SUMMARY OF EXPRESS TERMS

The Department is amending sections 360-10.3 and 360-10.8 of title 18 of the New York Codes, Rules and Regulations to align state regulations with current federal regulatory authority (*see* 42 C.F.R. Part 438 Subpart F) that requires enrollees in Medicaid managed care organizations (MMCOs) to exhaust the MMCO's action (i.e. internal) appeal process for most actions prior to a fair hearing. The federal exhaustion requirement was first promulgated by the Centers for Medicaid and Medicare Services (CMS) on May 6, 2016 and became effective April 1, 2018. *See* 81 FR 27498. Since that time, the Department has worked closely with MMCOs and other stakeholders to ensure that the exhaustion requirements were successfully implemented. The Department established working groups, developed implementation guidance, updated the model contracts between the Department and MMCOs, and published model action and action appeal determination notices, among other efforts to implement the new federal requirements. This rulemaking is thus primarily intended to bring the Department's regulations into alignment with current Medicaid managed care requirements and practice.

The Department is also taking this opportunity to address and clarify rules regarding procedure and presentation of evidence for Medicaid fair hearings and external appeals, including the scope of fair hearing decisions. See amendments and new provisions at 10 NYCRR 98-2.10(m) and 18 NYCRR 360-10.8(f)(5), (f)(7), (f)(8), (g), and (i).

In updating the State's regulations, the Department has decided to retain the regulation's primary focus on the fair hearing process and rights afforded to enrollees.

Because federal rules now require exhaustion of the action appeal process in most cases before an enrollee may avail themselves of the fair hearings process, many provisions concerning or related to MMCO "notices of action" were moved or removed as not being pertinent. See, e.g., 18 NYCRR 360-10.8(e)(2)(i)(*e*) of the current regulation regarding procedures for requesting an appeal, which would be moot in any action appeal determination notice. However, the underlying requirements on notices of actions are still present under federal regulation and State contracts with MMCOs. As such, the removal of these provisions should not, in and of itself, be construed as changing the notice of action requirements, as such requirements may still be applicable pursuant to other sources of authority.

Pursuant to the authority vested in the Commissioner of Health by Social Services Law Sections 22(8) and 363-a and Public Health Law Sections 201(1)(v) and 206(1)(f), Sections 360-10.3 and 360-10.8 of Title 18 and Section 98-2.10 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) are amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (a) and paragraphs (a)(1)-(a)(7) of section 360-10.3 of title 18 is amended to read as follows:

(a) Action means[, in the case of] a determination or other act of an MMCO, or its management contractor on behalf of the MMCO, with respect to an enrollee that is not a prospective enrollee and that constitutes a:

(1) [the] denial or limited authorization of a requested service, including type or level of service; or

(2) [the] reduction, suspension, or termination of a previously authorized service; or

(3) [the] denial, in whole or in part, of payment for a service; or

(4) [the] failure to provide services in a timely manner, as set forth in the guidelines established by the commissioner; or

(5) [the] failure to act to resolve service authorization requests, complaints, grievances, and appeals with reasonable promptness. Reasonable promptness shall mean compliance with the timeframes established by Public Health Law, Social Services Law, and applicable

Federal regulations, as set forth in the guidelines established by the commissioner;

(6) [the] denial of a request for out of network services for a managed care enrollee who is required to receive medical assistance services from an MMCO and who resides in a social services district where there is only one MMCO participating in the Medicaid Managed Care Program; [or]

(7) adverse benefit determination as that term is defined in federal regulations; or

[(7) the] (8) restriction of an enrollee to certain providers under the MMCO's recipient restriction program.

The decision of a primary care practitioner participating in a primary care partial capitation provider (PCPCP) exercising his or her professional judgment is not an action.

Subdivisions (b) through (m) of section 360-10.3 are redesignated as subdivisions (e) through (p), subdivisions (n) and (o) of section 360-10.3 are redesignated as subdivisions (r) and (s), and new subdivisions (b), (c), and (d) are added to read as follows:

(b) *Action appeal process* means the process established by an MMCO or its management contractor through which an enrollee may appeal an action.

(c) *Action appeal determination* means a final determination made by an MMCO or its management contractor with respect to an action taken by the MMCO or its management contractor that was appealed through the action appeal process, where such determination and notice thereof was provided within the timeframes

established by, as applicable, the Public Health Law or Social Services Law, regulations promulgated pursuant thereto, applicable federal regulations, or as set forth in guidelines established by the commissioner.

(d) *Deemed exhaustion* means the exhaustion of the action appeal process through the failure of the MMCO, or its management contractor, to adhere to the notice and timing requirements of, as applicable, the Public Health Law or Social Services Law, regulations promulgated pursuant thereto, applicable federal regulations, or as set forth in guidelines established by the commissioner.

Subdivision (i) of section 360-10.3, as redesignated as subdivision (l) above, is amended to read as follows:

(l) *Notice of action* means a notice issued by an MMCO or its management contractor when an action is taken. Also known as the "notice of intent to restrict" in the case of [an MMCO's determination to restrict an enrollee under the MMCO's recipient restriction program] a recipient restriction action.

A new subdivision (q) is added to section 360-10.3 to read as follows:

(q) *Recipient restriction action* means an action by the MMCO or its management contractor that restricts an enrollee to certain providers under the MMCO's recipient restriction program.

Subdivision (a) of section 360-10.8 is amended to read as follows:

(a) Part 358 of this Title is incorporated by reference as if set forth fully herein and is applicable to enrollees, MMCOs, and management contractors, except that, where a provision in this section is inconsistent with Part 358 of this Title, the provision in this section will apply. For the purposes of this section, the term MMCO shall, in addition to its meaning within this subpart, also refer to managed long term care plans certified pursuant to Section 4403-f of the Public Health Law and authorized to provide medical assistance services.

Paragraphs (4) and (5) of subdivision (b) of section 360-10.8 are amended, and a new subdivision (6) is added, to read as follows:

(4) a PCPCP has upheld the decision of a PCP to: deny a request for a referral; deny or reduce a benefit or service; or authorize a service in an amount less than requested; [or]

(5) an MMCO, or its management contractor, has [taken an action] made an action appeal determination, that is not wholly in favor of the enrollee, or the action appeal process is deemed exhausted, as those terms are defined in section 360-10.3 of this Subpart[.]; or

(6) an MMCO, or its management contractor, has taken a recipient restriction action, as defined in section 360-10.3 of this Subpart.

Paragraph (4) of subdivision (c) of section 360-10.8 is amended, and a new paragraph (5) is added, to read as follows:

(4) the sole issue is a participating provider denied or reduced a service, denied access to a referral, or authorized a service or benefit in an amount less than requested, unless the enrollee has received a determination or notice of action from the MMCO, or its management contractor, confirming the decision of the provider and has exhausted the action appeal process; or[.]

(5) an MMCO, or its management contractor, has taken an action and the enrollee has not exhausted the action appeal process, as those terms are defined in section 360-10.3 of this Subpart.

Paragraphs (1) and (2) of subdivision (d) of section 360-10.8 are amended, and new paragraphs (3) through (5) are added, to read as follows:

(1) Except as provided in paragraphs (2) through (4) of this subdivision, an enrollee must request a fair hearing in accordance with section 358-3.5 of this Title.

(2) A request for a fair hearing regarding an MMCO's or its management contractor's action appeal determination may [must] be requested [by the enrollee within 60 days of:

(i) the date of the MMCO's or its management contractor's notice of action; or

(ii) the MMCO's or its management contractor's failure to act on service authorization requests, complaints, grievances, or appeals within the

timeframes established by the Public Health Law and applicable Federal regulations, as set forth in guidelines established by the commissioner.] only after the enrollee exhausts the MMCO's or its management contractor's action appeal process as evidenced by an action appeal notice, or the action appeal process is a deemed exhausted.

(3) Subject to the requirements of paragraph (2) of this subdivision, a request for a fair hearing regarding an MMCO's or its management contractor's action or action appeal determination must be requested within 120 calendar days of the date of the MMCO's or its management contractor's action appeal determination notice or the exhaustion of the action appeal process, whichever is earlier. Notwithstanding the previous sentence, a request for a fair hearing regarding a recipient restriction action must be made within 60 calendar days of the date of notice of intent to restrict.

(4) Upon notice of a fair hearing request, if the MMCO contends the action appeal process has not been exhausted, the MMCO must promptly notify the Office of Administrative Hearings and appellant. Such notice should include a brief summary of the matter and procedural history with the MMCO, if any, and how the enrollee can request a determination or appeal, as applicable. Failure to inform the appellant shall not constitute a waiver of the requirement to exhaust the MMCO's action appeal process.

(5) If a hearing officer determines that, for any fair hearing request, the enrollee did not file, or otherwise request, an action appeal, the hearing officer must

promptly, but in no case less than 3 business days, dismiss the case for lack of jurisdiction.

Subdivision (e) of 360-10.8 is amended to read as follows:

(e) Notices.

(1) A social services district shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing, pursuant to section 358-2.2 of this Title, whenever the social services district:

(i) denies a request for exemption or exclusion from enrollment in an MMCO; or

(ii) determines to disenroll an enrollee from an MMCO; or

(iii) denies a request to enroll in, disenroll from, or change an MMCO.

(2) Except for a PCPCP, an MMCO or its management contractor shall notify an enrollee in writing in a manner and form determined by the department of any action the MMCO or its management contractor has taken or intends to take in accordance with the information and timeframe requirements of, as applicable, this Subpart, Public Health Law, Social Services Law, federal regulations, or in guidelines as set forth by the commissioner for MMCO actions and grievance systems.

([2]3)] [An] Except for a PCPCP, an MMCO or its management contractor shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever [a notice of action] an action appeal determination notice or notice of intent to

restrict is issued unless the determination is wholly in the enrollee's favor. [For the purposes of this paragraph, "MMCO" means an HMO, PHSP, or HIV SNP.] A notice [of action] that sets forth all of the information required by subparagraph (i) of this paragraph, or by subparagraph (ii) in the case of a notice of intent to restrict, will be considered an adequate notice for the purposes of section 358-2.2 of this Title.

(i) The [notice of action] action appeal determination notice shall include:

(a) the date the enrollee's appeal was filed, a summary of the appeal, and the date the appeal process was completed;

([*a*]*b)* the action the MMCO has taken or intends to take and the effective date of the action;

([*b*]*c)* the specific reason for the action appeal determination, including clinical rationale, if any;

([*c*]*d)* the name of the MMCO and, if the action is being taken by its management contractor on behalf of an MMCO, the name of the management contractor;

([*d*]*e)* a toll-free phone number and address by which the enrollee may request general assistance from the MMCO to understand the [notice of action] action appeal determination notice and their rights as described in this paragraph;

[*(e)* the enrollee's right to file an appeal with the MMCO, or with its management contractor, if applicable, and the procedures for exercising these rights, including:

(1) the timeframe in which to request an appeal;

(2) the circumstances under which an expedited resolution is available and how to request it;

(3) the enrollee's right to designate a representative to request an appeal on their behalf and how to do so;

(4) the address and toll-free phone number to request an appeal;

(5) the timeframe for resolution of standard and expedited appeals and how the enrollee will be notified of the appeal determination]

(f) the enrollee's right to a fair hearing and the procedures for exercising this right, including:

(1) the timeframe in which to request a fair hearing;

(2) the address and toll-free phone number to request a fair hearing;

(3) the enrollee's right to designate a representative to request a fair hearing on their behalf;

(4) an explanation that a request for an appeal with the MMCO or its management contractor is not a fair hearing and that a separate request for a fair hearing must be made;

(5) the specific laws and/or regulations upon which the action is based;

(*6*) the enrollee's right to present written and oral evidence at the fair hearing;

(*7*) the enrollee's right to [see] be provided upon request and free of charge, reasonable access to and copies of their case file and all documents, records, and other information relevant to the action and action appeal, and to request evidence prepared by the MMCO for the enrollee's fair hearing and how to make such request. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

(*8*) the enrollee's right to representation by legal counsel or other person; information concerning the availability of community legal services to assist the enrollee with their MMCO appeal or at the fair hearing; and the enrollee's right to bring witnesses to the fair hearing and to question witnesses at the fair hearing;

(*9*) if the action or sole issue in dispute is one of those described in subdivision (c) of this section or in section 358-3.1(f) of this Title, an explanation that although the enrollee has the right to have a hearing scheduled, the hearing officer at the hearing may determine that the

enrollee does not have the right to a hearing or continuation of benefits; and

(*10*) [if the action is a restriction under the MMCO's recipient restriction program:

(i) a recipient information packet, which provides a summary of the specific reason(s) for the restriction, including, but not limited to, a summary of any review conducted of the enrollee's pattern of service utilization and evidence confirming that the enrollee's use of services meets a condition for restriction, as defined in section 360-6.4(d) of this Part or in the guidelines in the contract between the MMCO and the State.

(ii) the date the restriction will begin;

(iii) the effect and scope of the restriction;

(iv) the right of the enrollee to select a provider for the restricted service within two weeks of date of the notice of intent to restrict if the MMCO provides a choice of providers to the enrollee;

(v) the right of the MMCO to select a provider for the restricted service if a choice is not provided to the enrollee or if the enrollee does not select such provider within two weeks of being given a choice;

(vi) the right of the enrollee to change providers as provided by section 360-6.4(e) of this Part and section 360-10.7(b) of this Subpart;

(vii) the right of the enrollee to explain and present documentation upon appeal to the MMCO showing the medical necessity of the services cited in the recipient information packet;

(viii) the right of the enrollee to examine all records maintained by the MMCO or the state which identify medical assistance services paid for on behalf of the enrollee;

(ix) a statement that filing an appeal with the MMCO does not suspend the effective date of the restriction and that filing an appeal with the MMCO does not take the place of or abridge the enrollee's right to a fair hearing;

(x) the right of the enrollee to request that benefits be continued unchanged pending resolution of the fair hearing, how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of those services; and

(11)] if an MMCO or its management contractor has determined to reduce, suspend, or terminate a service or benefit currently authorized: the circumstances under which the enrollee's benefits will be continued unchanged; how to request that benefits be continued; [explanation that a request for an MMCO appeal is not a request for the enrollee to have benefits continue;] and the circumstances under which the enrollee may be required to pay the costs of continued services. Such notice shall be issued within the timeframes required by federal regulations [at 42 CFR 438.404(c)(1)], this section and sections 358-2.23, 358-3.3(a)(1), and 358-3.3(d)(1) of this Title.

(ii) The notice of intent to restrict shall include:

(a) The information included in clauses (*b*) through (*f*), excluding subclause (*f*)(*10*), in subparagraph (i) of this paragraph;

(b) the enrollee's right to file an appeal with the MMCO, or with its management contractor, if applicable, and the procedures for exercising these rights, including:

(1) the timeframe in which to request an appeal;

(2) the circumstances under which an expedited resolution is available and how to request it;

(3) the enrollee's right to designate a representative to request an appeal on their behalf and how to do so;

(4) the address and toll-free phone number to request an appeal;

(5) the timeframe for resolution of standard and expedited appeals and how the enrollee will be notified of the appeal determination;

(c) an explanation that a request for an appeal with the MMCO or its management contractor is not a fair hearing and that a separate request for a fair hearing must be made;

(d) a recipient information packet, which provides a summary of the specific reason(s) for the restriction, including, but not limited to, a summary of any review conducted of the enrollee's pattern of service utilization and evidence confirming that the enrollee's use of services meets a condition for restriction, as defined in section 360-6.4(d) of this Part or in the guidelines in the contract between the MMCO and the State.

(e) the date the restriction will begin;

(f) the effect and scope of the restriction;

(g) the right of the enrollee to select a provider for the restricted service within two weeks of date of the notice of intent to restrict if the MMCO provides a choice of providers to the enrollee;

(h) the right of the MMCO to select a provider for the restricted service if a choice is not provided to the enrollee or if the enrollee

does not select such provider within two weeks of being given a choice;

(i) the right of the enrollee to change providers as provided by section 360-6.4(e) of this Part and section 360-10.7(b) of this Subpart;

(j) the right of the enrollee to explain and present documentation upon appeal to the MMCO showing the medical necessity of the services cited in the recipient information packet;

(k) the right of the enrollee to examine all records maintained by the MMCO or the state which identify medical assistance services paid for on behalf of the enrollee;

(l) a statement that filing an appeal with the MMCO does not suspend the effective date of the restriction and that filing an appeal with the MMCO does not take the place of or abridge the enrollee's right to a fair hearing; and

(m) the right of the enrollee to request that benefits be continued unchanged pending resolution of the fair hearing, how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of those services.

([ii]iii) The [notice of action] action appeal determination notice and notice of intent to restrict shall include other information as may be required by federal or State law or regulation, or by guidelines issued by the commissioner for MMCO actions and grievance systems.

([iii]iv) The [notices] action appeal determination notice and notice of intent to restrict shall be issued by the MMCO within the timeframes specified in the guidelines for MMCO actions and grievance systems, issued by the commissioner, subject to all applicable requirements of State and federal statutes and regulations.

([3]4) A PCPCP shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever a grievance determination notice is issued upholding a participating provider's decision to deny a request for a referral, or to deny or reduce a benefit or service, or to authorize a service in an amount less than requested. The grievance determination notice shall include information, and be issued within the timeframes specified in the contract between the PCPCP and the State.

Paragraphs (3) through (5) of subdivision (f) of section 360-10.8 are redesignated (4) through (6), paragraph (5) as redesignated is amended, and new paragraphs (3), (7) and (8) are added, to read as follows:

(3) The MMCO or its management contractor must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to its action appeals process or process to request a fair hearing, subject to exhaustion of the action appeals process. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

([3]4) The MMCO must prepare evidence to justify its challenged determinations. Upon request, the MMCO must provide to the enrollee or the enrollee's authorized representative copies of the documents the MMCO will present at the fair hearing. Upon request, the MMCO must also provide the enrollee or the enrollee's authorized representative access to the enrollee's MMCO case file, and provide copies of documents contained in the file. Such copies must be provided at a reasonable time before the date of the hearing. If the request for copies of documents is made less than five business days before the hearing, the social services district and the MMCO must provide the enrollee and the enrollee's authorized representative such copies no later than at the time of the hearing. Such documents must be provided without charge and must be provided to the enrollee and the enrollee's authorized representative by mail within a reasonable time from the date of the request if the enrollee or the enrollee's authorized representative request that such documents be mailed; provided however, if there is insufficient time for such documents to be mailed and received before the scheduled date of the hearing such documents may be presented at the hearing instead of being mailed.

([4]5) The MMCO [may] has the right to present the evidence at the hearing or request a waiver of personal appearance and submit written evidence. If the MMCO elects to waive a personal appearance and submit written evidence, the MMCO may present evidence via phone or other real time communication. If the MMCO will not be making a personal appearance at the fair hearing, the written material must be submitted at least three business days prior to the scheduled

hearing: to the office of administrative hearings (OAH); and to the enrollee or enrollee's representative, unless the material was previously provided to the enrollee or the enrollee's authorized representative in accordance with paragraph (3) of this subdivision. If the hearing is scheduled fewer than three business days after the request, the MMCO must deliver the evidence to the hearing site no later than one business day prior to the hearing; otherwise it must appear in person. If the MMCO has reversed its initial determination and provided the service to the enrollee, the MMCO may request a waiver of personal appearance and submit papers explaining that it has withdrawn the initial determination and is providing the services or treatment. Only the enrollee or the enrollee's authorized representative may withdraw his or her request for a fair hearing.

([5]6) The MMCO must comply with all fair hearing decisions and directives, pursuant to section 22 of the Social Services Law.

(7) An MMCO request for waiver of personal appearance must be in writing and include:

(i) appropriate contact information, including names and phone numbers or other information relevant to the manner of appearance, for a primary and back-up contact person;

(ii) the fair hearing number;

(iii) the scheduled hearing date; and

(iv) a summary of the specific facts relevant to the issue under review at the hearing.

(8) The MMCO shall have the opportunity to seek a correction to a fair hearing decision in accordance with section 358-6.6 of this Title.

Subdivision (g) of section 360-10.8 is redesignated as new subdivision (h), and a new subdivision (g) is added to read as follows:

(g) Where any party presents evidence at a fair hearing that was not provided to the other party reasonably in advance of the hearing, the other party may request a recess or temporary adjournment to review such evidence and for an opportunity to submit rebuttal evidence. In determining whether and the extent to which to grant such a request, the hearing officer must consider the time remaining to issue a final administrative determination and whether either party would be unduly prejudiced by the granting or denying of such request.

Paragraph (2) of subdivision (h) of section 360-10.8, as redesignated above, is amended to read as follows:

(2) [Fair] Action appeals and fair hearings about MMCO [determinations] actions.

(i) Pursuant to 42 CFR 438.420, an enrollee may continue to receive services or treatment unchanged when an MMCO or its management contractor has terminated, suspended, or reduced a previously authorized service or treatment, or proposes to do so, if:

(a) the enrollee has filed a request for [a fair hearing] an action appeal within 10 calendar days of the notice of action or grievance

determination notice, or by the intended date of the action, whichever is later;[and]

(b) there is a valid order for the treatment or service from a participating provider or from the provider originally authorized by the MMCO to provide the treatment or service;

and

(c) the enrollee requests that benefits continue.

(ii) If the conditions for aid continuing [is granted] pursuant to subparagraph (i) of this paragraph are met, benefits [will] shall be [reinstated] continued by the MMCO, or its management contractor, until:

(a) the enrollee or the enrollee's authorized representative withdraws the [fair hearing] action appeal request; [or]

(b) the provider order expires; [or]

(c) the enrollee fails to request a fair hearing and continuation of benefits within 10 calendar days after the MMCO, or its management contractor, issues an action appeal determination notice; or

([c]d) in a case where an enrollee requests a fair hearing and continuation of benefits within 10 calendar days as described in clause *(c)* of this subparagraph, the enrollee or the enrollee's authorized representative later withdraws the fair hearing or a fair hearing decision is issued that is adverse to the enrollee.

(iii) Pursuant to section 358-3.6 of this Title, an enrollee may continue to receive services or treatments unchanged, pending the fair hearing, when an MMCO has determined to restrict the recipient under the MMCO's recipient restriction program and the enrollee requests a fair hearing prior to the effective date of the restriction.

(iv) If a fair hearing decision is not in favor of the enrollee, the enrollee may be required to reimburse the MMCO for the cost of any health care services received while waiting for the fair hearing determination, to the extent they were furnished solely because of the requirements of this subdivision.

A new subdivision (i) is added to section 360-10.8, to read as follows:

(i) Fair Hearing Decisions about MMCO Actions.

Unless otherwise agreed to by all parties, orders for benefits or services as a result of a fair hearing decision shall be limited to the amount or duration of benefits or services that were the subject of the action taken by the MMCO or its management contractor and which the enrollee appealed. Such decisions may only order the MMCO to authorize or provide benefits or services that are in the MMCO's benefit package.

A new subdivision (m) is added to section 98-2.10 of title 10 to read as follows:

(m) Where a certified external appeal agent renders a determination with respect to health benefits provided through title XIX of the Federal Social Security Act,

such determination may only direct the provision of benefits or services that are in the health care plan's benefit package as determined by the contract between the health care plan and the Department of Health.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law ("SSL") section 363-a and Public Health Law ("PHL") section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program. PHL section 206(1)(f) grants the commissioner the power to enforce the provisions of the public health law and the Medicaid program, or its successor, pursuant to title eleven of the SSL.

SSL section 22(7) and (8) provides that the Department shall promulgate such regulations, not inconsistent with federal or state law, as may be necessary to implement an appeals and fair hearings system for the Medicaid program. This includes rules that establish grounds for appeals and fair hearings. See SSL 22(5).

Legislative Objectives:

SSL 22 provides a state statutory right to a fair hearing for certain state actions including those related to the Medicaid program. These provisions were established to create an effective and efficient means of appealing Medicaid decisions, as required by and in accordance with federal law and regulation. The amendments to these sections of law further this legislative objective by aligning the state regulations with federal requirements and by addressing and clarifying rules regarding procedure and presentation of evidence to further the efficient administration of fair hearing cases.

Needs and Benefits:

SSL 364-j governs the Medicaid managed care program and PHL 4403-f governs requirements for Medicaid managed long term care plans, under which certain Medicaid recipients are required or allowed to enroll in and receive services through Medicaid managed care organizations (MMCOs). As Medicaid recipients, enrollees in MMCOs have a federal and state statutory right to a fair hearing, the process for which must be established in state regulations pursuant to SSL 22. Additionally, both Article 49 of the PHL and Article 49 of the Insurance Law establish a right to an external appeal for enrollees of managed care organizations.

The majority of the amendments in this proposed rule are intended to reflect Federal regulations for appeals and fair hearings that were revised in 2016 and became effective starting in 2018. *See* 42 C.F.R. Part 438, Subpart F and 81 FR 27498. The federal regulations altered the processes that have been codified in the Department's regulations for MMCO appeals and fair hearings. Amending the Department's regulation to align with the new federal process requirements is necessary to ensure their continued relevance and effectiveness. The proposed regulations will ensure that the action appeal process for all services established by an MMCO is fully maximized by the MMCO and the individual as required, while continuing to ensure that individuals receive access to a fair hearing.

Additionally, the Department is amending and introducing rules regarding procedure and presentation of evidence for Medicaid fair hearings and external appeals. These new rules are intended to clarify and standardize procedures regarding the review and submission of evidence prior to or at fair hearing and to promote uniformity in the

application of Medicaid rules for the authorization and utilization of services in fair hearing and external appeals processes.

Recently, the Department received many suggestions for amendments to the Medicaid appeals and fair hearing processes as a result of the State's Medicaid Redesign Team II (MRT) initiative. The Department continues to consider the ideas and proposals discussed and submitted to the Department as part of the MRT process. Though some elements of the proposed rule are similar to some MRT proposals received, the proposed rule is not a reflection of the Department's review or evaluation of any particular MRT proposal. The Department continues to review MRT proposals submitted and may promulgate additional regulatory amendments at a later date.

Costs to Regulated Parties:

There are no additional costs to regulated parties. LDSSs and MMCOs are already required to maintain and update plans of care and MMCOs are required to have an internal appeals process.

Costs to State Government:

There will be no additional costs to State Government as a result of the proposed regulations.

Costs to Local Government:

There will be no additional costs to Local Government as a result of the proposed regulations.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of the proposed regulations.

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

The proposed regulations do not impose any new reporting requirements.

Duplication:

The proposed regulations align State regulations with those promulgated by CMS and in model contract provisions between MMCOs and the Department. Alignment was necessary to eliminate conflicting provisions among these authorities.

Alternatives:

One alternative would be to continue regulations that do not reflect Federal regulations for appeals and fair hearings that were revised in 2016, and that do not make important updates to the rules regarding procedure and presentation of evidence. The Department rejected this alternative as lacking benefit. The other alternative would be to continue to delay the proposed rules to reflect Federal regulations and important updates, in order to fully evaluate all proposals for reforming the appeals and fair hearings process. The Department rejected this alternative as unnecessary because additional amendments can be considered while moving forward with vitally needed updates to the existing rules.

Federal Standards:

The proposed regulations do not exceed any minimum federal standards.

Compliance Schedule:

There is no compliance schedule imposed by this amendment, which shall be effective upon publication of a notice of adoption.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation has no implications for job opportunities.