The New York State Department of Health Office of Health Insurance Programs will implement several important changes related to Medicaid managed care service authorization appeals, fair hearings and grievances (complaints) as required by the Center for Medicare and Medicaid Services Medicaid and Children's Health Insurance (CHIP) Programs Final Rule published May 6, 2016, amending federal rules at 42 CFR Part 438. This is a major change affecting the majority of New Yorkers enrolled in the state's Medicaid managed care programs. These changes apply to New York's mainstream Medicaid managed care, Health and Recovery Plans (HARPs), HIV Special Needs Plans, Managed Long-Term Care Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus.

The Office of Health Insurance Programs will hold a free informational webinar for providers, community representatives and enrollees to learn more about the new appeals process on the following dates. No registration is required. The same information will be provided on both dates. This session will be recorded and shared at a later date.

March 28, 2018 1:00 PM – 3:00 PM
Join: https://meetny.webex.com/meetny/onstage/g.php?MTID=e600354c1c6d2830118b32a617b0e09b0
Call: US Toll Free: 1-844-633-8697
Local: 1-518-549-0500
Access code: 646 221 892

March 30, 2018 10:00 AM – 12:00 PM
Join: https://meetny.webex.com/meetny/onstage/g.php?MTID=e06f32a614c724ad4609db2d5c211c7e9
Call: US Toll Free: 1-844-633-8697
Local: 1-518-549-0500
Access code: 645 278 217

The informational webinar will review the new requirements for service authorization requests, appeals, and complaints. Starting May 1, 2018, plans will be required to complete review of service authorization requests under different time frames, issue revised enrollee notices, and, for adverse determinations made on May 1, 2018 and thereafter, follow revised appeal processes. Although there are several changes, two key provisions are:

- Starting with plan service determinations made on May 1, 2018 and thereafter, enrollees wishing to dispute a plan's adverse determination regarding their services must exhaust the plan's internal appeal process BEFORE requesting a State Fair Hearing. This means the enrollee must request a plan appeal, which may be expedited, and receive a Final Adverse Determination upholding the plan's decision prior to requesting a State Fair Hearing. Enrollees will have 120 days from the Final Adverse Determination to request a State Fair Hearing. If the plan does not respond to the Plan Appeal or the response is late, the appeal process will be deemed exhausted and the enrollee may request a State Fair Hearing.

- Upon review, health plans may determine to reduce, suspend or terminate authorized services. The enrollee will be able to have their aid continue from the plan upon filing a plan appeal within 10 days of the Initial Adverse Determination notice, or before the effective date of the decision, whichever is later. If the plan upholds its decision, and issues a Final Adverse Determination, the enrollee may have their aid continue by requesting a State Fair Hearing within 10 days of the Final Adverse Determination notice, or before the effective date of the decision, whichever is later. If the enrollee loses their plan appeal or Fair Hearing, they may have to pay for the services they received while their appeal/fair hearing was being decided.

If you have any questions related to the regulation changes, please contact 438reg@health.ny.gov. Thank you.