Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 15.04: Interim Guidance for MLTC Partial Capitation Appeal Notices

Date of Issue: August 10, 2015

Within Section 1.B. of Appendix K of the Partial Capitation Model Contract, there are four required notice templates relating to Expedited and Standard Appeals. This document describes how these notices will be affected by the elimination of the exhaustion requirement for internal appeals.

This guidance is effective immediately and will also be reflected in the forthcoming renewal of the partial capitation contracts for the period between January 1, 2015 and December 31, 2016.

Notice Template 1:

Plans must send the enrollee a letter indicating the plan will not make a determination on the appeal because the appeal request was not submitted by the member within 60 business days of the notice of action.

Please note the 45 day notice period has been changed to **60 business days**.

Notice Template 2: (no change)

Plans must send the enrollee a written acknowledgement of receipt of the appeal request. The notice must contain at least the following:

- Name, address and telephone number of the individual or department designated by the plan to respond to the appeal.
- If a member has requested an expedited appeal and the plan has decided not to expedite the appeal, the acknowledgement must indicate that the appeal will be handled on a standard basis, and inform the member of his/her right to file a grievance and how to do so.
- The acknowledgement must identify any additional information the plan requires from any source to make the appeal decision.

Notice Template 3: (no change)

If the plan wants to extend the time it can take to render an internal appeal decision, it must send the enrollee a written notice with at least the following:

- Reason for extension
- How the delay is in the best interest of the member
- Any additional information that the plan requires from any source to make its determination

The plan may send this on its own, or combine it with the written acknowledgement.

Notice Template 4:

To reflect the elimination of the internal appeal exhaustion requirement, and related policy changes, plan appeal final determination notices must comply with the following:

Final Determination Notices

The Contractor shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired enrollees. Notices shall include that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

All notices must include up-to-date contact information for the Independent Consumer Advocacy Network (ICAN), along with the following statement: "You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:"

A) Notice to the enrollee of Action Appeal Determinations shall be dated and include:

1) Date the action appeal was filed and a summary of the action appeal;

2) Date the action appeal process was completed;

3) The results and the reasons for the determination, including the clinical rationale, if any;

4) If the determination was not wholly in favor of the enrollee, and:

a) The contractor upheld its original action, a statement that reminds the enrollee of their right to request a fair hearing, including:

i) That a request for a fair hearing must have been made to the State within 60 calendar days of the initial action notice;

ii) The date by which such request must have been made; and

iii) If time remains for a fair hearing to be requested, instructions on how to request a fair hearing; or a statement that time to request a fair hearing has expired.

b) The contractor modified its original action in any way, a statement that the action appeal determination constitutes a new action, and the enrollee has a right to request a fair hearing, including:

i) That a request for a fair hearing must be made to the State within 60 calendar days of the date of the action appeal notice; and

ii) A completed NYSDOH standard "Managed Long Term Care Action Taken" notice for denial of benefits or for termination or

reduction in benefits, as applicable, containing the enrollee's fair hearing and aid continuing rights.

5) The right of the enrollee to contact the New York State Department of Health regarding his or her complaint, including the NYSDOH's toll-free number for complaints; and

6) For action appeals involving personal care services, the number of hours per day, number of hours per week, and the personal care services function (Level I/Level II):

   a) That were previously authorized, if any;

   b) That were requested by the enrollee or their designee, if so specified in the request;

   c) That are authorized for the new authorization period, if any; and

   d) The original authorization period and the new authorization period, as applicable.

7) For action appeals involving medical necessity or an experimental or investigational treatment, the notice must also include:

   a) A clear statement that the notice constitutes the final adverse determination and specifically use the terms "medical necessity" or "experimental/investigational;"

   b) The enrollee's coverage type;

   c) The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;

   d) Statement that the enrollee is eligible to file an external appeal and the timeframe for filing, and if the action appeal was expedited, a statement that the enrollee may choose to file a standard action appeal with the contractor or file an external appeal;

   e) A copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form;

   f) The contractor's contact person and telephone number;

   g) The contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent; and

   h) If the contractor has a second level internal review process, the notice shall contain instructions on how to file a second level action appeal and a statement in bold text that the timeframe for requesting an external

appeal begins upon receipt of the final adverse determination of the first level action appeal, regardless of whether or not a second level of action appeal is requested, and that by choosing to request a second level action appeal, the time may expire for the enrollee to request an external appeal.