

15. MEMBER HANDBOOKS

Overview

This chapter sets forth the State's requirements for MCO member handbooks. Appendix E of the Medicaid Managed Care/Family Health Plus (MMC/FHPlus) Model Contract contains the State's member handbook guidelines. The Model Contract is available at www.nyhealth.gov/health_care/providers/index.htm. The chapter is organized into two sections: the first contains the State's requirements regarding content and distribution of handbooks; the second describes the review and approval process.

Requirements

Guidelines for member handbooks are incorporated into MCO contracts. The contract also mandates that MCOs provide all new enrollees with a member handbook within 14 days of their effective date of enrollment. Handbooks are to be written in a style and reading level that will accommodate the reading skills of many Medicaid recipients. In general the writing should be within a fourth- to sixth-grade reading level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. All handbooks must be submitted to the State for review and approval prior to being issued or amended. Handbooks must be developed in languages other than English whenever at least five percent of potential enrollees in the MCO's service area speak a language other than English as their primary language. In addition, verbal interpretation services must be made available to enrollees and potential enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

MCOs must have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include Braille or audio tapes for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

A complete list of required elements can be found in Appendix E of the MMC/FHPlus Model Contract. At a minimum member handbooks must contain the following information:

- Services included in the MCO benefit package and how to obtain them;
- Services included in the MCO benefit package for which members may self-refer in certain instances (e.g., initial behavioral health assessments);
- Services not covered in the benefit package, but available on a fee-for-service basis;
- Excluded (non-covered) services;
- Instructions on what to do in an emergent or urgent medical or behavioral health situation;

- Instructions on how to choose a PCP, how to change PCPs, and notification that the MCO will assign the member a PCP if one is not selected within thirty (30) days of enrollment;
- A statement strongly encouraging the enrollee to obtain a baseline physical examination and comprehensive risk assessment, and further encouraging attendance at scheduled orientation sessions and other educational and outreach activities;
- Notification of the enrollee's right to obtain family planning services and the full range of reproductive health services and HIV blood testing and pre- and post-test counseling, when performed as a part of a family planning encounter, from either an MCO provider or any appropriate non-network provider who takes Medicaid without a referral from the MCO (note: the State has developed specific language to be included in all member handbooks for this topic);
- Notification of the enrollee's right to directly access obstetrics and gynecology services from MCO participating providers pursuant to Public Health Law Section 4406 b(1);
- Conditions of guaranteed eligibility and lock-in, disenrollment procedures and timeframes, and causes for which an enrollee would lose entitlement to receive services under this program (e.g., being incarcerated or moving out of state);
- A notice that enrollment and disenrollment are subject to verification and approval by the LDSS;
- A description of the Member Services function and listing of the MCO's Member Services telephone number and toll-free twenty-four (24) hour telephone number (if different);
- A description of the MCO's complaint procedure, including the name, title, or department; address; and telephone number of the person(s) responsible for assisting enrollees in complaint resolution (the description must inform members of their right to contact the LDSS or SDOH at any time and must include addresses/telephone numbers for both agencies);
- Instructions on what to do when there is a change in family size or eligibility status;
- Information regarding member rights and responsibilities;
- Information concerning the enrollee's rights under State law to formulate advance directives, and of the MCO's policies respecting the implementation of such rights and proxies pursuant to 10 NYCRR Sections 98.14(f) and 700.5;
- Description of the manner in which members may participate in the development of

MCO policies for the program.

- Language from the model handbook addressing other required disclosures regarding access to family planning and reproductive health services, self-referral policies, obtaining OB/GYN services, the definitions of “medical necessity” and “emergency services”, protocols for actions, utilization review, complaints, complaint appeals, action appeals, external appeals, fair hearings, and newborn enrollments, and listings of member entitlements, including benefits, rights and responsibilities, and information available upon request.

Review Process

MCOs are required to submit member handbooks to the Division of Managed Care & Program Evaluation’s Bureau of Intergovernmental Affairs for review and approval at least 60 days prior to distribution. The Bureau will complete its review within 60 days of receipt, and will maintain a log to track the following information:

- Name of MCO
- Name of reviewer
- Date handbook was submitted
- Date review was completed and documentation of any comments/revisions sent to the MCO
- Date final review and approval was granted

The Department will review and approve an English language version. MCOs that contract with a professional translation service will provide the Department with an English version of the translated handbook, along with a letter from the translation service stating that the English copy accurately reflects the language contained in the non-English handbook. MCOs that do not contract with a professional translation service will submit the non-English handbooks to the State for review and approval at least 120 days prior to anticipated distribution.

To ensure that all MCOs distribute accurate and consistent member handbooks, the State has developed a model handbook and both member handbook guidelines. The MMC model handbook is available at http://www.nyhealth.gov/health_care/managed_care/pdf/modelhandbook10_05.pdf . MCOs are required to update member handbooks as necessary. At a minimum, the Department will review handbooks at the beginning of each new contract cycle, or every other year, whichever is less.

15. MEMBER HANDBOOKS FOR FAMILY HEALTH PLUS

Following the Partnership Plan requirements and review process, SDOH has issued guidelines for FHPlus member handbooks which can be found in Appendix E of the Medicaid Managed Care/Family Health Plus Model Contract at

www.nyhealth.gov/health_care/providers/index.htm