Appeals & Grievances in Managed Long Term Care & Managed Care

In 2016, CMS adopted changes in federal Medicaid managed care regulations requiring "exhaustion" of Plan Appeals prior to requesting a Fair Hearing. These changes became effective in NYS in MAY 2018. The federal changes are in 42 CFR 438 SubPart F.

NYLAG 2018 Trainings on Changes:

- View the recorded webinar on You-tube here and download the PowerPoint presentation by NYLAG EFLRP held on April 18, 2018.
- Fact Sheet by NYLAG EFLRP.
- "Exhaustion of MLTC Plan Appeals Before Requesting a Fair Hearing, Starting May 1, 2018"(By Valerie Bogart; reprinted with permission from: Elder and Special Needs Law Journal, Spring 2018, Vol, 28 No. 2, published by the New York State Bar Association, One Elk Street, Albany, NY 12207.

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I. Since May 1, 2018 - Member Must Request Internal "Plan Appeal" before requesting a Fair Hearing

Beginning May 1, 2018, the member MUST first request an Internal Plan Appeal of an Initial Adverse Determination by the plan. Only after a decision on that internal appeal is made by the plan, called a "Final Adverse Determination" or "FAD," may the member request a FAIR HEARING. 42 C.F.R. 438.402(c).

This is true regardless of whether the plan's action is to reduce, terminate, or deny services. And - there are new rules for when a provider or representative may request an appeal or hearing for an individual. Click here.

AID CONTINUING -BEWARE!!!!! If the PLAN'S action is to reduce or terminate services, then the member MUST request the internal appeal within 10 days of the date of the notice, or before the effective date of the notice, in order to be entitled to AID CONTINUING. This is very new. Before, the member had to request a Fair Hearing in order to receive AID CONTINUING.

- **WHICH PLANS?** The new rules apply to all Medicaid managed care plans - mainstream Medicaid managed care plans, Medicaid Special Needs Plans, HARP plans, and Managed Long Term Care (MLTC) plans, and Medicaid Advantage and Medicaid Advantage Plus (MAP) plans.
- **WHICH TYPES OF ACTIONS REQUIRE A "PLAN APPEAL?"**

The rules apply to APPEALS not to GRIEVANCES or COMPLAINTS.

An **Appeal** is a request to review an **action** taken or an **adverse determination** made by a plan. If your MLTC plan **denies** a new service or an increase in an existing service, or **reduces or stops** services that you already had, you have the right to appeal. The plan's original determination is called an **"Initial Adverse Determination."** For example, the plan reduces your personal care services from 12 to 8 hours/day, or denies your request to participate in the Consumer-Directed Personal Assistance Program (CDPAP), or denies your request to increase your hours of personal care services.

A grievance is a complaint you make directly with the MLTC plan about the quality of care, services or treatment you received or about communications with the plan. A grievance is not about the scope, amount or type of service that was approved by the plan. EXAMPLES include the aide or transportation is late or doesnaï¿½ï¿½t show, aide isnaï¿½ï¿½t trained well, you canaï¿½ï¿½t reach your care coordinator by phone, you were treated rudely, or you disagree with the plan's decision to extend its time frame to decide your request for new or increased services. 42 CFR 438.404(c). See more about the time frames for plan to approve or deny your request for new or increased services here. See more about GRIEVANCES here.

- **Does This Change Affect The Allowed Reasons for when a Plan May Reduce Services?**

  NO. State Regulations were amended in 2015 to clarify the limited grounds for reductions, and to strengthen the requirements for the content of notices of reduction. Notices must specify the justification for reducing hours to less than was previously found medically necessary. See MLTC Policy 15.09: *Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA)* -Notice of Adoption. CDPA Changes PCS Changes

  - The State DOH strengthened the NOTICE requirements further in 2016 in MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services.* This policy continues in effect. These rules are based on *Mayer v. Wing*, 922 F. Supp. 902, 911(S.D.N.Y. 1996), as codified in state regulation at 18 NYCRR 505.14(b)(5)(c). Also see MLTC Policy 16.07: *Guidance on Taskaï¿½ï¿½based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services.*
  - *However,* eff. Nov. 8, 2021, DOH weakened the regulations to allow plans to reduce services more easily after a Transition Period ends. This rule only applies in certain circumstances where the member enrolled in the plan having transferred from Immediate Need services or because their prevsious plan closed, and certain other grounds. See this article for more info. The rule above from MLTC Policy 16.06 still applies for all other reductions of hours for MLTC members.

II. NYS Dept. of Health Regulations, Webpages and Fact Sheets On the New Exhaustion Requirement - and NEW MODEL NOTICES

- Federal Regulations - 42 CFR Part 438 Subpart F. In 2018, NYS Dept. of Health issued extensive guidance to implement the changes, described below.
- **In Sept. 2020, NYS Dept. of Heath proposed amendments of State Medicaid managed care regulations to implement the federal changes.**

  - Proposed changes posted here - Amendment of Sections 360-10.3 & 360-10.8 of Title 18 NYCRR and Section 98-2.10 of Title 10 NYCRR (Medicaid Managed Care State Fair Hearings and External Appeals Processes and Standards
  - NYLAG filed comments on the proposed changes - available here.
- **Webpage with Guidance for mainstream Medicaid managed care plans** -- Service Authorization and Appeals for Mainstream Medicaid Managed Care Plans, HARP, and HIV SNP. Includes FAQs, webinars, and guidance for "mainstream" plans, which are those plans serving 4.5 million New Yorkers who do not have Medicare or other 3rd party insurance, including many eligible through the Affordable Care Act or SSI. This includes the new HARP plans for people with behavioral

health needs. Model notices also posted here.

- **Webpage with Guidance for MLTC plans** -- Service Authorization and Appeals - Includes FAQs, webinars and guidance , and Model notices
- **Medicaid Update for Providers** - Click on March 2018 edition - page 5 of PDF
- **Model Notices of Denial or Reduction of Services --** The NYS Dept. of Health model notices, which managed care and MLTC plans must use after May 1, 2018 when denying or reducing or stopping a service, are posted on both of the above webpages. For MLTC plans, the most common disputed service is personal care or CDPAP services or Durable Medical Equipment, but in mainstream plans the plan may be denying authorization for a prescription drug, a surgical procedure, an out-of-network benefit, as well as personal care or CDPAP services. The key notices are posted under "DOH MODEL NOTICES" at this link:

    - **Initial Adverse Determination**
        - ◊ Denial Notice - (Web) - (PDF) - 11.4.2021
        - ◊ Notice to Reduce, Suspend or Stop Services - (Web) - (PDF) - 11.4.2021 - has AID CONTINUING rights if request plan appeal before effective date. See Unofficial sample reduction notice reducing home care services
    - **Final Adverse Determination** - The plan's final decision after the internal "Plan Appeal," from which member may request a **Fair Hearing** and/or an **External Appeal)**
        - ◊ Denial Notice - (Web) - (PDF) - 11.4.2021
        - ◊ Notice to Reduce, Suspend or Stop Services - (Web) - (PDF) - 11.4.2021 - has Aid Continuing rights if request Fair Hearing before effective date
    - Extension Notice - (Web) - (PDF) - 11.4.2021 -- Plan must send this notice if it extends its time to review the appeal for up to 14 additional days.
    - Approval Notice - (Web) - (PDF) - 11.20.2017
- MLTC Model Contract - - click here and then Model Contracts - Partial Capitation Plans - see Appendix K
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N.Y. STATE DEPaï¿½ï¿½T OF INSURANCE, EXTERNAL APPEALS

- NYS Public Health Law AÂ§ 4403, 4403-f
- **CMS Special Terms & Conditions**- - Agreement between the State and CMS governing MLTC and Medicaid managed care. Look for most recent "ST&C" on NYS 1115 Waiver Information Webpage
- MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services*

III. "PLAN APPEAL" - Must request Internal Appeal First - and Wait for Decision - Before Requesting a Fair Hearing

A. DEADLINE TO REQUEST INTERNAL APPEAL_ - Warning re Aid Continuing

If the plan's "Initial Adverse Determination" is to REDUCE or STOP services, you must request the appeal **within 10 days of the date of the notice**, or before the EFFECTIVE DATE of the notice, which must be at least 10 days after the date of the notice. Otherwise you will not receive AID CONTINUING.

NOTE: You are entitled to Aid Continuing even if the authorization period for the service has expired, or after you have transitioned to the plan from fee for service home care.. See this discussion.

If the plan's "initial adverse determination" is not a reduction, but denies a new service, or denies an increase in an existing service, or authorizes a service in less than the amount you requested, after April 1, 2018 the member will have **60 calendar days** to request an internal appeal, from the date of the notice. This is an **increase from 45 days** under the old rules before May 1, 2018.

You MAY request an internal appeal if the plan misses the deadline to decide your request for new services or for increased services. Federal regulations specifically state that this constitutes a **denial** which can be appealed. 42 CF.R. 438.404(c)(5). These deadlines are explained in this article.

B. HOW TO REQUEST THE INTERNAL APPEAL:

You may either:

Call the member services phone number of your plan. The federal regulations require you to confirm an ORAL request in WRITING unless you request that your appeal be "expedited" (Fast Track). See more about Fast Track appeals in #3 below. 42 C.F.R. 438.406(b)(3) The date of the oral appeal must be considered the filing date of the appeal for purposes of Aid Continuing and the statute of limitations. Id.

FAX the request - fax number should be on the NOTICE received from the plan. Use the Appeal Request Form that should be part of the NOTICE from the plan (part of this PDF).

E-mail the request -- the e-mail address should be on the NOTICE received from the plan. Attach the Appeal Request Form form that should be part of the NOTICE from the plan (part of this PDF).

Write to your plan. Write to Member Services return receipt requested and write APPEAL REQUEST on the envelope and on the letter. Make sure you include your Member ID number, name, address, Medicaid number, phone number, and the reasons for your appeal. The Appeal Request Form that should be attached to the plan's notice contains all of this information.

We will post fax numbers, e-mails, telephone numbers, and addresses as soon as they are available for each plan in this article. They are not available as of January 30, 2018. State DOH is requiring plans to provide fax and phone numbers and mailing address. They suggest but are not requiring plans to provide email addresses or an online portal.

IF YOU NEED HELP REQUESTING 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 CFR 438.406(a).

C. Who May Request the Internal Appeal for the Member?

The federal regulation says, "If State law permits and **with the written consent of the enrollee**, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee." AÂ§ 438.402(c)(1)(ii). Arguably, this language requires the member to give written consent for a representative to file an appeal request, which could delay filing a request with disastrous consequences -- the client could miss the deadline to request Aid Continuing.

To prevent problems, we recommend having a member pre-designate a person or organization to request appeals when needed. See this suggested form and read tips about using it.

In the preamble to the regulations, CMS states, aï¿½ï¿½aï¿½Â¦we defer to state determinations regarding the design of their grievance and appeal system; state law could vary regarding who the state recognizes as an authorized representative.aï¿½ï¿½ 81 Fed. Reg. at 27510. New York has always been expansive in permitting family or representatives to request the appeal, thus ensuring that the right to appeal is not unduly restricted. For example, the OTDA fair hearing request form allows a person requesting the hearing to indicate whether they are the aï¿½ï¿½requesteraï¿½ï¿½ or the aï¿½ï¿½representative.aï¿½ï¿½ NYS DOH's templates for model MLTC notices issued In March 2015 state, aï¿½ï¿½You can have someone you trust ask for an Internal Appeal for you.aï¿½ï¿½

ADVOCACY TIP: Have Member Sign Form To Designate a Family Member or Representative to Request an Appeal - and Submit Form to Plan Now, BEFORE the plan takes adverse action.

In the Model Appeal and Hearing Request Forms that the State is requiring all plans to use (Requests forms are attached in the same PDF after the model notices), the form allows someone to request the appeal on the member's behalf, without requiring the member to sign the request form, ***if the member has authorized the person with the plan before***. Here is a suggested authorization form, developed by NYLAG EFLRP, by which a member may pre-designate a family member, lawyer, social worker, or ICAN to act

on her behalf - or to authorize someone to act. We suggest that these be completed, signed and provided to the care manager for the client's file, so that in the event the plan later takes an adverse action, the designated person, attorney, etc. may request the appeal *without being delayed by the need to get the client's signature*.

TIPS on completing the managed care authorization form:

- The member may designate more than one person/organization in this form to request an appeal. Check all that apply. Note that the form has an additional checkbox for the member to indicate that the individual may also act on their behalf for the entire appeal. Member should check that too.
- Send it certified to the plan with a cover letter so you have proof that it was provided. Or give it to the care manager in person, and have the care manager sign your copy as received. Attach that proof of delivery when you request an appeal later.

NYS DOH has issued two helpful FAQaï¿½ï¿½s regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. In the original FAQ issued by DOH to managed care plans, Question V. 7 provides:

FAQ V. 7. 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 enrolleeAÂ´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.

This FAQ is important for several reasons. First, the plan must process the appeal request aï¿½ï¿½ and presumably comply with Aid Continuing aï¿½ï¿½ even if it has not received the memberaï¿½ï¿½s written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, NYS DOH acknowledges the plansaï¿½ï¿½ duty to provide reasonable accommodation of such disabilities. These must include policies and procedures to recognize aï¿½ï¿½previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.aï¿½ï¿½ Id. The model Appeal Request Form incorporates this policy by stating, aï¿½ï¿½If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.aï¿½ï¿½

A Supplemental Final Rule FAQs (2/7/18), issued by the DOH division that oversees aï¿½ï¿½mainstreamaï¿½ï¿½ 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.

*F*AQ 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. AÂ§ 438.402(c)(1)(ii) requires the enrolleeAÂ´s written consent for the provider or authorized representative to file a Plan Appeal on the enrolleeAÂ´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.

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.

D. Right to Request Expedited or "Fast Track" Appeal

You or your provider have the right to request an **expedited or "Fast Track" appea**l. The plan must expedite its appeal decision if it determines (for an appeal request made by the member) or if the provider indicates (if the provider is requesting the appeal on the enrollee's behalf or supporting the enrollee's appeal) that "taking the time for a standard resolution could seriously jeopardize the Enrolleeaï¿½ï¿½s life, physical or mental health or ability to attain, maintain or regain maximum function." 42 CFR 438.410.

The Appeal Request Form that plans should send with adverse notices has a check-off for requesting a Fast Track Appeal.

E. RIGHTS in the INTERNAL APPEAL PROCESS

- **Appeal must consider all documents and information submitted in the appeal**, regardless of whether it was submitted initially in the initial adverse benefit determination. 42 CFR 438.406(b)(2)(iii)
- **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 (See # below). 42 CFR 438.406(b)(4).

- ♦ COMMENT: On the Appeal Request Form that plans must attach to their Initial Adverse Determination notices, there is a checkbox if you want to include additional documents with the appeal request, or if you want to give information in person. You could also write in that you would like additional time to submit additional documentation.

- **"Provide the enrollee and his or her representative the enrollee's case file**, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the ... plan ...in connection with the appeal of the adverse benefit determination. This information must be provided free of charge nd sufficiently in advance of the resolution timeframe for appeals as specified in AÂ§ 438.408(b) and (c)." 42 CFR 438.406(b)(5).

    - ♦ Comment: Regulation requires plan to provide the case file and documents relied on in all appeals, not conditioned on enrollee requesting the file. If you want the file to be provided directly to the representative, attach a signed HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA .
    - ♦ The State DOH Final 42 CFR 438 FAQs - - revised February 7, 2018 -- has specific instructions for plans to provide the case file when the appeal is requested. Under **Section IV Appeals** heading in the FAQ see:

2. Is it the StateAÂ´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 enrolleeAÂ´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 internallyaï¿½ï¿½generated documents but does not necessarily generally include all medical records that may be in the planAÂ´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.

- **Appeal must be decided by a plan employee who was not involved in the initial adverse determination** being appealed, and who is not a subordinate of anyone involved in the initial adverse determination. They must also have appropriate clinical expertise. 42 CFR 438.406(b)(2).
- **IF YOU NEED HELP REQUESTING or taking other Procedural Steps Relating to the 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 CFR 438.406(a).

F. WHEN and with what NOTICE Must Plan Decide INTERNAL APPEAL?

1. **STANDARD APPEAL** -The plan must decide a standard appeal within **30 calendar days** of receipt of the appeal request, subject to extension by up to 14 days on the enrollee's request or if the plan shows the State, upon request, that additional information is needed and how the delay is in the enrollee's request. 42 CFR 438.408(b)(2), (c)
2. **FAST TRACK or EXPEDITED APPEAL** - The Plan must decide an expedited appeal within 72 hours after the plan receives the appeal, subject to same extension of up to 14 days as for standard appeals, above. 42 CFR 438.408(b)(3). Plan must make a reasonable effort to give oral notice for expedited appeals and must send written notice within 2 business days of decision for all appeals

If the plan has extended the time for it to decide an appeal, -- see Extension Notice - (Web) - (PDF) - 11.4.2021 -- it must make reasonable efforts to give the enrollee prompt oral notice of the delay, and within 2 calendar delays give the enrollee writeen notice of the reason for the delay and of the right to file a grievance about the delay. The plan must resolve the appeal "as expeditiously as the enrollee's health condition requires and no later than the date the extension expires." 42 CFR 438.408(c)(2).

See Model notices above.

IV. "DEEMED EXHAUSTION" - Member May Request a Fair Hearing

without Internal Appeal if Plan Failed to Meet Notice and Timing Requirements

The federal regulations allow **ONE exception to the "exhaustion" requirement - if the member requested the plan appeal, and the plan failed to decide the appeal within the time limits in** 42 C.F.R. Sec. 438.408. In other words, where the managed care plan aï¿½ï¿½fails to adhere to the notice and timing requirements of this section, the enrollee is deemed to have exhausted the [managed care plan'] aï¿½Â¦ appeals process. The enrollee may initiate a State fair hearing.aï¿½ï¿½ 42 CFR 438.408(c)(3); 438.402(c)(1)(i)(A). The referenced regulation specifies the TIME LIMITs for the plan to decide a Plan Appeal, both standard and expedited appeals, and the circumstances for when the plan may extend the time to decide by up to 14 days.

when CMS published this federal regulation, its response to comments said that States may define *deemed exhaustion* more broadly. New York State has not done so. **Deemed exhaustion applies** -- allowing a fair hearing request despite no Final Adverse Decision -- only if the appeal was requested, and the plan did not decide it on time or with the right notices. Consumers have asked the State to define *deemed exhaustion* to apply in other situations as well, such as the following. However, the State has not expanded the definition to include situations where:

- No written notice of Initial Adverse Determination (IAD) was provided by the plan, or
- The IAD does not include the requisite information re the right to Aid Continuing, how to request an appeal, etc.
- The IAD did not incorporate necessary translation or alternative formats, was not on the required template, or did not offer auxiliary aids and services, free of cost, during the appeal, thus impeding the enrolleeaï¿½ï¿½s time to appeal or request Aid Continuing.
- The IAD does not comply with other applicable requirements, ie. MLTC Policy 16.06;
- Plan did not decide the appeal within 30 days from memberaï¿½ï¿½s appeal request, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless extended pursuant to the regulations by up to 14 calendar days. AÂ§ 438.408

V. RIGHT TO REQUEST FAIR HEARING after Adverse Internal Appeal Decision ("Final Adverse Determination").

AID CONTINUING ALERT - If the plan's Initial Adverse Determination was a proposed reduction of services, and the plan denied the appeal - in whole or in part - the Final Adverse Determination notice should again give the member the right to request a Fair Hearing with Aid Continuing. See Model notices above. Again, the member must meet the short deadline to request the Fair hearing within 10 days of the date of the Final Adverse Determination notice or before the effective date of that notice. Otherwise the member will not receive AID CONTINUING - even if the member obtained aid continuing on the internal

appeal requested with the plan.

AID CONTINUING rights apply even if plan reduces services:

- **After the 90-day Transition Period.** This is the first 90 days you are enrolled in an MLTC plan if you transitioned to MLTC from a different fee-for-service Medicaid long term care service in NYC or a county with mandatory MLTC. These include personal care, Consumer-Directed Personal Assistance, Lombardi, Certified Home Health Agency (CHHA), Adult Day Health Care, or Private Duty Nursing. While Aid Continuing applies, beware of diluted grounds allowing plans to more easily reduce hours after the transition period. See more about Transition periods here.
- **At the end of an "Authorization Period."** In 2014, the State budget enacted an important change in the Social Services Law that guarantees the right to receive AID CONTINUING if the plan reduces services, "without regard to expiration of a prior service authorization." Soc. Services Law Sec 365-a, subd. 8. See NYLAG Statement in Support of A4996. Before this change, the Department of Health had authorized MLTC plans to reduce or terminate hours of home care services, with no right to Aid Continuing, if the planaï¿½ï¿½s service reduction coincided with the end of the planaï¿½ï¿½s aï¿½ï¿½authorization periodaï¿½ï¿½ for the services. That policy allowed disruption and even termination of these services without these crucial hearing rights. Implemented in --

aï¿½ï¿½MLTC Policy 14.05: Aid-continuing

MLTC Policy 14.05(a): Proper Handling of EnrolleesAÂ´ Request for Fair Hearing

NEW 120-DAY TIME LIMIT TO REQUEST FAIR HEARING - the new federal regulations allow 120 calendar days to request a fair hearing., from the date of the Final Adverse Determination (the plan's internal appeal decision). This is longer than the previous limit of 60 days. 42 CFR 438.408

How to request a Fair Hearing - See this link to OTDA website. Fax requests are recommended since you can keep proof of fax. IF there is an Aid Continuing deadline, phone call or fax is recommended.

See WNYLC website on NY Fair Hearings

VI. EXTERNAL APPEALS -- Option to File After Internal Appeal - Instead of or in Addition to Fair Hearing

The planaï¿½ï¿½s **Final Adverse Determination** notice denying your Internal Plan Appeal will explain your right to request an **External Appeal**, if the reason for the denial is because they determine the service is not medically necessary or is experimental or investigational.

You may request an External Appeal even if you also request a Fair Hearing. The Fair

Hearing decision supersedes the decision after the External Appeal. NY Public Health Law 4910.

External Appeals are administered by the NYS Department of Financial Services (DFS), which is the NYS insurance department that regulates all health insurance, long term care insurance, etc. It is a different State agency than OTDA that administers Medicaid Fair Hearings. They have a good website with all the required forms and instructions -- https://www.dfs.ny.gov/complaints/file_external_appeal, The appeal is entirely on paper so your submission must be complete.

External Appeals are available to any NYS resident who is a member of a health plan -- a group health plan offered by their employer, a privately purchased plan, and others -- not just Medicaid. So you need to educate the Hearing officer about the Medicaid standards.

Expedited (Fast-Tracked) External Appeals

Expedited external appeals are decided within 72 hours of being filed, but require extra work by the appellant or representative. For an external appeal to be expedited, the denial must concern an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or -- **most common in MLTC appeals -- the patient's physician must attest that the patient has not received the treatment and a 30-day timeframe would seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health.** Or the patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. A patient may request an expedited internal and external appeal at the same time.

- IN MLTC cases seeking an increase in hours, consider using this fast track External Appeal because it is fast. Doctor must sign the attestation form re urgency - factors described above.

If you request both an External Appeal and a Fair Hearing, the decision from your Fair Hearing will be the one that is followed by your plan. NY Public Health Law 4910.

TIP: If the issue is a REDUCTION of home care, an External Appeal is not recommended. The procedural rights placing the burden of proof on the plan to prove a change in consumer's medical condition or other circumstances are well known to ALJs and may be less familiar to DFS reviewers. See MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services and discussion of Mayer v. Wing here* Plus consumer should be receiving Aid Continuing so there is no urgency to expedite the process.

DFS has recently created a searchable database to search external appeal decisions like the OTDA fair hearing decision archive.

https://www.dfs.ny.gov/public-appeal/search --You can search by "home health care" or "personal care services"

VII. MORE ON GRIEVANCES - NOW CALLED "COMPLAINTS"

How to Request a Grievance or Complaint

You or someone you have authorized on your behalf can file a complaint with the plan in writing, over the phone or in person. Your member handbook or member services representative should explain how to file the complaint.

For most plans, one requests a complaint or appeal by calling the member services telephone line. A consumer must be assertive in requesting that they be referred to file a Grievance or Appeal, and know the difference. Otherwise, the call may never be routed correctly.

TIMING: The plan must decide your grievance within **90 days** after receiving the grievance. 42 CFR 438.408(b). .

If you are not satisfied with how your grievance is handled, or it is an emergency, you can also call the State Department of Health MLTC Complaint Hotline at 1-866-712-7197**.**

VIII. WHERE TO GO FOR HELP - CLICK HERE for List of Organizations

Government Hotlines

NYS Department of Health MLTC Complaint Hotline	(866) 712-7197
Fair Hearing Requests (must wait until after internal appeal decision)	(800) 342-3334

Article ID: 184
Last updated: 20 Jun, 2025
Revision: 36
Medicaid -> Appeals & Grievances in Managed Long Term Care & Managed Care
http://health.wnylc.com/health/entry/184/