

Medicaid Managed Care Programs

Effective date: 12/28/11

SUMMARY OF EXPRESS TERMS

The proposed rule repeals various sections of Title 18 NYCRR that contain managed care regulations and replaces them with a new Subpart 360-10 that consolidates all managed care regulations in one place and makes the regulations consistent with Section 364-j of the Social Services Law (SSL). Section 364-j of the SSL contains the Medicaid managed care program standards. The new Subpart 360-10 will also apply to the Family Health Plus (FHP) program authorized in Section 369-ee of the Social Services Law. FHP-eligible individuals must enroll in a managed care organization (MCO) to receive services and FHP MCOs must comply with most of the programmatic requirements of Section 364-j of the SSL.

The new Subpart 360-10 identifies the Medicaid populations required to enroll and those that are exempt or excluded from enrollment, defines good cause reasons for changing/disenrolling from an MCO, or changing primary care providers (PCPs), adds enrollee fair hearing rights, adds marketing/outreach and enrollment guidelines, and identifies unacceptable practices and the actions to be taken by the State when an MCO commits an unacceptable practice.

The proposed rule repeals the existing Subparts 360-10 and 360-11 and Sections 300.12 and 360-6.7 of Title 18 NYCRR. Section 300.12 applied to the Monroe County Medicap program, a managed care demonstration project that was undertaken in the mid-1980s and that no longer exists. Section 360-6.7 addresses processes and timeframes for disenrollment from the various types of MCOs and these provisions are included in the

new Subpart 360-10. Subpart 360-11 implemented provisions relating to special care plans formerly contained in SSL Section 364-j; these provisions were added by Chapter 165 of the Laws of 1991 and later removed by Chapter 649 of the Laws of 1996.

360-10.1 Introduction

This section provides an introduction to the managed care program. Section 364-j of Social Services Law provides the framework for the Statewide Medicaid managed care program. Certain Medicaid recipients are required to receive services from Medicaid managed care organizations. Section 369-ee added the Family Health Plus (FHP) program to Social Services Law. Individuals eligible for FHP are required to receive services from a managed care plan unless they are participating in the Family Health Plus premium assistance program.

360-10.2 Scope

This section identifies the topics addressed by the Subpart.

360-10.3 Definitions

This section includes definitions necessary to understand the regulations.

360-10.4 Individuals required to enroll in a Medicaid managed care organization

This section identifies the individuals who will be required to enroll in an MCO.

360-10.5 Individuals exempt or excluded from enrolling in a Medicaid mandatory managed care organization

This section identifies the good cause reasons for a Medicaid recipient to be exempt or excluded from enrollment in a mandatory managed care program. The section also includes the procedures for requesting an exemption or exclusion and the timeframes for processing the request. This section also describes the notices that must be provided to a Medicaid recipient if his/her request is denied.

360-10.6 Good cause for changing or disenrolling from an MCO

This section describes the good cause reasons for an enrollee to change MCOs and the process for requesting a change or disenrollment. This section also identifies the timeframes for processing the request and the notices that must be provided to the enrollee regarding his/her request.

360-10.7 Good cause for changing primary care providers

This section describes the good cause reasons for a managed care enrollee to change primary care providers, the process through which the enrollee may request such a change and the timeframes for processing the request.

360-10.8 Fair Hearing Rights

This section identifies the circumstances under which a Medicaid or FHP enrollee may request a fair hearing. Enrollees may request a fair hearing for enrollment decisions

made by the local social services district and decisions made by an MCO or its utilization review agent about services. The section describes the notices that must be sent to advise the enrollee of his/her of her fair hearing rights. The section also explains when aid continuing is available for managed care issues and how the enrollee requests it when requesting a fair hearing

360-10.9 Appeal Rights for Recipients Enrolled in Medicaid Advantage

This section identifies the Medicaid and Medicare appeal rights that are available for recipients enrolled in a Medicaid Advantage plan.

360-10.10 Marketing/Outreach

This section defines marketing/outreach and establishes marketing/outreach guidelines for MCOs including requiring MCOs to submit a marketing/outreach plan, requiring MCOs to get approval of materials before distribution, and establishing limits for marketing/outreach representative reimbursement.

360-10.11 MCO unacceptable practices

This section identifies additional unacceptable practices for MCOs. These are generally related to marketing/outreach.

360-10.12 MCO sanctions and due process

This section identifies the actions the Department is authorized to take when an

MCO commits an infraction.

Pursuant to the authority vested in the Commissioner of Health by sections 201 and 206 of the Public Health Law and sections 363-a, 364-j, and 369-ee of the Social Services Law (SSL), Subparts 360-10 and 360-11 and sections 300.12 and 360-6.7 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York are repealed and a new Subpart 360-10 is added, to be effective upon filing with the Department of State.

Sections 300.12 and 360-6.7 are repealed.

Subpart 360-10 is repealed and a new Subpart 360-10 is added to read as follows:

SUBPART 360-10

MEDICAID MANAGED CARE PROGRAMS

Sec.

360-10.1 Introduction

360-10.2 Scope

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360-10.4 Individuals required to enroll in a Medicaid managed care organization

360-10.5 Individuals exempt or excluded from enrollment in a Medicaid managed care organization

360-10.6 Good cause for changing or disenrolling from a Medicaid managed care organization

360-10.7 Good cause for changing primary care providers

360-10.8 Fair hearings

360-10.9 Appeal Rights for Recipients Enrolled in Medicaid Advantage

360-10.10 Marketing/Outreach

360-10.11 MMCO unacceptable practices

360-10.12 MMCO sanctions and due process

Section 360-10.1 Introduction.

(a) Most Medicaid recipients are required and some recipients may elect to receive health services from a Medicaid managed care organization (MMCO). Individuals eligible for Family Health Plus, except for those who participate in the Family Health Plus Premium Assistance Program, are required to receive health care services from a MMCO.

(b) An MMCO must provide or arrange for the provision of all services set forth in its benefit package to its enrollees. The commissioner shall assure that Medicaid recipients in managed care have access to all services to which they are entitled under the Medicaid program, including services, if any, that are not included in their MMCO's benefit package and provided through the Medicaid Fee for Service Program. Family Health Plus enrollees are eligible for the services specified in section 369-ee of the Social Services Law.

Section 360-10.2 Scope.

This Subpart describes:

(a) individuals required to enroll in an MMCO;

(b) individuals exempt or excluded from enrollment in an MMCO;

(c) good cause reasons for permitting an enrollee to change or disenroll from an MMCO;

(d) good cause reasons for permitting an enrollee to change primary care providers (PCPs);

(e) the fair hearing rights for managed care enrollees;

(f) the appeal rights of recipients enrolled in a Medicaid Advantage plan

(g) marketing/outreach requirements for MMCOs;

(h) MMCO unacceptable practices;

(i) MMCO sanctions and due process.

Section 360-10.3 Definitions. As used in this Subpart, unless expressly stated otherwise or unless the context of the subject matter requires different interpretation:

(a) “Action” means, in the case of an MMCO or an approved utilization review agent:

(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 and applicable federal regulations, as set forth in the guidelines established by the commissioner; or

(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.

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.

(b) “Disenrollment” means the process by which a Medicaid recipient’s enrollment in an MMCO is terminated.

(c) “Enrollee” (Participant) means a Medicaid recipient who receives, is required to receive, or elects to receive his or her health care services from an MMCO, or a FHP eligible individual who is required to receive health care services from an MMCO.

(d) “Enrollment” means the process by which an enrollee’s membership in an MMCO begins.

(e) “Grace period” means the period prescribed by federal or State statute during which an enrollee may elect to change MMCOs for any reason.

(f) “Lock-in period” means the period of time during which the enrollee may not disenroll from the MMCO unless the enrollee can demonstrate that he/she has good cause as defined in section 360-10.6 of this Subpart. The lock-in period shall begin on the effective date of enrollment and end after the first twelve months of enrollment, provided

however, an enrollee may disenroll from an MMCO without cause during the grace period.

(g) “Medicaid Advantage Program” means the program that the State has developed to enroll persons who are dually eligible for Medicare and Medicaid services in Medicaid managed care pursuant to section 364-j of the Social Services Law.

(h) A Medicaid managed care organization (MMCO), for purposes of this Subpart, means one of the following entities that meets the requirements of section 364-j of the Social Services Law and is authorized to participate in the Medicaid and/or Family Health Plus Programs: health maintenance organizations (HMOs), prepaid health services plans (PHSPs), comprehensive HIV special needs plans (HIV SNPs), and primary care partial capitation providers (PCPCPs). An MMCO is required to enter into a contract with the State; such contract must specify the services provided under the MMCO’s benefit package, subject to any exclusions or limitations imposed by federal or State law.

(i) “Notice of action” means a notice issued by an MMCO or an approved utilization review agent when an action is taken.

(j) “Participating provider” means a provider of medical care and/or services that has a provider agreement with an MMCO.

(k) “Primary care practitioner (provider)” or “PCP” means a physician or nurse practitioner providing primary care to and management of medical and health care services of an enrollee.

(l) “Prospective Enrollee” means any individual residing in the Contractor’s Service Area that has not yet enrolled in a MMCO’s Medicaid managed care or FHP

product.

(m) “Social services district,” for purposes of this Subpart, means the social services district or other designee of the Department.

(n) “Service authorization request” means a request by an enrollee, or a provider on the enrollee’s behalf, to an MMCO for the provision of a service, including a request for a referral or for a non-covered service.

(o) “Utilization review” means the review by an MMCO, other than a PCPCP, to determine whether health care services that have been provided, are being provided, or are proposed to be provided to an enrollee, whether undertaken prior to, concurrent with or subsequent to the delivery of such services, are medically necessary.

(p) “Utilization review agent” means any company, organization or other entity registered to perform utilization review, pursuant to title one of article forty-nine of the public health law and applicable federal regulation.

Section 360-10.4. Individuals required to enroll in an MMCO

(a) All Medicaid recipients, except for those who are eligible for an exemption or an exclusion pursuant to section 360-10.5 of this Subpart, residing in a social services district that has been approved to implement mandatory enrollment must enroll in an MMCO.

(b) Excluded populations may not enroll in an MMCO.

(c) Exempt populations are not required to enroll in an MMCO in a social services district where enrollment is mandatory; however, they may elect to voluntarily

enroll.

(d) All FHP eligible individuals, except for those participating in the FHP premium assistance program, must enroll in an MMCO to receive services.

Section 360-10.5. Individuals exempt or excluded from enrollment in an MMCO.

(a) A Medicaid recipient is exempt from enrollment in an MMCO if the recipient meets one of the criteria for exemption identified in paragraph (b) of section 364-j (3) of the Social Services Law.

(b) A Medicaid recipient identified in section 364-j (3)(e) of the Social Services Law is exempt from enrollment unless the commissioner has established program features for that population.

(c) A Medicaid recipient shall be excluded from enrollment in an MMCO if the recipient meets one of the criteria identified in section 364-j (3)(c) of the Social Services Law.

(d) Determination of a Medicaid recipient's eligibility for an exemption or exclusion shall be the responsibility of the social services district.

(1) Determinations made prior to enrollment.

(i) If a Medicaid recipient requests an exemption or exclusion from enrollment in an MMCO, the Medicaid recipient or the Medicaid recipient's representative must file a written request with the appropriate social services district. The social services district shall require the Medicaid recipient to provide documentation to support the request for an exemption or exclusion where appropriate.

(ii) The social services district must make a determination within 10 days after receipt of all necessary information and notify the Medicaid recipient in writing whether the request for an exemption or exclusion is granted or denied.

(iii) When a request for an exemption or exclusion is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

(2) Determinations of a Medicaid recipient's eligibility for an exemption or exclusion from enrollment in a managed care program after enrollment has occurred.

(i) When the social services district becomes aware that an enrollee is excluded from participating in accordance with subdivision (c) of this section, the social services district will initiate disenrollment of the enrollee.

(ii) A Medicaid recipient may apply for an exemption or an exclusion by filing a written request with the appropriate social services district. The social services district shall require the Medicaid recipient to provide documentation to support the request for an exemption or exclusion where appropriate.

(a) The social services district must make a determination in sufficient time to ensure that the disenrollment will be effective no later than the first day of the second month following the month in which the social services district received the request, unless the recipient requests expedited disenrollment pursuant to paragraph (iii) of this subdivision.

(b) The social services district must notify the recipient in writing of its determination to approve or deny the request for an exemption or exclusion.

(c) When a request is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

(iii) An enrollee may request an expedited disenrollment or change if; an immediate risk to the enrollee's health exists, the enrollment was non-consensual, or for other reasons as set forth in the contract between the MMCO and the State. The social services district may request documentation to substantiate the request. The effective date of the expedited disenrollment or change must comply with the timeframes found in the contract between the MMCO and the State.

(a) The social services district must notify the recipient in writing of its determination to approve or deny the request for an expedited disenrollment.

(b) When a request is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

Section 360-10.6 Good cause for changing or disenrolling from an MMCO

(a) Medicaid recipients

(1) A recipient who is required to enroll in an MMCO and who resides in a social services district with more than one MMCO available has good cause to change his or her MMCO during the lock-in period if:

(i) the MMCO has failed to furnish accessible and appropriate medical care, services or supplies to which the enrollee is entitled under the terms of the contract under which the MMCO has agreed to provide services. This includes, but is not limited to the failure to:

(a) arrange for the provision of primary care services;

(b) arrange for the provision of in-patient care;

(c) arrange for consultation with specialists and other ancillary service providers;

(d) arrange for covered services with qualified licensed or certified providers; or

(ii) the MMCO fails to adhere to the standards prescribed by the commissioner and such failure negatively and specifically impacts the enrollee; or

(iii) it is determined by the social services district, the commissioner, or its agent that the enrollment was not consensual; or

(iv) the enrollee, the MMCO and the social services district agree that a change of MMCOs would be in the best interest of the enrollee; or

(v) the MMCO has elected not to cover the Medicaid managed care benefit package service that the enrollee seeks and the service is offered by one or more other MMCOs in the enrollee's service area; or

(vi) the enrollee's medical condition requires related services to be performed at

the same time, but all such related services cannot be arranged by the MMCO because the MMCO has elected not to cover one of the services the enrollee seeks and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or

(vii) there exists any other good cause reason or another programmatic requirement for change or disenrollment, as provided for in the contract between the MMCO and the State.

(2) If there are no other MMCOs available in the enrollee's social services district, an enrollee seeking to disenroll from his or her current MMCO will be required to remain enrolled in the MMCO unless the reason for the disenrollment is described in subparagraph (i) or (ii) of paragraph (1) of this subdivision.

(3)(i) If an enrollee wishes to change or disenroll from an MMCO for good cause, the enrollee or the enrollee's representative must file a written or verbal request with the social services district.

(ii) The social services district must make a determination on the request in sufficient time to ensure that a change, if approved, is effective no later than the first day of the second month following the month in which the request was received, unless the enrollee has requested an expedited change pursuant to subparagraph (iii) of paragraph (2) of subdivision (e) of section 360-10.5 of this Subpart. If the social services district fails to make the determination before the first day of such second month, the request is considered approved.

(iii) An enrollee whose request for a change of MMCO has been denied by the

social services district shall be provided with a written notice which states the decision, the reasons for the denial, the facts upon which the denial is based, cites the relevant statutory and regulatory authority and advises the enrollee of his or her right to a fair hearing. The notice must comply with the requirements specified in subdivision (a) of section 358-2.2 of this Title.

(c) Family health plus enrollees

(1) If there is another MMCO available in the enrollee's social services district, an enrollee may change his or her MMCO during the lock-in period if:

(i) the MMCO has failed to furnish accessible and appropriate medical care, services or supplies to which the enrollee is entitled under the terms of the contract under which the MMCO has agreed to provide services. This includes, but is not limited to, the failure to:

(a) arrange for the provision of primary care services;

(b) arrange for the provision of in-patient care;

(c) arrange for consultation with specialists and other ancillary service providers;

(d) arrange for covered services with qualified licensed or certified providers; or

(ii) the MMCO fails to adhere to the standards prescribed by the commissioner and such failure negatively and specifically impacts the enrollee; or

(iii) it is determined by the social services district, the commissioner, or its agent that the enrollment was not consensual; or

(iv) the enrollee, the MMCO and the social services district agree that a change of MMCOs would be in the best interest of the enrollee; or

(v) the MMCO has elected not to cover the FHP benefit package service that the enrollee seeks and the service is offered by one or more other MMCOs in the enrollee's service area; or

(vi) the enrollee's medical condition requires related services to be performed at the same time, but all such related services cannot be arranged by the MMCO because the MMCO has elected not to cover one of the services the enrollee seeks and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or

(vii) there exists any other good cause reason or another programmatic reason for disenrollment, as provided for in the contract between the MMCO and the State.

(2) If the enrollee resides in a social services district in which there are no other MMCOs available, the enrollee will be required to remain enrolled in the MMCO unless the enrollee chooses to discontinue his or her participation in the FHP program.

(3)(i) If an enrollee wishes to change or disenroll from an MMCO for good cause, the enrollee or the enrollee's representative must file a written or verbal request with the social services district.

(ii) The social services district must make a determination on the request in sufficient time to ensure that a change, if approved, is effective no later than the first day of the second month following the month in which the request was received, unless the enrollee has requested an expedited change pursuant to subparagraph (iv) of this paragraph. If the social services district fails to make the determination before the first day of such second month, the request is considered approved.

(iii) An enrollee whose request for a change of MMCO has been denied by the social services district shall be provided with a written notice which states the decision, the reasons for the denial, the facts upon which the denial is based, cites the relevant statutory and regulatory authority and advises the enrollee of his or her right to a fair hearing. The notice must comply with the requirements specified in subdivision (a) of section 358-2.2 of this Title.

(iv) An enrollee may request an expedited disenrollment or change if; an immediate risk to the enrollee's health exists, the enrollment was non-consensual, or for other reasons as set forth in the contract between the MMCO and the State. The social services district may request documentation to substantiate the request. The effective date of the expedited disenrollment or change must comply with the timeframes found in the contract between the MMCO and the State.

(a) The social services district must notify the recipient in writing of its determination to approve or deny the request for an expedited disenrollment.

(b) When a request is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

Section 360-10.7 Good cause for changing primary care practitioners.

(a) An MMCO must allow enrollees to change PCPs without cause within 30 days

of the enrollee's first appointment with the PCP. After the first 30 days, the MMCO may elect to limit enrollees to changing PCPs every six months without cause.

(b) If the MMCO has elected to restrict PCP changes, an enrollee nevertheless has good cause to change PCPs at any time if:

(1) the provider has failed to furnish accessible and appropriate medical care, services or supplies to which the enrollee is entitled under the terms of the contract under which the MMCO has agreed to provide services. This includes, but is not limited to, the failure to:

(i) provide primary care services;

(ii) arrange for in-patient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;

(iii) arrange for consultation appointments;

(iv) coordinate and interpret any consultation findings with an emphasis on continuity of medical care;

(v) arrange for services with qualified licensed or certified providers;

(vi) coordinate the enrollee's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury; or

(2) the enrollee disagrees with a treatment plan; or

(3) the enrollee and provider are not able to communicate due to a language barrier or other impediment to communication; or

(4) the provider is not able to reasonably accommodate the enrollee's special needs; or

(5) there is a change in the provider's practice, including but not limited to the following:

- (i) the provider moves to a location that is not convenient for the enrollee; or
- (ii) there is a significant change in the hours the provider is available and the enrollee cannot reasonably make appointments during the new hours; or
- (iii) the provider no longer has hospital privileges; or

(6) the provider fails to adhere to the standards prescribed by the commissioner and such failure negatively and specifically impacts the enrollee; or

(7) the enrollee and the provider agree that a change would be in the best interest of the enrollee; or

(8) the provider leaves the MMCO's network.

(c) Requests to change PCPs.

(1) An enrollee must submit a request to change PCPs to the MMCO according to the procedures established by the MMCO.

(2) The MMCO must provide the enrollee with a decision on the enrollee's request within 30 days of receipt of the request.

(3) If approved, the change must be effective no later than the first day of the second month following the month in which the request is received.

Section 360-10.8 Fair hearings

(a) In addition to the fair hearing rights in Part 358 of this Title, enrollees have a right to a fair hearing if:

(1) a social services district denies a request for an exemption or exclusion from Medicaid managed care;

(2) a social services district denies a request to enroll in, disenroll from, or change an MMCO;

(3) the social services district requires the enrollee to disenroll from an MMCO;

(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 an approved utilization review agent has taken an action, as defined in section 360-10.3 of this Subpart.

(b) Enrollees do not have a right to a fair hearing if:

(1) the sole issue is a federal or State law requiring a change adversely affecting some or all enrollees; or

(2) the sole issue is a result of a change in the contract between the MMCO and the State, that has been approved by the federal government; or

(3) the sole issue is an act of an MMCO that does not constitute an action; or

(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 approved utilization review agent confirming the decision of the provider.

(c) 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 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) An HMO, PHSP or HIV SNP 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 is issued.

(i) the notice of action shall include:

(a) the action the MMCO has taken or intends to take;

(b) the reason for the action, including clinical rationale, if any;

(c) the enrollee's right to file an appeal;

(d) the enrollee's right to a fair hearing;

(e) the procedures for exercising these rights;

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

(g) the enrollee's right to have benefits continue pending resolution of the appeal, 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) the notices shall be issued 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) 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.

(4) If an MMCO has determined to reduce, suspend, or terminate a service or benefit currently being provided, the fair hearing notice will include the enrollee's right to have benefits continue pending the resolution of the fair hearing, how to request that benefits be continued, the timeframe to make the request, and the circumstances under which the enrollee may be required to repay the costs of these services, pursuant to subdivision (e) of this section.

(d) Responsibilities of social services districts and MMCOs

(1) For fair hearings about enrollment, disenrollment, or Medicaid eligibility, a representative of the social services district must appear at the hearing or obtain a waiver of personal appearance, and the district must comply with the other requirements of sections 358-4.2 and 358-4.3 of this Title.

(2) For fair hearings challenging MMCO determinations concerning services or treatment, the social services district may, but is not required to, appear at the fair hearing.

(3) 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) The MMCO may present the evidence at the hearing or submit written evidence. 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) The MMCO must comply with all fair hearing decisions and directives, pursuant to section 22 of the Social Services Law.

(e) Enrollees have a right to have their benefits continue unchanged until a fair hearing decision is issued ("aid continuing") under the circumstances described in this subdivision.

(1) Fair hearings about enrollment issues

(i) When an individual files a request for a fair hearing about an enrollment decision made by the social services district before the effective date specified in the notice from the social services district, the individual's enrollment status may remain the same pending the fair hearing.

(a) If the recipient is not enrolled and has a request for an exemption or exclusion denied, the Medicaid recipient will remain in fee-for-service Medicaid until the fair hearing decision is issued if the recipient alleges a basis for exemption or exclusion that is described in subdivision (3) of section 364-j of the Social Services Law. Otherwise, the Medicaid recipient will be required to enroll in an MMCO until the fair hearing decision is issued.

(b) If a recipient's request to enroll in an MMCO is denied, the Medicaid recipient

will remain in fee-for-service Medicaid until the fair hearing decision is issued.

(c) If a recipient is enrolled and has a request for disenrollment, including a request for an exemption or exclusion, denied, the Medicaid recipient will remain enrolled in the MMCO until the fair hearing decision is issued.

(d) If an enrollee is required to disenroll from an MMCO, the enrollee will remain enrolled until the fair hearing decision is made.

(2) Fair hearings about MMCO determinations. An enrollee may continue to receive services or treatment pending the fair hearing when an MMCO or its approved utilization review agent has terminated, suspended, or reduced a previously authorized service or treatment, or proposes to do so, if:

(i) the enrollee has filed a request for a fair hearing within 10 days of the notice of action or grievance determination notice, or by the intended date of the action, whichever is later; and

(ii) there is a valid order for the treatment or service from a participating provider; and

(iii) for enrollees of an HMO, PHSP or HIV SNP, the period of the original service authorization has not expired; and

(iv) the enrollee requests that benefits continue pending the fair hearing decision.

(3) If aid continuing is granted pursuant to paragraph (2) of this subdivision, benefits will be reinstated by the MMCO until:

(i) the enrollee or the enrollee's authorized representative withdraws the fair hearing request; or

(ii) the time period or service limits of the previously authorized service have been met; or

(iii) the participating provider order expires; or

(iv) a fair hearing decision is issued that is adverse to the enrollee.

(4) 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.

Section 360-10.09 Appeal Rights for Recipients Enrolled in Medicaid Advantage

(a)(1) When a Medicaid recipient is enrolled in the Medicaid Advantage Program and the enrollee is dissatisfied with an action taken by the MMCO regarding a service or treatment covered by both Medicaid and Medicare, the enrollee has the option to: appeal the action through the MMCO's internal Medicaid appeal process, including requesting a fair hearing as described in Section 360-10.08; or to appeal the action through the Medicare Advantage appeal process pursuant to 42 CFR 422 Subpart M.

(2) If the enrollee chooses to appeal the determination through the Medicare appeal process, the enrollee may not request a fair hearing.

(3) If the enrollee chooses to appeal a service denial, suspension, reduction, or termination through the Medicaid appeal process, the enrollee has up to 60 days from the date of the MMCO's notice of denial of coverage to pursue a Medicare appeal, regardless of the status of the Medicaid appeal.

Section 360-10.10 Marketing/Outreach

(a) An MMCO may only engage in marketing/outreach activities to the extent and in a manner approved by the department, in accordance with marketing/outreach and enrollment guidelines issued by the commissioner.

(b) MMCOs shall comply with marketing/outreach and enrollment guidelines issued by the commissioner.

(c) MMCOs shall comply with State and federal laws and implementing regulations regarding marketing/outreach.

(d) Marketing/outreach shall include but not be limited to activities of the MMCO, a subcontractor, or individuals or entities affiliated with the MMCO, during which information and material regarding Medicaid managed care or the FHP program and information about a particular MMCO's affiliated products are presented. Such information may be presented through verbal exchanges, the distribution of written materials and/or the giving away of nominal gifts, as per guidelines issued by the commissioner.

(e) MMCOs shall comply with State and federal laws and implementing regulations regarding confidentiality, including adherence to HIV, mental health, and substance abuse confidentiality requirements established under state law and implementing regulations; and ensure marketing/outreach representatives' compliance with such requirements through annual training, employee newsletters, and inclusion in the MMCO's policies and procedure manual.

(f) MMCOs shall prepare a marketing/outreach plan. Marketing/outreach plans shall not be implemented without the prior written consent of the commissioner.

(g) Each marketing/outreach plan shall include, but not be limited to:

(1) goals and general marketing/outreach strategy;

(2) a description of marketing/outreach activities;

(3) a staffing plan related to marketing/outreach including training and compensation methodology and levels;

(4) a description of how the MMCO will meet the informational needs of eligible persons including those who speak a language other than English as a first language and/or who have a hearing, visual, physical or cognitive impairment, in order to enable such persons to make a voluntary and informed choice;

(5) a description of the activities the MMCO will implement to monitor compliance with this section, including how the MMCO will ensure compliance with State and federal laws and implementing regulations regarding confidentiality; and

(6) identification of the primary marketing/outreach locations at which marketing/outreach will be conducted.

(h) Marketing/outreach materials include materials that are produced in any medium by or on behalf of an MMCO and can be reasonably interpreted as intended to market to prospective enrollees. Marketing/outreach materials may not be used by an MMCO without the prior written consent of the commissioner or his or her designee, and shall include:

(1) advertising, public service announcements, printed publications, and other

broadcast or electronic messages designed to increase awareness and interest in Medicaid managed care or the FHP program and/or an MMCO's Medicaid or FHP managed care product; and

(2) any information that references the Medicaid managed care or the Family Health Plus program, is intended for general distribution, and is produced in a variety of print, broadcast, and direct marketing media. This includes but shall not be limited to: scripts or outlines of presentations, radio advertisements, television advertisements, billboards, newspapers, leaflets, informational brochures, videos and broadcast materials, telephone book yellow page advertisements, letters, posters and the member handbook.

(i) The sites at which MMCOs may distribute marketing/outreach materials, subject to the approval of the commissioner or his or her designee, may include, but shall not be limited to: community centers; resource centers; markets; pharmacies; shopping malls; any social services district office, subject to the approval of the social services district; primary care provider offices; health centers; approved areas in hospitals and other provider sites; schools; health fairs; and other non-prohibited sites authorized by the commissioner or his or her designee where prospective enrollees are likely to gather.

(j) Prohibited marketing/outreach and enrollment practices shall include but not be limited to:

(1) marketing/outreach without the permission of the commissioner;

(2) using deceptive or coercive marketing/outreach materials and practices such

as:

(i) making false statements;

(ii) deceiving, misleading, or threatening an eligible person to influence or induce selection of a particular plan;

(iii) discouraging enrollment on the basis of health status or need for health care services;

(iv) signing a person's name on the enrollment agreement without consent;

(3) making any unsolicited personal contact;

(4) conducting door-to-door solicitation or making inquiries at the home of a prospective enrollee without the prospective enrollee having requested or assented to that contact;

(5) marketing/outreach in patient rooms or at treatment sites (other than waiting areas) unless requested by the prospective enrollee;

(6) marketing/outreach in emergency rooms, including waiting areas;

(7) seeking to induce selection of an MMCO by offering gifts to prospective enrollees which exceed the value specified in the marketing/outreach guidelines;

(8) distributing new or revised marketing/outreach materials that have not been approved by the department;

(9) violating State or federal confidentiality laws and implementing regulations;

(10) providing misleading or false information to the department or the department's designee to substantiate a prospective enrollee's eligibility for enrollment;

or

(11) accepting the enrollment of a person the MMCO is not authorized to enroll.

Section 360-10.11 MMCO unacceptable practices

(a) In addition to the unacceptable practices set forth in Part 515 of this title, it is an unacceptable practice for an MMCO or any of its representatives to:

(1) fail to provide medically necessary services that the MMCO is required to provide under its contract with the State or eligible social services district;

(2) impose premiums or charges on enrollees that are in excess of the premiums or charges allowed under the Medicaid managed care program or the Family Health Plus program;

(3) discriminate among enrollees on the basis of their health status or need for health care services. This includes requests for termination of enrollment by the MMCO, refusal by the MMCO to re-enroll an enrollee, or any practice to discourage enrollment, except when an enrollee has been disenrolled at the request of the MMCO in accordance with the guidelines in the contract between the MMCO and the State or an eligible social services district;

(4) misrepresent or falsify information that it provides to a prospective enrollee, health care provider, social services district, the State, or the federal government;

(5) commit one of the prohibited marketing/outreach or enrollment practices defined in subdivision (j) of section 360-10.10 of this Part;

(6) violate any other applicable requirements of section 1903 or 1932 of the federal social security act and implementing regulations; or

(7) fail to comply with the terms of the contract with the State or an eligible social services district.

Section 360-10.12 MMCO sanctions and due process

(a) Upon a determination that an MMCO has committed an unacceptable practice, the department may impose one or more of the following sanctions:

(1) civil monetary penalties;

(2) suspension of new enrollment, including auto assignments, after the effective date of the sanction; or

(3) termination of the contract between the MMCO and the State or an eligible social services district.

(b) Before imposing a sanction pursuant to this section, the department shall provide the MMCO with a notice of proposed agency action. The written notice shall specify the proposed action and the reason for such action, and shall provide the MMCO with an opportunity to submit documentation or written arguments objecting to the sanction.

(c) The department shall provide the social services district with notice of its intent to impose a sanction.

(d) When the department imposes one of the sanctions described in subdivision (a) of this section, the MMCO will be afforded due process in accordance with 18 NYCRR Parts 515, 516, and 519, and 42 CFR 438.710.

(e) Nothing in this section shall be deemed to prevent the commissioner from appointing temporary management of an MMCO pursuant to subdivision 23 of section 364-j of the social services law upon a determination that an MMCO has repeatedly failed

to meet the substantive requirements of sections 1903(m) and 1932 of the federal social security act.

(f) Nothing in this section limits other remedies available to the State or an eligible social services district under the contract.

Subpart 360-11 is repealed.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law (SSL) section 363-a and Public Health Law 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.

Legislative Objectives:

Section 364-j of the SSL governs the Medicaid managed care program, under which certain Medicaid recipients are required or allowed to enroll in and receive services through managed care organizations (MCOs). Section 369-ee of Social Services Law authorized the State to implement the Family Health Plus (FHP) program, a managed care program for individuals aged 19 to 64 who have income too high to qualify for Medicaid.

The intent of the Legislature in enacting these programs was to assure that low-income citizens of the State receive quality health care and that they obtain necessary medical services in the most effective and efficient manner.

Chapter 59 of the Laws of 2011 amended SSL section 364-j to expand mandatory enrollment into Medicaid managed care by eliminating many of the exemptions and exclusions from enrollment previously contained in the statute.

Needs and Benefits:

The proposed regulations reflect current program practices and requirements,

consolidate all managed care regulations in one place, and conform the regulations to the provisions of SSL section 364-j, including the recent amendments made by Chapter 59 of the Laws of 2011. The proposed regulations identify the individuals required to enroll in Medicaid managed care and identify the populations who are exempt or excluded from enrollment.

The proposed regulations also contain provisions, which apply to both the Medicaid managed care and the FHP programs: specifying good cause criteria for an enrollee to change MCOs or to change their primary care provider; explaining enrollees' rights to challenge actions of their MCO or social services district through the fair hearing process; establishing marketing/outreach guidelines for MCOs; and identifying unacceptable practices and sanctions for MCOs that engage in them.

Costs:

The proposed regulations do not impose any additional costs on local social services districts beyond those imposed by law. The current managed care program operates under a federal Medicaid waiver pursuant to section 1115 of the Social Security Act. Through the waiver, the State receives federal dollars for its Safety Net and FHP populations. Administrative costs associated with implementation of the managed care program incurred at start-up were covered by planning grants. Since 2005, administrative costs for the managed care program have been included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

Local Government Mandates:

The proposed regulations do not create any additional burden to local social services districts beyond those imposed by law.

Paperwork:

Social Services Law requires that Medicaid recipients be advised in writing regarding enrollment, benefits and fair hearing rights. In compliance with the law, the proposed regulations describe the circumstances under which a Medicaid managed care participant should be provided with such notices, who is responsible for sending the notice and what should be included in the notice. There are reporting requirements associated with the program for social service districts and MCOs. The social services district is required to report on exemptions granted, complaints received and other enrollment issues. MCOs must submit network data, complaint reports, financial reports and quality data. These requirements have been in existence since 1997 when the mandatory Medicaid managed care program began. There are no new requirements for the social services districts or the MCOs in the proposed regulations.

Duplication:

The proposed regulations do not duplicate any State or federal requirements unless necessary for clarity.

Alternative Approaches:

The Department is required by SSL section 364-j to promulgate regulations to implement a statewide managed care program. The proposed regulations implement the

provisions of SSL section 364-j in a way which balances the needs of MA recipients, managed care providers and local social services districts. No alternatives were considered.

Federal Standards:

Federal managed care regulations are in 42 CFR 438. The proposed regulations do not exceed any minimum standards of the federal government.

Compliance Schedule:

The mandatory Medicaid managed care program has been in operation since 1997. As a result, all counties in the State have some form of managed care. The requirements in the proposed rules have been implemented through the contract between the State or eligible social services and participating MCOs.

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REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Businesses and Local Governments:

Section 364-j of Social Services Law (SSL) authorizes a Statewide Medicaid managed care program that includes mandatory enrollment of most Medicaid beneficiaries. In 1997 the State applied for and received approval of a Federal waiver under Section 1115 of the Social Security Act to implement mandatory enrollment. Section 369-ee of SSL authorizes the Family Health Plus (FHP) program and requires eligible persons to receive services through managed care organizations (MCOs). Currently, all counties have implemented some form of managed care. As of April, 2011, forty-nine counties have a mandatory Medicaid managed care program; nine counties have a voluntary Medicaid managed program. All counties have a FHP program.

As a result of the implementation of the Medicaid managed care program and FHP programs, most Medicaid recipients and all FHP eligible persons are required to enroll and receive services from providers who contract with a managed care organization (MCO). MCOs must have a provider network that includes a sufficient array and number of providers to serve enrollees, but they are not required to contract with any willing provider. Consequently, local providers may lose some of their patients. However, this loss may be offset by an increase in business as a result of the implementation of FHP.

The proposed regulations do not impose any additional requirements beyond those in law and the benefits of the program outweigh any adverse impact.

Compliance Requirements:

No new requirements are imposed on local governments beyond those included in law and there are no requirements for small businesses.

Professional Services:

No professional services will be necessitated as a result of this rule. However, the services of a professional enrollment broker will be available to counties that choose to access them. The costs of these services are shared by the State and the local districts.

Compliance Costs:

No additional costs for compliance will be incurred as a result of this rule beyond those imposed by law. Administrative costs associated with implementation of the managed care program incurred at start-up were covered by planning grants. Since 2005, administrative costs for the managed care program have been included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap. Additionally, the 1115 waiver reduced local government costs by authorizing Federal participation for the Safety Net and Family Health Plus (FHP) populations.

Economic and Technology Feasibility:

Administrative costs incurred at program start-up were covered by planning grants. Since 2005, administrative costs for the managed care program are included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation

(Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Minimizing Adverse Impact:

The mandatory Medicaid managed care program is implemented only when there are adequate resources available in a local district to support the program. No new requirements are imposed beyond those included in law.

The benefits of the managed care program outweigh any adverse effects. Managed care programs are designed to improve the relationship between individuals and their health care providers and to ensure the proper delivery of preventive medical care. Such programs help avoid the problem of individuals not receiving needed medical care until the onset of advanced stages of illness, at which time the individual would require higher levels of medical care such as emergency room care or inpatient hospital care. The State has fourteen years of Quality Data that demonstrate that Medicaid beneficiaries enrolled in managed care receive better quality care than those in fee-for-service Medicaid.

Small Business and Local Government Participation:

The regulations do not introduce a new program. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

All rural counties with managed care programs will be affected by this rule. As of April 2011, all rural counties have a Medicaid managed care and Family Health Plus (FHP) program.

Compliance Requirements:

This rule imposes no additional compliance requirements other than those already contained in Section 364-j of the Social Services Law (SSL).

Professional Services:

No professional services will be necessitated as a result of this rule. However, the services of a professional enrollment broker will be available to counties that choose to access them. The costs of these services are shared by the State and the local districts.

Compliance Costs:

No additional costs for compliance will be incurred as a result of this rule beyond those imposed by law. The administrative costs incurred by local governments for implementing the Statewide managed care program are included with all other Medicaid administrative costs and beginning in 2005, there was no local share for administrative costs over and above the administrative cost base of the Medicaid administrative cap. Additionally, the Federal Section 1115 waiver which allowed the State to implement mandatory enrollment, reduced local government costs by authorizing Federal participation for the Safety Net and FHP populations.

Minimizing Adverse Impact:

The benefits of the managed care program outweigh any adverse effects. Managed care programs are designed to improve the relationship between individuals and their health care providers and to ensure the proper delivery of preventive medical care. Such programs help avoid the problem of individuals not receiving needed medical care until the onset of advanced stages of illness, at which time the individual would require higher levels of medical care such as emergency room care or inpatient hospital care. The State has many years of Quality Data that demonstrate that Medicaid beneficiaries enrolled in managed care receive better quality care than those in fee-for-service Medicaid.

Feasibility Assessment:

Administrative costs incurred at program start-up were covered by planning grants. Since 2005, administrative costs for the managed care program are included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current

program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

JOB IMPACT STATEMENT

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

EMERGENCY JUSTIFICATION

Chapter 59 of the laws of 2011 enacted a number of proposals recommended by the Medicaid Redesign Team established by the Governor to reduce costs and increase quality and efficiency in the Medicaid program. The changes to Social Services Law section 364-j to expand mandatory enrollment into Medicaid managed care by eliminating many of the prior exemptions and exclusions from enrollment take effect April 1, 2011. Paragraph (t) of section 111 of Part H of Chapter 59 authorizes the Commissioner to promulgate, on an emergency basis, any regulations needed to implement such law. The Commissioner has determined it necessary to file these regulations on an emergency basis to achieve the savings intended to be realized by the Chapter 59 provisions regarding expansion of Medicaid managed care enrollment.