"Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing—Started May 1, 2018

By Valerie Bogart

Introduction

Beginning May 1, 2018, members of Medicaid managed care plans in New York State, which include Managed Long Term Care (MLTC) plans, who wish to appeal an adverse determination by the plan must first request an internal "plan appeal" within their plan, and wait until the plan issues a decision on that appeal before they may request a Fair Hearing. This is called the "exhaustion" requirement, because the member must first "exhaust" the internal appeal available within the plan before requesting a State administrative Fair Hearing. 42 C.F.R. § 438.402(c). This article explains the new requirement, and an exception called "deemed exhaustion," which allows a request for a Fair Hearing before the plan decides an internal appeal.

Who Is Affected

This massive change in appeal rights affects 4.7 million Medicaid recipients in New York, 200,000 of whom are members of MLTC plans. When MLTC became mandatory in 2012 and rolled out statewide gradually over the next few years, exhaustion of internal appeals was required. In July 2015, the State lifted the exhaustion requirement entirely, allowing members to seek a Fair Hearing immediately to appeal an adverse plan determination.[1]

The vast majority of Medicaid managed care members in New York—4.5 million people—are members of "Mainstream" Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARP), or HIV Special Needs Plans (HIV SNP). Enrollment in these MMC plans is mandatory for most Medicaid recipients who do not have Medicare or other primary insurance. While most people in these plans are under 65 and have Medicaid through the Affordable Care Act, some plan members are seniors or people with disabilities who either receive SSI or have no income at all, and who are not eligible for Medicare, usually because of immigration status. These seniors and people with disabilities obtain all medical care through the MMC plan, including personal care and other Long Term Services and Supports, They will also be required to request an internal plan appeal first to contest a proposed reduction or discontinuance of any long-term care services.[2] Notably, "exhaustion" has never been required in the over 20 years that managed care has been mandatory for the non-Medicare population.

Primary Concerns

Educating Millions of Plan Members, Their Families and Representatives

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As New York implements this new requirement, there are concerns that 4.7 million people will not be adequately informed of this huge change. While plans' notices of adverse determinations have been modified to explain the new requirement, despite attempts to make the long, dense notices understandable to consumers in English and other languages, many will not read or understand the entire notice. Many will not show the complete notice to their family or representative—or will show the representative the notice in a foreign language that the representative does not understand.

Just educating the elder law bar, legal services advocates, and private geriatric care managers is a daunting task, let alone the huge network of social workers in hospitals, senior centers, and other community-based organizations. Lawyers and other professionals in the habit of requesting a Fair Hearing immediately must learn to request an internal plan appeal first instead of a Fair Hearing.

Barriers to Filing Appeals—Risk of Denial of Aid Continuing

The stakes are especially high when the plan proposes to reduce or discontinue personal care or other long-term care services. The right to Aid Continuing has been a key element of due process since the seminal case of *Goldberg v. Kelly*. 397 U.S. 254 (1970). It has always been a challenge to file the appeal request within the short 10-day window between the date of the notice and the effective date of the reduction. Now, the appeal must be filed with a managed care or MLTC plan that may not have trained its call center staff to route these requests to ensure timely filing. Anyone who has tried to call the member services 800 number of an insurance plan knows a call may easily be misrouted. The New York State Office of Temporary Disability Assistance [OTDA] should educate people who mistakenly request hearings about the new requirements, but has said it will not assist them in requesting a plan appeal. As a result, it is likely that home

care will be reduced—with no Aid Continuing—for MLTC members whose hearing requests will ultimately be dismissed, months after they requested them, for failure to "exhaust."

There are four additional barriers to filing the appeals, putting Aid Continuing at risk, all discussed at length below.

First, requests made orally must be confirmed in writing, unless an "expedited" appeal is requested. Fortunately, the regulations provide that the date of the oral request locks in Aid Continuing. 42 C.F.R. § 438.402(c)(3)(ii).

Second, the consumer must either sign the appeal or hearing request or designate, in writing, a representative to request the appeal or hearing. 42 C.F.R. § 438.402(c)(ii). This burdensome requirement is a departure from the state OTDA practice of allowing anyone to request a Fair Hearing on an individual's behalf, whether as a "representative," or as a mere "requester." See OTDA request form at http://otda.ny.gov/hearings/forms/request.pdf.

Third, plans—and not OTDA—are now the arbiter of whether Aid Continuing applies, at least at the initial level of the plan appeal. Will MLTC plans provide Aid Continuing where, for example, the plan's adverse notice is defective or was untimely—as OTDA has historically ruled in such cases? The federal regulations define at least one circumstance that warrants "deemed exhaustion," allowing a Fair Hearing request without exhausting the plan appeal. 42 C.F.R. § 438.408. That is where the plan failed to decide the internal plan appeal by the deadline. However, CMS permits states to deem exhaustion on a broader basis than does the final regulation, but the State has not done so to date. See note 5, *infra*, at p. 27510 and discussion in the next section below.

Fourth, if the decision after the internal Plan Appeal decision is adverse, the consumer must *again* appeal in the short time limit to get Aid Continuing. While the second appeal is a request for a Fair Hearing, which is familiar to the elder law bar, this is now a second hurdle for consumers, requiring them to respond quickly to request appeals *two times.* Also, this request must comply with the new requirement that the consumer make or sign the hearing request or give written consent to a representative to sign it.

I. Background—Revision of Federal Regulations in 2015-2016

This change in appeal rights is required by federal Medicaid regulations, as amended in 2016. In 2015, the Obama Administration initiated a formal rulemaking process to amend the Medicaid managed care regulations, which had last been amended in 2002.[3] After hundreds of comments were filed, by organizations including the National Health Law Program[4] and the New York Legal Assistance Group, the final regulations were adopted in 2016.[5] The regulations on grievances and appeals are at 42 C.F.R. Part 438. The regulations are effective on various dates in 2017. The effective date for the exhaustion requirement in New York's appeal system was extended to May 1, 2018.

The impetus for the revision was the expansion of Medicaid managed care from being a small demonstration program covering limited primary care services for families and children in the 1990s, to the principal model for delivering all Medicaid services for all populations, including Long Term Services and Supports (LTSS) for the elderly and disabled. Grievance and appeals systems are just one of many aspects of managed care affected by the amendments to the regulations. For summaries of the other changes, see the National Health Law Program series of seven issue briefs on the revisions.[6]

In its explanation of requiring "exhaustion" in the final regulation, CMS described its desire to align Medicaid appeals with those enrollees will experience in private health insurance as well as in Medicare Advantage.

> While we understand commenters' concerns and recommendations regarding direct access to a state Fair Hearing for vulnerable populations, we also have concerns regarding inconsistent and unstructured processes. We believe that a nationally consistent and uniform appeals process (particularly one consistent with how other health benefit coverage works) benefits enrollees and will better lead to an expedited resolution of their appeal.

81 Federal Register 88 at p. 27509 (May 6, 2016). The notion that Medicaid recipients flow back and forth from Medicaid to employer-based insurance to Qualified Health Plans through the ACA underlies many of the changes made, including the exhaustion requirement. Advocacy groups, including NYLAG, had opposed the exhaustion requirement, arguing that it would cause delay in accessing Fair Hearings, would put Aid Continuing rights at risk, and would confuse beneficiaries accustomed to requesting hearings directly on Medicaid eligibility issues. NYLAG comments pointed out that exhaustion had been confusing and harmful when it was required in New York briefly for MLTC until 2015.

CMS claimed that any delay in accessing Fair Hearings caused by the exhaustion requirement was mitigated by shorter deadlines for plans to decide appeals (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 Federal Register 88 at 27510. CMS' preamble to the final regula-

tions states, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." *Id*. As of June 29, 2018, the State has not responded to advocates' request to apply deemed exhaustion in other circumstances, such as when the plan fails to send any written notice, or sends a notice that is not timely and adequate, failing to comply with all requirements including language access and state DOH guidance.[7]

II. New York State Rulemaking and Policy Guidance on New Exhaustion Requirement

State regulations on managed care appeals have not yet been amended to incorporate the federal changes, so they should not be relied upon. 18 N.Y.C.R.R. Part 360-10. The New York State Department of Health [DOH] convened a Service Authorizations and Appeals Stakeholder Workgroup in 2017 to elicit stakeholder input on implementing the exhaustion requirement and other federal changes. Stakeholders included representatives of the MLTC and mainstream managed care plans and consumer advocates, including NYLAG. The Workgroup was led by administrators in two different divisions of DOH—one that oversees mainstream plans and one that oversees MLTC plans.

The Workgroup focused on revising the adverse notice templates, which are now posted on a new webpage called "Service Authorizations and Appeals," available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. These templates must be used by both mainstream managed care and MLTC plans for Initial Adverse Determinations, which must be appealed to a plan appeal, and Final Adverse Determinations, which state the plan's decision after the plan appeal, which may be appealed to a Fair Hearing. New Appeal Request Form and Fair Hearing Request Forms for MLTC and other managed care appeals are included in the new model adverse notices. Since these forms will be pre-populated with information about the client's appeal, it is recommended that they be obtained from the client and used to file the appeal request.

Beside the notice templates, policy guidance is being issued both separately and jointly by the two DOH divisions that oversee the two types of Medicaid managed care plans—one for MLTC plans and one for plans for Medicaid recipients who do not also have Medicare—Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP). The division overseeing mainstream Medicaid managed care has conducted webinars and posted policy guidance and Frequently Asked Questions for plans. These are all available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. The "Information for ALJs" posted on that webpage is for both MLTC and mainstream plans.

Policy guidance from the MLTC division is posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm. This includes a webinar "presentation" for MLTC plans, FAQ's dated Jan. 29, 2018 (and revised Mar. 14, 2018). Additionally, the guidance posted for Mainstream MMC plans should be binding for MLTC plans since it is issued by the same state agency, which is the Single State Agency that administers the New York Medicaid program. 42 U.S.C. § 1396a(a)(5).

Health care providers received a Medicaid Update article on the change, posted at https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc.

In March 2018, members of all managed care and MLTC plans received a letter from their plan with a revised Member Handbook chapter on appeals. The Member handbook is incorporated in the plans' contract with NYS DOH. Most plans post this handbook on their websites. Unfortunately, many plans posted the amended section on appeals separately, leaving the old Member handbook posted on their sites with the old appeal rules. This will lead to confusion since the old Handbook does not explain the new exhaustion requirement. See, e.g. https://www.fideliscare.org/Products/FidelisCareatHome(MLTC).aspx (last accessed 6/29/18).[8]

NYLAG's article on appeals in MLTC Plans will be updated to include links to any guidance issued by NYS DOH, available at http://www.wnylc.com/health/entry/184/.

III. Definitions and Types of Notices; Appeal vs. Grievance

The exhaustion requirement specifically states, "An enrollee may request a State Fair Hearing after receiving notice under §438.408 that the adverse benefit determination is upheld." 42 C.F.R. § 438.402(c). These terms are defined below. Appeals and grievances are also distinguished.

An **Appeal** is a request to review an **adverse benefit determination** made by a plan.[9] In New York, the notice of a plan's adverse benefit determination is called an **"Initial Adverse Determination" (IAD).** The plan must use the new notice templates issued by DOH.[10] *Adverse benefit determination* means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.

3. The denial, in whole or in part, of payment for a service.

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

5. The failure of a plan to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

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

7. The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities**.**

42 C.F.R. § 438.400(b). Thus an MLTC plan must issue a Notice of Initial Adverse Determination when it proposes to:

1. Reduce or stop personal care, adult day care, or other services, or

2. Deny a request for a new service, such as Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing, or

3. Deny or partly deny a request to increase hours of personal care services or other services

If the plan decides the appeal in whole or in part adversely to the consumer, it must issue a notice of **"Final Adverse Determination" (FAD),** which explains the reason for the decision and explains the right to request a Fair Hearing. 42 C.F.R. § 438.408.

Grievance—which DOH is calling a "**complaint**"—means "an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by [the plan] to make an authorization decision." 42 C.F.R. § 438.400(b). EXAMPLES of grievances that may be filed with MLTC plans as complaints include:

1. The aide or transportation is late or does not show,

2. The aide is poorly trained or otherwise does not provide quality care,

3. Member cannot reach care manager by phone, or care manager does not respond or was rude.

4. Member disagrees with plan's decision to extend time to decide a request for new or increased services.

Grievances/Complaints may not be appealed to a Fair Hearing, but may be appealed internally in a Complaint Appeal. DOH has posted a model template for a Complaint Appeal Resolution Notice and for a Complaint Resolution Notice. See https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

IV. More on Initial Adverse Determinations—Reductions and Denials

Because Aid Continuing requires special notice content, timing and procedures, Initial Adverse Determinations (IAD) for plan REDUCTIONS or discontinuance of services will be discussed separately from DENIALS of new or increased services.

A. Focus on Reductions in Hours or Services

After a plan sends an Initial Adverse Determination (IAD) to reduce or discontinue a service, Aid Continuing is only granted when the Plan appeal is requested before the effective date of the IAD. As has been true since *Goldberg v. Kelly*, *supra*, the plan need only mail the notice 10 days in advance of the effective date.[11] With mailing time and weekends, the consumer may well only receive the notice a day or two before the deadline to request the internal appeal. Clients should be advised to always keep the envelope in which notices are mailed. If the postmark is dated later than the mailing date, this can be a ground to obtain Aid Continuing based on untimely notice, even if the appeal is requested after the effective date of the reduction.[12] In the past, advocates successfully made that argument to OTDA. Now, the argument must be made to the plan itself—the same one that mailed the notice late.

i. Aid Continuing required even if the latest authorization period has expired

Managed care plans authorize services for specific authorization periods, which for MLTC plans may range up to six months. If a plan has authorized 24-hour/7 day personal care services for a period that expires on December 31, the prior federal regulations arguably allowed the plan to end or reduce that service authorization effective December 31, precluding the consumer from receiving Aid Continuing because the authorization period expired. The amended regulations end this practice, entitling the consumer to Aid Continuing regardless of whether the authorization period for the contested service ends during the course of the appeal, as long as it had not expired at the time the appeal or hearing was requested. 42 C.F.R. §438.420(b)-(c). Additionally, to protect New York Medicaid recipients from the harshness of the former version of the federal regulations, the legislature amended the Social Services Law in 2015 to guarantee

that Aid Continuing is required regardless of whether the authorization period expired. N. Y. Social Serv. L. 365-a, subd. 8.

ii. Practitioners should become familiar with the new initial adverse determination (IAD) notices

The DOH templates for the IAD notices, while adopting many recommendations made by NYLAG and other advocates, may still be confusing to consumers, their families and representatives.[13] The notices are in the form of a letter, rather than of a traditional notice. Here is the first paragraph of a hypothetical reduction notice dated May 1, 2018:

> 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 June 30, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal 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.

In this example, May 11 is the effective date of the proposed action and the deadline to request the appeal to secure Aid Continuing, yet appears in the notice only *after* the plan appeal deadline—60 days from the date of the notice or June 30. This may mislead consumers into thinking they have plenty of time to appeal, obscuring the 10-day time limit to secure Aid Continuing. Also, the language explaining the deadline to get Aid Continuing (May 11) is subtle—"If you want to keep your services the same until your Plan Appeal is decided…" The language may not be clear to members.

The content of a notice to reduce services must comply with other precedent that requires a change in the consumer's medical condition or other circumstances that justify the reduction. A key authority is NYS DOH MLTC Policy 16.06, see note 7, *infra*. This is an important directive for practitioners opposing a proposed reduction. The directive clarifies the limited reasons why a plan may reduce personal care services, and requires very specific facts in the notice justifying the reduction. Permitted reasons include a change in the medical condition or social circumstances that result in needing fewer hours, not merely the fact that the plan conducted a new assessment that determined fewer hours are needed. The directive also clarifies that "mistake" may only rarely justify a reduction. The directive is rooted in a lawsuit brought against the New York City Medicaid program in the 1990s, challenging a pattern of arbitrary reductions in personal care hours. *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996). That decision was codified in state regulation, which applies to MLTC plans. 18 N.Y.C.R.R. § 505.14(b)(5)(c).

The lack of an adequate justification for reducing services, and lack of specificity of an alleged justification in the plan's notice, has been a frequent basis for reversal of proposed reductions in Fair Hearings.[14] Will a plan, reviewing its own proposed reduction and notice, critically review the content of the notices against the applicable standards? It seems doubtful, even though the plan employee conducting the plan appeal must have been "neither involved in any previous level of review or decision-making nor a subordinate of any such individual." 42 C.F.R. § 438.406(b)(2). NYLAG and other advocates have asked the state DOH and OTDA to include the inadequacy of an IAD as a ground for waiving exhaustion through "deemed exhaustion".

Plans also may fail to send any notice at all, giving only oral notice, or may send the notice less than 10 days in advance of the proposed effective date, making the notice untimely and defective. Practitioners should advise clients to keep all envelopes in which plan correspondence is mailed. The postmark may show that the notice was not mailed until days after the date of the notice. If the right to Aid Continuing is not recognized by the plan, this postmark should convince them that the notice was untimely. In such cases, if the plan will not authorize Aid Continuing, advocates should request a Fair Hearing and ask OTDA to apply "deemed exhaustion" and order Aid Continuing because the initial IAD notice was untimely. Also, complaints can be made in such cases to the New York State DOH MLTC Complaint Line: 1-866-712-7197 or e-mail mltctac@health.ny.gov. NYLAG is interested in hearing about these cases.

B. Initial Adverse Determinations—Denial of a New Service or of an Increase in a Service

If a plan member has requested a new service, or an increase in services, such as an increase in hours of personal care services, the federal regulations specify deadlines for the plan to issue determinations on these requests, which the consumer may then appeal in a "plan appeal."

i. Background—how to request an increase or a new service—"Service Authorization Request"

A "Service Authorization Request" is a request by or on behalf of a member to increase an existing service or to authorize a new service. 18 N.Y.C.R.R. § 360-10.3(o). The federal regulation for managed care service authorizations was also amended in 2016. 42 C.F.R. § 438.210.

The deadline for the plan to issue a written Initial Adverse Determination notice on these requests depends on whether "expedited" review was requested. For standard requests, the plan decision must be issued within 14 calendar days from the date of the receipt of the request,

but the plan may extend that time for another 14 calendar days on the member's request or if the plan "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." § 438.210(d). The member, or her provider, may request that the plan expedite a decision.

> For cases in which a provider indicates, or the [plan] determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the [plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

42 C.F.R. § 438.210(d)(2). The plan may extend the time to decide an expedited decision by up to 14 calendar days, on the same basis as extending the time for a standard request.

Advocacy Tip—A request for an increase in hours or other services or for a new service should be made in writing, or if made orally, should be confirmed in writing. This would start the clock for the plan to make a decision following the deadlines above. Additionally, a statement from a physician or other medical professional is recommended to substantiate the increase or need for the service. The request can be made by calling Member Services or by FAX or certified mail. If the request is made in person with the care manager or at the in-home bi-annual nursing reassessment, ask the nurse or care manager to acknowledge receipt on the member's copy.

ii. Initial Adverse Determination of Service Authorization and Plan Appeal

The plan must use the State-required template for the IAD notice.[15] Under the new rules effective May 1, 2018, the member will have 60 calendar days to request a Plan Appeal (internal appeal) from the date of the notice. This is an increase from 45 days under the old rules before May 1, 2018.

The plan is required to send a notice of decision on a service authorization request "on the date that the time frames expire," 42 C.F.R. § 438.404(c)(5), or the plan must send written notice it is extending the deadline by up to 14 days. 42 C.F.R. § 438.408(c)(2). If the plan fails to issue an IAD notice, or give notice of extension of the deadline, this constitutes a "denial and is thus an adverse benefit determination." *Id.* The member may request a Plan Appeal.

C. Nuts and Bolts of Filing PLAN APPEALS of an Initial Adverse Determination (IAD)

DOH is requiring plans to accept appeal requests by phone, fax, or mail. Plans have the option of also accepting appeal requests by e-mail or online. The phone and fax number mailing address, and at plan option, email address and online portal, should all be on the plan's IAD notices, but are not posted on all plan websites or Member Handbooks. The IAD Notice template includes a Plan Appeal Request Form, which is pre-populated with information about the member and the issue. This Appeal Request Form should be used if available. However, two new strict requirements for filing appeals must be heeded in order to ensure timely filing and, in cases of reductions, ensure Aid Continuing. First, an oral request must be confirmed in writing, unless it requests an expedited appeal. Second, the consumer must sign the written request, or authorize a representative in writing to request the appeal. Both of these new requirements are described below.

i. Oral appeal must be confirmed in writing unless it requests expedited appeal

"Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal." 42 C.F.R. § 438.402(c)(3). In other words, if a request is made by phone, unless the member, her provider or representative requests that the appeal be expedited or "fast tracked" (defined below), the phone request must be followed up by a written appeal request. Providing some relief, the regulation provides that "…oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." 42 C.F.R. § 438.402(c)(3). The phone call requesting the appeal, therefore, if made before the effective date of a reduction, locks in Aid Continuing.

An FAQ issued by State DOH regarding this regulation provides guidance as to the consequence of not confirming an oral appeal in writing:

> FAQ 5. How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?
>
> Enrollees must follow verbal requests in writing unless the request is for an expedited Plan Appeal. 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 Ap-

> peal, and the plan must make a determination even if a written Plan Appeal is not received.

DOH FAQ No. V. 5, dated Feb. 7, 2018.[16]

The federal regulation does not require written confirmation of an oral appeal request if an expedited appeal is requested. An appeal is expedited (fast-tracked) 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 C.F.R. § 438.410(a). The language implies that a *provider's* request that the appeal be expedited is binding on the plan, while the plan must determine whether it agrees that a the appeal must be expedited when requested by the *member.*

ii. Client must sign the appeal request or give written authorization for a representative to file request

The new federal regulations require the member to file the appeal request directly, and only allows a health care provider or an authorized representative to request an appeal, grievance, or a State Fair Hearing on the enrollee's behalf "with the written consent of the enrollee." § 438.402(c)(1)(i) and (ii). Additionally, "providers cannot request continuation of benefits as specified in § 438.420(b)(5)"—referencing Aid Continuing. *Id*. A legal practitioner, geriatric care manager, or even a family member must obtain the client's signature to show her consent for the representative to request the appeal or Fair Hearing, which will likely delay filing an appeal request. The model Appeal Request Form asks for the signature of both the enrollee and the "requester." As a result, the client could miss the deadline to request Aid Continuing and her home care hours could be reduced.

However, the DOH model Notice template states, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal."[17] The model Appeal Request Form has a checkbox to indicate "yes" or "no" to the question, "Have you authorized this person with [Plan Name] before?" If the practitioner or a family member had been authorized before, attach any written authorization or explain when and how the authorization was made on an attachment to the request.

NYLAG has created an Authorization form on which a client can authorize her attorney, a family member, a neighborhood organization, the ICAN Ombudsprogram (www.icannys.org), or all of the above, to request plan appeals and Fair Hearings and, if applicable, represent her in such appeals. Form is available at http://www.wnylc.com/health/download/646/. The practitioner should have all clients sign the form before there is a crisis, keep the signed copy on file, and give a copy to client and the family member. The form should be sent to the plan return receipt requested, or given to the care manager, with the care manager asked to sign the client's copy to acknowledge receipt. Attach a copy of the signed authorization to the appeal request, and check YES to the question, "Have you authorized this person with [Plan Name] before?"

The state DOH has issued two FAQs regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. These FAQs do not expressly apply to MLTC plans, since they were issued by a separate division within DOH that oversees Mainstream Medicaid Managed Care (MMC) and not MLTC plans. However, as stated above, the policy should be binding on MLTC plans as well.

In the original FAQ issued by DOH to managed care plans, Question V. 8 provides:

> 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?
>
> 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 the decision under dispute and such authorization has not expired.[18]

This FAQ is important for several reasons. First, the plan must process the appeal request—and presumably comply with Aid Continuing—even if it has not received the member's written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, DOH acknowledges the plans' duty to provide reasonable accommodations of such disabilities. These must include policies and procedures to recognize "previously designated representatives, and establish-

ing designation of a representative where the enrollee cannot provide written authorization due to an impairment." *Id*. The model Appeal Request Form incorporates this policy by stating, "If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal."

A Supplemental FAQ, also issued by the DOH division that oversees "mainstream" Medicaid managed care plans, states that Aid Continuing will not be provided if the appeal is requested by a health care provider, unless the enrollee has authorized the provider as their representative.

> FAQ IV. 2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?
>
> 42 C.F.R. § 438.402(c)(1)(ii) requires the enrollee´s written consent for the provider or authorized representative to file a Plan Appeal on the enrollee´s behalf. 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, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.[19]

The prohibition on a health care provider requesting Aid Continuing, unless specifically authorized by the plan member, reflects a suspicion that providers are acting in their own interests in receiving payment for services and not in the interests of the member.

iii. Appellant's potential liability to repay cost of services received as Aid Continuing—and appeal request form checkbox to indicate that Aid Continuing is not requested

It has always been true that a Medicaid recipient may be held liable to pay for services received as Aid Continuing, if the recipient is ultimately found, after a hearing, not eligible for those services. As before, the revised federal managed care regulations provide:

> (d) *Enrollee responsibility for services furnished while the appeal or state Fair Hearing is pending.* If the final resolution of the appeal or state Fair Hearing is adverse to the enrollee, that is, upholds the [plan's] adverse benefit determination, the [plan] may, consistent with the state's usual policy on recoveries under 431.230(b) of this chapter and as specified in the [plan's] contract, recover the cost of services furnished to the enrollee while the appeal and state Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

42 C.F.R. § 438.420(d). New York's model contract for MLTC plans has language in the *Member Handbook* advising the member that "if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing."[20] Both the Initial and Final Adverse Determination Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 C.F.R. § 438.404(b)(6).

The federal regulations arguably allow states to limit Aid Continuing to those appellants who specifically request Aid Continuing when they file the appeal. New York continues to take a more liberal view and presumes that the appellant is requesting Aid Continuing unless they indicate otherwise. Hence, the model Appeal Request Form has a checkbox to indicate, "I do not want my services to stay the same while my Plan Appeal is being decided."

Though clients should be advised about the potential liability to repay services provided with Aid Continuing if they ultimately lose the Fair Hearing, they should also be advised about the high probability that they will win their appeal of a reduction, at least for personal care or CDPAP services. In a study analyzing all Fair Hearing decisions posted on the OTDA online archive involving reductions of home care hours by MLTC plans in the last seven months of 2015, MLTC plans prevailed in only 1.2 percent (13 out of 1,027) of the hearings.[21] The report explains the law and policies governing plan reductions, including the plan's burden of proof that a reduction is justified by a change in the medical condition or other circumstances. Since that Report was issued, the client's ability to defeat a proposed reduction in hours has been strengthened by additional State policy directives.[22]

If a member loses the plan appeal, DOH policy allows plans to begin recovery of the cost of Aid Continuing services 10 days after the adverse FAD is issued, if the member has not requested a fair hearing by that date. If the member then requests a hearing within the 120-day

statute of limitations, the plan must halt recovery pending the Fair Hearing decision.[23]

D. When Must Plan Decide Standard Appeals and Expedited Appeals—and Member's Right to Request Fair Hearing if Plan Does Not Meet Deadlines (Deemed Exhaustion)

Where delay is harmful to the client, such as where the client is seeking an increase in home care hours or a new service, or does not have Aid Continuing on a reduction, the practitioner will need to monitor the plan's compliance with the regulatory deadlines for deciding the plan appeal, and oppose any extension of the deadline that does not comply with the regulations described below. Importantly, the plan's failure to comply with the deadlines set forth below constitutes grounds for "deemed exhaustion," allowing the member to request a Fair Hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i).

The Deadlines. A standard appeal must be decided by the plan within **30 calendar days** of receipt of the appeal request, subject to an extension of up to **14 calendar days** described below. 42 C.F.R. § 438.408(b). The member or her provider or representative has the right to request an expedited or "Fast Track" appeal, if "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 C.F.R. § 438.410. An expedited appeal must be decided within **72 hours** after the plan receives the appeal, subject to the same 14-day extension as for standard appeals. 42 C.F.R. § 438.408(b).

Extension of the Deadline. The Plan may extend its time to decide a standard or expedited appeal by up to 14 calendar days if the enrollee requests the extension, or if the plan "shows (to the satisfaction of the State agency, upon request)that there is need for additional information and how the delay is in the enrollee's interest." 42 C.F.R § 438.408(c). The regulation does not explain by what procedure the extension would be approved to the State agency's (DOH) satisfaction, but presumably the enrollee would utilize the existing DOH MLTC Complaint Line—1-866-712-7197 or email mltctac@health.ny.gov**.**

If the "… plan extends the timeframes not at the request of the enrollee, it must complete all of the following:

i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.

ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

42 C.F.R § 438.408(c)(2). DOH has issued a model Notice of Extension for plans to use to fulfill the requirement above.[24]

If a member or her representative wishes to dispute an extension, from the regulations above, the member may file a grievance with the plan and/or file a complaint with the State DOH at 1-866-712-7197 or e-mail mltctac@health.ny.gov.

The plan's failure to comply with the deadlines set forth above constitutes grounds for "deemed exhaustion," allowing the member to request a Fair Hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i). The hearing request could be requested either 72 hours after a request for expedited review was filed, or 30 days after a standard appeal was filed, subject to the 14 day extension if warranted.

V. Member Rights in Plan Appeal

While practitioners may not have utilized the internal Plan Appeal process when it was optional, going instead directly to a Fair Hearing, now there is no choice but to use it. At best, the client will win the plan appeal and no Fair Hearing will be necessary. Even if not favorably decided, the plan appeal provides an opportunity to obtain the plan's case file, and to provide additional documentation in support of the claim to the plan, with no harm to the client if there is Aid Continuing. At worst, the plan appeal can cause great harm to the client, adding extra delay until a Fair Hearing is held and decided, which can be harmful when an increase is being requested or services are reduced without Aid Continuing.

i. Plan must provide case file to enrollee and representative without request

In the past, the plan only had to provide the case file upon request. Under the new regulation, the plan must:

> 5) 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 … (or at the direction of the [plan] in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §§ 438.408(b) and (c).

42 C.F.R. § 438.406(b)(5). NYS DOH has issued several FAQs to clarify the plan's duty to provide the case

file while the plan appeal is pending. See *Supplemental* NYS DOH FAQ, *infra*, note 19.

2. Is it the State´s expectation that Health Plans will send a case file upon every request for a Plan Appeal (standard and expedited) requests?

> Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.

3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?

> 42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.

4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical Fair Hearing evidence packet?

> The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal. Upon receiving a Plan Appeal, the plan must automatically send the enrollee´s case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally–generated documents but does not necessarily generally include all medical records that may be in the plan´s possession. The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the Fair Hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the Fair Hearing request from OAH.

If you want the file to be provided directly to the representative, submit a signed HIPPA release—OCA Form No. 960—Authorization for Release of Health Information Pursuant to HIPAA, available at http://www.nycourts.gov/forms/Hipaa_fillable.pdf.

ii. Right to present new evidence in person or in writing

Plan must consider new evidence submitted in support of the appeal "…without regard to whether such information was submitted or considered in the initial adverse benefit determination." 42 C.F.R. § 438.406(b)(2)(iii).

The plan must provide the 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. 42 C.F.R. § 438.406(b)(4)

TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if the appellant or her representative wants to include additional documents with the appeal request, or to give information in person. The member or representative could also write on the form that they request time to submit additional written documentation.

iii. Reasonable accommodations to help with 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 C.F.R. § 438.406(a).

iv. Appeal must be decided byindividuals who were not involved in initial decision

The plan appeal must be decided by individuals:

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

42 C.F.R. §§ 438.406(b)(2)(i) and (ii).

VI. Plan's "Final Adverse Determination" (FAD) After the Plan Appeal and Request for Fair Hearing

DOH has issued a model notice template for a Final Adverse Determination (FAD), which is a Plan's decision after the plan appeal that is wholly or partially adverse to the member. Practitioners should note that the word "Final" on the notice means that this is the decision after the Plan's plan, meaning that the member has met the exhaustion requirement and may request a Fair Hearing.

Where the appeal involves a reduction in home care hours or other services, the FAD Notice is both a decision explaining the reason for denying the appeal AND a new Notice of Reduction, which again must be provided 10 days before the effective date of the proposed reduction. A Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action, in order to secure Aid Continuing. In the state's model FAD notice template,[25] note that the "effective date" is listed *after* the statute of limitations for requesting a Fair Hearing, which is now 120 calendar days. 42 C.F.R. § 438.408(f)(2). This placement may cause members to delay seeking representation or requesting a Fair Hearing. Of course, it is crucial to request a Fair Hearing within 10 days of the notice date, and not wait for the 120-day statute of limitations.

Where the effective date has already lapsed by the time the member has consulted an attorney, one strategy is to obtain the postmarked envelope in which the notice was mailed. If it was not mailed 10 days in advance of the effective date, Aid Continuing should be awarded. See endnote 11, *infra*. Another strategy is to look for other defects in the notice content. See, e.g., the Medicaid Matters NY Report on MLTC Reductions, *infra*, n. 14 for more information.

The next step is to request a Fair Hearing. Hearings may be requested by the same modes as in the past, see http://otda.ny.gov/hearings/request/. Just like for Plan Appeals, the new regulations require the member to SIGN the request, or authorize a representative to do so. See above recommendation to have all clients sign "authorization" to request appeal or hearing in advance to have on file, and to attach to hearing request.

It is recommended to use the new Fair Hearing Request Form that should be part of the FAD Notice from the plan, since it has pre-populated information that is useful to OTDA.

If plan does not send the FAD notice by the deadline (30 days for standard appeals and 72 hours for expedited appeals, both subject to 14 day extension) then the member may request the Fair Hearing even though the plan has not made a decision on the internal appeal. This is called "Deemed Exhaustion." 42 C.F.R. § 438.402(c)(1)(A).

VII. 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 the plan determines the service is not medically necessary or is experimental or investigational. An external appeal, like Fair Hearings, requires exhaustion of the internal plan appeal and may only be requested after receipt of the FAD.

One may request an external appeal even if one also requests a Fair Hearing, but the decision from the Fair Hearing supersedes the External Appeal decision. New York Public Health Law § 4910.

If the issue involves a plan's proposal to reduce or stop a service, the member MUST request a Fair Hearing before the effective date of the FAD in order to receive Aid Continuing.

For more information about External Appeals see http://www.dfs.ny.gov/insurance/extapp/extappqa.htm.

VIII. Additional Information and Contacts

For updates on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/.

Fax, phone and email contact info to request appeals for all MLTC plans will be posted here when available, 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.

NYS DOH Managed care webpage on appeals https://www.health.ny.gov/health_care/managed_care/plans/appeals/

ICAN—Independent Consumer Advocacy Network—Helps with MLTC and mainstream appeals on long term services and supports—TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org.

Jane Perkins, *Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems* (National Health Law Program, May 12, 2016), available at http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WoGveSXwa2w.

Endnotes

1. See New York State Dept. of Health MLTC Policy 15.03: *End of Exhaustion Requirement for MLTC Partial Plan Enrollees,* dated July 2, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.
2. The law and regulations applying to "mainstream" managed care are at N.Y. Soc. Serv. Law . § 364-j; 18 N.Y.C.R.R. Subpart 360-10. All managed care plans, including MLTC plans, are also regulated

as Managed Care Organizations (MCO) at NYS Public Health Law Article 44 and Article 49. Federal Medicaid requirements preempt those under state Public Health Law, if the federal Medicaid requirements are more strict. For example, state law allows plans to have more than one level of internal appeal. The federal regulation allows only one internal appeal for Medicaid plans, and this controls. 42 C.F.R. § 408.402(b).

3. Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015).

4. NHELP comments filed in July 2015 are available at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>.

5. Notice of Final Rule, 81 Federal Register 88 at p. 27498 (May 6, 2016).

6. National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs, available at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>.

7. See MLTC Policy 16.06, *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services,* available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

8. The Model MLTC contract is posted on the MRT 90 Webpage cited above. Click on Health Plans, Providers and Professionals at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm. Click on Model Contracts and select Partial Capitation Contract. Direct link is https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf (Contract 1/1/2015 - 12/31/16 is most current available). The *Member Handbook* is in Appendix K, and is not yet revised.

9. 42 C.F.R. § 438.400(b).

10. Model notices posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. Though this webpage is directed to mainstream managed care plans, the same model notices are required for MLTC plans.

11. 42 C.F.R. § 438.404(c)(1) cross-references the long-standing regulations that establish timeliness of notices and other Medicaid fair hearing rights outside of managed care, 42 C.F.R. §§ 431.211—431.214.

12. *See, e.g.*, Fair Hearing No. 7182969J, dated Feb. 17, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-2/Redacted_7182969J.pdf (notice not mailed at least 10 days before effective date, citing 42 C.F.R. §§438.404, 431.211; 18 N.Y.C.R.R. §§ 358-2.23, 360-10.8).

13. See template posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf; see sample of completed reduction notice in hypothetical case posted at http://www.wnylc.com/health/download/644/.

14. See V. Bogart, R. Novick, A. Lowenstein, et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf hereafter "Medicaid Matters NY Report on MLTC Reductions".

15. Since it does not include the Aid Continuing provisions of a reduction notice, DOH devised a separate template, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

16. DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), 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 hereafter referred to as "DOH 42 C.F.R. 438 FAQ".

17. DOH Notice to Suspend, Reduce or Stop Services, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm, under heading "Who May Ask for a Plan Appeal."

18. DOH 42 C.F.R. 438 FAQ, *supra*, note 15, Question V.8.

19. DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; SUPPLEMENTAL FINAL RULE FAQ's— *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), Question IV.2. revised Feb. 7, 2018, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#iv (hereafter "Supplemental NYS DOH FAQ").

20. See Model Contract for Partial Capitation Plans, *supra* note 8, Appendix K (pp. 145 and 147 of PDF).

21. See Medicaid Matters NY Report on MLTC Reductions, supra note 14.

22. See NYS DOH MLTC Policy 16.06, *supra*, note 7, and MLTC Policy 16.07: *Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services,* both dated Nov. 17, 2016, both available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

23. DOH Webinar Presentation for Plans, April 13, 2018, available at https://health.ny.gov/health_care/managed_care/plans/appeals/2018-04-13_appeals.htm (Slides 38-39 of PDF at https://health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-04-13_appeals.pdf). NYLAG has opposed this policy, contending that plans should not be permitted to collect the cost of services provided as Aid Continuing until the 120-day statute of limitations for requesting the fair hearing has expired.

24. Extension notice available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf.

25. Model FAD Notice of Reduction, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_reduce_services.htm.

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