

2016 FINAL RULE 42 CFR 438 Service Authorization and Appeals

Frequently Asked Questions for Managed Long Term Care Plans: Partial Capitation, benefit determinations for MAP and Medicaid Advantage plans

I. General Questions:

1. What is the implementation date for changes to 42 CFR 438.210 and Subpart F?

The effective date for the Medicaid Managed Care service authorization and appeals processes changes is 5/1/18.

2. What is the scope of use for the MMC/MLTC Model Notices?

These notices will be used for Mainstream Medicaid Managed Care, HIV/SNP, HARP, MLTC Partial Capitation, and Medicaid benefit determinations of Medicaid Advantage and Medicaid Advantage Plus plans.

3. Will the plain language recommendations of the Services Authorizations and Appeals Workgroup be used universally within the state?

The workgroup recommended the use of plain, easily understood language for member communications. This includes “approval,” “denial,” “decision,” and “complaint.” The Department has adopted this approach for the 8 model notices issued and strongly suggests plans utilize this language in member communications.

II. Notice Submissions:

1. Will DOH approval of templates from plans and their delegates be required prior to implementation in 2018?

Yes, plans must submit all templates for approval prior to implementation.

2. Will approval of template submissions need to be submitted to the Bureau of Long Term Care (for MLTC and Medicaid Advantage) separately from the DHPCO?

Yes, any templates used for Mainstream MMC, HARP, and HIV SNP notices should be sent to DHPCO; while any templates for MLTC Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus should be sent to DLTC. For submissions, use the following BMLs:

DHPCO- MMCTemplateNotices@health.ny.gov

DLTC- MLTCModelNotices@health.ny.gov

3. Can plans modify the State Model Notices?

Segments of the model notices may be removed, as appropriate, depending on the decision type. All notice templates must be approved for use by the Department and meet all content and format requirements prior to their use.

4. Can plans use BIGA-approved 1557 Language Services and Non-Discrimination templates in the new template submissions?

Plans may continue to use templates for non-discrimination and language services meeting 45 CFR 92 (§1557 of the ACA) requirements that have been approved by the Bureau of Program Implementation and Enrollment (BPIE). These must be updated to reflect large print content requirement as indicated in the models consistent 42 CFR 438.10(d)(3) and (6). The plan contact information must be included in these sections.

5. Do plans need to submit separate coversheets for each template individually?

Yes.

6. Does the coversheet need to be a in a separate document from the template it applies to when submitted?

No, a submitted template can include the coversheet in the same document. Plans must not submit a document that contains multiple notices or multiple coversheets.

7. Is there a naming convention for the unique identifier? Does the unique identifier need to be included in a specific place in the footer of the notice?

There is no required naming convention, and no specific location. The identifier must be unique for each template, and appear in the footer on every page of the template.

8. What is the process for submitting vendor templates?

Each plan must submit its vendors' (management contractor delegated to conduct issue coverage and/or utilization review determinations) templates; only plan representatives can sign coversheets. Templates received directly from vendors will not be reviewed. Vendor templates approved for one plan are NOT automatically approved for use by other plans. To expedite review, the unique identifier under which a vendor template has already been approved for use by another plan may be included in the comment box on the coversheet.

III. Model Notices:

1. Does the IAD need to include information about the process for requesting Fair Hearings?

Yes, this is required under 42 CFR 438.404(b)(4).

2. When is the External Appeal Form used versus the Fair Hearing Form?

The External Appeal Form is to be distributed with the FAD when the determination is subject to Article 49 of Public Health Law. The Fair Hearing Forms have been incorporated within the FAD notices and are always to be distributed with the FAD as included in the model notice templates.

3. Will there be a State Model Notice for the acknowledgement letter for complaints/grievances for plans to use?

No.

4. Why does fast track “[at hour received]” language appear in the IAD without AC, but not in the IAD with AC?

It is anticipated that the IAD with AC is only used when a plan is changing a service that has already been authorized, or in the case of long term services and supports (LTSS) or nursing home stay, that is changing the service in the subsequent authorization period. The [hour received] notation is for a response to an expedited service authorization request, subject to the 72 hour review required under 42 CFR 438.210(d)(2).

5. For all letter templates, there are both [] brackets and { } brackets, please clarify the meaning and when the types of bracketed text should be excluded/included. Does NYS have instructions on how to interpret these brackets like CMS (for example see <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Integrated-Denial-Notice-Instructions-CMS-10003.pdf>)?

Brackets are intended to identify placeholder information and instructions throughout these notices. The { } brackets are used for instructions, while the [] brackets are used as placeholders for content to be inserted. Further, instructions are highlighted in green or yellow, and static fields (for contact information that may be hard-coded in the plan’s template) are highlighted in blue. The static fields should be filled in with correct contact information in the templates submitted for DOH approval.

6. What does the State expect to see in “Coverage Type” in the header? Is this the type of Medicaid Plan (i.e., Medicaid without SSI, Medicaid with SSI)?

Coverage type refers to MLTC: Partial Capitation, MAP etc. The plan may elect to indicate the plan-specific name for the coverage type or premium group within the product line.

7. On the 2nd page of the Approval Letter first paragraph, do we need to state the provider's name as well as their participating versus non-participating status with the plan?

Yes, if a specific provider is identified include the name of the provider. If not, use the "this service will be provided by a" placeholder. In both cases, identify if the approval is for an in-network or out-of-network provider.

8. Does the IAD apply to Concurrent, Prospective, and Retrospective review determinations?

Yes, the IAD is intended for use for all of these purposes.

9. With regards to the extension letter, the plan asks for information during the review period on pre-service and concurrent reviews. This is not a formal extension but a request for information. Can we continue to send our own letters in this phase of the process?

Yes.

10. What is the State looking for with "UR Agent name"? Is this a plan delegate?

The "UR Agent Name" placeholders are for any entity delegated through a management contract to issue coverage and/or utilization review determination notices on behalf of the plan.

11. Can you define the "Plan Tracking ID" number on the IAD- is this the same as our authorization number?

This is the identifier the plan uses to track the case. This may be your plan's authorization number.

12. For all letters, does NYS expect to see the same copy that was mailed to the member also be sent to the provider (an exact duplicate)?

The provider notice may (but is not required to) be an exact duplicate of the notice going to the enrollee. The provider notice must include all required content as per statute, regulation and the MLTC Model Contract.

13. Can you please clarify what information should be included for Service developer/manufacturer?

Inclusion of the service developer/ manufacturer is a requirement specific to the FAD added by 10 NYCRR 98-2.9(e)(7). This information is to be included as

applicable and available under the regulation. This should be the name of a company, not a restatement of what the item or service is. This information does not have to be included if the service developer/manufacturer is unknown to the plan.

14. Will you be re-issuing the revised Fair Hearing Form to us for the latest version to consider for implementation or should we use the previous documents?

As of May 1, 2018, the LDSS-4687 and LDSS-4688 Managed Care Action Taken Forms currently in use will not be used in connection with the IAD or FAD notices. Fair hearing rights and fair hearing request forms have been incorporated into the FAD model notice.

15. The fair hearing request form has multiple numbers at the top of it on the first line. How should these numbers be used?

The codes included at the top of these request forms are the codes used by OTDA to process fair hearing requests and indicate MLTC or MMC, and whether the service is a home care service. Codes should be utilized as follows:

- *General MMC/ HARP/ HIV SNP= 229*
- *MMC/ HARP/ HIV SNP Home Care Services= 266*
- *General MLTC= 212*
- *MLTC Home Care Services= 211*

16. In the “Insert when extension is for an appeal” portion of the Extension Notice, what does [EXPDate] signify?

This placeholder is the “expiration date” of the extension; the date by which a plan must make a determination and provide notice to the enrollee. Inclusion of this date is necessary to identify and inform the enrollee when deemed exhaustion applies if the enrollee does not receive timely notice of the appeal resolution following an extension.

17. For out of network referral denials, the model notice indicates plans should populate the placeholder with two in-network providers. Can the plan refer the enrollee to our website for a list of participating providers or do the provider names actually need to be merged into the notice?

When issuing an out of network referral denial as defined at PHL 4900(7-f-1), plans must include in the notice the names and contact information of provider(s) able and available to provide the service in-network. Inclusion of at least two named providers, where possible, is recommended. See also Department of Financial Services guidance at:

http://www.dfs.ny.gov/insurance/health/OON_guidance.htm and http://www.dfs.ny.gov/insurance/health/OON_law_supplement_qa.htm

18. Will translated templates be provided?

No.

IV. Service Authorization Determinations:

1. What is meant by “administrative denial?”

Any Service Authorization Determination or retrospective determination (i.e., claim denial) that is not a utilization review determination subject to Public Health Law Article 49. This includes, but is not limited to adverse determinations for benefits not covered and covered benefits with service limits.

2. The implied effective date for reduction in service or stopping service in the IAD example is 10 calendar days from date of letter. The letter would be dated 1/1 and the effective date would be 1/11. The Current IAD template in use by the plan states 10 Business Days. Please clarify.

42 CFR 431.211 requires advanced notice of an adverse determination at least 10 calendar days prior to such an action, except under circumstances identified in 42 CFR 431.213 and 431.214. Plans may elect to provide greater than 10 calendar days advanced notice.

3. Can plans continue to combine Acknowledgment and Determination Notices when a determination is made before the acknowledgement timeframe expires?

Yes.

4. What needs to be included in the clinical rationale when the determination is there is not enough information to determine if the service is medically necessary?

*If there is not enough information to determine medical necessity, the plan must request the needed information before making a determination. If the information is not received on time, the notice should include: the criteria for approval; a statement indicating how the information received was insufficient (or that no information was received) to make the determination; and a statement regarding the **specific** information needed to make a medical necessity determination.*

V. Appeals:

1. How do PHL 4904(5) requirements (to overturn adverse determinations when notice of an Internal Appeal determination is not provided timely) align with deemed exhaustion requirements at 42 CFR 438.408(c)(3)?

Both requirements are applicable. Failure of the plan to respond to any Plan Appeal on time means the enrollee has exhausted the plan’s internal appeal process and may request a fair hearing. The plan is required to comply with PHL

4904(5) if the decision was subject to PHL Article 49, and reverse the initial denial.

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.

5. Current FAD placeholder language does not address the enrollee's right to file a standard internal appeal after a FAD is issued on an expedited internal appeal. Do enrollee's no longer have this right?

42 CFR 438.402(b) limits the plan to only one level of internal appeal, superseding the provision at PHL 4904(2)(c). For determinations subject to PHL 49, enrollees may file an expedited external appeal at the same time as they file an expedited internal appeal.

6. On the extension model notice, in paragraph 2, there is an explanation of how the delay is in the best interest of the enrollee. CMS has specific Medicare rules

for the MCO and when the extension can occur. Will NYS adhere to these same rules for Medicaid?

Plans must adhere to the requirements set forth in 42 CFR 438.210(d) and 438.408(c) for decisions to extend determination/resolution timeframes.

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 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.

8. What is the state's definition of "60 working days" in: "You have 60 working days from getting this notice to ask for a Complaint Appeal?" Shouldn't this statement reference business days? (Mon – Fri are working days; however, if Christmas falls on a Monday that is a non-working business day.)

"Working days" is used as a more reader-friendly version of the term "business days." However; if the last day to ask for a Complaint Appeal falls on a "non-working business day," the enrollee has until the next "working business day" to submit the request.

VI. Fair Hearings:

1. How will the State reconcile state regulations that allow fair hearing requests concurrent with internal appeals with 42 CFR 438 requiring exhaustion of internal appeals prior to a fair hearing request?

As of May 1, 2018, enrollees will be required to exhaust appeals rights as provided in 42 CFR 438 Subpart F before requesting a fair hearing. The State will revise 10 NYCRR 360-10.8 to reflect the federal rule requirement.

2. Why did the Fair Hearing timeframe change to 120 days from the FAD (currently 60 from IAD)?

Per 42 CFR 438.408(f)(2) the enrollee must request a fair hearing no later than 120 calendar days from the date of the plan's notice of appeal resolution. In the comments for the Final Rule, CMS provides that enrollees now have 120 days from the appeal resolution to request a fair hearing (see pages 27510, 27511, 27516)

3. Can an enrollee still request a Fair Hearing for services that are not covered by the Benefit Package?

Yes, administrative denials are included in the definition of an adverse benefit determination in 42 CFR 438.400(b), to which Fair Hearing rights apply.

VII. Aid Continuing:

1. What are the timeframes for requesting Aid Continuing?

Enrollees may request Aid Continuing subject to timeframe requirements in 42 CFR 438.420. For determinations subject to Aid Continuing, an enrollee must request a Plan Appeal within 10 days of when the plan sends the Initial Adverse Determination, or prior to the effective date of the determination, whichever is later, to receive Aid Continuing. If the Plan Appeal is upheld, the enrollee must request a state fair hearing within 10 days of when the plan sends the Final Adverse Determination to receive Aid Continuing.

2. Is Aid Continuing applicable to all concurrent review determinations?

No. An enrollee has a right to Aid Continuing in the following circumstances:

- *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*
- *For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.*

3. Will plans be permitted to recuperate costs of services from beneficiaries if an adverse determination is upheld on internal appeal/fair hearing?

When the appeal or fair hearing is adverse to the enrollee, enrollees may be held liable for the cost of services they received during the appeal or fair hearing review as provided by 42 CFR 438.420(d). Plans should not attempt to recoup such costs after an upheld Plan Appeal until after the enrollee fails to request a fair hearing within 10 days of the Final Adverse Determination, or, for enrollees requesting a fair hearing, after the adverse fair hearing decision.

VIII. Complaints:

1. In the Complaint Notice, what is the intent of the member providing information in person? What is the State's expectation of the plan once this has been received?

Enrollees have the right to present evidence in person if they choose to do so. This information must be considered when reviewing a Plan Appeal. This does not change the timeframe for making a determination.