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Starting Soon...

Don't Take 'NO' for an Answer: Navigating Medicaid Denials and Appeals

November 10, 2025

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- Type Questions in the Q&A Section at the Bottom of Your Screen
- Presentation is Posted: Pierrolaw.com/Resources Under Medicaid Planning
- Fill Out Our Survey with Feedback

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October	The Home Care Assessment Process
Sept.	How to Maximize Medicaid Home Care
August	Major Changes Ahead for NY Medicaid Home Care
July	Nursing Home Medicaid
June	Medicaid Asset Protection Trusts
	....and many more!

https://www.pierrolaw.com/medicaid-planning-videos/

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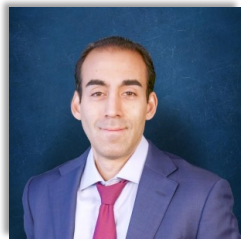
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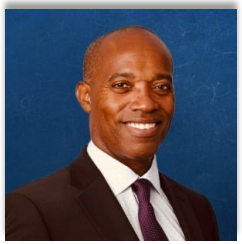
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Agenda 11/10/25

- 2025 Medicaid Numbers: Review
- Reductions
- Reasons for Denials
- Internal Appeals and Exhaustion Requirement
- Fair Hearings

MEDICAID INCOME & ASSET ELIGIBILITY RECAP

	INCOME / MTH		ASSET LIMIT	
YEAR	SINGLES	COUPLES	SINGLES	COUPLES
2025	$1,820	$2,453	$32,396	$43,781

- Community Spouse Income Allowance: $3,948
- Community Spouse Resource Allowance: $74,820 - $157,920
- Institutionalized Income Allowance: $50 (no change)

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REDUCTIONS

Examples:

- Plan is proposing to **reduce hours** it previously authorized
- Plan is proposing to **discontinue services** due to increased ADL requirements (now 3 or assistance/monitoring with Alzheimer's or Dementia Diagnosis)
- **What are your options to appeal?**

REDUCTIONS (cont.)

- **Must appeal within 10 days** of date of notice to have aid continue during the appellate process
- **Grandfathering vs. New Enrollees**
  - If Medicaid recipient was previously assessed and enrolled with an MLTC plan under 2 ADL requirement, they have "Legacy status" and they should be re-evaluated under the old criteria
  - If there is any lapse in coverage = no legacy status and re-enrollment is governed by new ADL requirements.

POSSIBLE REASONS FOR DENIAL

Denied Due to Income

- Can be solved with Income Trust Planning

Denied Due to Assets

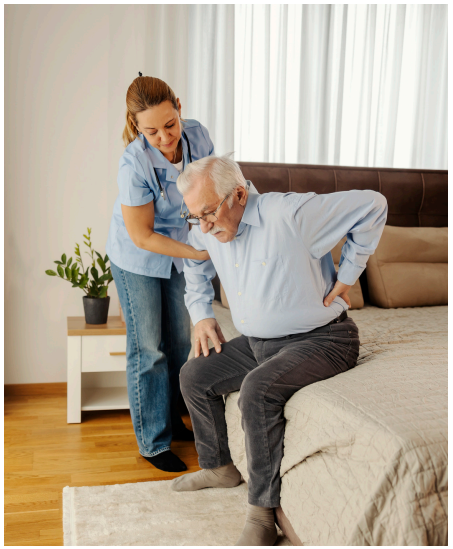
- There is considerable room for interpretation of countable and exempt assets

Approved but with a Look-Back Penalty

- A period of ineligibility due to a past asset transfer that violated Medicaid rules - ensure no errors were made in the calculation

Approved without sufficient services

- Denial due to lack of Medical Need or Insufficient Hour Determinations



CAN YOU SIMPLY REQUEST A FAIR HEARING?

- If appealing a decision made by a Managed Long-Term Care (MLTC) Company, the Appellant must first request an **Internal Appeal** from the plan. This follows the receipt of an Initial Adverse Determination by the plan

- Only after a decision on that internal appeal is made by the plan, called a "Final Adverse Determination" or "FAD," may the member request a **FAIR HEARING**
  - True: regardless of whether the plan's action is to reduce, terminate, or deny services

- These rules came into effect in 2018. Prior to 2018, the appellant could just ask for a fair hearing and not have go through as many steps

INTERNAL APPEAL – Often the 1st Step

How Can You Request an Internal Appeal?

1. Call your MLTC Plan and request an internal appeal. You must also confirm an oral request for an appeal with something in writing.
   - Written requirement is waived if the internal appeal is an expedited request

2. Fax in a request. Fax number should be provided on the notice received from the plan

3. Email the request. An email address should also be provided in the notice

4. Write to the plan using a letter that is return receipt requested.

APPLICANT DEADLINES

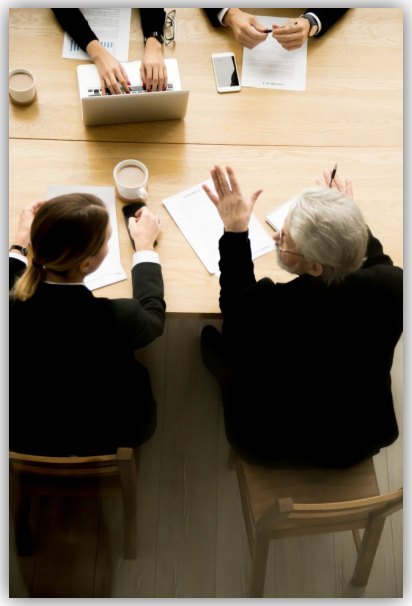
- **If the plan's "initial adverse determination" is not a reduction,** but denies a new service, or denies an increase in an existing service, or authorizes a service in less than the amount requested, the Appellant has **60 calendar days** to request an internal appeal, from the date of the notice

- **PRACTICE TIP –**
  KEEP TRACK OF YOUR DATES!

RIGHTS IN THE INTERNAL APPEAL PROCESS

- **Appeal must consider all documents and information** submitted in the appeal, regardless of whether it was submitted initially in the initial adverse benefit determinatio
- **Must provide the enrollee a reasonable opportunity**, in person and in writing, to present evidence and testimony and make legal and factual arguments
  - Plan must inform the appellant of the time frame available for submission of evidence
  - Appellant can request more time from the plan to make a submission

RIGHTS IN THE INTERNAL APPEAL PROCESS



- **Must provide the enrollee and his or her representative the enrollee's case file**, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal.
  - This information must be provided free of charge
  - Appeal must be decided by a plan employee in the initial adverse determination who was not involved being appealed, and who is not a subordinate of anyone involved in the initial adverse determination

RIGHTS IN THE INTERNAL APPEAL PROCESS

When and with what notice must Plan decide internal appeal?

- **STANDARD APPEAL**
  - The plan must decide a standard appeal within **30 calendar days of receipt of the appeal request**
  - Subject to extension by up to 14 days on the enrollee's request or if the plan shows the State, upon request, that additional information is needed.

RIGHTS IN THE INTERNAL APPEAL PROCESS

- **FAST TRACK or EXPEDITED APPEAL**
  - The Plan must decide an expedited appeal within 72 hours after the plan receives the appeal, subject to same extension of up to 14 days as for standard appeals, above
  - Plan must make a reasonable effort to give oral notice for expedited appeals and must send written notice within 2 business days of decision for all expedited appeals
  - If there is a delay – plan must make reasonable efforts to promptly inform the consumer of the delay, give the reasons for the delay and allow for a grievance to be filed in response to the delay.

"DEEMED EXHAUSTION" EXCEPTION

- The regulations provide for an exception to the "exhaustion" requirement.
- Where the managed care plan "fails to adhere to the notice and timing requirements of sec. 438.408, the enrollee is deemed to have exhausted the [managed care plan's] ... appeals process.
- **The enrollee may initiate a State fair hearing."**

EXTERNAL APPEAL

- If Plan determines in their Final Adverse Determination that a service is not medically necessary or is experimental or investigational, appellant can file for an external appeal.
- External appeals are administered by the NYS Department of Financial Services (which regulates all health insurance and long-term care insurance).
- Appeal is completed exclusively on paper so documentation is key to ensure a positive result and appellant must educate the Hearing Officer on Medicaid rules and standards.
- **Filing for an external appeal does not take away from having the ability to request a fair hearing**

FAIR HEARING

RIGHT TO REQUEST FAIR HEARING after Adverse Internal Appeal Decision ("Final Adverse Determination")

Example:

- If the plan wholly or partly denies the Internal Appeal, the plan will issue a "Final Adverse Determination" notice
- You have 120 calendar days to request a fair hearing from the date of the Final Adverse Determination (the plan's internal appeal decision) This is longer than the previous limit of 60 days.

FAIR HEARING Cont.

If you are appealing a decision made by a local Department of Social Services, like the denial of a Medicaid application or the calculation of a penalty period, there is a 60-day period to file for the hearing

- Be sure to review denial notice for the date and the procedure for filing for the hearing.

EXAMPLE 1 – MEDICAID DECISION

Jane Doe Applied for Chronic Care Medicaid in March 2025

- April 2025 – **Approved**, but with 6-month penalty period due to asset transfers
- **Fair hearing requested immediately**
  - Hearing held before administrative law judge and decision rendered deciding validity of penalty period calculation
    - If decision is unfavorable, filing Article 78 proceeding is possible

EXAMPLE 2 – MLTC DECISION

John Doe Approved for Community Medicaid in April 2025

- Enrolled with MLTC following NYIA process and received **4 hours a day of assistance**
- John accepts the amount of hours, but then **requests an increase in services up to 12 hours per day**
- MLTC issues **Initial Adverse Determination**

EXAMPLE 2 – MLTC DECISION (cont.)

- **Internal Appeal** is requested

- **Internal appeal is denied**, and Final Adverse Determination is issued

- **Fair Hearing request is filed immediately**
  - Hearing held before administrative law judge and decision is made regarding number of hours granted by MLTC
    - If decision is unfavorable, filing Article 78 proceeding is possible

NEXT MEDICAID MONDAY

12-12:30pm, December 8, 2025

"Preparing for the Storm –
How to Build your Ark"

Best predictions for what's in store for 2026

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PRESENTED BY

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Thank You!
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