New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations

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Federal Medicaid managed care rules published in May 6, 2016 amended procedures for service authorization, appeals, fair hearings, and aid continuing. Medicaid managed care plans, including mainstream, HIV Special Needs Plans and Health and Recovery Plans, must continue to comply with requirements in NYS statute, NYS regulation, and the Medicaid Managed Care Model Contract where not superseded by federal rule, including but not limited to the provision of evidence packets, appearance at state fair hearings, and compliance with the Office of Administrative Hearings directives and decisions.

Right to Fair Hearing regarding plan services authorization determinations:

1) 42 CFR §§438.402(c)(1)(i) and 438.408(f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld.

2) 42 CFR §§438.402(c)(1)(i)(A), 438.408(c)(3), and 438.408(f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applies when:

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State-specified timeframes; or
- a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408.

3) 42 CFR §438.408(f)(2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing.

4) Pursuant to 42 CFR §438.424(a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Right to Aid Continuing

Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365-a(8), and 18 NYCRR §360-10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:

- 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.

NYS MMC plans are required to provide AC:

- **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan's appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

The MMC plan must continue the enrollee's services provided under AC until one of the following occurs:

- the enrollee withdraws the request for aid continuing, the plan appeal or the fair hearing;
- the enrollee fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (Final Adverse Determination)[1];
- OAH determines that the Enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or
- the provider order has expired, except in the case of a home bound enrollee.

Where the final resolution upon plan appeal or fair hearing is to uphold an adverse benefit determination, the enrollee may be held liable for services in accordance with 42 CFR §438.420(d).

[1] Services authorized under AC must be continued for at least 10 days from when the Final Adverse Determination is sent.