authorization request. A standard request must be processed in 14 days unless the timeframe is extended, id. at § 210(d)(1), and an expedited request must be made in 72 hours unless the timeframe is extended to a maximum of 14 days, id. at § 210(d)(2). All of the standards in the federal regulation for expediting or extending the time to decide requests should be set out in Part 360.

Because the Service Authorization procedure is fundamental to understanding exhaustion and the fair hearing process, its omission from the proposed amendments undermines the Department's aim of aligning our state regulatory scheme with the federal scheme and jeopardizes consumer protection. For example, the denial of the service authorization request triggers the MCO obligation to issue the IAD (Notice of Action) within the timeframes set out above. See 42 CFR § 438.404(c)(4),(6). Another example that encompasses appeal rights is that under the federal regulation an enrollee has the right to request a Plan Appeal if the MCO misses the deadline to decide a service authorization request. See 42 CFR § 438.404(c)(5) (stating that the failure to issue a service authorization within defined timeframes constitutes a denial which can be appealed). This right, to appeal a delayed service authorization, is an important consumer protection which must be set out in the regulation.

ii. Plan Appeal:

Similarly, the obligations of the MCO to handle Plan Appeals are mostly omitted from the proposed amendments. NYLAG recognizes that the term "Action Appeals Process" at 18 NYCRR § 360-10.3(b) has been added to the definitions subdivision. Also, at 18 NYCRR § 360-10.8(f)(3) the requirement that an MCO must provide reasonable assistance to an enrollee during an appeal had been added. However, these additions are insufficient to align the state and federal regulations and to protect consumer rights such as timeframes for processing appeals and the right to present documentation and testimony during a Plan Appeal. The absence of these key consumer protections from the federal regulation in the Department's proposed amendments is unreasonable, arbitrary and capricious. NYLAG urges the Department to further amend 18 NYCRR § 360-10.8 to outline the Plan Appeal procedure in detail, some of which is discussed below.

An MCO must adhere to timeframes to decide an appeal as set forth in the 42 CFR § 438.408. These timeframes are only vaguely referred to in the proposed amendment at 18 NYCRR § 360-10.3(c). An MCO must review and issue a determination of a Plan Appeal (Action Appeal Process) within 30 days of initiation of the appeal under the standard timeframes, 42 CFR § 438.408(b)(2), and within 72 hours for an expedited appeal unless the procedure for an extension was followed, id. § 438.408(b)(3). See also id. at § 438.410 (requiring an MCO to have a procedure to process expedited appeals within 72 hours). If an MCO fails to meet these deadlines, an enrollee's appeal is deemed exhausted and she may request a fair hearing. 42 CFR § 438.402(c)(A). The absence of these crucial deadlines from the proposed amendment to Part 360-10.8 undercuts consumer protections as hearing officers, state employees, MCOs and other stakeholders including the public rely on these regulations to administer the Plan Appeal and Fair Hearing procedures. As the proposed amendments stand now, the state and federal regulations must be read together to understand deadlines and appeal rights.

Many other requirements in 42 CFR 438 Subpart F regarding the MCO's obligations to adequately administer the Plan Appeal procedure are missing and should be added. These include the requirements set out in 42 CFR § 438.406(b):

- Acknowledge receipt of each appeal;
- Those reviewing the Plan Appeal should not be involved in the Service Authorization determination;
- Denials based on a lack of medical necessity must be reviewed by individuals with appropriate clinical expertise;
- All additional documentation provided must be reviewed during the Plan Appeal process;
- The enrollee must be given a reasonable opportunity to present evidence and testimony and to make legal and factual arguments in person or in writing; and
- The MCO must provide the enrollee with her case file without her request and free of charge.

These obligations comprise an enrollee's minimum due process rights during the Plan Appeal and should be explicit in 18 NYCRR § 360-10.8.

B. The Adequacy Requirements for the Initial Adverse Determination Notice Must be Added To Meet Due Process Requirements

Under the mandatory exhaustion procedure, two notices—an IAD (Notice of Action) and FAD (Action Appeal Determination Notice)—must meet distinct timeliness and adequacy rules. For example, each notice has different statutes of limitations to request the next level of appeal and each notice must explain the different instructions for how to file appeal. Unfortunately, the proposed amendments do not treat the notices under separate subdivisions in 18 NYCRR § 360-10.8(e)(pp. 9-17). In fact the IAD (Notice of Action) is not even discussed; only the FAD (Action Appeal Determination Notice) requirements are detailed. As a result, important consumer protections are unreasonably omitted, and the resulting regulation is confusing, incomplete, and misleading. It is not enough simply to cross-reference generally to applicable federal regulations.

As stated above, NYLAG urges the Department to reorganize Section 360-10.8 so that there are separate subdivisions specifying the requirements for Service Authorizations and Plan Appeals. However the Department chooses to add this critical information to the regulations, a new subsection must be added either in the NOTICE subsection 10.8(e) or in a new subsection devoted to the service authorization process that explicitly outlines the requirements of the IAD (Notice of Action). We also suggest further amendments to 18 NYCRR § 360-10.8(e)(3) regarding the FAD below.

i. *New Section Needed for Requirements of Initial Adverse Determination (Notice of Action)*

The minimum due process requirements of a timely and adequate IAD notice are set forth 42 CFR § 438 Subpart F. These requirements, including the following, should be included in the regulation. The notice must:

- Explain that the enrollee has 60 days from the date of the Initial Adverse Determination (IAD) to request a Plan Appeal, 42 CFR § 438.402(c)(2)(ii);
- State the MCO's decision or intended decision on the service authorization or continuing service authorization, id. at § 438.404(b)(1);
- State the reasons for the decision, id. at §438.404(b)(2);
- State the right to be provided with relevant documents and criteria relied on to make the decision, id.;
- Explain the procedures to appeal the decision and how the Plan Appeal may be expedited, id. at § 438.404(b)(4)(5); and,
- Explain the right to aid continuing, id. at § 438.404(b)(6).

Our state laws and regulations include additional notice adequacy requirements, many of them should be carried over here, including but not limited to, providing the effective date of the proposed or intended action, a citation to the specific law and/or regulations upon

which the action is based, and the enrollees right to representation by counsel or an authorized representatives. See 18 NYCRR § 358-2.2.

In addition to an adequate notice, the MCO must issue a timely notice. The deadline by which the MCO must issue the notice as set forth in 42 CFR § 438.404(c) should be explicitly included in the amended regulation. These requirements are:

- For a termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least ten days in advance of the intended action, 42 CFR § 438.404(c)(1)(citing §§ 431.211, 431.213, and 431.214);

- For service authorization denials reviewed on a standard basis, within 14 days calendar days of the request unless the requirements to extend the authorization are followed, id. at § 438.404(c)(3); and,

- For service authorization denials reviewed on an expedited basis, as expeditiously as possible but within 72 hours notwithstanding a proper extension of time, id. at § 438.404(c)(6).

These timeframes ensure that consumers' rights are protected under mandatory exhaustion. If a timely notice is not received, an enrollee has the right to request a Plan Appeal without notice, see 42 CFR § 438.404(c)(5) (stating that failure to issue a service authorization within defined timeframes constitutes a denial which can be appealed). Moreover, in cases of reduction of a service such as personal care, the enrollee only has a short window to request a Plan Appeal to access aid continuing benefits. Therefore, a subdivision detailing the adequacy and timeliness of an IAD should be added.

ii. *Final Adverse Determination (Action Appeal Determination Notice)*

Section 10.8(e)(3)(i)(a)-(f) sets forth the proposed requirements of the Final Adverse Determination (FAD). NYLAG suggests that certain specific timeframes and deadlines be more explicitly included in the final regulation.

First, the statute of limitation to request a fair hearing, now 120 days from the date of receipt of the FAD—unless exhaustion is deemed—should be specifically included at 18 NYCRR § 360-10.8(e)(3)(i)(f)(1). The proposed amendment of this subdivision does not specify the 120-day time limit.

Additionally, the specific timeline by which the MCO must issue a FAD should be clearly stated. The federal timeframes, subject to a 14-day extension for which the requirements should be specifically included, are as follows:

- In a standard Plan Appeal of a denial an MCO must issue the FAD no later than thirty days after the appeal was requested, 42 CFR §438.408(b)(2); and,

- In an expedited plan appeal of a denial an MCO must issue the FAD with 72 hours of receipt of the appeal, id. at § 438.408(b)(3)

Finally, special attention should be made to clearly state the MCO obligations to provide at least ten days advance written notice of a reduction, termination or suspension of a previously approved Medicaid service. The amended advance notice requirement at 18 NYCRR § 10.8(e)(3)(1)(f)(10) should be more explicit.

3. Deemed Exhaustion Definition in 18 NYCRR § 360-10.3 Should be Revised to be More Specific and Expanded to Protect Consumers

Section 360-10.3(d) (p. 5) amends the current regulation to define deemed exhaustion. We recommend amending this definition to be more precise, and also more protective of consumer rights where the MCO fails "to adhere to the notice and timing requirements" required for processing and issuing notices after plan appeals.

Under the federal regulation deemed exhaustion applies:

> In the case of an MCO … that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's … appeals process. The enrollee may initiate a State fair hearing.

42 CFR § 438.402(c)(A). Section 438.408 refers to the plan's resolution of a requested plan appeal, including time frames for issuing a determination after the plan appeal ("FAD," using the state terminology).

First, the regulation must more specifically state the timeframes by which the MCO must respond to the Plan Appeal, which are set out in 42 CFR § 438.408, as suggested above. It must state that deemed exhaustion applies where the MCO has not issued written notice of resolution within 30 days from the date of receipt of member's appeal request by plan, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless the plan properly extended the time pursuant to the regulations by up to 14 calendar days. Id. at § 438.408. If those time frames are set forth in another subsection of Part 360-10 as we recommend, this definition could cross-reference to that amended section. Also, to align with the federal regulation, the definition of deemed exhaustion must affirmatively state that where the Plan Appeal process has been deemed exhausted the enrollee may initiate a State Fair Hearing. 42 CFR § 438.402(c)(A).

Second, exhaustion applies not only when the plan fails to issue a FAD within the time limits prescribed in federal regulation, but when it fails to adhere to other notice and timing requirements on plan appeals. Moreover, in adopting the exhaustion requirement in federal regulations, CMS stated, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." 81 Fed. Reg. No. 88, May 6, 2016, p. 27510. Therefore, we recommend that the regulation deem exhaustion where the plan failed to provide an IAD at all, or where the IAD was not timely and adequate. In such cases, the enrollee's ability to request a plan appeal at all – or within the time limit to obtain Aid Continuing -- is obstructed. The enrollee cannot be penalized for failing to request a plan appeal when she was not adequately and timely notified by the plan of the adverse determination, of the right to appeal and how to do so. The regulations should state that an enrollee may request a fair hearing in the following circumstances:

a. No written notice of initial adverse determination (IAD) was provided by the plan, which denies the enrollee from being informed of the manner to request a plan appeal;

b. An IAD was issued but does not does not adhere to notice requirements, including those listed below, any of which impede the enrollee's ability to understand how and when to request an appeal and how and when to request Aid Continuing. Deemed exhaustion should apply if the IAD:

   i. Lacks the requisite information re the right to Aid Continuing, how to request an appeal (i.e. has the wrong fax number), etc.

   ii. Fails to incorporate necessary translation or alternative formats

   iii. Is not issued on the required template, or

   iv. Did not offer auxiliary aids and services, free of cost, during the appeal

   v. Does not comply with other applicable requirements, i.e. 18 NYCRR 505.14(b)(5)(iv)(c)(2), as further interpreted by DOH MLTC Policy 16.06.

   vi. As said above, was not timely issued, especially where the adverse determination is to reduce services, in which the notice must be provided in advance to afford the opportunity to request Aid Continuing.

c. The MCO fails to comply with proposed 360-10.8(d)(4) by failing to promptly notify an enrollee who requested a hearing prior to exhausting the plan appeal. See NYLAG's recommendation at Section 6 including that this notice be given within five days of the plan being notified that the hearing was requested.

d. Plan has not issued written notice of resolution within 30 days from date of receipt of member's appeal request by plan, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless extended pursuant to the regulations by up to 14 calendar days. 42 CFR § 438.408

Finally, Section 360-10.8(c) (p. 7) describes circumstances when an enrollee may not request a hearing. The notion of deemed exhaustion is absent from this subdivision specifically at §§ 360-10.8(c)(4) and (5). Deemed exhaustion should be expressly incorporated into these two subdivisions so that it reads (modification in bold):

> (c) Enrollees do not have a right to a fair hearing if:
> …(4) the sole issue is a participating provider denied or reduced a service, denied access to a referral, or authorized a service or benefit in an amount less than requested, unless the enrollee has received a determination or notice of action from the MMCO, or its management contractor, confirming the decision of the provider **and has exhausted the PLAN APPEAL process or the PLAN APPEAL process has been deemed exhausted**.

4. The Procedure to Request a Fair Hearing Should Guard Consumer Protections Set Out in the Federal Regulation

Section 360-10.8(d) outlines the requirements for requesting for a fair hearing. NYLAG shares the following comments.

First, the proposed language in section 360-10.8(d)(2) (pp. 7-8) is awkward and should be improved for readability and clarity. Additionally, the use of the phrase "as evidenced by" is distracting in the context of the Plan Appeal process and the request for an administrative hearing. NYLAG suggests the following changes marked in bold:

> (2) A request for a fair hearing regarding an MMCO's or its management contractor's ~~action appeal determination~~ **Final Adverse Determination** may be requested only after the enrollee requests a **Plan Appeal** ~~exhausts~~ and the MMCO's or its management contractor ~~action appeal process as evidenced by an action appeal notice,~~ **has either issued a Final Adverse Determination** or the ~~action appeal process~~ **Plan Appeal** is ~~a~~ deemed exhausted.

Second, § 360-10.8(d)(3), which defines the 120-day statute of limitations to request a fair hearing, should also be revised for clarity and accuracy. The proposed amendment incorrectly places a deadline for an enrollee to request a fair hearing when exhaustion of the Plan Appeal has been deemed. A statute of limitations begins to run upon receipt of the notice of fair hearing rights, here a FAD. Accordingly, there can be no deadline to request a fair hearing where exhaustion has been deemed, as by its definition the appellant has not received written notice of a deadline. See generally Kipp v. Blum, 80 A.D.2d 557, 557-58 (2nd Dep't 1981); Bates v. Blum, 86 A.D.2d 563, 564 (1st Dep't 1982). Moreover, no deadline to initiate a fair hearing where exhaustion has been deemed is present in the federal regulation. As such, language purporting to set a deadline by which an enrollee must request a fair hearing in the instance of deemed exhaustion should be stricken. NYLAG proposes the following changes to the amended subdivision:

> (3) Subject to the requirements of paragraph (2) of this subdivision, a request for a fair hearing ~~regarding an MMCO's or its management contractor's action or action appeal determination~~ must be requested within 120 calendar days of the date of the MMCO's or its management contractor's ~~action appeal determination notice~~ **Final Adverse Determination** ~~or~~ **unless** the ~~action appeal~~ Plan Appeal process **is deemed exhausted**, ~~whichever is earlier.~~

5. The MCO's Duty to Produce the Plan Appeal Case File and Fair Hearing Evidence Packet Should Comport with Federal Regulations and Contractual Requirements

The proposed changes to this subsection do not square with the requirements of the federal regulations and the MCO's contractual requirements with New York State. Because an enrollee has a right to review documentation at the Plan Appeal and Fair Hearing appeal levels, the MCO's duty to provide documents appears in multiple places in § 360-10.8. See18 NYCRR § 360-10.8(e) (production of case file is part of an adequate notice), id. at § 360-10.8(f) (obligations of an MCO after a fair hearing has been requested). The proposed

amendments do not go far enough to align the state regulation with consumer protections in the Plan Appeal process as set out in the federal regulation; nor do they align with current Department policy as reflected in the state's contracts with the MCOs.

Plan Appeal: Section 438.406(b)(5) of the federal regulations states that the MCO must provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal of adverse benefit determination. For the Plan Appeal process, the production of the case file and relevant documentation is not predicated on the enrollee's request and must be provided sufficiently in advance of the resolution timeframe for appeals. Id. Accordingly, the recommended subdivision on Plan Appeals currently absent from the proposed regulation should specifically require plans to provide the case file without request.

Fair Hearing: Similarly, at the fair hearing level the evidence packet must be produced without the enrollee's request per the state's contracts with MCOs. Mainstream Medicaid Managed Care organizations and Managed Long Term Care organizations must automatically provide enrollees with evidence packets prior to the fair hearing. See Managed Care Model Contract, Sec. 25.6(b); Partial Capitation Model Contract, Sec. Q(2). These identical provisions require the MCO to provide the authorized representative or enrollee with the evidence packet that will be submitted at the fair hearing within ten days of receipt of the fair hearing notice free of charge. Section 360-10.8(f)(4) should be amended to reflect these contractual requirements and to protect consumer rights.

Nonetheless, the requirement to produce the evidence packet does not diminish an enrollee's right to request specifically identified documents from her case file. See 18 NYCRR 358-4.2(d) (the agency must provided specifically identified documents for the purpose of preparing for a fair hearing). This right should also be clearly stated.

6. Any Jurisdictional Review by OAH Must Protect Consumer Rights—Proposed 18 NYCCR § 360-10.8(d)(4) & (5)

The question of jurisdiction is novel as it arises out of the mandatory exhaustion of the Plan Appeal, barring deemed exhaustion, before requesting a Fair Hearing. Prior to implementation of the federal regulations 42 CFR 438 Subpart F in 2018, a hearing officer was not taxed with this question. The proposals in § 360-10.8(d)(4) & (5)(pp. 8-9) to establish a process to review the jurisdictional question before the scheduled fair hearing present an opportunity to improve the efficiency of the fair hearing process and increase consumer access to adjudication on the merits of their medical assistance claims. NYLAG reminds the Department that the majority of Medicaid beneficiaries represent themselves in these hearings and they are unfamiliar with the legal concept of jurisdiction. Furthermore, many appellants will not understand the distinction between a Plan Appeal and Fair Hearing. This underscores the need for any new procedure to safeguard consumer protections. NYLAG urges the Department to improve the proposed procedure and not only guard, but strengthen, the consumer protections as explained below.

A. Where the MCO Contends Appellant Failed to Exhaust, the Fair Hearing Request Should be Deemed to be a Request for Plan Appeal, which the MCO Should be Required to Process while the Fair Hearing is Pending

Section 360-10.8(d)(4) (p. 8) requires the MCO to "promptly notify" the Office of Administrative Hearings (OAH) and the appellant if the MCO "contends the action appeal process (Plan Appeal) has not been exhausted." The MCO would then explain to the appellant how to request the Plan Appeal. While this is helpful, NYLAG proposes additional protections, which we earlier suggested in comments provided to the Department of Health in the summer of 2017.

Upon being notified that a fair hearing was requested, the MCO should be required to automatically process the Plan Appeal as if it was requested simultaneously with the Fair Hearing, where timely, when an appellant requested a fair hearing without exhausting the Plan Appeal. It is logical that an appellant by filing a fair hearing request is dissatisfied with the MCO's decision and has an interest in appealing it. Thus, the fair hearing request should be deemed a request for a Plan Appeal where one was not requested earlier. If the MCO does not reverse its initial denial, it would issue a FAD, which would be made part of the record for the pending fair hearing, avoiding dismissal of the hearing for lack of exhaustion.

This proposal improves efficiency. By requiring the MCO to immediately process the Plan Appeal when the fair hearing is requested, consumers may be approved for medically necessary services obviating the need for a fair hearing in the first place. Furthermore, fewer cases without jurisdiction will be scheduled before hearing officers. At least one MCO has already implemented this common-sense procedure.[4] Moreover, CMS' policy underlying the exhaustion requirement is to align Medicaid managed care appeal processes with those of private health insurance plans and Medicare Advantage plans, for national consistency. See 81 Fed. Reg. No. 88, supra, at p. 27509-10. The goal is not simply to play "gotcha" and deprive consumers of their right to contest an MCO's adverse determination because they did not understand the exhaustion requirement. Where the MCO has been notified by OTDA's OAH that a fair hearing was requested, the plan is on notice that the consumer is dissatisfied with the plan's action, and should be required to process the Plan Appeal as if the consumer requested it directly with the plan.

B. Alternately, the MCO must be Directed to Notify Appellant within Five Days of Receipt of the Fair Hearing Request of Appellant's Failure to Exhaust and Explain How to Appeal. If Appellant requests Plan Appeal, the FAD Should Be Reviewed in Pending Hearing.

If the Department does not require the automatic Plan Appeal, the proposed regulation should be altered to provide added consumer protection. We agree with the requirement that the plan "promptly" inform OAH and the appellant of the MCOs' view that the appellant failed to exhaust, but the regulation should specify that the MCO must notify the appellant of the exhaustion requirement and the time limit for requesting a plan appeal

[4] See DAFH 8057753H, dated Jan. 8, 2020, available at https://otda.ny.gov/fair%20hearing%20images/2020-1/Redacted_8057753H.pdf (Where member requested a fair hearing without having requested a plan appeal, hearing request dismissed for lack of jurisdiction, even though MLTC plan representative testified that a plan appeal was then in process because the fair hearing automatically triggered a Plan Appeal). We submit that under our proposed changes, a hearing in this posture would have been adjourned to await the plan's appeal decision, and if that decision was adverse, the issue of the hearing would have been amended to review the FAD.

within 5 business days of the plan's receipt from OAH of notice of the fair hearing filing. The Commissioner would develop a notice for such instances. If the Appellant then requests a Plan Appeal, the plan's decision should become part of the record for the pending fair hearing, and preclude dismissal of the fair hearing for failure to exhaust. Further, this subdivision should reflect that the MCO **MUST NOT** recommend that the appellant withdraw the fair hearing. See 18 NYCRR § 358-3.1 ("the right to request a fair hearing cannot be limited or interfered with in any way."). There may be a material issue of fact and if directed to withdraw a fair hearing, the appellant might unjustly lose the right to the hearing.

C. No Hearing Should be Dismissed for Failure to Exhaust Without an Expedited Hearing for the Appellant to Submit Evidence that the Exhaustion Requirement was Met.

Where the MCO has notified OAH that it contends the appeal process has not been exhausted, under proposed § 360-10.8(d)(4), the appellant must be afforded an expedited hearing to provide documentation or testimony regarding the factual issue of whether she filed a Plan Appeal. The basis for this expedited hearing falls under 18 NYCRR § 358-3.2(b)(9),(10) regarding an urgent need for medical assistance.

In no instance, may OAH order the dismissal of a case on the ground that the request lacks jurisdiction without holding a fair hearing. The new subdivision (5) to § 360-10.8(d) (pp. 8-9) provides a three-business-day deadline by which a hearing officer must dismiss a case for lack of jurisdiction. It is unclear from the draft language whether a hearing officer's dismissal would occur prior to, during, or after a fair hearing. Any determination of jurisdiction must be made by a hearing officer following a fair hearing, in order to protect consumer rights.

A fair hearing is required because a review of jurisdiction may raise material issues of fact that must be reviewed by a hearing officer. The fair hearing provides an appellant the opportunity to provide testimony and documentation of the filing of any Plan Appeal and to rebut the MCO's position that the fair hearing lacks jurisdiction. An enrollee is also entitled to administrative review on the question of deemed exhaustion. Accordingly, the hearing officer cannot decide the legal question of jurisdiction based on the papers provided by one side, here the MCO, which has more resources and understanding of the procedure than an individual Medicaid enrollee.

Hearing officers currently elicit testimony regarding whether a Plan Appeal has been filed. See DAFH 7907526H, dated June 17, 2019, (finding a lack of jurisdiction after weighing appellant's testimony which contradicted that of the MCO); DAFH 8098574H, dated June 17, 2020, (holding a lack of jurisdiction where the appellant sent the Plan Appeal to the incorrect address), DAFH 7890664Z, dated May 24, 2019, (finding jurisdiction on appeal of one notice after three hearings).

The hearing should be scheduled on an expedited basis. Dismissal of a fair hearing because of exhaustion will delay the appellant's access to the services at issue, so the hearing process should be expedited to minimize this delay. Also, if our suggestions above to deem the hearing request to constitute a Plan Appeal request are not adopted,

then it is critical for the fair hearing to be expedited. In some cases the appellant may still have time to request a Plan Appeal in other cases the enrollee will need to start over with a new Service Authorization request.

To that end, NYLAG proposes the following modification to section 360-10.8(d)(5):

> "**Following a fair hearing, which shall be scheduled on an expedited basis,** if a hearing officer determines that, for any fair hearing request, the enrollee did not file, or otherwise request, a **Plan Appeal and that exhaustion has not been deemed**, the hearing officer must promptly, but in no [case] less than 3 business days, dismiss the case for lack of jurisdiction."

7. The Aid Continuing Regulation Should Codify the Department's Longstanding Policy of Granting Aid Continuing if an Appeal is Filed Before the Effective Date of the Adverse Determination, Subject to the Consumer's Right to Opt Out

NYLAG proposes specific changes to the proposed amendments in 18 NYCRR § 360-10.8(h) (pp. 21-22) the subdivision that outlines Aid Continuing benefits.

This review of § 360-10.8 provides the Department with the opportunity to memorialize consumer protections that have been in place for years. Since Medicaid managed care has become mandatory, New York State has adopted the policy of granting aid continuing on a timely appeal request UNLESS the consumer opts out of the benefit. This position existed before exhaustion was required, and was published in Department of Health policy guidance issued to implement exhaustion in 2017:

> …NYS [managed care] plans are required to provide [Aid Continuing]:
>
> . . .immediately upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (IAD), or the effective date of the action, whichever is later, **unless the enrollee indicates they do not wish their services to continue unchanged.** (emphasis added).

"New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations," dated Dec. 15, 2017, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm. This policy was further reflected in the online Fair Hearing request form at the OTDA website, in the Department's mandatory IAD and FAD notice templates, described above at n 1, and in numerous policies and procedures issued for plans, ALJs, and the public when the Department implemented exhaustion.[5] If this

[5] NYS DOH Bureau of Managed Long Term Care, Presentation on 42 CFR 438 Service Authorization and Appeals, Dec. 7, 2017, available at e.g. https://www.health.ny.gov/health_care/managed_care/plans/appeals/42-cfr-438_mmc_saa.htm (slide 10 of the PDF version, stating "We are going back to the process that was in place before July 2015. If member uses the Appeal form, AC [Aid Continuing] should be provided unless the member checks the box indicating they don't want it."), PDF available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf.

longstanding policy and practice developed with stakeholder input is changed now, the departure from past practice would be arbitrary and capricious agency policy making and potentially violate the State APA. Therefore, this policy and practice should be codified in § 360-10.8(h).

To the extent that the proposed amendment to the Aid Continuing benefit seeks to limit the duration of aid continuing based on an expired authorization period for any services, such a proposition violates New York State Social Services Law § 365-a(8). Section 365-a(8) states that a Medicaid enrollee is entitled to aid continuing without regard to the expiration of the prior service authorization.

Additionally, some simple oversights in drafting need to be corrected. As exhaustion is mandatory, an enrollee is entitled, where applicable, to aid continuing during the duration of the Plan Appeal and also while the Fair Hearing decision is pending. However, while the proposed draft makes clear that an enrollee may be entitled to aid continuing on a Plan Appeal, § 360-10.8(h)(2)(i)(a), the entitlement to aid continuing while the Fair Hearing decision is pending is not. As the amendment is drafted, one must read the introduction to § 360-10.8(h)(2) to see that the subdivision applies to both Plan Appeals and Fair Hearings with § 360-10.8 (h)(2)(ii)(c). NYLAG proposes that the Plan Appeal and Fair Hearing be discussed separately, specifically stating the right to Aid Continuing in both stages of appeal.

Additionally, in § 360-10.8(h)(2)(i)(a) the term "grievance determination notice" should be removed as there is no aid continuing on a grievance. See 42 CFR § 438.420 (reserving aid continuing to adverse benefit determinations).

8. Section 360-10.8(i) Should be Stricken Because Fair Hearing decisions about MCO Actions Cannot be Limited by the Amount or Duration of a Benefit that was the Subject of the Plan Appeal

NYLAG opposes the addition of the proposed 18 NYCRR § 360-10.8(i) (p. 23) because it clashes with existing state fair hearing regulations, basic due process rights in fair hearings, and is prejudicial to appellants. Section 360-10.8(i) states that the "orders for benefits or services as a result of a fair hearing decision shall be limited to the amount or duration of benefits or services that were the subject of the action taken by the MMCO and which the enrollee appealed." This restriction is improper for the following reasons.

First, it is not uncommon for the "amount of services" that is the "subject of the action taken by the MMCO and which the enrollee has appealed" to be a material issue of fact at a fair hearing. For example, the IAD often lists the incorrect service requested or misstates the number of hours requested by the enrollee. For example, clients report that they asked for overnight assistance, but the notice shows a request was made for 10 or 12 hours of daily personal care. The amount of the benefit request may be listed as "unspecified" in the notice. It is common for enrollees, their families, social workers and physicians to

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Reference to July 2015 was to the date of a policy change. Exhaustion of plan appeals had been required earlier, until this requirement was lifted in July 2015, and then reinstated in May 2018.

request "24-hour care," not knowing that there are two types of 24-hour care.[6] Even where the MCO should be able to infer that the member means to request continuous 24-hour "split shift" care, the MCO notice incorrectly state that live-in identify 24-hour care was requested.[7] While some sophisticated Medicaid recipients or their families raise the factual errors in the plan's notice regarding the amount of hours they requested, many do not realize this is an issue. Again, the hearing officer must review all of the evidence and assess the credibility and weight of the testimony and documentation to make a factual determination of the amount of the benefit appealed. A hearing officer impartially reviewing the evidence before her, therefore cannot be precluded by a regulation from issuing a decision that orders a different "amount" of a Medicaid benefit than the MCO may have characterized was in issue.

Second, the amount of a Medicaid benefit that may be ordered by a hearing officer cannot be limited solely to the amount characterized in the plan's notice, because an enrollee has the right to a fair hearing on the *adequacy* of medical assistance. See 18 NYCRR § 358-3.1(b)(6). A hearing officer is charged with the review of medical assistance benefits with her expertise and judgement when adequacy is at issue, and thereby must consider all of the evidence without limitation. Language limiting the fair hearing decision to the appealed action or benefit unreasonably jeopardizes the right to a fair hearing on adequacy.

Third, the purpose of the fair hearing is for the hearing officer to impartially review the correctness of an MCO determination, which includes a review of the correctness of the plan's assessment of need. To the extent the ALJ determines that a MCO determination is incorrect, a hearing officer ought not to be constrained in ordering the amount of care that would have been authorized had the MCO correctly conducted the assessment of the enrollee's medical need. In making that determination the hearing officer must continue to have discretion and authority to order the amount of care that is actually medically necessary.

Further, a fair hearing decision on a medical benefit cannot be limited by the duration of benefits that was the subject of the Plan Appeal. First, such a limit is not practical. As exhaustion is mandatory, an enrollee must proceed through two levels of appeals and it may take months before a final decision on the merits. Any arbitrary authorization period may have lapsed before the fair hearing decision is issued. More importantly, a decision

[6] Compare 18 NYCRR 505.14(a)(4) with 18 NYCRR 505.14(a)(2).

[7] Another situation where the MCO notice mischaracterizes the amount requested is where two spouses both were enrolled in the same plan, with one aide assisting both spouses as a "mutual case." On paper, one spouse may have received 4 hours/day and the other 24/7 live-in, but both spouses benefited from having the aide 24/7. When the spouse authorized for the higher hours dies or is admitted to a nursing home, the plan often reduces the hours for the remaining spouse, under the pretext that this spouse was authorized on paper to receive fewer hours. That authorization, however, is a fiction, since the surviving spouse benefited from the mutual care plan. When the surviving spouse requests restoration of the 24/7 care the plan mischaracterizes the request as a request for an increase in hours, rather than as a reduction, a distinction with significant differences regarding burden of proof. The hearing officer must have authority to review the facts and determine what the issue is and not be constrained to the way the MCO framed the issue. See, e.g. DAFH 7918018Q, dated May 28, 2019.

after a fair hearing cannot be limited to a duration set out in an authorization period, as the MCO is bound by federal and state law requiring adequate and timely notice before reducing an enrollee's benefit.

Ultimately, to limit the hearing officer to the "amount or duration of benefits or services," under all circumstances, unfairly tilts the scales in favor of the MCO stripping appellants of the opportunity to argue the adequacy of medical benefits or to rebut the MCO's characterization of the Service Authorization request or review of the Plan Appeal.

For these reasons, the proposed § 360-10.8(i) (p. 23) should not be adopted in the final regulation.

9. Miscellaneous

Certain additions to the proposed regulation are redundant and should be removed as the rights and obligations set out in 18 NYCRR § 358 are incorporated into 18 NYCRR 360-10.8 where the provision is not inconsistent. See 18 NYCRR § 360-10.8(a). NYLAG recommends that the following proposals be stricken:

- Proposed § 360-10.8(f)(8) (p. 21) provides that an MCO may request a correction to a fair hearing decision. The opportunity to request a correction to a fair hearing decision under § 358-6.6 already applies to an MCO and therefore does not need to be added here.
- Proposed § 360-10.8(g) (p. 21) states that an MCO may request an adjournment if new evidence is presented at the fair hearing. An MCO may already request an adjournment for this reason under 18 NYCRR § 358-5.3(b) which allows the hearing officer in her discretion to adjourn a hearing when it is in the parties' due process interests. Despite proposed language such a regulation could prejudice *pro se* appellants who have the right to bring new evidence to a fair hearing. 18 NYCRR § 358-3.4(g). Taylor v. Bane, 606 N.Y.S.2d 112 (4th Dept. 1993). Accordingly, the proposed subdivision (g) is redundant and should be removed.

Thank you for the opportunity to comment on these important regulations, which outline the Plan Appeal and Fair Hearing procedure for millions of Medicaid beneficiaries in New York State receiving health benefits through their managed care plans. Because NYLAG's recommendations would substantially revise the proposed amended regulation, we request that a second round of notice comment be issued.

Sincerely,

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