Partial Capitation Model Action Notices
Frequently Asked Questions
August 12, 2015

These Frequently Asked Questions ("FAQs") relate to the partial capitation model action notices:

- MLTC Initial Adverse Determination ("IAD")
- LDSS-4687 Action Taken - Denial, Reduction or Termination of Benefits (211) ("4687 Action Taken Notice")

Please consult all previously released materials in conjunction with the following FAQs. If you have any questions regarding this information, please email them to the following address: mltcworkgroup@health.ny.gov.

General Questions

Q1. Can you clarify when Plans must send the IAD and 4687 Action Taken Notices to enrollees and/or their representatives?

A1. With exceptions, Plans must send the IAD and 4687 Action Taken Notice to the enrollee whenever an action occurs, such as:

- a denial or a limited authorization of a requested service (including the type or level of service); or
- a reduction, suspension, or termination of a previously authorized service;
- a denial, in whole or in part, of payment for a service; or
- a failure to provide services in a timely manner; or
- a determination that a requested service is not a covered benefit; or
- a failure to act within the timeframes for resolution and notification of determinations regarding grievances, appeals, and grievance appeals, as provided in this Appendix and applicable law.

Q2. What are the exceptions?

A2. Plans are not required to send the IAD or 4687 Action Taken Notice (or any written notice of action) to enrollees and/or their representatives in the following circumstances:

- When there is a prepaid capitation arrangement with a participating provider and the participating provider submits a fee-for-service claim to the Plan for a service that falls within the capitation payment;
- if a participating provider of the Plan itemizes or "unbundles" a claim for services encompassed by a previously negotiated global fee arrangement;
- if a duplicate claim is submitted by the enrollee or a participating provider, no notice is required, provided an initial notice has been issued;

- if the claim is for a service that is carved-out of the MLTC benefit package and is provided to MLTC enrollees through Medicaid fee-for-service, however, the Plan should notify the provider to submit the claim to Medicaid;
- if the Plan makes a coding adjustment to a claim (up-coding or downcoding) and its provider agreement with the participating provider includes a provision allowing the Plan to make such adjustments; or
- if the Plan has paid the negotiated amount reflected in the provider agreement with a participating provider for the services provided to the enrollee and denies the participating provider's request for additional payment.

Q3. When should the Plan send the IAD and 4687 Action Taken Notices to providers? Are they always sent together?

A3. Plans must send the IAD and 4687 Action Taken Notice to the requesting provider when the Plan denies a service authorization request or authorizes a service in an amount, duration, or scope that is less than requested.

When the Plan denies, in whole or in part, the payment for a service (*i.e.*, a claim denial), Plans must send the IAD, but not the 4687 Action Taken Notice, to the requesting provider.

For claim denials based on billing issues, such as those identified in the answer above (A2), Plans may send a custom IAD (*i.e.*, Explanation of Payment) to the requesting provider.

Q4. How does ending the Internal Appeal exhaustion requirement, and the accompanying policy changes, affect plan Internal Appeal notice requirements?

A4. The Division of Long Term Care (DLTC) recently distributed Interim Guidance for MLTC Partial Capitation Appeals Notices to MTLC partial capitation plans. This guidance is based on the current Mainstream model contract, and outlines content requirements for Internal Appeal notices for any action that occurred on or after July 1, 2015. Please note the significant modifications to Internal Appeal decision notices (a.k.a. "final determination" or "final adverse determination" notices).

Q5. Has DLTC released a policy statement about the end of the Internal Appeal exhaustion requirement and related policy changes, such as new aid-continuing rules and new filing deadlines?

A5. Yes. On July 2, 2015, DLTC released *MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees* to MLTC partial capitation plans. The policy is posted to the MRT 90 website (https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm).

Q6. Who decides whether to grant aid-continuing?

A6. The Office of Temporary and Disability Assistance (OTDA) determines whether the appellant will receive aid-continuing. Plans must comply with OTDA aid-continuing directives immediately.

Q7. Can an enrollee get aid-continuing when they request to increase services?

A7. Generally, no. An enrollee is eligible for aid-continuing only when the plan determines to reduce, terminate, or suspend covered services. (A limited exception applies to Varshavsky class members. OTDA will notify the plan of the aid-continuing order in such cases, as well as in regular aid-continuing cases.)

(*See* 18 NYCRR 358-3.3 and 358-3.6; *see also* 42 CFR § 438.404)

Q8. What is the deadline to ask for aid-continuing?

A8. Usually enrollees have the right to aid-continuing when they are entitled to timely notice, such as when a plan proposes to reduce, terminate, or suspend covered services. Timely notice requires Plans to send the notice at least ten (10) calendar days before the date the proposed action takes effect.

Enrollees have the right to aid-continuing if they request a Fair Hearing within ten (10) calendar days from the notice date (*i.e.*, the date it is sent) or by the date the proposed action takes effect, whichever is later.

Q9. Given that an Internal Appeal and Fair Hearing can run simultaneously, is a plan required to wait until the Fair Hearing is decided before implementing the Internal Appeal decision?

A9. If aid-continuing is not granted, the plan may implement its Internal Appeal decision to reduce or terminate services with respect to the benefit(s) at issue. However, to the extent that the Fair Hearing decision is more favorable than the Internal Appeal decision, the plan will have to reinstate the benefit(s) as directed by OTDA in the Fair Hearing decision.

If aid-continuing is granted, the plan must maintain the level of benefits provided for in the aid-continuing order from OTDA.

Q10. What happens if the Plan's Internal Appeal finds in the member's favor before the Fair Hearing concludes? Does the Fair Hearing process end?

A10. No. The Fair Hearing continues until a decision is reached unless OTDA determines that the hearing request is withdrawn or abandoned.

Q11. What if the Fair Hearing concludes before the Internal Appeal? Does the Internal Appeal end?

A11. No, however the Plan must comply with the Fair Hearing decision as required by state and federal law. The Plan should render its Internal Appeal decision accordingly, providing at least the amount of care required by the Fair Hearing decision.

If the Plan decides to adopt the Fair Hearing decision, it may refer to the Fair Hearing decision as the rationale required on the notice.

Q12. Has the External Appeal process changed as a result of the elimination of the Internal Appeal exhaustion requirement?

A12. The rules for External Appeals have not changed. They are still available under the same circumstances. An overview of these rules is located in the External Appeal section on the last page of the model IAD notice.

Q13. Does the plan have to send the IAD and 4687 Action Taken Notice if the enrollee agrees with the plan's action? For example, what should happen when a member requests a reduction in home delivered meals because the member's daughter comes for lunch every Wednesday?

A13. Yes. The plan must send the IAD and 4687 Action Taken notices even if the member agrees with the proposed reduction, termination, or suspension of services. This is required even if the enrollee requested the action.

Note that the enrollee request itself does not constitute sufficient reason for a plan to reduce, suspend, or terminate services, even if the enrollee provides an apparently valid justification. The plan must verify the change in circumstances and assess whether the proposed or requested reduction, suspension, or termination is supportable by applicable authority and/or medical necessity.