NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 2, 2015

Dear Health Plan Administrator:

In an effort to improve the frequency and consistency of compliance with State and Federal notice content requirements the Department has developed two model notices: the Model Managed Long Term Care (MLTC) Initial Adverse Determination and the Model Managed Long Term Care Action Taken - Denial, Reduction or Termination of Benefits (211). Development of model notices will foster enrollee comprehension, reduce the size and length of a typical notice, create one fair hearing notice, and streamline review of such notices during compliance reviews and operational surveys. Plans are required to implement processes to utilize these models **by 5/15/15**. The Department will conduct a training session shortly. This directive is applicable to MLTC Partial Cap and Medicaid Advantage Plus (MAP) plans. Model notices for PACE plans will be forthcoming.

This communication contains detailed information on the use of these models, approval procedures, and deadlines. Please be sure to share this information with appropriate staff in your organization.

Model MLTC Initial Adverse Determination Notice

This model notice was developed for all administrative and medical necessity Actions, except for Actions based on a restriction to benefits. The model contains gray placeholder fields for both static (unchanging) plan-specific information, such as the time allowed to file an appeal, and dynamic fields that change with each Action notice. It is important that plans create mechanisms to ensure the various dynamic placeholders are utilized correctly to match the Action being taken. The model only addresses content requirements, all other notice procedures and requirements such as determination timeframes, provider notice, translations, special needs formats, clinical peer/health professional review, etc., remain the same.

As a reminder, the clinical rationale MUST:

- State the enrollee and the nature of his/her medical condition;
- State the medical service, treatment or procedure in question;
- State the basis or bases on which the plan/utilization review agent determined that the service, treatment or procedure is or was not medically necessary, experimental/investigational, or not materially different from an alternate in-network service, which demonstrates that the plan/agent considered enrollee-specific clinical information in its determination.
- Be sufficiently specific to enable the enrollee and the enrollee's health care provider to make an informed judgment regarding 1) whether or not to appeal the adverse determination, and 2) the grounds for such an appeal; and
- Be written in easily understood language.

Managed Long Term Care Action Taken – Denial, Reduction or Termination of Benefits (211) (LDSS-4687 02/15)

This model notice is designed to ensure enrollees are made aware of their due process rights and must be included with the Model MLTC Initial Adverse Determination Notice and all other Action notices, including those for restrictions to benefits. Considerable input from the advocate community was solicited to help clarify the language, *e.g.* regarding aid continuing rights for services that are stopped, reduced, or restricted. Plans must develop mechanisms to ensure the form is appropriately completed for the Action being taken.

Below is a list of certain new and noteworthy aspects of this model notice:

- The "MLTC reference number" may be any number the plan utilizes to track actions, authorizations, or notices.
- "will not be increased" checkbox is to be utilized when an enrollee asks for more of a service during an authorization period, but the increase is denied. This is particularly relevant for enrollees in receipt of CBLTCS or who are homebound.
- "detailed explanation of change in medical condition or social circumstances" This information MUST be included in the reason for denial if the Action determines to reduce or stop CBLTCS the enrollee has been receiving.
- "ADD SPECIFIC BENEFIT CITATION AS APPLICABLE; for common actions and their corresponding citations, see the citation reference table" The regulatory citations have been updated and cover most medically necessary decisions. However, where there are specific regulations or statutes that govern the Medicaid managed care benefit, the plan must complete this section with additional appropriate citations. The Department will be providing a reference table of common citations that apply to MLTC, such as 18 NYCRR 505.14(a) for personal care services. However, it is the duty of each plan to research and include appropriate citations for every form it sends. Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.
- Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.
- Essential action information is repeated in the box on the Fair Hearing Request Form sheet. This sheet is separate to allow the enrollee to request a fair hearing by mail and still retain their original notice. The information is repeated to facilitate OTDA processing of the fair hearing request.

Implementation of the Models

Please send an attestation to christina.pierotti@health.ny.gov **no later than 3/15/15** indicating your plan's intention to adopt these models. Attach copies of the model notices to the attestation, with the static placeholder fields completed for your plan. (Note: plans may change the format of the notices to accommodate their letterhead and systems, but the content must appear substantially similar to the model, and must utilize at least a 10 point font.) In general, we will not permit modification of model language for individual plans. However, brief, non-substantive introductory language or additional header reference fields may be added to the models if submitted for approval 30 days prior to use.

The implementation target date is **5/15/15**. We recognize the coding complexity involved to operationalize these notices. However, the Department will continue to cite plans for each

instance of notice non-compliance, and delays in implementing the new models will exacerbate this concern. We appreciate all efforts to meet this deadline as expeditiously as possible.

Sample Notices, Plan Training and Future Development

To demonstrate how to complete these fields, attached is a sample notice for a personal care services denial. Mainstream Managed Care (MMC) recently released multiple illustrative examples that are broadly demonstrative of how to complete the MMC versions of these models, which are substantially similar to Managed Long Term Care (MLTC) models. Additional examples of completed model notices for MLTC and a training session on their implementation and use are currently under development.

Moving forward, the Division of Health Plan Contracting and Oversight, in conjunction with the Division of Long Term Care, will convene a stakeholder workgroup to continue discussions on the model notices and address ongoing concerns, such as new legislative content requirements, and combining the fair hearing and appeals notice requirements into a single model. More information on the additional examples, training session, and workgroup will be forthcoming.

Thank you for your prompt attention to this matter. Please feel free to submit any questions to the mltcworkgroup@health.ny.gov with any questions, comments, or concerns you may have.

Sincerely,

Mark L. Kissinger
Director, Division of Long Term Care
Office of health Insurance Programs

Enclosures

Notice of MLTC Action Taken

LDSS-4687

DENIAL, REDUCTION OR TERMINATION OF BENEFITS

Notice Template

MANAGED LONG TERM CARE ACTION TAKEN
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

Notice Date: [DATE]	**This Action will take effect on [EFFDATE]**	**Call [PLANTOLLFREE#] for help**

Case Name (c/o, if present) and Address:	
[ENROLLEE NAME ENROLLEE ADDRESS]	[MLTC/URA NAME MLTC/URA ADDRESS]
CIN: [MEDICAID CIN]	Reference No.: [MLTC REFERENCE NUMBER]

[Managed Long Term Care Plan Name] has made a decision about your health care service.

On [EFFDATE] this health care service: [TYPE OF SERVICE]

- ☐ is not approved
- ☐ is partially approved
- ☐ will not be increased
- ☐ claim will not be paid. THIS IS NOT A BILL
- ☐ will be reduced
- ☐ will stop
- ☐ access will be restricted

[(*Include for only for partial approval, concurrent and LTSS*) This Action affects the health care you are getting now:

- Before this Action, from [STARTDATE] to [ENDDATE], the plan approved:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
- You requested approval for:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
- Starting [EFFDATE], the plan approval [is only for:][**changes** to:][**stays** at:][**ends**.]
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
- This means from [NEWSTARTDATE] to [NEWENDDATE], your health care service is approved for:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
- We will review your care again [IN TIME FRAME/ ON DATE].]

[Managed Long Term Care Plan Name] is taking this Action because:

[DETAILED REASON FOR ACTION, including, as applicable: clinical rationale; info needed on appeal; benefit available from FFS; LTSS/PCS requested service level/amount. If Action discontinues or reduces any LTSS, must provide detailed explanation of change in medical condition or social circumstances since the previous authorization was made. If Action is to deny an out of network referral based on training/experience, must demonstrate that in-network providers are available and have appropriate training and experience to meet the enrollee's particular needs.]

This Action is taken under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Section 365-a(2); Public Health Law Section 4403-f; [ADD SPECIFIC BENEFIT CITATION AS APPLICABLE; for common actions and their corresponding citations, see the citation reference table]

IF YOU THINK THIS ACTION IS WRONG – YOU HAVE THE RIGHT TO A FAIR HEARING
If this Action will change your care, and you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within 10 days from the date of this notice or by the date the Action takes effect.
SEE IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON NEXT PAGE

This notice can be read to you in another language. This notice is available in other [languages and] formats for special needs. Call [PLANTOLLFREE#] for help.

INSTRUCTIONS AND IMPORTANT INFORMATION ABOUT YOUR RIGHT TO FAIR HEARING

CALL [PLAN'S TOLL FREE #] FOR HELP

- **You have 60 days** from the date of this notice to ask for a Fair Hearing. You must ask for a Fair Hearing on time.
- **If your health care will be reduced or stopped, or you are being restricted, and <u>you want your health care to stay the same, you must ask for a Fair Hearing within 10 days</u> from the date of this notice or by the date the Action takes effect.** Your health care service will then stay the same until the Fair Hearing decision. If you lose your fair hearing you may have to pay for health care services you got while waiting for the decision.
- **To ask for a Fair Hearing**, you can go online, call, mail, fax, or walk in.
  - o Fill out the form on line at http://otda.ny.gov/oah/FHReq.asp.

    OR
  - o Fill out the Managed Long Term Care Fair Hearing Request Form that came with this notice. Mail or fax it with all pages that came with this notice. Keep a copy of this notice and all pages that came with it for yourself. Or, have this form with you when you call or walk in.
  - o **MAIL FAIR HEARING REQUEST FORM TO:**
    New York State Office of Temporary and Disability Assistance
    Office of Administrative Hearings
    Managed Care Unit
    P.O. Box 22023
    Albany, New York 12201-2023
  - o **FAX FAIR HEARING REQUEST FORM TO:**
    518-473-6735
  - o **CALL:** 1-800-342-3334
  - o **SPEECH or HEARING IMPAIRED**:
    Contact the New York Relay Service at 711 or 1-800-622-1220. Request that the operator call the State at 1-877-502-6155. Service at this number will only be provided to callers using TDD equipment.
  - o **WALK IN – New York City Only:**
    Office of Temporary and Disability Assistance
    Office of Administrative Hearings
    14 Boerum Place - 1st Floor
    Brooklyn, New York 11201
- **After you ask for a Fair Hearing,** the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and your plan and decide whether the plan's Action was wrong.
- **To prepare for the hearing**
  - o **Bring a copy** of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this form and all the pages that came with it to your hearing.
  - o **Your plan will send you a copy of the "evidence packet" before the hearing**. This is information your plan used to make their decision about your health care service. The plan will give this information to the hearing officer to explain their action. If there is not time enough to mail it to you, the plan will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call [PLAN'S TOLL FREE #] to ask for it.
  - o **You have the right to see your case file.** Your case file has your health records and may have more information about why your health care service was changed or not approved.
  - o **To find out how to see your case file**, or to ask for a copy of it, call [PLAN'S TOLL FREE #] or write to your Managed Long Term Care Plan at the address on the front page of the Managed Long Term Care Action Taken Notice. Your case file will be provided to you before the hearing. Your case file will only be mailed to you if you say you want the documents to be mailed and there is enough time to mail them before the hearing.
  - o **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just tell why the Action should not be taken. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
  - o **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers." In New York City, call 311.
- **After the hearing,** you will be sent a written decision about your case. If you also asked for an Internal or an External Appeal, the Fair Hearing decision will be the final answer about your benefits.
- **The Independent Consumer Advocacy Network (ICAN)** can answer your questions and give you free, independent advice about your coverage, complaints, and appeals' options. Contact ICAN at:

  Phone: 1-844-614-8800 (**TTY Relay Service:** 711); **Web:** www.icannys.org; **Email:** ican@cssny.org

This notice can be read to you in another language. This notice is available in other [languages and] formats for special needs. Call [PLANTOLLFREE#] for help.

MANAGED LONG TERM CARE FAIR HEARING REQUEST FORM

DEADLINE If you want a Fair Hearing, **you must ask for it on time.**

- **You have 60 days** from the date of this notice to ask for a Fair Hearing. The last day to ask for a Fair Hearing about this Action is [**DATE+60**].
- If your health care will be reduced, stopped or restricted**:** If you want to **KEEP YOUR HEALTH CARE THE SAME** until the Fair Hearing decision, you must ask for a Fair Hearing **within 10 days** from the date of this notice, or by the date the Action takes effect.
- You may also have the right to ask for an Internal Appeal with your managed long term care plan or an External Appeal with the State. (See full information sent with this notice.) If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing. If this Action will change your care, **you must still ask for a Fair Hearing within 10 days from the date of this notice or by the date the Action takes effect, if you want to keep your health care the same until the Fair Hearing decision.**

Fill out this form Send to the New York State Office of Temporary and Disability Assistance. See full instructions**.**

☐ **I want a Fair Hearing. This Action is wrong because:**

Client Signature:		
Client Name:	Please print	Phone: Area code ( ) -

For Actions that will reduce, stop or restrict your health care: Your health care service WILL NOT CHANGE until the Fair Hearing decision, if you ask for a Fair Hearing within **10 days** from the date of this notice, or by the date this Action takes effect**.** However, if you lose the Fair Hearing, you may have to pay for health care services that you got while you were waiting for the Fair Hearing decision.

Check this box only if you **do not want** to keep your health care the same:

☐ I **do not want** to keep my health care the same. I agree that the plan can take the Action described in this notice before my Fair Hearing decision is issued.

FOR NYS OTDA ONLY (211) MANAGED LONG TERM CARE ACTION TAKEN - DENIAL, REDUCTION OR TERMINATION OF BENEFITS

Notice Date [DATE]	This Action will take effect on [DATE]	Call [PLANTOLLFREE#] for help

Case Name (c/o, if present) and Address:

[ENROLLEE NAME
ENROLLEE ADDRESS]

CIN: [MEDICAID CIN]

[MLTC/URA NAME
MLTC/URA ADDRESS]

Reference No.: [MLTC REFERENCE NUMBER]

On [EFFDATE] this health care service: [TYPE OF SERVICE]

☐ is not approved
☐ is partially approved
☐ will not be increased
☐ claim will not be paid. THIS IS NOT A BILL.
☐ will be reduced
☐ will stop
☐ access will be restricted

[(*Include for only for partial approval, concurrent and LTSS*: This Action affects health care you are getting now:

- Before this Action, from [STARTDATE] to [ENDDATE], the plan approved:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
- You requested approval for:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
- Starting [EFFDATE], the plan approval [is only for:][**changes** to:]/[**stays** at:]/[**ends**.]
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
- This means from [NEWSTARTDATE] to [NEWENDDATE], your health care service is approved for:
  [HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]

This notice can be read to you in another language. This notice is available in other [languages and] formats for special needs. Call [PLANTOLLFREE#] for help.

Notice of MLTC Action Taken

LDSS-4687

DENIAL, REDUCTION OR TERMINATION OF BENEFITS

Sample of Actual Notice

MANAGED LONG TERM CARE ACTION TAKEN
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

Notice Date: 04/01/2015	**This Action will take effect on 04/15/15**	**Call 1-800-555-5555 for help**

Case Name (c/o, if present) and Address:

Jane Smith
123 Main Street
New York, NY 00000

CIN: XX88888X

ZZZ Health Plan
564 First Street
New York, NY 00000

Reference No.: AA999999XXX

ZZZ Health Plan has made a decision about your health care service.

On 04/15/2015 this health care service: Personal Care Level 1

- [ ] is not approved
- [ ] is partially approved
- [ ] will not be increased
- [ ] claim will not be paid. THIS IS NOT A BILL
- [XX] will be reduced
- [ ] will stop
- [ ] access will be restricted

This Action affects the health care you are getting now:

- Before this Action, from 10/15/14 to 04/14/15, the plan approved:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week = Total 208 hours
- You requested approval for:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week
- Starting 04/15/15, the plan approval **changes** to:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week, for 6 months
- This means from 04/15/15 to 10/14/15, your health care service is approved for:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week = Total 104 hours
- We will review your care again September 2015.

ZZZ Health Plan is taking this Action because:

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

This Action is taken under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Section 365-a(2); Public Health Law Section 4403-f; 18 NYCRR Section 505.14(a).

IF YOU THINK THIS ACTION IS WRONG – YOU HAVE THE RIGHT TO A FAIR HEARING
If this Action will change your care, and you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within 10 days from the date of this notice or by the date the Action takes effect.
SEE IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON NEXT PAGE

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INSTRUCTIONS AND IMPORTANT INFORMATION ABOUT YOUR RIGHT TO FAIR HEARING

CALL 1-800-555-5555 FOR HELP

- **You have 60 days** from the date of this notice to ask for a Fair Hearing. You must ask for a Fair Hearing on time.
- **If your health care will be reduced or stopped, or you are being restricted, and <u>you want your health care to stay the same, you must ask for a Fair Hearing within 10 days</u> from the date of this notice or by the date the Action takes effect.** Your health care service will then stay the same until the Fair Hearing decision. If you lose your fair hearing you may have to pay for health care services you got while waiting for the decision.
- **To ask for a Fair Hearing**, you can go online, call, mail, fax, or walk in.
  - o Fill out the form on line at http://otda.ny.gov/oah/FHReq.asp.

  OR
  - o Fill out the Managed Long Term Care Fair Hearing Request Form that came with this notice. Mail or fax it with all pages that came with this notice. Keep a copy of this notice and all pages that came with it for yourself. Or, have this form with you when you call or walk in.
  - o **MAIL FAIR HEARING REQUEST FORM TO:**
    New York State Office of Temporary and Disability Assistance
    Office of Administrative Hearings
    Managed Care Unit
    P.O. Box 22023
    Albany, New York 12201-2023
  - o **FAX FAIR HEARING REQUEST FORM TO:**
    518-473-6735
  - o **CALL:** 1-800-342-3334
  - o **SPEECH or HEARING IMPAIRED**:
    Contact the New York Relay Service at 711 or 1-800-622-1220. Request that the operator call the State at 1-877-502-6155. Service at this number will only be provided to callers using TDD equipment.
  - o **WALK IN – New York City Only:**
    Office of Temporary and Disability Assistance
    Office of Administrative Hearings
    14 Boerum Place - 1st Floor
    Brooklyn, New York 11201
- **After you ask for a Fair Hearing,** the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and your plan and decide whether the plan's Action was wrong.
- **To prepare for the hearing**
  - o **Bring a copy** of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this form and all the pages that came with it to your hearing.
  - o **Your plan will send you a copy of the "evidence packet" before the hearing**. This is information your plan used to make their decision about your health care service. The plan will give this information to the hearing officer to explain their action. If there is not time enough to mail it to you, the plan will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-555-5555 to ask for it.
  - o **You have the right to see your case file.** Your case file has your health records and may have more information about why your health care service was changed or not approved.
  - o **To find out how to see your case file**, or to ask for a copy of it, call 1-800-555-5555 or write to your Managed Long Term Care Plan at the address on the front page of the Managed Long Term Care Action Taken Notice. Your case file will be provided to you before the hearing. Your case file will only be mailed to you if you say you want the documents to be mailed and there is enough time to mail them before the hearing.
  - o **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just tell why the Action should not be taken. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
  - o **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers." In New York City, call 311.
- **After the hearing,** you will be sent a written decision about your case. If you also asked for an Internal or an External Appeal, the Fair Hearing decision will be the final answer about your benefits.
- **The Independent Consumer Advocacy Network (ICAN)** can answer your questions and give you free, independent advice about your coverage, complaints, and appeals' options. Contact ICAN at:

  Phone: 1-844-614-8800 (**TTY Relay Service:** 711);
  Web: www.icannys.org; **Email:** ican@cssny.org

This notice can be read to you in another language. This notice is available in other formats for special needs. Call 1-800-555-5555 for help.

MANAGED LONG TERM CARE FAIR HEARING REQUEST FORM

DEADLINE If you want a Fair Hearing, **you must ask for it on time.**

- **You have 60 days** from the date of this notice to ask for a Fair Hearing. The last day to ask for a Fair Hearing about this Action is **06/15/2015**.
- If your health care will be reduced, stopped or restricted**:** If you want to **KEEP YOUR HEALTH CARE THE SAME** until the Fair Hearing decision, you must ask for a Fair Hearing **within 10 days** from the date of this notice, or by the date the Action takes effect.
- You may also have the right to ask for an Internal Appeal with your managed long term care plan or an External Appeal with the State. (See full information sent with this notice.) If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing. If this Action will change your care, **you must still ask for a Fair Hearing within 10 days from the date of this notice or by the date the Action takes effect, if you want to keep your health care the same until the Fair Hearing decision.**

Fill out this form Send to the New York State Office of Temporary and Disability Assistance. See full instructions**.**

☐ **I want a Fair Hearing. This Action is wrong because:**

Client Signature:		
Client Name:	Please print	Phone: Area code ( ) -

For Actions that will reduce, stop or restrict your health care: Your health care service WILL NOT CHANGE until the Fair Hearing decision, if you ask for a Fair Hearing within **10 days** from the date of this notice, or by the date this Action takes effect**.** However, if you lose the Fair Hearing, you may have to pay for health care services that you got while you were waiting for the Fair Hearing decision.

Check this box only if you **do not want** to keep your health care the same:

☐ I **do not want** to keep my health care the same. I agree that the plan can take the Action described in this notice before my Fair Hearing decision is issued.

FOR NYS OTDA ONLY (211) MANAGED LONG TERM CARE ACTION TAKEN - DENIAL, REDUCTION OR TERMINATION OF BENEFITS

Notice Date 04/01/2015	This Action will take effect on 04/15/2015	Call 1-800-555-5555 for help

Case Name (c/o, if present) and Address:

Jane Smith
123 Main Street
New York, NY 00000

CIN: XX88888X

ZZZ Health Plan
564 First Street
New York, NY 00000

Reference No.: AA999999XXX

On 04/15/2015 this health care service: Personal Care Level 1

- ☐ is not approved
- ☐ is partially approved
- ☐ will not be increased
- ☐ claim will not be paid. THIS IS NOT A BILL.
- ☒ will be reduced
- ☐ will stop
- ☐ access will be restricted

This Action affects the health care you are getting now:

- Before this Action, from 10/15/14 to 04/14/15, the plan approved:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week = Total 208 hours
- You requested approval for:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week
- Starting 04/15/15, the plan approval **changes** to:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week, for 6 months
- This means from 04/15/15 to 10/14/15, your health care service is approved for:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week = Total 104 hours

This notice can be read to you in another language. This notice is available in other formats for special needs. Call 1-800-555-5555 for help.

MODEL MLTC INITIAL ADVERSE DETERMINATION Notice

Notice Template

MODEL MLTC INITIAL ADVERSE DETERMINATION (2/15)

[MLTC/ UR AGENT/BENEFIT MANAGER LETTERHEAD]
[Plan Name]
[Address]
[Phone]

This notice can be read to you in another language. This notice is available in other [languages and] formats for special needs.
Call [PLAN'S TOLL FREE #] for help.

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee ID: [ID number or CIN]
Health care service: [describe requested or claimed service including amount/duration]
Provider: [requesting provider]

Dear [Enrollee]:

You are getting this notice because your managed long term care plan did not approve your health care service or is changing the health care service you are getting now. This is an **initial adverse determination**. **You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked [Plan Name] to approve the health care service described above. {[UR Agent Name/Benefit Manager] on behalf of} [Plan Name] has determined that {insert as applicable}

[*this service will not be covered*]
[*coverage for this service will be reduced*]
[*coverage for this service will be stopped*]
[*this claim will not be paid*]

[This action will take effect on {effdate}.] The plan is taking this action because the {insert as applicable}

[*health care service is not medically necessary*]
[*request did not have enough information to determine if the health care service is medically necessary*]
[*health care service is experimental/investigational*]
[*health care service is not covered by your managed care benefits*]
[*health care service can be provided by a participating provider*]
[*health care service is not very different from a health care service that is available from a participating provider*]
[*other decision*].

[Insert detailed reason for Action, including, if applicable, the clinical rationale (which must include the basis for the determination demonstrating review of enrollee specific clinical information, and be sufficiently specific to enable judgment as to basis for appeal)]. If Action discontinues or reduces any LTSS service, must provide detailed explanation of change in medical condition or social circumstances since the previous authorization was made. If Action is to deny an out of network referral based on

training/experience, must demonstrate that in-network providers are available and have appropriate training and experience to meet the enrollee's particular needs.]

{insert as applicable} [While this health care service is not covered by [Plan Name], you may be able to get it from regular Medicaid. {To get this service, use your New York State Benefit card to see any provider that accepts New York Medicaid.}]

{insert as applicable for partial approval, concurrent, or LTSS}
[{Before this Action, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]}
You requested approval for:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
Starting [EFFDATE], the plan approval [is only for:][**changes** to:][**stays** at:][**ends**.]
[HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
This means from [NEWSTARTDATE] to [NEWENDDATE], your health care service is approved for:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{We will review your care again [IN TIME FRAME/ ON DATE].}
{This health care service will be provided by [a participating][an out of network] provider.}{You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.}]

[Insert for OON provider denial, the in-network providers available and how to access them. For OON referral denial based on training/experience, the name of the provider(s) must be included.]

[Insert for OON service not materially different, the alternate in-network treatment that is available, how to access/get approval for the alternate service]

If You Think This Action is Wrong

If you agree with this Action, you do not need to do anything. If you think this Action is wrong, there are several things you can do:

- **You can ask the State for a Fair Hearing** – an administrative law judge will decide your case. If your health care is being reduced, stopped or restricted, you must ask for a fair hearing if you want to keep your health care the same until your case is decided.
- **You can ask [Plan Name] for an Internal Appeal** – The plan will look at your case again. This may be the fastest way to fix the problem. Your health care may change while you are waiting for an Internal Appeal decision.
- **You may be able to ask the State for an External Appeal –** this is may be the best way to show how this health care is medically necessary for you. Your health care may change while you are waiting for an External Appeal decision.
- If you ask for all of these, the Fair Hearing decision will always be the final answer.

There are different times to request each type of appeal. READ THE FOLLOWING INFORMATION CAREFULLY or you may lose one or more options.

Fair Hearing

See the "MANAGED LONG TERM CARE ACTION TAKEN" notice sent with this letter for instructions on how to ask for a Fair Hearing. You can call 1-800-342-3334 to ask for a Fair Hearing.

You have **60 days** from the date on this notice to ask for a Fair Hearing. If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing.

If your health care is being reduced, stopped or restricted: If you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within **10 days** from the date of this notice, or by the date the Action takes effect.

Internal Appeal

See "IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS" sent with this letter to learn how Internal Appeals work. You have [**60 working days**] from the date of this notice to ask for an Internal Appeal. To ask for an Internal Appeal, you can write or call us {*or* use appeal form and mail to}

Write to: [Plan Name]
[Address]
[City, State Zip]
Call: [PLAN'S TOLL FREE #].

[Insert any specific information the plan or agent needs to receive upon appeal]

{Insert for OON not materially different, if plan requires for UR review} [If we said that the health care service you asked for is not very different from a health care service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the health care service you are asking for.
2) two medical or scientific documents that prove the health care service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

We will review your appeal to see if the health care service you are asking for is medically necessary for you. If your doctor does not send this information, we will still review your appeal. However, you may not be eligible for an External Appeal.]

{Insert for OON referral denial based on training/experience} [If you think our participating provider does not have the correct training or experience to treat you, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing that says our participating provider does not have the correct training and experience to meet your specific health care needs, and

2) that recommends an out of network provider with the correct training and experience to meet your specific health care needs, who is able to provide the requested services.

We will review your appeal to see if a referral to the out of network provider is medically necessary for you. If your doctor does not send this information, we will still review your appeal. However, you may not be eligible for an External Appeal.]

External Appeal

An External Appeal is a review of your case by health care professionals that do not work for your plan or the State. This is only available if we said your health care was:

- not medically necessary,
- was experimental/ investigational, or
- was not different from care you can get in the plan's network.
- available from a participating provider who has the training and experience to meet your needs

See "IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS" sent with this letter to learn how to ask for an External Appeal. Once you are eligible to apply, you will have 4 months to ask for an External Appeal.

Other Help

You can call [PLAN NAME] at [PLAN'S TOLL FREE #] if you have any questions about this notice. You can also file a complaint about your managed long term care at any time with the New York State Department of Health by calling 1-866-712-7197.

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:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org

Sincerely,

MLTC/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Important Information About Your Right to Appeal
Managed Long Term Care Action Taken Form

cc: Requesting Provider

IMPORTANT INFORMATION ABOUT YOUR RIGHT TO APPEAL

CALL [PLAN'S TOLL FREE #] FOR HELP

You can ask for an Internal Appeal

- An Internal Appeal allows you to ask your plan to look at your case again. You can have someone you trust ask for an Internal Appeal for you. There is no penalty and your plan will not treat you differently because you asked for an Internal Appeal.
- **Asking for an Internal Appeal is not a request for Fair Hearing and is not a request to keep your health care the same.** The Action you are asking to be corrected is stopped only if you win the Internal Appeal.
- You must ask for an Internal Appeal within [**60 working days**] from the date on this notice.
- Your plan will make a decision about your Internal Appeal within 30 days.
- Your Internal Appeal will be fast tracked if:
  - o Your provider says the appeal needs to be faster;
  - o You are asking for more of a service you are getting right now; OR You are asking for home care services after you leave the hospital.

  Your plan will make a decision about your fast track Internal Appeal within 3 working days.
- You can ask for your Internal Appeal to be fast tracked if you think a delay will cause harm to your health. If your request for a fast track Internal Appeal is denied, your plan will let you know in writing and will review your appeal in the regular time.
- If your plan needs more information about your case, and it is in your best interest, it may take up to 14 days longer to review your regular or fast track Internal Appeal. Your plan will tell you in writing if this happens. You or your provider may also ask the plan to take up to 14 days longer to review your Internal Appeal.

- **To ask for an Internal Appeal**, write to {or fill out appeal form and mail to}:

  [PLAN APPEALS DEPARTMENT]
  [ADDRESS1]
  [ADDRESS 2]
  [City, State Zip]

  Or call [PLAN'S TOLL FREE #]
  If you call, you will be asked to follow up in writing (unless your Internal Appeal is fast tracked)
- With your Internal Appeal, send your plan information to support your case. Check this notice to see if there is specific information your plan needs. You can also give information to your plan in person.
- You can ask your plan for the clinical review criteria, if any, the plan used to make this decision.
- You have the right to see your case file.
- You will get the plan's decision about your Internal Appeal in writing. If fast tracked, you will also be contacted by phone. If you lose your Internal Appeal, your plan will send you its Final Adverse Determination.
- [{insert if applicable} Check your plan's handbook to see how you can ask for a second level appeal. {or insert 2nd level appeal information}.]
- The Independent Consumer Advocacy Network (ICAN) can answer your questions and give you free, independent advice about your coverage, complaints, and appeals' options. Contact ICAN at: Phone: 1-844-614-8800 (TTY Relay Service: 711); Web: www.icannys.org; Email: ican@cssny.org

You may be able to ask for an External Appeal

- An External Appeal is a review of your case by health care professionals that do not work for your plan or the State. This is only available if your plan said your health care was: **1)** not medically necessary, **2)** experimental or investigational, **3)** not different from care you can get in the plan's network, or **4)** available from a participating provider who has the training and experience to meet your needs.
- **Before you ask for an External Appeal:**
  - o You must file an Internal Appeal with your plan and get the plan's Final Adverse Determination; **or**
  - o If you ask for a fast track Internal Appeal with your plan, you may also ask for a fast track External Appeal at the same time; **or**
  - o You and your plan may jointly agree to skip the plan's Internal Appeal process and go directly to the External Appeal.

- You have **4 months** to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the plan's Internal Appeal process.
- You can ask someone you trust to file the External Appeal for you. You will need your doctor's help to fill out the External Appeal application.
- To get an External Appeal application and instructions:
  - o Call [Plan Name] at [PLAN'S TOLL FREE #]; or
  - o Call the New York State Department of Financial Services at 1-800-400-8882; or
  - o Go on line: www.dfs.ny.gov
- The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing.

You can file a complaint about your managed long term care plan at any time with the New York State Department of Health
Call: 1-866-712-7197 or Email: mltctac@health.ny.gov

This notice can be read to you in another language.
This notice is available in other [languages and] formats for special needs. Call [PLAN'S TOLL FREE #] for help.

MODEL MLTC INITIAL ADVERSE DETERMINATION Notice

Sample of Completed Notice

MODEL MLTC INITIAL ADVERSE DETERMINATION (2/15)

ZZZ Health Plan

564 First Street
New York, New York 00000

This notice can be read to you in another language. This notice is available in other formats for special needs.
Call 1-800-555-5555 for help.

April 1, 2014

Jane Smith
123 Main Street
New York, NY 00000

Enrollee ID: XX88888X
Health care service: request for 2 hours/day level 1 personal care, 4 days/week
Provider: Sweet Care at Home

Dear Ms. Smith:

You are getting this notice because your managed long term care plan did not approve your health care service or is changing the health care service you are getting now. This is an **initial adverse determination**. **You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked ZZZ Health Plan to approve the health care service described above. ZZZ Health Plan has determined that coverage for this service will be reduced. This action will take effect on 04/15/15. The plan is taking this action because the health care service is not medically necessary.

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

Before this Action, from 10/15/14 to 04/14/15, the plan approved:
2 hours/day level 1 personal care, 4 days/week, 8 hours/week = Total 208 hours
You requested approval for:
2 hours/day level 1 personal care, 4 days/week, 8 hours/week
Starting 04/15/15, the plan approval **changes** to:
1 hours/day level 1 personal care, 4 days/week, 4 hours/week, for 6 months
This means from 04/15/15 to 10/14/15, your health care service is approved for:
1 hours/day level 1 personal care, 4 days/week, 4 hours/week = Total 104 hours
We will review your care again September 2015.

If You Think This Action is Wrong

If you agree with this Action, you do not need to do anything. If you think this Action is wrong, there are several things you can do:

- **You can ask the State for a Fair Hearing** – an administrative law judge will decide your case. If your health care is being reduced, stopped or restricted, you must ask for a fair hearing if you want to keep your health care the same until your case is decided.
- **You can ask ZZZ Health Plan for an Internal Appeal** – The plan will look at your case again. This may be the fastest way to fix the problem. Your health care may change while you are waiting for an Internal Appeal decision.
- **You may be able to ask the State for an External Appeal –** this is may be the best way to show how this health care is medically necessary for you. Your health care may change while you are waiting for an External Appeal decision.
- If you ask for all of these, the Fair Hearing decision will always be the final answer.

There are different times to request each type of appeal. READ THE FOLLOWING INFORMATION CAREFULLY or you may lose one or more options.

Fair Hearing

See the "MANAGED LONG TERM CARE ACTION TAKEN" notice sent with this letter for instructions on how to ask for a Fair Hearing. You can call 1-800-342-3334 to ask for a Fair Hearing.

You have **60 days** from the date on this notice to ask for a Fair Hearing. If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing.

If your health care is being reduced, stopped or restricted: If you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within **10 days** from the date of this notice, or by the date the Action takes effect.

Internal Appeal

See "IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS" sent with this letter to learn how Internal Appeals work. You have **60 working days** from the date of this notice to ask for an Internal Appeal. To ask for an Internal Appeal, you can write or call.

Write to: ZZZ Health Plan
564 First Street
New York, New York 00000
Call: 1-800-555-5555.

External Appeal

An External Appeal is a review of your case by health care professionals that do not work for your plan or the State. This is only available if we said your health care was:

- not medically necessary,
- was experimental/ investigational, or
- was not different from care you can get in the plan's network.
- Available from a participating provider who has the training and experience to meet your needs

See “IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS” sent with this letter to learn how to ask for an External Appeal. Once you are eligible to apply, you will have 4 months to ask for an External Appeal.

Other Help

You can call ZZZ Health Plan at 1-800-555-5555 if you have any questions about this notice. You can also file a complaint about your managed long term care at any time with the New York State Department of Health by calling 1-866-712-7197.

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:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org

Sincerely,

Mary Jones, M.D.
Long Term Service Clinical Reviewer

Enclosure: Important Information About Your Right to Appeal
Managed Long Term Care Action Taken Form

cc: Requesting Provider

IMPORTANT INFORMATION ABOUT YOUR RIGHT TO APPEAL

CALL 1-800-555-5555 FOR HELP

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- Your plan will make a decision about your Internal Appeal within 30 days.
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  ZZZ Health Plan
  564 First Street
  New York, NY 00000

  Or call 1-800-555-5555
  If you call, you will be asked to follow up in writing (unless your Internal Appeal is fast tracked)
- With your Internal Appeal, send your plan information to support your case. Check this notice to see if there is specific information your plan needs. You can also give information to your plan in person.
- You can ask your plan for the clinical review criteria, if any, the plan used to make this decision.
- You have the right to see your case file.
- You will get the plan's decision about your Internal Appeal in writing. If fast tracked, you will also be contacted by phone. If you lose your Internal Appeal, your plan will send you its Final Adverse Determination.
- [{insert if applicable} Check your plan's handbook to see how you can ask for a second level appeal. {or insert 2nd level appeal information}.]
- The Independent Consumer Advocacy Network (ICAN) can answer your questions and give you free, independent advice about your coverage, complaints, and appeals' options. Contact ICAN at: Phone: 1-844-614-8800 (TTY Relay Service: 711); Web: www.icannys.org; Email: ican@cssny.org

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  - o If you ask for a fast track Internal Appeal with your plan, you may also ask for a fast track External Appeal at the same time; **or**
  - o You and your plan may jointly agree to skip the plan's Internal Appeal process and go directly to the External Appeal.

- You have **4 months** to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the plan's Internal Appeal process.
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- To get an External Appeal application and instructions:
  - o Call ZZZ Health Plan at 1-800-555-5555; or
  - o Call the New York State Department of Financial Services at 1-800-400-8882; or
  - o Go on line: www.dfs.ny.gov
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You can file a complaint about your managed long term care plan at any time with the New York State Department of Health
Call: 1-866-712-7197 or Email: mltctac@health.ny.gov

This notice is available in other languages and formats for special needs. Call [PLAN'S TOLL FREE #] for help.

Sample of MLTC Plan Letter to Members Explaining that Internal Appeals No Longer Required –

Notice sent to all MLTC Members

June 2015

Many people are confused by this notice. They think plan is cutting services. Plan is only informing them of change in appeal procedures.

ElderServe Health now RiverSpring at Home
94 West 225th Street
Bronx, NY 10463

THIS LETTER CONTAINS IMPORTANT INFORMATION ABOUT A CHANGE IN YOUR RIGHTS WHEN WE MAKE DECISIONS ABOUT YOUR CARE. PLEASE READ IT CAREFULLY.

5/29/2015

Dear .....,

WHAT IS THIS LETTER ABOUT?

Starting **July 1, 2015**, when we make a *care decision* you disagree with, you will be able to request a State fair hearing right away.

This includes when we do not give you care that you request, like when you ask for personal care. It also includes when we stop or reduce your care, like when you already have personal care and we try to stop or reduce the number of hours.

THE CURRENT APPEAL PROCESS (this will go away soon):

Right now, there is a two step process. If you disagree with our care decision, you must first ask us to review our decision on your care. This is called an "internal appeal." If you ask for an internal appeal, new reviewers evaluate your case, and then tell you in writing whether we think our decision was right.

If you still disagree, you can then ask for a State fair hearing. A State hearing officer will hold a hearing and then decide whether we must give you the care you asked for or want to keep. The State fair hearing decision overrules our decision, but you have to request an internal appeal before you can get a State fair hearing.

THE NEW APPEAL PROCESS (starting July 1, 2015):

You will be able to ask for a State fair hearing right away. You are not required to ask for an internal appeal first. This change also affects your appeal rights, such as the deadline to ask for a State fair hearing, or how to have your care continue. These changes are very important.

For care decisions **on or after July 1, 2015**, we will begin using new decision notices. These notices will explain your new appeal options in more detail. So if you receive any decision notice about your care, please read it very carefully.

HOW TO KEEP YOUR SERVICES DURING THE NEW APPEAL PROCESS:

Sometimes you can keep your services until you get an appeal decision (this is called "aid-continuing"). You will get aid-continuing IF:

- we decide that your care should be reduced or stopped; AND
- you ask for a State fair hearing by the deadline for aid-continuing.

IMPORTANT: If you ask for an internal appeal but don't ask for a State fair hearing, you will not get aid-continuing. The ONLY way to get aid-continuing is if you ask for a State fair hearing before the aid-continuing deadline. We will send you a notice that will tell you what to do to make sure your care stays the same until the fair hearing decision is issued.

WHEN WILL THIS CHANGE HAPPEN?

This change will happen for every decision we make about your care that is dated on or after July 1, 2015. **This date is very important.**

- For decisions **before July 1, 2015**, the old rules still apply: you must ask us for an internal appeal before you can get a State fair hearing.

- For decisions **on or after July 1, 2015**, the new rules apply: you will be able to ask for a State fair hearing right away.

QUESTIONS?

If you have questions about this letter, you can call us at 1-800-360-3700. [(TTY users call 1-866-236-5800. (or,TTY users: call 711 and follow the prompts to dial 1-800-360-3700).

You can also contact the Independent Consumer Advocacy Network ("ICAN") to get free, independent advice about this letter. Contact ICAN toll-free at 1-844-614-8800. (TTY users: call 711 and follow the prompts to dial 844-614-8800).

ICAN can address your questions about coverage, complaints and appeals' options, and they can help you manage the appeal process. To find out more about ICAN, visit them online at www.icannys.org.