NYLAG
New York Legal Assistance Group

July 16, 2025

New York State Dept. of Health
Submitted electronically via MLTCinfo@health.ny.gov

Re: MAP Integrated Appeals and Grievances demonstration Wind-down

The New York Legal Assistance Group (NYLAG) submits this comment with recommendations concerning the proposed Phase-Out plan for the MAP Integrated Appeals and Grievances demonstration

ABOUT NYLAG & ITS WORK FOR AGING and DISABILITIES COMMUNITIES

Founded in 1990, New York Legal Assistance Group (NYLAG) is a leading civil legal services organization combatting economic, racial, and social injustice by advocating for people experiencing poverty or in crisis. Our services include comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. NYLAG exists because wealth should not determine who has access to justice. We aim to disrupt systemic racism by serving individuals and families whose legal and financial crises are often rooted in racial inequality. NYLAG goes to where the need is, providing services in more than 150 community sites (e.g. courts, hospitals, libraries) and on our Mobile Legal Help Center. NYLAG's staff of 400 impacted the lives of nearly 130,000 people last year.

NYLAG has multiple units that work to enforce health care rights. Our Public Benefits Unit and Evelyn Frank Legal Resources Program advocate for low-income families, children, veterans, the elderly, Holocaust survivors, those living with disabilities, and other vulnerable populations to have access to the public benefits they are entitled to, including counseling on Medicare choices and resolving obstacles to obtaining Medicaid and Medicare eligibility, and adequate services to enable them to remain in their homes and avoid institutionalization. LegalHealth partners with medical professionals to address the non-medical needs of low-income people with serious health problems. NYLAG's LGBTQ Law Project provides low-income LGBTQIA+ communities with comprehensive civil legal services including access to care for transgender patients.

We are glad to see that the Level 1 Plan Appeal will remain as an integrated appeal, without requiring members to select which of two avenues of appeal to pursue (Medicaid vs. Medicare).

The challenge will be educating members about requesting the Level 2 appeal now that these appeals will no longer be auto-forwarded to NYS OTDA for a fair hearing. Members must be educated both about which type of appeal process to follow – Medicare or Medicaid – and how to request each respective appeal. Our comments make recommendations to improve this education and messaging for members.

1. **Phase-Out Clarification**-Page 2 of the phase-out plan states that through December 31, 2025, all adverse decisions appeals will be handled under the old rules using the integrated system. We ask that it be clarified that plans must use the integrated notices, and continue to auto-forward Level 2 appeals of Coverage Determination Notices issued prior to Dec. 31, 2025. We support Medicare Rights Center's request for further clarification about this phase-out period.

2. Comments on draft Member Handbook Insert Regarding the Unified Plan-level Appeals and Grievance Process and Letter from Plan to Members (page 6 of the phase-out plan).

The letter to members should explain exactly how the procedure is changing from the past, and give examples of which services are Medicaid, Medicare, or both. The vast majority of hearings in the integrated appeals process concerned Medicaid long term services and supports.[1] The handbook, ANOC notice, and other information should be tailored to specify the following. Suggested additions are in red underline:

"…What is changing on January 1, 2026?
The way you request a Level 2 Appeal will change. Beginning in January 2026, if you lose the Level 1 Plan appeal, your next appeal steps will depend on whether the service is covered by Medicare or Medicaid. We will send you a written notice called a "*Coverage Determination Notice*,"[2] which will tell you whether you lost your Level 1 Plan appeal.

If the service is covered by Medicaid --
Starting on January 1, 2026, if our Level 1 Plan Appeal decision is adverse, meaning you lost your appeal, and the benefit is covered by Medicaid, you or your authorized representative must ask the State for a Level 2 Fair Hearing ~~Medicaid~~ appeal ~~(Fair Hearing~~). You will have 120 days to ask for a Level 2 Fair Hearing."

- **How is this different than how Level 2 appeals have been handled until now for Medicaid services**? If you received an adverse Level I Plan Appeal decision in the past from a Medicaid Advantage Plus (MAP) plan like ours, a state Level 2 Fair Hearing was ***automatically*** requested on your behalf. You did not have to request a Level 2 Fair Hearing yourself. Starting in January 2026, if you lose a Level 1 Plan Appeal, you will have to request a state Level 2 Fair Hearing yourself if the service is a Medicaid service.

- If we are ~~changing~~[3] reducing or stopping the ~~care~~ Medicaid services you are getting right now and you want your services to stay the same while you appeal our decision at a Fair

[1] *New York Integrated Appeals and Grievances Demonstration: Second Brief Report*, April 2023 (RTI International, prepared for CMS), available at https://www.cms.gov/priorities/innovation/data-and-reports/2023/fai-ny-iag-2nd-brief-report, (reporting that 84% of the 2nd level appeals/hearings concerned personal care and CDPAP in the first and second years of the demonstration, with the remaining 16% split between home health, dental, DME, and pre-utilization determinations, and other services) hereafter "Integrated Appeals Second Report").

[2] The member handbook should use the exact title of the notices that the member will receive. We are not sure if this will still be the "Coverage Determination Notice" as used until now by MAP plans.
[3] "Changing" needs to be more specific – since this sentence is about reductions and terminations.

Hering, you must ask for the Fair Hearing within 10 calendar days from the Level 1 Appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the fair hearing decision. If you lose your Fair Hearing, you may have to pay for services you got while waiting for the decision.

- **Which services are covered MEDICAID services**? Personal care services, consumer-directed personal assistance services (CDPAP), private duty nursing, adult day care, social adult day care, incontinent supplies and other medical supplies, hearing aids, eyeglasses, home-delivered meals, and Personal emergency response systems.

If the service is covered by Medicare -- If our Level 1 Appeal decision is adverse to you, and the benefit is covered by Medicare, we will automatically send your case to Level 2 of the Medicare appeal process. ~~as soon as your Level 1 appeal is complete~~.

- **Which services are MEDICARE services?** Doctors' and specialists' office or clinic visits, chiropractic care, mental health care, inpatient hospital stays, x-ray and other radiology services, surgery, Infusions or medications administered in a doctor's office, and ambulance services. Also, though dental care is usually a Medicaid service, in this plan dental care is a Medicare service.[4]

If the benefit is covered by both Medicare and Medicaid -
If you lose a Level 1 Appeal decision, we will automatically send your case to Level 2 of the Medicare appeal process, and you can also ask for a Level 2 ~~Medicaid appeal~~ Fair Hearing.

- **Which services can be covered by both MEDICARE and MEDICAID?** Visiting nurse services, certified home health aide services, services in a rehabilitation center or skilled nursing facility, physical, speech or occupational therapy in the home or in a clinic, and durable medical equipment.

Do I still get External Appeal rights for Medicaid covered benefits?

- Yes, if we said the service is not medically necessary, experimental or investigational, not different from care you can get in our network or available from a participating provider who has the correct training and experience to meet your needs, then you can still ask the State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will always be the final answer.

[*End of NYLAG's inserts – return to DOH draft Member Handbook language*]

3. More education for consumer and the public is needed about the changes – The Phase-out plan doesn't mention any additional educational outreach or online information by plans or DOH. As reported in the *Integrated Appeals Second Report*, supra, note 2, there continued to be consumer confusion about integrated appeals well into the demonstration, particularly about auto-forwarding of hearings, scheduling delays, etc. Now, consumer confusion can be expected to continue concerning identifying whether a service is Medicare or Medicaid and knowing which

[4] Include if this is the case –that D-SNPs in NYS now cover all dental care.

appeal process to follow. This will place a burden on plans as well as providers – and potentially harm consumers who fail to request a hearing on a timely basis.

Confusion could be eased by clear information on the DOH website including fact sheets. The *Integrated Appeals Second Report* stated, "One plan suggested that the State or Maximus … put more information about the integrated appeals process on their websites to boost enrollee awareness." Supra n. 2 at p. 3-3. To our knowledge consumer-oriented information about the integrated appeals process was never posted, but clear information about the new procedures should be posted now.

One place to post information could be in the dropdown for MAP plans at https://www.health.ny.gov/health_care/medicaid/redesign/duals/. Materials could include a chart classifying which services are Medicare, Medicaid, or both, and the steps to appeal each type. Also, a fact sheet or webpage should include a graphic showing the sequence of notices that the member will receive, with the names of the notices, and showing the next steps needed by the consumer to appeal.

Language access- It is imperative that the ANOC notice and member handbook inserts, along with online information and downloadable fact sheets, be available in Spanish and other languages common among MAP members. The *Integrated Appeals Second Report*[5] cited complaints that notices, and other information were not available in Spanish and other preferred languages, despite the large proportion of members for whom English is not the primary language.

4. Grace period for Late Requests for Level 2 Fair Hearings and Aid Continuing status.

Given the confusion that is likely to occur with the changes, for the first year of the change, members who request Fair Hearings after the short time limit to get Aid Continuing but within the 120-day statute of limitations to request fair hearings should be given Aid Continuing by OTDA.

5. The ANOC notice – We request an opportunity to review and comment on the Annual Notice of Change template before plans finalize the ANOC notices. Our comments on the member handbook insert below should be considered for the ANOC template. While we do not see DOH's ANOC template online, we did find this recent related document online:

New York State Department of Health Instructions for the Provision of Medicaid Managed Care-Specific Information within Medicare Advantage Dual Special Needs Plan Marketing and Communications – effective June 18, 2025.

Here are a few recommendations for **section V. Medicaid Managed Care-Specific Appeal and Grievance Information** of these instructions to plans:

- In section V.a. ii. In the section that states, "The below information is for our members enrolled in the **Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program**."

[5] Report, supra, note 2, at pp 5-1, ES-2, and 3-1.

We make the same recommendation made above for the member handbook insert, which is to add examples of the most common types of services that are Medicare services, Medicaid services, or both.

- We commend highlighting Aid Continuing rights within a clear border.

- Everywhere the term "Medicaid appeal" appears this should be changed to "Level 1 Medicaid plan appeal" to distinguish these appeals from Level 2 Fair Hearings and to clarify that the appeal is with the plan.

- While ICAN and Community Health Advocates and CHAMP are listed in Section IV, they should also be listed in Section V – adding a section for "where to get help" and specifying that ICAN is for problems with personal care, CDPAP and other long-term care services, and explaining what the other organizations can assist with.

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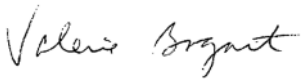
Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please feel free to contact us at rwallach@nylag.org.

Sincerely,



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