NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Medicaid Managed Care Plans:

Service Authorizations and Appeals

Public Informational Webinar for Processes Effective 5/1/18

March 2018

Welcome

- This session is being recorded
- Several hundred participants, so all lines are muted
- If you have a question, please use the Q&A feature
  - We will answer as many questions as time allows
- The session may be closed after 500 participants
- We will post these slides, and answers to questions on the Department's website after the presentations

Goals for Today's Webinar

- Review New York's Medicaid managed care service authorization and appeal process for enrollees
- Key changes that start May 1, 2018 and apply to:
    - Medicaid Managed Care
    - HIV Special Needs Plan
    - Health and Recovery Plan (HARP)
    - MLTC Medicaid Plan
    - Medicaid Advantage
    - Medicaid Advantage Plus
  - Changes are in red throughout the presentation
  - Only discussing changes to enrollee appeal process; these slides are not a complete description/instructions for filing appeals and complaints
- Where to find more information and how to get help when an enrollee wants to appeal a plan decision or file a complaint

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Agenda

- Define common terms
- What regulations?
- New York Medicaid managed care plan service authorization and appeals
- Fair Hearings and External Appeals
- Medicaid managed care complaints
- Where to find more information and help

Definitions

Service Authorization

- There are some treatments and services that need to be approved by the plan before an enrollee can receive them or in order to continue receiving them.

- A Service Authorization request is when an enrollee or their provider asks a plan for approval for these treatments and services.

Initial Adverse Determination

- An Initial Adverse Determination is the written notice sent from the plan to the enrollee when:
  - The plan denies a service request or approves the request in an amount, duration, or scope that is less than what was requested
  - The plan decides to reduce, suspend or stop a service already being received
  - The plan denies payment for a claim

Reduction, Suspension & Termination

- When the plan makes a decision to reduce, suspend or stop a previously authorized service during the period for which the service was approved

- When the plan makes a decision to partially approve, reduce, suspend or stop the level or quantity of long term services and supports (LTSS) or nursing home stay in the next authorization period

Aid to Continue

- Applies when the plan makes a decision to reduce, suspend or stop a service
- An enrollee can ask for “aid to continue” unchanged, if they file a timely appeal or fair hearing. This means they can keep their services unchanged until there is a decision
- If the enrollee loses their appeal or fair hearing, they may have to pay for services they received while the appeal was being decided

Plan Appeal

- A Plan Appeal is when an enrollee asks the plan to look at the their case again

Final Adverse Determination

- A Final Adverse Determination is the written notice sent from the plan to the enrollee when the plan denies or partially denies the Plan Appeal

Fair Hearing

- A Fair Hearing is the chance for an enrollee to tell an administrative law judge why they think the plan's decision is wrong.
- The judge determines if the plan's denial is upheld or overturned
- The Fair Hearing decision will be final

External Appeal

- An External Appeal is an independent review of the enrollee's service request by qualified reviewers who do not work for the health plan or the state
- An External Appeal is available only if the plan's denial said the service was
  - not medically necessary
  - experimental or investigational
  - not different from care you can get in the plan's network, or
  - available from a participating provider who has correct training and experience to meet your needs
- An External Appeal determination is binding on the plan and enrollee, however, a Fair Hearing decision overrules an external appeal determination

What Regulations?

Laws and Regulations

New York's Medicaid managed care plans have to comply with many federal and state statutes designed to protect enrollee access to care and appeal rights

Federal

- Social Security Act
- Affordable Care Act
- Title 42 USC Chapter 7
- Title 42 CFR Chapter IV
- Title 29 USC Chapter 18
- Title 29 CFR Chapter XXV

State

- NYS Public Health Law
- NYS Social Services Law
- NYS Insurance Law
- Title 10 NYCRR
- Title 11 NYCRR
- Title 18 NYCRR

42 Code of Federal Regulations Part 438

- Today we are looking at the impact of a change made to 42 CFR 438
- We are only discussing the changes to Medicaid managed care:
  - Service authorization requests
  - Appeals
  - Aid continuing
  - Fair hearings, and
  - Complaints
- This was part of a major change to regulations published on May 6, 2016 by the US Health and Human Services Center for Medicare and Medicaid Services (CMS) for Medicaid and Children's Health Insurance Programs
- Because plans also have to follow New York State Law, 42 CFR 438 requirements are blended with State requirements for plans

New York's Medicaid Managed Care Appeal Process

Service Authorization Request

- A Service Authorization request is when an enrollee or their provider asks a plan for approval for treatments and services.
- The plan's member handbook lists which services require prior approval
- Doctors and other care providers often request approval on behalf of an enrollee
- Approval may be for a service, the location where the service is provided, a specific provider, and may specify a time period or amount.

Service Authorization Request

- Plans must respond to a service authorization and provide notice to the provider and enrollee within 14 days
- If the enrollee's health is at risk, the plan must Fast Track, and decide in **72 hours**
- If the request is for more of, or extension of, a service the enrollee is getting now – the plan will Fast Track these requests
- If the plan needs more information and its in the enrollee's best interest to delay, it may take up to 14 days longer to decide. The plan will notify the enrollee in writing if this happens.
- State law provides special timeframes for some requests; like home care after a hospital admission, and more inpatient substance use disorder treatment. These special times are listed in the plan's member handbook

Service Authorization Request

- The plan's decision may be to:
  - Approve
  - Partially Approve
  - Deny
- The plan will notify the enrollee by phone and in writing
- If the plan denies or partially approves the request, the written notice is called the Initial Adverse Determination

Reduction, Suspension, and Termination

- Part of the plan's job is to review care an enrollee is getting now, and make sure its still right for the enrollee
- The plan may send notice of an Initial Adverse Determination when:
  - When the plan makes a decision to reduce, suspend or stop a previously authorized service during the period for which the service was approved
  - When the plan makes a decision to partially approve, reduce, suspend or stop the level or quantity of long term services and supports (LTSS) or nursing home stay in the next authorization period

Initial Adverse Determination

- The enrollee's appeal rights are described in the Initial Adverse Determination, including:
  - the specific reason for the decision
  - If the enrollee thinks the plan's decision is wrong, they must first ask for a Plan Appeal, and allow time for an answer, **BEFORE asking for a Fair Hearing**
  - How and when to ask for a Plan Appeal, including an appeal form
  - How to get help understanding the notice and asking for an appeal
- The Department created model Initial Adverse Determination notices and appeal forms for plans to use
- The plan's member handbook has full information about the enrollee's appeal rights

Plan Appeals

- If the enrollee thinks the plan's decision about a service is wrong, the enrollee can ask the plan to look at their case again. This is called a Plan Appeal

Plan Appeals

- The enrollee has 60 days from the date of the Initial Adverse Determination to ask for a Plan Appeal
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Initial Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Plan Appeal and keep their service the same

- The Plan Appeal can be made by: mail, phone, or fax. The plan may also take requests in-person, by email, or online.

- If the enrollee asks for a Plan Appeal by phone, the enrollee must follow up in writing, unless the appeal will be Fast Tracked.

Aid to Continue

- If the plan decides to reduce, suspend or stop services the enrollee is getting now, the enrollee can ask to keep services they are getting the same while waiting for a decision. This is called Aid to Continue. If the enrollee loses the appeal, they may have to pay for services they received while the waiting for the decision

- **To keep their services the same, the enrollee must request a Plan Appeal within 10 days of the date of the Initial Adverse Determination, or by the effective date of the decision, whichever is later.**

- If the enrollee uses the Plan Appeal Request Form to ask for a Plan Appeal, the plan will keep the enrollee's services the same, unless the enrollee says they do not want to do this.

- Plans must also immediately provide Aid to Continue if the Office of Administrative Hearings (OAH) orders the plan to do so.

Plan Appeals

- The enrollee can choose someone else to ask for the Plan Appeal for them.
- This could be anybody, like a family member, doctor or representative. The enrollee and **that person must sign and date a paper saying the enrollee wants that person to ask for them**
- If the enrollee already told the plan that someone may represent them, that person may ask for the Plan Appeal

Plan Appeals

- To prepare for the Plan Appeal, the enrollee can ask to see, or ask for a free copy of, the guidelines, medical records and other documents the plan used to make the Initial Adverse Determination.

- During the Plan Appeal, the enrollee can present evidence to support their appeal in writing or in person. This may be any information that they want the plan to review, such as medical records, doctors' letters or other information that explains why the enrollee needs the service

Plan Appeals

- The plan must write to the enrollee to let them know the plan received the Plan Appeal
- The plan must send the enrollee a copy of the enrollee's **case file.** The case file has all the information the plan looked at about the service and the Plan Appeal

Plan Appeals

- The plan has 30 days to decide the Plan Appeal
  - Plans must send written notice within 2 business days of their decision
- Fast Track appeal are decided in **72 hours**
  - Enrollees are told the decision by phone. The written notice is sent within 24 hours of the decision.
- If the plan needs more information and its in the enrollee's best interest to delay, it may take up to 14 days longer to decide. The plan will to notify the enrollee in writing if this happens.

Plan Appeals

- After review of the Plan Appeal, the plan may:
  - Overturn the Initial Adverse Determination
    - This means the service will be approved, or the plan will not reduce, suspend or stop the enrollee's services
    - The plan must provide or approve the enrollee's services within 72 hours of the decision, or sooner if the enrollee's health requires it.
  - Partially Overturn the Initial Adverse Determination
    - This means the service will be only approved partially, or the plan decided to restore some of the services they planned to change. The enrollee has partially lost the appeal
  - Uphold the Initial Adverse Determination
    - This means the plan is not changing their decision. The plan decided to deny the request, or the plan will reduce, suspend, or stop the enrollee's services. The enrollee has lost the appeal

Final Adverse Determination

- If the enrollee lost, or partially lost the Plan Appeal, the plan will send the enrollee a Final Adverse Determination notice, including:
  - the specific reason for the decision
  - **Information about the enrollee's Fair Hearing rights**
  - For some decisions, the enrollee's right to External Appeal
  - Ways for the enrollee to get help understanding the notice and their rights.
- The Department created model notices for Final Adverse Determinations and a Fair Hearing request form for plans to use
- The plan's member handbook has information about the enrollee's Fair Hearing and External Appeal rights

Fair Hearings and External Appeals

Fair Hearings

- An enrollee can ask for a Fair Hearing about a plan decision **after** going through the Plan Appeal process. This means that the enrollee asked for a Plan Appeal and either:
  - Received a Final Adverse Determination; **or**
  - The time for the plan to decide the appeal has expired, including any extensions. If there is no response, or the response is late, the enrollee can ask for Fair Hearing. This is called **Deemed Exhaustion**

Fair Hearings

- If the enrollee thinks the Plan Appeal decision is still wrong:
  - The enrollee has 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Final Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Fair Hearing and keep their service the same

Aid To Continue

- If the plan decides to reduce, suspend or stop services the enrollee is getting now, the enrollee can ask to keep services they are getting the same while waiting for a decision. This is called Aid to Continue. If the enrollee loses the Fair Hearing, they may have to pay for services they received while waiting for the decision

- **To keep their services the same, the enrollee must request a Fair Hearing within 10 days of the date of the Final Adverse Determination, or by the effective date of the decision, whichever is later.**

- If the enrollee asks for a timely Fair Hearing, the Office of Administrative Hearings will order the plan to keep the enrollee's services the same, unless the enrollee says they do not want to do this.

Fair Hearings

- The Fair Hearing decision is final
- If the enrollee wins the Fair Hearing, the plan must provide or approve the enrollee's services within 72 hours of the Fair Hearing decision, or sooner if the enrollee's health requires it.

External Appeals

- An **External Appeal** is a review of the enrollee's case by health professionals that do not work for the plan or the state.

- An enrollee can ask for an External Appeal if the plan said the service was:
  - not medically necessary;
  - experimental or investigational;
  - not different from care you can get in the plan's network; **or**
  - available from a participating provider who has the necessary training and experience.

External Appeals

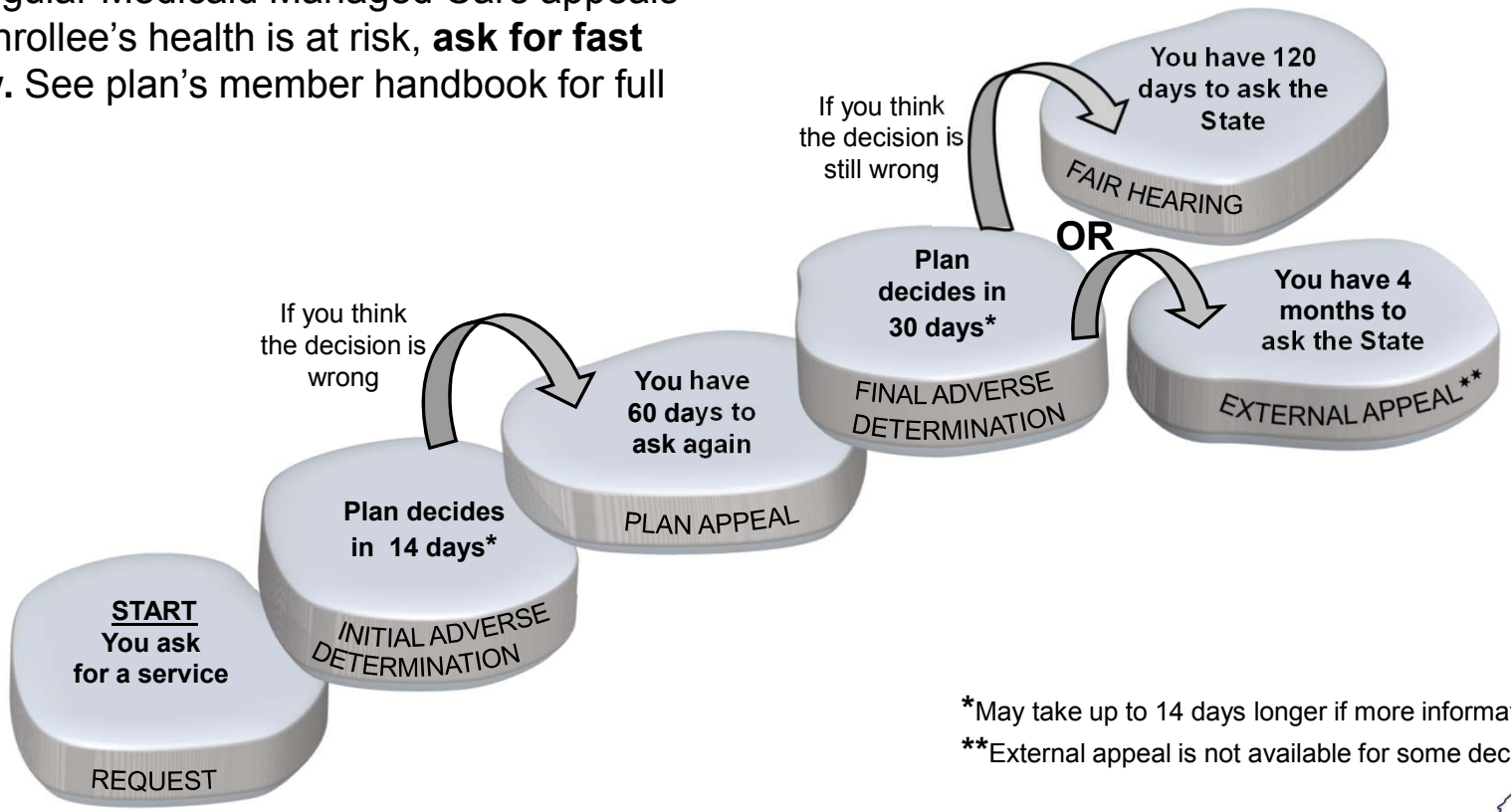
- Before asking for an External Appeal:
  - An enrollee must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
  - If the enrollee asks for a fast track Plan Appeal, he or she may also ask for a fast track External Appeal at the same time; **or**
  - The enrollee and plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

External Appeals

- The enrollee has 4 months to ask for an External Appeal from getting the Final Adverse Determination, or from agreeing to skip the Plan Appeal process.
- Requesting an External Appeal does not extend timeframes to ask for a Fair Hearing.
- There are no Aid to Continue rights provided by asking for an External Appeal.
- An enrollee can ask for both a Fair Hearing and an External Appeal, but the Fair Hearing decision will be the final answer

Steps to take if a service request is denied

This is the regular Medicaid Managed Care appeals process. If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



*May take up to 14 days longer if more information is needed

**External appeal is not available for some decisions

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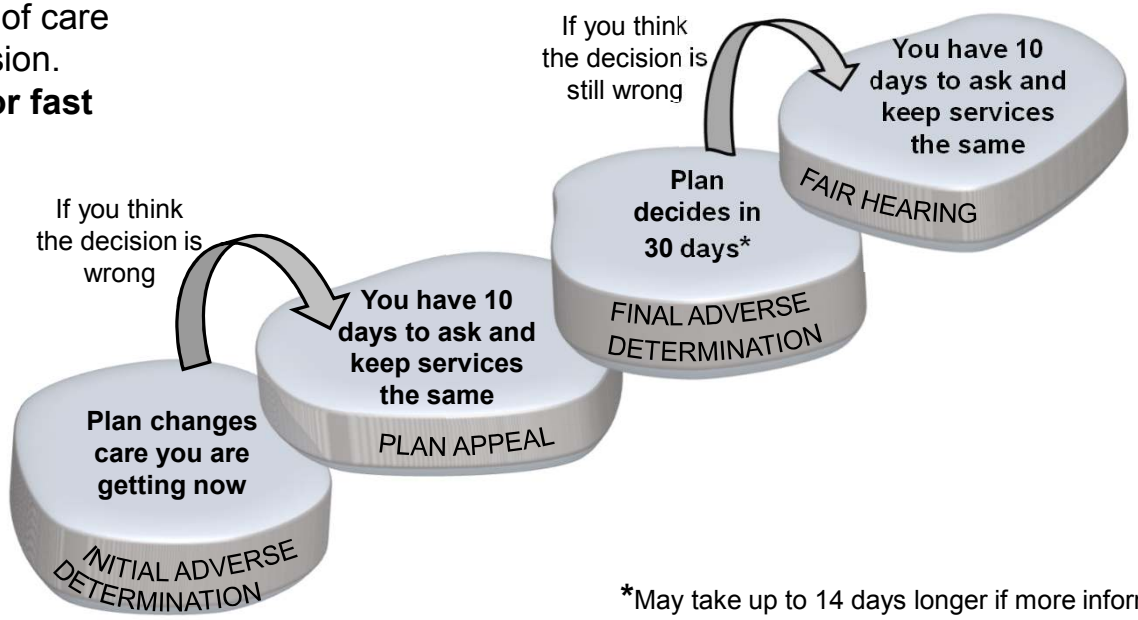
If plan decision is to reduce suspend or stop a service and enrollee wants to keep services the same during appeal

Enrollee may have to pay the cost of care received while waiting for the decision. If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



*May take up to 14 days longer if more information is needed

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Managed Care Complaints

Managed Care Complaints

- Enrollees may file a Complaint with the plan at any time verbally or in writing.
- Complaints may include:
  - How a service is being provided;
  - Choices for service providers within a plan's network;
  - Plans extending timeframes for service authorization decisions or appeals; or
  - Any other issue the enrollee has regarding the plan, its vendors, or its provider network

Managed Care Complaints

- The enrollee can choose someone else to file the complaint for them.
  - This could be anybody, like a family member, doctor or representative. The enrollee and **that person must sign and date a paper saying the enrollee wants that person to file for them**
  - If the enrollee already told the plan that someone may represent them, that person may file the complaint
- Plans must send written acknowledgement of a Complaint within 15 business days, unless it is immediately resolved (MMC-24 hours; MLTC same day). If additional information is needed to make a decision, this must be included in the acknowledgement letter.

Managed Care Complaints

- Plans must make a decision on the complaint and send written notice to the enrollee:
  - Fast Tracked- within 48 hours of all information being received; no longer than 7 days after the receipt of the Complaint
  - Standard- within 45 days of all information; no longer than 60 days from the receipt of the Complaint
- Notice of the acknowledgement and decision for a Complaint may be sent in the same letter if a decision is made within the timeframe for acknowledgement.
- The Complaint Resolution Notice must include the decision; the reason for the decision (including clinical information as appropriate) or explanation that a decision could not be made; and the right to file a complaint appeal with the plan or to file a complaint with the Department.

Complaint Appeals

- Enrollees have 60 work days to file a Complaint Appeal from the receipt of the Complaint Resolution Notice.
- Plans must send written acknowledgement of a Complaint Appeal within 15 work days. If additional information is needed to make a decision, this must be included in the acknowledgement letter.

Complaint Appeals

- Plans must make a decision on the Complaint Appeal and send written notice to the enrollee:
  - Expedited- within 2 work days of all information being received
  - Standard- within 30 work days of all information being received
- The Complaint Appeal Resolution Notice must include the decision, the reason for the decision (including clinical information as appropriate), the right to file a complaint with the Department, and, as applicable, information about any further appeal rights the plan offers.

Department of Health Complaints

- The Department maintains toll-free telephone lines that are available to anyone wishing to file a complaint regarding a New York State managed care plan's inadequate or inaccessible health care
- Enrollees may file a complaint with the Department of Health at any time.
- When filing a complaint:
  - Identify the plan and enrollee; and
  - Provide all related documents from/to the plan. Medical records are not necessary for initial submission of the Complaint.
- Issues not within the Department's jurisdiction may be referred to the appropriate agency.

Department of Health Complaints

Medicaid Managed Care Plans

Call:
1-800-206-8125

Email:
managedcarecomplaint@health.ny.gov

Managed Long Term Care Plans

Call:
1-866-712-7197

Email:
mltctac@health.ny.gov

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Summary of 42 CFR 438 Changes

Summary of Changes From 42 CFR 438

- New time frame for Fast Track decisions: 72 hours
  - Outpatient Pharmacy 24 hours
- Enrollee must first ask for a Plan Appeal and allow time for response, BEFORE asking for a Fair Hearing
- Enrollee has 60 days to ask for a Plan Appeal
- If plan decision is to reduce, suspend or stop a service, an enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination to keep their services unchanged until the decision (aid to continue)
- The enrollee must provide written authorization to designate someone, including their provider, to ask for a Plan Appeal or complaint on their behalf
- If no response to Plan Appeal or if response is late, the enrollee may ask for a Fair Hearing

Summary of Changes From 42 CFR 438

- New time frame for Fast Track appeal decisions: 72 hours
- Enrollee has 120 days from Final Adverse Determination to ask for a Fair Hearing
- If Plan Appeal decision is to reduce, suspend or stop a service, an enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination to keep their services unchanged until the decision (aid to continue)
- If Enrollee wins Plan Appeal or Fair Hearing, plan must authorize services in 72 hours

For more Information:

- Contact your plan at the number on your insurance card
- See your handbook insert
- See your plan's website

Questions?

438reg@health.ny.gov

Thank you!