

12. ENROLLMENT, DISENROLLMENT, AND EXEMPTION/EXCLUSION PROCESS

Overview

The local social services districts in New York have assumed primary responsibility for The Partnership Plan enrollment process. Under the existing Medicaid program, each LDSS was responsible for the determination of Medicaid eligibility. LDSS operations, including policies and staffing, have been enhanced to accommodate The Partnership Plan Program.

LDSS responsibilities now include development of enrollment materials, training of persons providing “counseling” to beneficiaries, making face-to-face counseling sessions available, processing enrollments, handling exemption requests and exclusion requests, effecting disenrollments, and responding to member inquiries and complaints.

Upon selection of an MCO, or automatic assignment to one, members are contacted by the MCO to complete the enrollment process. MCO responsibilities related to enrollment processes include the following:

- Orientation meetings/phone calls
- Distribution of identification cards
- Distribution of member handbooks
- PCP selection process
- Responding to member inquiries

The New York State Department of Health is responsible for monitoring enrollment activities and providing technical assistance to the LDSS and MCOs, as necessary. All enrollment activities must comply with the State’s policies and procedures, as described in this and other chapters of the Protocol and related appendices.

LDSS Enrollment and Disenrollment Responsibilities

The Human Resources Administration (HRA) in New York City and the LDSS in other counties have from the outset had primary responsibility for enrolling clients into MCOs. However, the State and interested counties may contract with the Enrollment and Benefits Counselor (Maximus) to assist in some portions of the enrollment process, including providing non-biased enrollment counseling to families and/or individuals making an MCO selection.

The State DOH retains responsibility for ensuring that the enrollment process is appropriate to meet the needs of clients and in accordance with State and Federal laws, regulations, policies, and procedures. Prior to commencement of mandatory enrollment in any county or borough, the State conducts a readiness review that specifically assesses each LDSS’s procedures, staffing levels, staff training, and systems for conducting enrollment activities (see Protocol Chapter 28 for details on the readiness review process).

LDSS activities are divided into the following sections:

- Enrollment
- Excluded/Exempt Populations
- Disenrollment
- Reporting
- Beneficiary Notification

Each of these activities is described below.

Enrollment

The LDSS, through its staff or with the assistance of the Enrollment and Benefits Counselor, is responsible for the following enrollment activities:

- Development and distribution of enrollment materials
- Ensuring accessibility to face-to-face counseling sessions
- Developing and staffing the telephone inquiry line
- Training enrollment counselors and program staff
- Processing MCO enrollments

Enrollment Materials

Enrollment materials must be provided to the recipient at least 60 days prior to the date by which clients must select an MCO. The enrollment materials must include the following information:

- Description of the program
- Description of who may be exempt or excluded from program participation
- Description of how to apply for an exemption or exclusion
- A listing of available MCOs
- Information on how to select an MCO
- Availability of face-to-face counseling sessions
- How to request additional information (e.g., through the telephone line)
- Enrollment (MCO selection) form
- How to enroll by mail, in person, or over the telephone
- Native Americans with Medicaid, as appropriate
- Medicaid Managed Care and HIV
- Benefits (covered and non-covered and how to access non-covered services)
- A summary of the following information:
 - Cost sharing benefits, if applicable
 - Service area
 - Provider network

Most, if not all, of the above-referenced information is now incorporated in the “You Have 60 Days to Choose a Health Plan” for NYC, Suffolk, Nassau, and the upstate mandatory program; there is also a brochure for the upstate voluntary program entitled “Now You Can Choose a Health Plan.”

In order to assist the LDSS, the State developed a model enrollment packet (you may request a sample county packet from bigaadmin@health.state.ny.us). However, the LDSS may structure the enrollment materials as it deems appropriate, provided the materials contain the required information and that such information is presented in a clear and understandable manner. If the local district makes any substantial changes to the State specified model enrollment packet, these enrollment materials must be reviewed and approved by the State prior to distribution to clients.

The LDSS must develop the enrollment materials in languages other than English whenever at least five percent of potential enrollees in the district speak a language other than English as a first language. In addition, verbal interpretation services must be made available to Partnership Plan enrollees who speak a language other than English as a primary language. Procedures have been developed to provide information about managed health care, including enrollment information, to SSI recipients who are not required to report each year to local service district offices for recertification

MCOs must also have mechanisms in place to communicate effectively with enrollees who are vision or hearing impaired, e.g., the services of an interpreter, including sign language assistance for enrollees who require such assistance, telecommunication devices for the deaf (TDD), etc.

Face-to-Face Counseling Sessions

The LDSS must inform prospective enrollees of their right to a face-to-face enrollment counseling session and must make such a session available to any prospective enrollee upon request. The sessions must be available in high-volume income maintenance offices (i.e., offices with Medicaid caseloads in excess of 5,000 families) and/or other geographically accessible locations. The LDSS may elect to establish a fixed schedule for enrollment counseling sessions. In addition, clients have the right to enrollment counseling in a confidential setting. The LDSS must provide such accommodations if requested.

The following information is provided to potential enrollees during the face-to-face counseling session:

- A review of the enrollment form, emphasizing the importance of completing the form accurately and thoroughly
- An overview of the program, including
 - Advantages of managed care
 - Timeframes for MCO selection
 - Auto-assignment conditions
 - Time periods for changing plans
 - Good cause disenrollment provisions

- Exemption and exclusion criteria
 - Complaint and grievance process
 - Guaranteed eligibility provisions
 - Out-of-plan services (e.g. family planning)
 - Lock-in period and process for changing plans for good cause
- Information on providers participating in each available MCO
 - How to choose a plan and PCP: for enrollments resulting from face-to-face counseling, where the enrollee has a preferred provider, the LDSS or Enrollment and Benefits Counselor must verify that the provider participates in the MCO selected by the prospective enrollee before processing the enrollment.
 - MCO covered services
 - Services which are still provided under “regular” Medicaid
 - A question and answer period

Telephone Inquiry Line

The LDSS must implement and maintain a telephone line for the purpose of assisting members who have questions regarding MCO enrollment or other aspects of the program. The same individuals responsible for other education and outreach activities may staff the telephone line.

Enrollment and Benefits Counselor Training

If an LDSS elects not to use Maximus (the State Contracted Enrollment and Benefits Counselor), the County staff responsible for these functions must be adequately trained and have the necessary resources to provide all of the following information:

- Who must enroll and who may be exempted or excluded from participation
- Exemption and exclusion process
- Available MCOs
- Information on six-month guaranteed eligibility and twelve-month lock-in
- Available providers within each MCO
- How to access services under managed care
- How to access family planning services
- What to do in an emergency
- Description of services available through the Medicaid fee-for-service program
- Disenrollment rights and time frames
- How to register a complaint
- Member’s appeal rights

Processing Enrollments

The LDSS and/or Enrollment and Benefits Counselor is responsible for the collection and processing of enrollment applications and requests for exemption or exclusion from mandatory

participation. Enrollments occur according to the schedule established by the State and LDSS. Generally, MCO enrollment schedules are coordinated with re-certification interviews, thus permitting individuals to obtain additional information and/or submit their enrollment forms during their visit to the income maintenance or LDSS office.

The LDSS and/or Enrollment and Benefits Counselor collects and processes enrollment information from each enrollee, including name, address, and MCO selection among others. LDSS staff or the Enrollment and Benefits Counselor also seeks to learn whether the client has any existing medical (e.g., pregnancy or chronic illness) or behavioral condition requiring immediate follow-up by the MCO, so that an identifier can be attached to the client's roster information alerting the MCO to that fact. The State utilizes a health-access screening questionnaire for this purpose. The New Enrollee Health Screening Questionnaire: Policy is attached as Appendix 12.3a; the New Enrollee Health Assessment Form is attached as Appendix 12.3b.

Individuals have a minimum of 60 days from receipt of the enrollment packet to select an MCO. The LDSS sends a reminder mailing to individuals who have not selected an MCO at least 30 days before expiration of the choice period.

Individuals required to mandatorily enroll in an MCO who fail to select an MCO and have not applied for an exemption or exclusion are assigned to an MCO according to the automatic assignment process defined by the State (see following section for further details). The LDSS delivers notice to such individuals that includes an explanation of a member's rights to change MCOs. Effective 4/1/02, all enrollees, including auto-assignees, have 90 days to change MCOs.

Each new enrollee also receives a letter from the MCO within 14 days of their effective date of enrollment, which includes the following language:

“You have 90 days to change to a new health plan if you don't like the one you chose or were assigned to. If you do not change your plan in 90 days, you must stay in the plan for nine months unless you have a good reason to leave the plan. This period is called “lock-in”. A new lock-in is applied when a person changes plans, for whatever reason. However, when a person switches from FHPlus to Medicaid Managed Care or vice versa, but stays in the same plan, a new lock-in is not applied. If you want to change plans now or have a good reason to change plans during the next nine months, call (name and phone number).”

Enrollees are permitted to change plans during this “grace” period by calling the local district “helpline” and are not required to come into the County office, although they may do so if they choose.

Individuals enrolled in MCOs at the time of program start-up are sent a notification informing them they have the option to remain with their current MCO or to select a new MCO. The notification includes information on how enrollees can execute an MCO change if they so desire and explains the process for applying for and receiving an exemption from mandatory

participation. The notification also specifies that if a change request is not made before the end of the month, the client is automatically left in his/her current MCO.

Case Additions

1. Newborns of enrolled mothers will be enrolled in the same plan of the mother, unless the MCO does not participate in the Medicaid managed care program. If a pregnant woman is enrolled in an FHPlus MCO that does not offer a Medicaid product, she will be asked to choose one of the Medicaid MCOs operating in her area for the unborn. If the mother fails to select a plan, the newborn will be assigned to the same Medicaid MCO in which other family members (e.g. siblings) are enrolled. If there are no other family members enrolled in a plan, the newborn will be assigned following auto-assignment rules.
2. Individuals being added to a Medicaid or Temporary Assistance case, if not otherwise known to be excluded from Medicaid managed care, will be automatically enrolled into the same plan as the other family members. If there are multiple persons currently enrolled in more than one MCO, the case add will be enrolled into the Medicaid managed care plan of the oldest family member that is enrolled in Medicaid managed care.

Newborn Enrollment

Children born to women eligible for and receiving Medical Assistance on the date of birth are automatically eligible for Medicaid for one year. LDSS responsibilities regarding newborn enrollment are as follows:

- Add eligible unborns to all cases that include a pregnant woman as soon as the pregnancy is medically verified;
- In the event the LDSS learns of a pregnancy before the MCO, establish MA eligibility and enroll the unborn in the mother's MCO;
- Upon notification of the birth, update WMS with demographic data for the newborn, if not already updated, and enroll the newborn in the mother's MCO if not already enrolled;
- Upon receiving notification of the birth of an infant who has not been pre-enrolled with an MCO, retroactively enroll the newborn back to the first day of the month of birth, if the mother was enrolled at that time;
- Notify the mother of the newborn's enrollment effective date.

The State updates WMS with information received from hospitals regarding the newborn in accordance with State law.

Guaranteed Eligibility

Guaranteed Eligibility was implemented with the July 1, 1999 contract. Individuals enrolled in MCOs are eligible for and may receive six months of coverage for the benefits offered through their MCO. Should eligibility for medical assistance terminate during the first six months of enrollment, enrollee(s) of full risk plans continue to receive those health care benefits for which

their MCO is financially responsible through the end of their sixth month of coverage. Enrollees of partial capitation programs receive services provided by or through their PCP. The only exceptions to the benefit limit are family planning and pharmacy services. The family planning free access policy continues, and pharmacy services are available through the fee-for-service program through the end of the guarantee period.

There are, however, several exceptions to the eligibility guarantee. The guarantee period does not apply if the individual is incarcerated, dies, moves out of state, or requests shortening of or end to guarantee. Also, women with a net available income in excess of the medically necessary income but at or below 200% of the federal poverty level who are eligible for Medicaid only while they are pregnant, and through the end of the month in which the sixtieth day following the end of the pregnancy occurs, are not eligible for the guarantee.

If, during the first six months of enrollment in an MCO, an enrollee becomes eligible for Medicaid only as a spend-down, the enrollee is eligible to remain enrolled in the MCO for the remainder of the six month period. During the six month guarantee period, an enrollee eligible for spend-down and in need of wraparound services has the option of spending down to gain full Medicaid eligibility for the wraparound services. In this situation, the local district monitors and manually sets coverage codes as appropriate.

When an eligible individual loses and regains eligibility within a 90-day period, she/he is not be entitled to a new six-month guarantee period for this re-enrollment to the same plan. However, a switch to a new plan generates a new guarantee period and also a new lock-in period.

The guaranteed eligibility period is tracked through the eligibility system (WMS) and is monitored by the local districts.

As indicated in the “Definitions and Acronyms” section, the definition of MCO includes HMOs, PHSPs, partial capitation plans and the Special Needs Plans for the HIV population. Individuals enrolled in any one of these types of MCOs are eligible for the guarantee.

Automatic Assignment Process

If an individual does not choose an MCO in the required time period, he/she is assigned automatically using an algorithm that conforms to the New York State Managed Care Act. Each night, the State updates on the information system its database of newly eligible and recertified clients, including an assignment “tickler file” identifying the number of “choice” days remaining for clients falling into a mandatory enrollment category. Once the tickler file reports that a client’s choice period has expired, his/her record is matched against the full WMS database to determine if he/she has chosen an MCO, or if other members on the same case are already enrolled in an MCO. If neither of these conditions is met, the client is automatically assigned in conformance with auto assignment guidelines (see Appendix 12.1). In New York City this process is administered by the Enrollment and Benefits Counselor (Maximus).

An individual is assigned to a plan only if it is geographically accessible as described in the waiver and the RFP. A plan must have sufficient capacity in order to participate in the auto assignment process. In accordance with State statute, in the first three years of mandatory enrollment, plans affiliated with Article 28 facilities (predominately prepaid health services plans) were guaranteed at least 25%, 22.5%, and 20% of the auto assignments, respectively.

As of June 2001, the auto-assignment algorithm was modified to include preference based on plan quality performance, as authorized by statute. The revised methodology has been implemented in counties that have completed one year of operation under The Partnership Plan. A detailed description of the new algorithm is included in Appendix 12.1a.

The auto assignment process rejects individuals who are excluded or have been prospectively exempted from mandatory enrollment. The excluded and exempt populations are identified by demographics on WMS (for example, nursing home residents), or through exemption and exclusion codes that are either file loaded to the Restriction/Exception Subsystem (for example, persons who can be identified by prior utilization as HIV+) or data-entered at the local district after self-identification. Appendix 12.1 contains more detailed information on the automatic assignment information criteria.

The State monitors, on an ongoing basis, the level of auto-assignments by local districts. If at any time the auto assignment rate rises above 40%, but remains below 50%, the State would investigate the potential reasons for this level of auto-assignments. If the rate rises above 50%, the State would develop a corrective action plan for the district, which would include targeted initiatives for lowering the auto-assignment rate by increasing the level of self-selection. The State consults with its contracted Enrollment and Benefits Counselor (Maximus) on the specific efforts and initiatives to be undertaken to reduce the auto-assignment rate and make continuous progress toward minimizing the number of persons so assigned. The State's methodology for calculating auto-assignment rates is attached as Appendix 12.2.

In New York City, the Enrollment and Benefits Counselor is involved in a wide variety of outreach efforts in the community designed to enhance awareness of The Partnership Plan and encourage individuals to select the MCO of their choice. Recipients receive multiple mailings, including reminder notices encouraging self-selection. Plans are also permitted (within limits discussed elsewhere) to assist individuals in completing enrollment materials. Counselors encourage self-selection when providing counseling to recipients in face-to-face sessions or by telephone.

The support of community-based organizations is also sought in spreading the word to participants about the importance of reviewing materials, availing themselves of counseling, and making the choice that best meets their family's needs.

In the upstate counties, a variety of program approaches is used including the provision of written materials and counseling emphasizing the importance of informed choice. Some districts intend to do 100% face-to-face counseling; however, this may not be possible in all cases.

Excluded/Exempt Populations

Certain individuals may be either excluded or exempted from mandatory participation in The Partnership Plan. Excluded populations do not participate in The Partnership Plan. Exempt populations are not required to participate; however, individuals designated as exempt may elect to voluntarily enroll. Excluded/exempt populations are discussed in detail within Chapter 2 of this protocol.

Excluded Populations

Some excluded populations can be identified through the eligibility system. The State and/or the LDSS appends the eligibility records with an identifier that enables the Enrollment and Benefits Counselor or the LDSS to determine whether an individual is excluded from participating. In those cases where the State can determine in advance an individual's exclusion status, the system flags the eligibility files to preclude any mailings regarding enrollment and to prevent auto-assignment from taking place.

In those cases where an individual feels that s/he meets the criteria for an excluded category and the eligibility system has not been pre-coded, the individual may provide information and documentation to the LDSS to support the request. In addition, the LDSS may research the individual's case file to determine if the individual meets the exclusion criteria. If the LDSS agrees with the individual, the LDSS appends the individual's eligibility record to reflect the exclusion.

The LDSS or the Enrollment and Benefits Counselor initiates disenrollment of an enrollee whose status changes to an excluded category. The enrollee receives a notice of disenrollment including their right to request a fair hearing.

Exempt Populations

In some cases, the State and LDSS can identify exempt populations through existing claims and eligibility data. The State and/or LDSS appends the eligibility records with an identifier that enables the Enrollment and Benefits Counselor or the Local District to determine whether an individual is exempt from mandatory participation. In cases where the State can determine in advance an individual's exempt status, the system "flags" these persons' eligibility files to prevent an auto-assignment from taking place. However, in the case of persons who may be exempt but cannot be identified in advance, the algorithm assigns these individuals to an MCO unless they actually apply for and receive an exemption from the LDSS (see below).

Individuals who are identified as exempt through analysis of existing aid category or through claims data do not receive a notice indicating that the State has found them to be exempt from mandatory participation. Exempt individuals are informed of their option to enroll in an MCO or be waived from mandatory participation. These persons may be receiving the same enrollment package as others being recertified or applying for assistance. This package includes information on exemptions and who is eligible. However, the recipient's case is electronically

“flagged” as exempt which prevents auto-assignment. Exempt individuals so flagged do not receive a reminder notice regarding the requirement to enroll in a managed care plan. If the recipient chooses to enroll in a managed care plan, the worker inputting the enrollment information gets a computer message that alerts them that an exemption code is on file; and if the client chooses to disenroll at a later date, he/she will not be auto-assigned as long as that exemption code remains.

In certain cases, the State and LDSS may lack the information necessary to determine in advance whether the individual is exempt from participation. Accordingly, the State has developed an exemption application to enable such individuals to apply for exemption from participation. The LDSS collects and processes applications for exemption from mandatory participation in The Partnership Plan. The exemption application forms and criteria for approving or denying requests are provided by the State to the Local Districts. Exemption forms, including the “look-alike” screening form, are available to beneficiaries through the LDSS. Copies of the exemption and exclusion applications are available upon request at bigaadmin@health.state.ny.us.

Eligible MCO enrollees may apply for an exemption at any time. However, if the person is enrolled in an MCO, s/he may be required to access services through the MCO until the LDSS and State have had the opportunity to process the application and disenroll the individual from an MCO.

Disenrollment

The LDSS is responsible for informing members of their rights to change MCOs. These rights must be defined in the enrollment confirmation notice sent to individuals after they have selected a plan or been auto-assigned.

Members are permitted to change MCOs without cause during their first 90 days of enrollment, regardless of whether they choose an MCO or are auto-assigned. After the 90 day switch window, members are “locked into” their MCO for the remainder of their first year (nine months). The only exception to the lock-in is if “good cause” for disenrollment can be shown prior to that time as defined by regulation.

Disenrollment requests are processed to take effect on the first day of the following month if the request is made before the fifteenth day of the month, or on the first day of the second following month if the request is made on the fifteenth day of the month or later. An expedited disenrollment process is available in certain circumstances. See Chapter 23 for a description of this process. Enrollees may request to disenroll directly with the LDSS, and do not have to approach the MCO for a disenrollment form. The LDSS has a standard disenrollment form for such requests. Recipients may call the State’s hotline, the local district or the Enrollment and Benefits Counselor (NYC) to request a disenrollment form. The form, once completed and signed, may be returned to the local district/broker by mail or in person. Individuals may also come in to the local district/broker offices and request assistance in completing the disenrollment form. Disenrollment forms may not be submitted to the MCO for processing.

MCO members are disenrolled automatically upon death or loss of eligibility (subject to any remaining applicable “six months guaranteed eligibility” coverage). For purposes of capitation payments to the MCOs, all such disenrollments are effective at the end of the month in which they occur.

Individuals whose eligibility or health status changes such that they meet the exclusion criteria are disenrolled at the end of the month in which their status change occurs. The only exception is for persons who move to a category from which voluntary enrollment is still permitted (exempt). In those cases, the individuals (e.g. HIV+) are left in their MCO and are free to request disenrollment, as described below. Retroactive disenrollments are used only when absolutely necessary. Circumstances warranting a retroactive disenrollment are rare and include when a member is later determined to have entered or stayed in a residential institution under circumstances which render the member excluded from managed care, to have been incarcerated, to be an SSI infant less than six months of age, or to have died, as long as the MCO was not at risk for provision of benefit package services for any portion of the retroactive period. In New York City, members who are not in guaranteed status and who move out of the MCO’s service area but not outside of the City of New York (i.e., move from one borough to another), are not disenrolled unless the member requests a disenrollment or transfer.

Individuals are not permitted to disenroll from an MCO absent meeting one of the specified disenrollment conditions. If disenrollment occurs based on good cause, the individual may be required to select another MCO or may be disenrolled into the Medicaid fee-for-service program, depending on what is determined to be in his/her best interests and the best interests of the program.

When necessary, the LDSS has the capability to disenroll a member more quickly, by manually processing the disenrollment through the Prepaid Capitation Plan Information Subsystem. Through the manual process, the LDSS is able to advance a disenrollment to the first of the following month, regardless of when in the month the processing takes place or, in extreme circumstances, retroactive to the first day of the month in which the request was made.

Expedited Disenrollment Process

The State has in place an expedited MCO disenrollment process administered by local districts in cases where SDOH or the local district determines that there is an urgent medical need to disenroll the member without delay or when there is reason to believe that an enrollment was not consensual. Individuals who are to be disenrolled from managed care based on their HIV, ESRD or SPMI/SED status are categorically eligible for an expedited disenrollment based on urgent medical need. Also, homeless individuals in a homeless shelter in New York City and other districts where homeless individuals are exempt, are categorically eligible for an expedited disenrollment.

The expedited disenrollment process is administered by the local districts in cooperation with the SDOH Office of Managed Care. Individuals may initiate a request for an expedited disenrollment by contacting the local district’s managed care office or the enrollment broker,

where applicable. MCOs may also refer their members to the local district or the enrollment broker if the MCO believes an expedited disenrollment is appropriate. Within twenty-four hours, a representative of the local district or the enrollment broker will contact the individual and obtain any additional information that may be required. The local district or enrollment broker will make a determination based upon the documentation provided. If the local district representative or enrollment broker believes the expedited disenrollment is warranted, the change will be processed within 48 hours.

If the representative believes an expedited disenrollment based on urgent medical need is not necessary, the concurrence of the Medical Director within the DOH Office of Managed Care will first be obtained and then the enrollee will be notified, or the Medical Director's office may order the expedited disenrollment.

In New York City, complaints of non-consensual enrollments, including complaints received by the enrollment broker or the SDOH, will be referred to the City DOH Division of Health Care Access and Improvement (HCAI) for expedited investigation. HCAI will make a presumptive determination. Conclusive proof will not be required, but HCAI will attempt to make some verification of the complaint to ascertain that the member did not sign an enrollment form nor authorize anyone else to sign the form by talking to the complainant and comparing the complainant's signature with the signature on the enrollment form, if possible. Upon HCAI's determination, HRA and the enrollment broker will be asked to expedite the disenrollment.

Expedited disenrollments based on urgent medical need will be effective the first day of the next month after determination except where medical need requires an earlier disenrollment. Expedited disenrollments based on non-consensual enrollment will be effective retroactive to the first day of the month of enrollment. Expedited disenrollments for homeless individuals will be effective on the first day of the month in which the disenrollment was requested.

Just (or "Good") Cause Disenrollment

Whether handled on an expedited or a routine basis, all managed care enrollees retain the right to disenroll from an MCO when "cause", as determined by the local district, exists. All just-cause disenrollments will be determined through a formal request filed with the local district by the member. Such requests may be made orally or in writing. However, if filed orally, the State will summarize the request in writing and require the individual to sign it. Just-cause for disenrollment will be generally defined as follows:

- A) The Contractor 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 Contractor 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, consultation with specialists, or laboratory and radiological services when reasonably necessary;
 - III) arrange for consultation appointments;

- IV) coordinate and interpret any consultation findings with 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
- B) The Contractor cannot make a Primary Care Provider available to the Enrollee within the time and distance standards prescribed by SDOH; or
 - C) The Contractor fails to adhere to the standards prescribed by SDOH and such failure negatively and specifically impacts the Enrollee; or
 - D) The Enrollee moves his/her residence out of the Contractor's service area or to a county where the Contractor does not offer the product the Enrollee is eligible for; or
 - E) The Enrollee meets the criteria for an Exemption or Exclusion as set forth in 2(b)(xi) of this Appendix; or
 - F) It is determined by the LDSS, the SDOH, or its agent that the Enrollment was not consensual; or
 - G) The Enrollee, the Contractor and the LDSS agree that a change of MCOs would be in the best interest of the Enrollee; or
 - H) The Contractor is a primary care partial capitation provider that does not have a utilization review process in accordance with Title I of Article 49 of the PHL and the Enrollee requests Enrollment in an MCO that has such a utilization review process; or
 - I) The Contractor has elected not to cover the Benefit Package service that an Enrollee seeks and the service is offered by one or more other MCOs in the Enrollee's county of fiscal responsibility; or
 - J) 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 Contractor because the Contractor 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
 - K) An FHPlus Enrollee is pregnant.

An Enrollee subject to Lock-In may initiate Disenrollment for Good Cause by filing an oral or written request with the LDSS.

MCO Requests for Disenrollment

MCOs may seek to disenroll a member under two circumstances:

- The member engages in conduct or behavior that seriously impairs the MCO's ability to furnish services to either the member or other members, provided that the MCO has made and documented reasonable efforts to resolve the problems presented by the member.
- Consistent with 42 CFR § 438.56 (b), the MCO may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs (except where continued enrollment in the MCO's MMC or FHPlus product seriously impairs the MCO's ability to furnish services to either the member or other members.
- Once a member has been disenrolled at the MCO's request, he/she will not be re-enrolled with that same MCO again in the future, unless the MCO first agrees to such enrollment. The local district may require that these individuals be returned to the fee-for-service program.

The MCO must file a formal request with the local district including the following information and documentation:

- A letter that describes in detail the circumstances leading to the request;
- Documentation of the plan's efforts to resolve the member's problems or address the situation;
- Affidavits, as appropriate, from plan providers and/or staff.

The local district upon receipt and review of this request and all accompanying information, will contact the enrollee to obtain his/her perspective and obtain their input. Following its investigation, the local district will render a decision, which if unfavorable to the client (disenrollment ordered over the client's objections) may be appealed through the Fair Hearing process.

State- or LDSS-Ordered MCO Changes

The SDOH has the right, upon notice to the LDSS, to limit, suspend or terminate enrollment activities by the MCO and/or enrollment into the MCO's plan upon ten (10) days written notice to the MCO, specifying the action(s) contemplated and the reason(s) for such action(s).

The State or LDSS may disenroll members from any MCO found to be in violation of service accessibility or financial solvency standards. Under these circumstances, individuals are given notice and permitted to select a different MCO.

Automatic Re-enrollment into MCOs

Individuals with mandatory enrollment status who are disenrolled from an MCO due to loss of eligibility, and who regain their eligibility within three months or less, will automatically be prospectively re-enrolled with the same MCO (subject to available capacity in the MCO). In this case, the original guarantee and lock-in period continue.

MCO Notification of Disenrollments

The Roster, along with any changes sent by the LDSS to the MCO in writing or electronically, serves as official notice to the MCO of the disenrollment of an enrollee.

The LDSS consults with the MCO regarding any retroactive disenrollment that would be effective prior to the first day of the month of the disenrollment request, except for SSI infants or in cases where it is clear that the MCO was not at risk for the provision of covered services. In all cases of retroactive disenrollment and at the time of disenrollment, the LDSS must notice the MCO of the MCO's responsibility to submit to the SDOH Fiscal Agent voided premium claims for any months of retroactive disenrollment in which the MCO was not at risk for the provision of covered services.

Reporting

The local districts report, and the State monitors, the following information and statistics on a monthly basis in a format prescribed by SDOH:

- Number of persons enrolled by health plan
- Number of persons auto-assigned by health plan
- Number of recipients requesting exemptions from mandatory enrollment
- Number of exemptions granted
- Number of disenrollments
- Number of complaints received directly by the county

Local districts in mandatory counties collect all this information each month for the prior month period and submit it to the State. In voluntary counties, the LDSSs submit complaint logs only. The State compiles the results and forwards these records to CMS on a quarterly basis.

Beneficiary Notification

Local districts and the Enrollment and Benefits Counselor in New York City are responsible for providing a series of notifications to recipients. These forms/notices, formerly appendices to this Protocol, are available upon request to bigaadmin@health.state.ny.us.

- Initial Notification Letter - This letter informs the applicant or recipient about the mandatory managed care program and their rights and responsibilities under this program, including the option for HIV/AIDS infected individuals who are categorically

exempt from the mainstream Medicaid managed care program to enroll in an HIV SNP on a voluntary basis in districts where HIV SNPs exist. The letter is sent (or given) to recertification clients as well as new applicants along with an enrollment kit which contains general informational materials on the program, the Helpline telephone number and a listing of MCOs, among other items.

- Reminder Notice – This letter is sent to all individuals in a mandatory category who have not responded with a completed enrollment form within 30 days (and within 45 days in some counties) of being sent or given an enrollment kit. There is a reminder template which may be customized by counties outside of NYC with SDOH approval.
- Exemption and Exclusion Request Forms – The exemption form is provided to recipients upon request if they wish to apply for an exemption. The exclusion form is used in NYC for individuals who self-identify as qualifying for an exclusion.
- Exemption and Exclusion Request Approval or Denial – This letter is designed to inform a recipient who applied for an exemption or exclusion of the LDSS's disposition of the request, and includes the right to a fair hearing, where appropriate.
- Enrollment Confirmation Notice – This letter indicates the effective date of enrollment, the name of the recipient's plan and the names of all individuals in the case who are being enrolled.
- Notice of Denial of Enrollment – This letter is used when an individual has been determined by the LDSS to be ineligible for enrollment into a Medicaid managed care plan and it includes fair hearing notification.
- Notice of Denial of Disenrollment – This letter is used when an individual has been denied a disenrollment for “good cause”. The letter includes the reason and basis for the denial and includes fair hearing notification.
- Notice of End of Medicaid Eligibility and Start of Guaranteed Coverage – This letter advises the enrollee that their Medicaid coverage is ending and how this change in status affects the enrollment in managed care. The letter includes information regarding “guaranteed eligibility” and fair hearing rights. In NYC, the eligibility notice includes notification of the start of guarantee.
- Notice of Disenrollment – If a member is disenrolled by the LDSS pursuant to a request made directly to it by an MCO or by a member for good cause, the LDSS shall notify the recipient of this action along with information about timeframes for selecting a new plan or returning to the fee-for-service program.
- Notice of End of Lock-in – Sixty days before their first plan enrollment anniversary date, recipients are notified of their ability to change MCOs if they choose. A failure to return

the notice will result in an individual being continued in his/her current plan. The notice explains the enrollee's right to change plans and includes a list of plans from which the individual may choose.

Other notices may be added for appropriate reasons as the program expands over the years.

MCO Responsibilities in the Enrollment Process

MCO responsibilities with respect to enrollment include the following (each of these areas is discussed in detail in the remainder of this chapter).

- New member orientation
- Assistance with PCP selection/changes
- Issuance of identification cards
- Distribution of member handbooks
- Ongoing assistance via toll-free member services line
- Non-discrimination
- Notification to LDSS of status changes
- Enrollment of newborns

New Member Orientation

MCOs must make all reasonable efforts to contact new members, in person, by telephone, or by mail, within thirty (30) days of their effective enrollment date. "Reasonable efforts" are defined to mean at least three attempts, with more than one method of contact being employed (e.g., combination of telephone and mail). Upon contacting the new member(s), MCOs must do at least the following:

- Inform the member about the MCO's policies with respect to obtaining medical services, including services for which the member may self-refer, and what to do in an emergency.
- Assist the member in selecting a primary care provider (PCP).
- Assess the member's need for any special health care services (e.g., prenatal or behavioral health services) and identify any language/communication barriers that the member may have. If a special need is identified, MCOs must assist the member in arranging for an appointment with his/her PCP or other appropriate provider.
- Offer assistance in arranging an initial visit to the member's PCP for a baseline physical and other preventive services, including a comprehensive risk assessment.
- Inform members about their rights for continuation of certain existing services.

- Inform members about accessing out-of-MCO services, including family planning services.
- Provide the member with an MCO toll free telephone number that may be called twenty-four (24) hours a day, seven (7) days a week if the member has questions about obtaining services and cannot reach his/her PCP (this telephone number need not be the Member Services line and need not be staffed to respond to Member Service-related inquiries).
- Advise the member about opportunities available to learn about MCO policies and benefits in greater detail (e.g., “welcome meetings”).
- Offer to provide the member with a complete list of network providers, including behavioral health providers, which may be accessed directly, without referral. The list should group providers by service type and must include addresses and telephone numbers.

MCOs must inform the LDSS of any members they are unable to contact within ninety (90) days of enrollment through reasonable means (e.g., all mailed materials are returned as undelivered and no working telephone number is available) and who have not sought any health care services through the MCO or its participating providers. LDSS staff will assist MCO staff to contact these members by making at least one additional documented attempt at contacting clients prior to further case action.

PCP Selection and Changes

Initial Selection/Assignment

MCOs must offer every member a choice of at least three PCPs within distance and travel time standards at the time of enrollment. If the member does not make a choice within thirty (30) days of enrollment, the MCO must assign the member to a PCP and inform him/her of the assignment, but only after the MCO has made all reasonable efforts to contact the individual in person, by telephone or by mail and inform the individual of his/her right to choose a PCP. “Reasonable efforts” means at least three attempts, with more than one method of contact being employed. PCP assignments must be made taking into consideration the following: a member’s geographic location; any special health care needs, if known by the MCO; and any special language needs, if known by the MCO. When a language barrier exists, the individual may be eligible for an exemption pursuant to Chapter 2.

In circumstances where the MCO operates or contracts with a multi-provider clinic to deliver primary care services, the member must choose or be assigned a specific provider or provider team within the clinic to serve as his or her PCP. This “lead” provider is held accountable for performing the PCP duties listed in Section 21.15 of the Model Contract.

MCOs must provide the LDSS with up-to-date listings of primary care providers, including their specialty, office locations, office hours, telephone number, and wheelchair accessibility status. The listings also must note any languages other than English spoken in the provider's office.

PCP Changes

MCOs must allow members the freedom to change PCPs, within 30 days after their first PCP appointment with or without cause, and no more than once every six months thereafter except with good cause. MCOs may request PCP changes, too. As a general rule, such changes should be processed and take effect by the first day of the month following the month in which the request is made (e.g., if a request is made on January 15, it should take effect on February 1). Under no circumstances may an MCO take longer than forty-five (45) days to process a request.

Members may change PCPs at any time (with 30 days notice) when "cause" to do so exists. "Cause," with regard to PCP changes, includes the following:

- The member cannot obtain timely appointments in accordance with the appointment availability standards specified by the State (see Section 15.2 of the Model Contract).
- The member is routinely asked to wait longer than the waiting time standards specified by the State when a scheduled appointment was obtained.
- The provider or the provider's staff has been abusive toward the enrollee.
- The member is not able to communicate with the provider due to a language barrier.
- MCOs may initiate a PCP change for a member under the following circumstances:
 - The member requires specialized care for an acute or chronic condition and the member, and MCO, agree that reassignment to a different PCP is in the member's interest.
 - The member's place of residence has changed such that he or she has moved beyond the PCP travel time distance standard (unless the member wishes to waive the opportunity to change PCPs).
 - The member's PCP ceases to participate in the MCO's network.
 - The member's behavior toward the PCP is disruptive, and the PCP has made all reasonable efforts to accommodate the member.
 - The member has taken legal action against the PCP.

Whenever initiating a change, MCOs must offer affected members the opportunity to select a new PCP in the manner described above.

Member Identification Cards

MCOs must issue identification cards to enrolled members containing the following information: the name of the individual's clinic (if applicable); the name of the individual's PCP and his or her telephone number; the toll-free telephone number for the MCO; and for ID cards issued after October 1, 2004, the Enrollee's Client Identification Number (CIN).

PCP information may be affixed to the card by a sticker, rather than embossed. If a PCP team is serving a member, the name of the individual shown on the card should be the lead provider. In the case of teams comprised of medical residents and an attending physician, this is the attending physician.

For MCOs with non-Medicaid enrollment, identification cards may identify the member as a Medicaid beneficiary through use of an alphanumeric code, but may not differ overtly in design from identification cards issued to the MCO's other members. ID card formats must be approved by the State.

MCOs must issue an identification card within fourteen (14) days of a member's enrollment. MCOs also must have another method for individuals to identify themselves as members prior to receiving the card (e.g., using a "welcome letter" from the MCO or temporary ID card). PCP information on identification cards must be updated as appropriate.

In addition to the MCO identification card, members receive a permanent (plastic) fee-for-service benefit card from the State. The State's card includes the client's name, identification number, and ISO (access) and Sequence number. The card contains a magnetic stripe with eligibility and enrollment data which providers can access through a card swipe (this information also can be obtained on-line using a PC or by calling the State's toll-free eligibility number). The State updates eligibility data daily and enrollment data weekly.

Member Handbook

MCOs must issue a handbook to new members within 14 days of the effective date of enrollment. Handbooks must be written in accordance with the criteria described in Chapter 15 of this Protocol, and must be submitted to the State for review and approval prior to being issued. New handbooks also must be distributed to current enrollees, to ensure they are informed about program changes under The Partnership Plan. Required information for member handbooks is outlined in Chapter 15 of this Protocol.

Member Services

MCOs must operate member services units designed to assist members with questions and concerns. The member services unit must be staffed by individuals with training specific to The Partnership Plan. The department must be staffed at a ratio of at least one member services representative for every 4,000 or fewer total enrollees.

The unit must operate during regular business hours and must be accessible via a toll-free telephone line. This toll-free telephone line may be called twenty-four (24) hours a day, seven (7) days a week if the member has questions and cannot reach his/her PCP (this telephone number need not be the Member Services line and need not be staffed to respond to Member Services-related inquiries). The MCO must have appropriate mechanisms in place to accommodate members who do not have telephones and therefore cannot readily receive a call back.

MCO Non-Discrimination

MCOs may not refuse an assignment or seek to disenroll a member or otherwise discriminate against a member on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, need for health services, capitation rate that the MCO will receive for such member, or type of illness or condition, except when that condition can be treated better by another provider type, and the enrollee agrees to the disenrollment.

Enrollment of Newborns

MCOs must register unborn children of members with the LDSS and enroll newborn children of members effective from the time of birth. MCOs are responsible for doing all of the following with respect to newborns:

- Exchanging known birth information with the LDSS (following guidelines included in Appendix H of the State MCO model contract).
- Providing services to newborns and reimbursing the hospital at the Medicaid rate or at the contractually agreed rate if the mother is a member at the time of the newborn's birth, even if the newborn is not yet on the roster.
- Within fourteen (14) days of the date on which the MCO becomes aware of the birth, issuing a member identification card or a letter informing the parent(s) about the newborn's enrollment and how to access care.
- Linking the newborn with a PCP prior to birth when the MCO is aware of the pregnancy, or prior to discharge from the hospital when the MCO receives notification of birth prior to discharge.

Capitation payments for newborns begin the month following certification of the newborn's date of birth, retroactive to the first day of the month in which the child was born, except in cases where the newborn is in an exempt or excluded category, in which case, no capitation is paid.

State Responsibilities in the Enrollment and Disenrollment Process

The State is responsible for ensuring that LDSSs are prepared to commence enrollment under The Partnership Plan. As previously discussed, the State conducts on-site reviews of each LDSS to ensure that all necessary policies, procedures, systems, and staff are in place to permit the LDSS to begin enrollment. Chapter 28 of this Protocol includes detailed information on the County readiness review process.

Other State functions related to enrollment and disenrollment include the following:

- Development of exemption and exclusion forms and review criteria
- Development of the model enrollment packet
- Coordination of LDSS and MCO data exchange activities

Exemption Forms

The State has developed uniform guidelines for applications for exemption from participation and applications for exclusion from participation in New York City.

Data Exchange Activities

The State has developed necessary systems to collect enrollment data from the LDSS. See Chapters 1, 13, 22, and 25 of this Protocol for a detailed description of data exchange activities.

12. ENROLLMENT AND DISENROLLMENT, AND EXEMPTION/EXCLUSION PROCESS IN FHPlus

Partnership Plan enrollment and disenrollment processes are utilized for FHPlus; however, The enrollment materials and processes reflect the FHPlus program features. Under FHPlus, there is no exclusion/exemption process, no auto-assignment to plans, and no fee-for-service wrap-around services. The role of the LDSS/Enrollment and Benefits Counselor is augmented by the use of Enrollment Facilitators who distribute enrollment materials and assist applicants in applying for health care coverage.

Since FHPlus is solely a managed care delivery system, an applicant must qualify financially and must select a FHPlus MCO at the time of application in order to get health care coverage. An application and enrollment form were designed to assist applicants in choosing an MCO for both FHPlus and Medicaid, so that regardless of which program they ultimately qualify for, they are enrolled in the MCO of their choice once the LDSS makes the eligibility determination.

FHPlus Enrollment Features

Participation in FHPlus is voluntary, and an individual may disenroll at any time. This discontinues their healthcare coverage unless the individual becomes Medicaid eligible.

FHPlus participants are enrolled for an initial enrollment period of twelve (12) months, with an initial ninety (90) day grace period to transfer to another MCO where available without cause.

LDSSs are responsible for disenrollments, including making determinations on requests to disenroll and transfer to another MCO when an individual's eligibility status changes:

- A FHPlus enrollee who becomes pregnant may transfer to another MCO that provides Medicaid managed care if she chooses to receive full Medicaid coverage, including during the Initial Enrollment Period.
- An enrollee who loses eligibility during the first six (6) months of enrollment is entitled to receive benefits for the remainder of that initial six-month period. During this period the enrollee may not change MCOs.
- Guaranteed eligibility is not available to enrollees who lose eligibility due to death, moving out of state, or incarceration.
- An enrollee who has lost eligibility and who voluntarily disenrolls from an MCO terminates the guaranteed eligibility period.
- Individuals who are disenrolled from an MCO due to loss of eligibility and who regain eligibility within ninety (90) days are automatically re-enrolled in the same MCO (subject to available enrollment capacity), and are not entitled to a new guarantee period.

- If a FHPlus enrollee gains Medicaid eligibility and their MCO also participates in Medicaid, they will stay enrolled in the same MCO, unless the enrollee indicates otherwise in writing. If the FHPlus MCO is not also a Medicaid MCO, the individual must select a Medicaid MCO if they reside in a mandatory area and are not excluded or exempt, or receive care on a fee-for-service basis.

Disenrollment for Good Cause

- An enrollee may initiate disenrollment from the FHPlus MCO for “good cause” at any time during the initial enrollment period, and may disenroll from the FHPlus MCO for any reason at any time during the 90 day grace period or after the twelfth (12th) month following the effective date of enrollment.
- An enrollee may initiate disenrollment for “good cause” by filing a written request with the LDSS or the MCO. The MCO must notify the LDSS of the request. The LDSS must respond with a determination within thirty (30) days after receipt of the request.
- Enrollees granted disenrollment for “good cause” may join another FHPlus MCO, if one is available
- In the event that the LDSS denies an enrollee’s request for disenrollment for “good cause”, the LDSS must inform the enrollee of the denial of the request with a written notice which explains the reason for the denial, states the facts upon which denial is based, cites the statutory and regulatory authority and advises the enrollee of his or her right to a fair hearing. In the event that the enrollee’s request to disenroll is approved, the notice must state the effective date of disenrollment.

Disenrollment Based on Pregnancy

A pregnant enrollee may initiate disenrollment from the FHPlus MCO to receive Medicaid coverage.

Pregnant Women

A pregnant woman applying for health insurance is not eligible for FHPlus and must receive coverage under Medicaid. However, if a woman becomes pregnant after enrollment in FHPlus, she is given the option of continuing under FHPlus until the end of the 60-day postpartum period, so as not to disrupt her care. The LDSS, upon learning of the pregnancy, must ensure that the woman has received an explanation about the services available to her under Medicaid compared to FHPlus, and should ascertain that the woman has determined if her current provider also participates in a Medicaid MCO if she resides in a mandatory area. In either situation, at the end of the 60-day postpartum period, a recertification is required.

Newborn Enrollments

The SDOH and LDSSs are responsible for ensuring that timely Medicaid eligibility determinations and enrollments of newborns are effected consistent with State laws, regulations and with the newborn enrollment guidelines in the ADM and the FHPlus Model Contract. MCOs are required to notice the LDSS of confirmed enrollee pregnancies, and report newborn demographic information within five (5) days after knowledge of the birth.

The LDSS must authorize Medicaid eligibility for newborns for one (1) year, regardless of changes in income or family size, if born to a woman eligible for and receiving FHPlus on the date of birth. (Social Services Law Section 366(4)(1)).

The LDSS must insure that Medicaid coverage is authorized for the unborn child as soon as a pregnancy is medically verified.

If the mother's FHPlus MCO also participates in Medicaid, newborn children not in a Medicaid managed care excluded category will be enrolled in the same MCO's Medicaid Managed Care product, effective from the first day of the child's month of birth. If the FHPlus MCO does not participate in Medicaid managed care, the pregnant woman must select a Medicaid managed care MCO for the unborn child, if a Medicaid managed care MCO is available.

The LDSS must update WMS with the demographic data for the newborn upon notification of the birth by the MCO, enrollee or hospital. The LDSSs must retroactively enroll the newborn back to the first (1st) day of the month of birth.

The LDSS is responsible for establishing Medicaid eligibility and enrolling the unborn in the MCO's Medicaid Managed Care product. If the MCO does not offer a Medicaid Managed Care product, the pregnant woman will be asked to select an MCO offering a MMC product for the unborn. If an MCO offering a MMC product is unavailable, or if enrollment is voluntary in the LDSS jurisdiction and an MCO is not chosen by the mother, the newborn will be eligible for Medicaid fee-for-service coverage, and such information will be entered on the WMS.

Beneficiary Notification

The following notifications are sent to FHPlus applicants/enrollees by the LDSS:

- Family Health Plus Eligibility Acceptance Notice: This letter provides the applicant with the eligibility determination, indicates the name of the MCO chosen by the applicant and explains that the individual has 90 days to change MCOs for any reason and that during the remaining 9 months they will only be allowed to change MCOs if there is "good cause".
- Notice of Ineligibility: This letter is used when an individual has been determined by the LDSS to be ineligible for FHPlus.
- Notice of Denial of Enrollment: This letter is used when an individual has been

determined by the LDSS to be ineligible for enrollment into an MCO because that MCO does not participate in FHPlus. The individual is given information about selecting a FHPlus MCO.

- Notice of Denial of Disenrollment: This letter is used when an individual has been denied a disenrollment for “good cause”. The letter includes the reason and basis for the denial and includes fair hearing notification.
- Notice of End of FHPlus Eligibility and Guaranteed Coverage: This letter advises the enrollee that their coverage is ending and how this change in status affects the enrollment in managed care. The letter includes information regarding “guaranteed eligibility” and fair hearing rights.
- Notice of Disenrollment: If a member is disenrolled by the LDSS pursuant to a request made directly to it by an MCO or by a member for “good cause”, the LDSS shall notify the enrollee of this action along with information about timeframes for selecting a new MCO. In counties where there is only one FHPlus MCO, the Notice informs the enrollee that they must stay in their present MCO in order to continue receiving health care coverage.
- Notice of End of Initial Enrollment Period: Sixty days before their first enrollment anniversary date, enrollees are notified of their right to change MCOs if they choose. This notice is only sent in counties where there is another FHPlus MCO available for transfer. A failure to choose to switch plans results in an individual being continued in his/her current MCO. The notice explains the enrollee’s right to change MCOs and includes a list of MCOs from which the individual may choose.

Please note that additional notices may be added as the Family Health Plus Program matures.

Transitions

The guiding design principles of FHPlus sought to ease transitions for enrollees whose eligibility changes. This is addressed in the following ways:

MCO Participation

The MCO Recruitment for FHPlus was limited to MCOs participating in the other public health programs in order to foster the development of common networks and to provide a seamless service delivery system, to the extent possible, for individuals whose coverage may change. A list of plans participating in each county and the products offered, is available at http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

Facilitated Enrollment Participation

By expanding existing facilitated enrollment efforts, both children and adults are able to apply

for health care coverage at convenient sites and times. Applicants are informed about the different programs they may be eligible for, the services covered, the MCOs they may choose, and are able to verify the participation of their preferred health care provider in those MCOs. Because FHPlus legislation enables the LDSS to delegate the face-to-face interview to the enrollment facilitator, individuals are less likely to experience what they perceive as barriers to applying for public health care programs.

Application

The joint application for “Access New York Health Care” with reduced documentation requirements and the joint Medicaid/Family Health Plus enrollment form were designed to allow individuals to apply for all health care programs and indicate their choice of plans. These forms also explain the individual’s rights and responsibilities under both FHPlus and Medicaid. These forms are available on the DOH website at www.nyhealth.gov/nysdoh/fhplus/application.htm.

In addition, recertification has been simplified through the use of a mail-in process. The SDOH mails a recertification form showing the enrollee the qualifying information last submitted to the LDSS. The enrollee then updates pertinent information, indicates any factors that have changed, attaches documentation and returns the information to the LDSS for a re-determination of eligibility.

Easing Transitions

When a LDSS receives an application for FHPlus for parents whose children are already in Medicaid, the LDSS aligns the children’s recertification date with the parent’s new coverage date, simplifying requirements for the family and easing administration for the LDSS.

At recertification, all family members are assessed for eligibility for either Medicaid or FHPlus and receive a determination as to their coverage type.

Individuals aged 21-64 who have been in receipt of public assistance and Medicaid who are discontinued or denied due to excess income or resources, but who have income at or below 100% FPL, are automatically evaluated for FHPlus eligibility. Their current coverage is extended for up to 60 days in order to allow time for this change to be processed.

FHPlus enrollees who become Medicaid eligible and who belong to an MCO that covers both programs stay in that MCO unless they indicate otherwise. If that MCO doesn’t also cover Medicaid and the enrollee has not chosen a different Medicaid MCO, or there is no Medicaid managed care in that county, they receive the full Medicaid benefit on a fee-for-service basis.

Medicaid and FHPlus enrollees who are disenrolled from an MCO due to loss of eligibility and who regain eligibility within 90 days are automatically re-enrolled in the same MCO, subject to available enrollment capacity in that MCO.

A woman in FHPlus who becomes pregnant is allowed to choose between FHPlus and Medicaid

until the time her eligibility needs to be re-determined, so that her care won't be interrupted. If she elects to stay in FHPlus, her Medicaid-eligible newborn is enrolled in the same MCO if that MCO also participates in Medicaid and if the child is eligible for managed care (not excluded).