New York State Social Services Law Section 364-J

* § 364-j. Managed care programs. 1. Definitions. As used in this section, unless the context clearly requires otherwise, the following terms shall mean:

(a) "Participant". A medical assistance recipient who receives, is required to receive or elects to receive his or her medical assistance services from a managed care provider.

(b) "Managed care provider". An entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management; and:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis; or

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act.

(c) "Managed care program". A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider, and as applicable, a mental health special needs plan or a comprehensive HIV special needs plan, under this section.

(d) "Medical services provider". A physician, nurse, nurse practitioner, physician assistant, licensed midwife, dentist, optometrist or other licensed health care practitioner authorized to provide medical assistance services.

(e) "Center of excellence." A health care facility certified to operate under article twenty-eight of the public health law that offers specialized treatment expertise in HIV care services as defined by the commissioner of health.

(f) "Primary care practitioner". A physician or nurse practitioner providing primary care to and management of the medical and health care services of a participant served by a managed care provider.

(g) "AIDS". AIDS shall have the same meaning as in article twenty-seven-f of the public health law.

(h) "HIV infection". HIV infection shall have the same meaning as in article twenty-seven-f of the public health law.

(i) "HIV-related illness". HIV-related illness shall have the same meaning as in article twenty-seven-f of the public health law.

(j) "Specialty care center". A "specialty care center" shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the disease or condition for which it is accredited or designated.

(k) "Special care". Care, services and supplies relating to the treatment of mental illness, mental retardation, developmental disabilities, alcoholism, alcohol abuse or substance abuse, or HIV infection/AIDS.

(l) "Responsible special care agency". Whichever of the following state agencies has responsibility for the special care in question: the department of health, the office of mental health, the office of mental

retardation and developmental disabilities, or the office of alcoholism and substance abuse services.

(m) "Mental health special needs plan" shall have the same meaning as in section forty-four hundred three-d of the public health law.

(n) "Comprehensive HIV special needs plan" shall have the same meaning as in section forty-four hundred three-c of the public health law.

(o) "Third-party payor". Any entity or program that is or may be liable to pay the costs of health and medical care of a recipient of medical assistance benefits, including insurers licensed pursuant to article thirty-two or forty-three of the insurance law, or organizations certified pursuant to article forty-four of the public health law.

(p) "Grievance". Any complaint presented by a participant or a participant's representative for resolution through the grievance process of a managed care provider, comprehensive HIV special needs plan or a mental health special needs plan.

(q) "Emergency medical condition". A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

(r) "Emergency care". Health care procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol, that are provided for an emergency medical condition.

(s) "Existing rates". The rates paid pursuant to the most recent executed contract between a local social services district or the state and a managed care provider.

(t) "Managed care rating regions". The regions established by the department of health for the purpose of setting regional premium rates for managed care providers.

(u) "Premium group". The various demographic, gender and recipient categories utilized for rate-setting purposes by the department of health.

(v) "Upper payment limit". The maximum reimbursement that the department of health may pay a managed care provider for providing or arranging for medical services to participants in a managed care program in accordance with the federal social security act and regulations promulgated thereunder.

(x) "Persons with serious mental illness". Individuals who meet criteria established by the commissioner of mental health, which shall include persons who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (i) whose severity and duration of mental illness results in substantial functional disability or (ii) who require mental health services on more than an incidental basis.

(y) "Children and adolescents with serious emotional disturbances". Individuals under eighteen years of age who meet criteria established by the commissioner of mental health, which shall include children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (i) whose severity and duration of mental illness results in substantial functional disability or (ii) who require mental health

services on more than an incidental basis.

2. (a) The commissioner of health, in cooperation with the commissioner and the commissioners of the responsible special care agencies shall establish managed care programs, under the medical assistance program, in accordance with applicable federal law and regulations. The commissioner of health, in cooperation with the commissioner, is authorized and directed, subject to the approval of the director of the state division of the budget, to apply for federal waivers when such action would be necessary to assist in promoting the objectives of this section.

(b) The commissioner of health has authority to allow social services districts to seek an exemption from this section for up to two years if the social services district can demonstrate and the commissioner of health and the commissioner of responsible special care agencies concurs that the district has insufficient capacity to participate in the program. An exemption under this paragraph may be renewed for additional two year periods.

3. (a) Every person eligible for or receiving medical assistance under this article, who resides in a social services district providing medical assistance, which has implemented the state's managed care program shall participate in the program authorized by this section. Provided, however, that participation in a comprehensive HIV special needs plan also shall be in accordance with article forty-four of the public health law and participation in a mental health special needs plan shall also be in accordance with article forty-four of the public health law and article thirty-one of the mental hygiene law.

(b) A medical assistance recipient shall not be required to participate in, and shall be permitted to withdraw from the managed care program upon a showing that:

(i) a managed care provider is not geographically accessible to the person so as to reasonably provide services to the person, or upon a showing of other good cause as defined in regulation. A managed care provider is not geographically accessible if the person cannot access its services in a timely fashion due to distance or travel time;

(ii) a pregnant woman with an established relationship, as defined by the commissioner of health, with a comprehensive prenatal primary care provider, including a prenatal care assistance program as defined in title two of article twenty-five of the public health law, that is not associated with a managed care provider in the participant's social services district, may defer participation in the managed care program while pregnant and for sixty days post-partum;

(iii) an individual with a chronic medical condition being treated by a specialist physician that is not associated with a managed care provider in the participant's social services district, may defer participation in the managed care program until the course of treatment is complete; and

(iv) a participant cannot be served by a managed care provider who participates in a managed care program due to a language barrier.

(c) The following medical assistance recipients shall not be required to participate in a managed care program established pursuant to this section, but may voluntarily opt to do so:

(i) a person receiving services provided by a residential alcohol or substance abuse program or facility for the mentally retarded;

(ii) a person receiving services provided by an intermediate care facility for the mentally retarded or who has characteristics and needs similar to such persons;

(iii) a person with a developmental or physical disability who

receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of the federal social security act or who has characteristics and needs similar to such persons;

(iv) Native Americans;

(v) Medicare/Medicaid dually eligible individuals not enrolled in a Medicare TEFRA plan; or

(vi) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and who is not required to pay a premium pursuant to subdivision twelve of section three hundred sixty-seven-a of this title.

(d) The following medical assistance recipients shall not be eligible to participate in a managed care program established pursuant to this section:

(i) a person receiving services provided by a long term home health care program, or a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

(ii) a person eligible for Medicare participating in a capitated demonstration program for long term care;

(iii) an infant living with an incarcerated mother in a state or local correctional facility as defined in section two of the correction law;

(iv) a person who is expected to be eligible for medical assistance for less than six months;

(v) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;

(vi) certified blind or disabled children living or expected to be living separate and apart from the parent for 30 days or more;

(vii) residents of nursing facilities at time of enrollment;

(viii) individuals receiving hospice services at time of enrollment;

(ix) individuals in the restricted recipient program;

(x) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or costsharing amounts, when payment of such premium or costsharing amounts would be cost-effective, as determined by the local social services district;

(xi) a foster child in the placement of a voluntary agency;

(xii) a person receiving family planning services pursuant to subparagraph eleven of paragraph (a) of subdivision one of section three hundred sixty-six of this title; and

(xiii) a person who is eligible for medical assistance pursuant to paragraph (v) of subdivision four of section three hundred sixty-six of this title; and

(xiv) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and who is required to pay a premium pursuant to subdivision twelve of section three hundred sixty-seven-a of this title.

(e) The following services shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies:

(i) day treatment services provided to individuals with developmental disabilities;

(ii) comprehensive medicaid case management services provided to individuals with developmental disabilities;

(iii) services provided pursuant to title two-A of article twenty-five of the public health law;

(iv) services provided pursuant to article eighty-nine of the education law;

(v) mental health services provided by a certified voluntary free-standing day treatment program where such services are provided in conjunction with educational services authorized in an individualized education program in accordance with regulations promulgated pursuant to article eighty-nine of the education law;

(vi) long term services as determined by the commissioner of mental retardation and developmental disabilities, provided to individuals with developmental disabilities at facilities licensed pursuant to article sixteen of the mental hygiene law or clinics serving individuals with developmental disabilities at facilities licensed pursuant to article twenty-eight of the public health law;

(vii) TB directly observed therapy;

(viii) AIDS adult day health care;

(ix) HIV COBRA case management; and

(x) other services as determined by the commissioner of health.

(f) The following medical assistance recipients shall not be eligible to participate in a managed care program established pursuant to this section, unless the local social services district permits them to do so;

(i) a person or family that is homeless and is living in a shelter; and

(ii) a foster care child in the direct care of the local social services district.

(g) The following categories of individuals will not be required to enroll with a managed care program until program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioner of mental health:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program and enrolled in a TEFRA plan;

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals; and

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law.

4. The managed care program shall provide participants access to comprehensive and coordinated health care delivered in a cost effective manner consistent with the following provisions:

(a) (i) a managed care provider shall arrange for access to and enrollment of primary care practitioners and other medical services providers. Each managed care provider shall possess the expertise and sufficient resources to assure the delivery of quality medical care to participants in an appropriate and timely manner and may include physicians, nurse practitioners, county health departments, providers of comprehensive health service plans licensed pursuant to article forty-four of the public health law, and hospitals and diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law or otherwise authorized by law to offer comprehensive health services or facilities licensed pursuant to articles sixteen, thirty-one and thirty-two of the mental hygiene law.

(ii) provided, however, if a major public hospital, as defined in the public health law, is designated by the commissioner of health as a managed care provider in a social services district the commissioner of health shall designate at least one other managed care provider which is

not a major public hospital or facility operated by a major public hospital; and

(iii) under a managed care program, not all managed care providers must be required to provide the same set of medical assistance services. The managed care program shall establish procedures through which participants will be assured access to all medical assistance services to which they are otherwise entitled, other than through the managed care provider, where:

(A) the service is not reasonably available directly or indirectly from the managed care provider,

(B) it is necessary because of emergency or geographic unavailability, or

(C) the services provided are family planning services; or

(D) the services are dental services and are provided by a diagnostic and treatment center licensed under article twenty-eight of the public health law which is affiliated with an academic dental center and which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide such dental services. Any diagnostic and treatment center providing dental services pursuant to this clause shall prior to June first of each year report to the governor, temporary president of the senate and speaker of the assembly on the following: the total number of visits made by medical assistance recipients during the immediately preceding calendar year; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs that provide dental benefits as a covered service; and the number of visits made by the uninsured during the immediately preceding calendar year; or

(E) other services as defined by the commissioner of health.

(b) Participants shall select a managed care provider from among those designated under the managed care program, provided, however, a participant shall be provided with a choice of no less than two managed care providers. Notwithstanding the foregoing, a local social services district designated a rural area as defined in 42 U.S.C. 1395ww may limit a participant to one managed care provider, if the commissioner and the local social services district find that only one managed care provider is available. A managed care provider in a rural area shall offer a participant a choice of at least three primary care practitioners and permit the individual to obtain a service or seek a provider outside of the managed care network where such service or provider is not available from within the managed care provider network.

(c) Participants shall select a primary care practitioner from among those designated by the managed care provider. In all districts, participants shall be provided with a choice of no less than three primary care practitioners. In the event that a participant does not select a primary care practitioner, the participant's managed care provider shall select a primary care practitioner for the participant, taking into account geographic accessibility.

(d) For all other medical services, except as provided in paragraph (c) of this subdivision, if a sufficient number of medical service providers are available, a choice shall be offered.

(e) (i) In any social services district which has not implemented a mandatory managed care program pursuant to this section, the commissioner of health shall establish marketing and enrollment guidelines, including but not limited to regulations governing

face-to-face marketing and enrollment encounters between managed care providers and recipients of medical assistance and locations for such encounters. Such regulations shall prohibit, at a minimum, telephone cold-calling and door-to-door solicitation at the homes of medical assistance recipients. The regulations shall also require the commissioner of health to approve any local district marketing guidelines. Managed care providers shall be permitted to assist participants in completion of enrollment forms at approved health care provider sites and other approved locations. In no case may an emergency room be deemed an approved location. Upon enrollment, participants will sign an attestation that: they have been informed that managed care is a voluntary program; participants have a choice of managed care providers; participants have a choice of primary care practitioners; and participants must exclusively use their primary care practitioner and plan providers except as otherwise provided in this section including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdivision. Managed care providers must submit enrollment forms to the local department of social services. The local department of social services will provide or arrange for an audit of managed care provider enrollment forms; including telephone contacts to determine if participants were provided with the information required by this subparagraph. The commissioner of health may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

(ii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the requirements of this subparagraph shall apply to the extent consistent with federal law and regulations. The department of health, may contract with one or more independent organizations to provide enrollment counseling and enrollment services, for participants required to enroll in managed care programs, for each social services district requesting the services of an enrollment broker. To select such organizations, the department of health shall issue a request for proposals (RFP), shall evaluate proposals submitted in response to such RFP and, pursuant to such RFP, shall award a contract to one or more qualified and responsive organizations. Such organizations shall not be owned, operated, or controlled by any governmental agency, managed care provider, comprehensive HIV special needs plan, mental health special needs plan, or medical services provider.

(iii) Such independent organizations shall develop enrollment guides for participants which shall be approved by the department of health prior to distribution.

(iv) Local social services districts or enrollment organizations through their enrollment counselors shall provide participants with the opportunity for face to face counseling including individual counseling upon request of the participant. Local social services districts or enrollment organizations through their enrollment counselors shall also provide participants with information in a culturally and linguistically appropriate and understandable manner, in light of the participant's needs, circumstances and language proficiency, sufficient to enable the participant to make an informed selection of a managed care provider. Such information shall include, but shall not be limited to: how to access care within the program; a description of the medical assistance services that can be obtained other than through a managed care provider, mental health special needs plan or comprehensive HIV special needs plan; the available managed care providers, mental health special needs plans and comprehensive HIV special needs plans and the scope of

services covered by each; a listing of the medical services providers associated with each managed care provider; the participants' rights within the managed care program; and how to exercise such rights. Enrollment counselors shall inquire into each participant's existing relationships with medical services providers and explain whether and how such relationships may be maintained within the managed care program. For enrollments made during face to face counseling, if the participant has a preference for particular medical services providers, enrollment counselors shall verify with the medical services providers that such medical services providers whom the participant prefers participate in the managed care provider's network and are available to serve the participant.

(v) Upon delivery of the pre-enrollment information, the local district or the enrollment organization shall certify the participant's receipt of such information. Upon verification that the participant has received the pre-enrollment education information, a managed care provider, a local district or the enrollment organization may enroll a participant into a managed care provider. Managed care providers must submit enrollment forms to the local department of social services. Upon enrollment, participants will sign an attestation that they have been informed that: participants have a choice of managed care providers; participants have a choice of primary care practitioners; and, except as otherwise provided in this section, including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdivision, participants must exclusively use their primary care practitioners and plan providers. The commissioner of health or with respect to a managed care plan serving participants in a city with a population of over two million, the local department of social services in such city, may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

(vi) Enrollment counselors or local social services districts shall further inquire into each participant's health status in order to identify physical or behavioral conditions that require immediate attention or continuity of care, and provide to participants information regarding health care options available to persons with HIV and other illnesses or conditions under the managed care program. Any information disclosed to counselors shall be kept confidential in accordance with applicable provisions of the public health law, and as appropriate, the mental hygiene law.

(vii) Any marketing materials developed by a managed care provider, comprehensive HIV special needs plan or mental health special needs plan shall be approved by the department of health or the local social services district and the commissioner of mental health, where appropriate, within sixty days prior to distribution to recipients of medical assistance. All marketing materials shall be reviewed within sixty days of submission.

(viii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the commissioner of health shall establish marketing and enrollment guidelines, including but not limited to regulations governing face-to-face marketing and enrollment encounters between managed care providers and recipients of medical assistance and locations for such encounters. Such regulations shall prohibit, at a minimum, telephone cold-calling and door-to-door solicitation at the homes of medical assistance recipients. The regulations shall also require the commissioner of health to approve any local district marketing

guidelines.

(f) (i) Participants shall have no less than sixty days from the date selected by the district to enroll in the managed care program to select a managed care provider, and as appropriate, a mental health special needs plan, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider or mental health special needs plan, the commissioner of health shall assign such participant to a managed care provider, and as appropriate, to a mental health special needs plan, taking into account capacity and geographic accessibility. The commissioner may after the period of time established in subparagraph (ii) of this paragraph assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants.

(ii) The commissioner may assign participants pursuant to such criteria on a weighted basis, provided however that for twelve months following implementation of a mandatory program, pursuant to a federal waiver, twenty-five percent of the participants that do not choose a managed care provider shall be assigned to managed care providers that satisfy the criteria set forth in subparagraph (i) of this paragraph, and are controlled by, sponsored by, or otherwise affiliated through a common governance or through a parent corporation with, one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(iii) For twelve months following the twelve months described in subparagraph (ii) of this paragraph twenty-two and one-half percent of the participants that do not choose a managed care provider shall be assigned to managed care providers, that satisfy the criteria set forth in subparagraph (i) of this paragraph and are controlled by, sponsored by, or otherwise affiliated through a common governance or through a parent corporation with, one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(iv) For twelve months following the twelve months described in subparagraph (iii) of this paragraph twenty percent of the participants that do not choose a managed care provider shall be assigned equally among each of the managed care providers, that satisfy the criteria set forth in subparagraph (i) of this paragraph and are controlled by, sponsored by, or otherwise affiliated through a common governance or through a parent corporation with one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(v) The commissioner shall assign all participants not otherwise assigned to a managed care plan pursuant to subparagraphs (ii), (iii) and (iv) of this paragraph equally among each of the managed care providers that meet the criteria established in subparagraph (i) of this paragraph.

(g) If another managed care provider, mental health special needs plan or comprehensive HIV special needs plan is available, participants may change such provider or plan without cause within thirty days of notification of enrollment or the effective date of enrollment, whichever is later with a managed care provider, mental health special needs plan or comprehensive HIV special needs plan by making a request of the local social services district except that such period shall be forty-five days for participants who have been assigned to a provider by the commissioner of health. However, after such thirty or forty-five day

period, whichever is applicable, a participant may be prohibited from changing managed care providers more frequently than once every twelve months, as permitted by federal law except for good cause as determined by the commissioner of health through regulations.

(h) If another medical services provider is available, a participant may change his or her provider of medical services (including primary care practitioners) without cause within thirty days of the participant's first appointment with a medical services provider by making a request of the managed care provider, mental health special needs plan or comprehensive HIV special needs plan. However, after that thirty day period, no participant shall be permitted to change his or her provider of medical services other than once every six months except for good cause as determined by the commissioner through regulations.

(i) A managed care provider, mental health special needs plan, and comprehensive HIV special needs plan requesting a disenrollment shall not disenroll a participant without the prior approval of the local social services district in which the participant resides, provided that disenrollment from a mental health special needs plan must comply with the standards of the commissioner of health and the commissioner of mental health. A managed care provider, mental health special needs plan or comprehensive HIV special needs plan shall not request disenrollment of a participant based on any diagnosis, condition, or perceived diagnosis or condition, or a participant's efforts to exercise his or her rights under a grievance process, provided however, that a managed care provider may, where medically appropriate, request permission to refer participants to a mental health special needs plan or a comprehensive HIV special needs plan after consulting with such participant and upon obtaining his/her consent to such referral and, provided further that a mental health special needs plan may, where clinically appropriate, disenroll individuals who no longer require the level of services provided by a mental health special needs plan.

(j) A managed care provider shall be responsible for providing or arranging for medical assistance services and assisting participants in the prudent selection of such services, including but not limited to:

(1) management of the medical and health care needs of participants by the participant's designated primary care practitioners or group of primary care practitioners to assure that all services provided under the managed care program and which are found to be necessary are made available in a timely manner, in accordance with prevailing standards of professional medical practice and conduct; and

(2) use of appropriate patient assessment criteria to ensure that all participants are provided with appropriate services, including special care;

(3) implementation of procedures, consistent with the requirements of paragraph (c) of subdivision six of section forty-four hundred three of the public health law for managing the care of participants requiring special care which may include the use of special case managers or the designation of a specialist as a primary care practitioner by a participant requiring special care on more than an incidental basis;

(4) implementation of procedures, consistent with the requirements of paragraph (b) of subdivision six of section forty-four hundred three of the public health law to permit the use of standing referrals to specialists and subspecialists for participants who require the care of such practitioners on a regular basis; and

(5) referral, coordination, monitoring and follow-up with regard to other medical services providers as appropriate for diagnosis and treatment, or direct provision of some or all medical assistance

services.

(k) A managed care provider shall establish appropriate utilization and referral requirements for physicians, hospitals, and other medical services providers including emergency room visits and inpatient admissions.

(l) A managed care provider shall be responsible for developing appropriate methods of managing the health care and medical needs of homeless and other vulnerable participants to assure that all necessary services provided under the managed care program are made available and that all appropriate referrals and follow-up treatment are provided, in a timely manner, in accordance with prevailing standards of professional medical practice and conduct.

(m) A managed care provider shall provide all early periodic screening diagnosis and treatment services, as well as interperiodic screening and referral, to each participant under the age of twenty-one, at regular intervals, as medically appropriate.

(n) A managed care provider shall provide or arrange, directly or indirectly (including by referral) for the provision of comprehensive prenatal care services to all pregnant participants including all services enumerated in subdivision one of section twenty-five hundred twenty-two of the public health law in accordance with standards adopted by the department of health pursuant to such section.

(o) A managed care provider shall provide or arrange, directly or indirectly, (including by referral) for the full range of covered services to all participants, notwithstanding that such participants may be eligible to be enrolled in a comprehensive HIV special needs plan or mental health special needs plan.

(p) A managed care provider, comprehensive HIV special needs plan and mental health special needs plan shall implement procedures to communicate appropriately with participants who have difficulty communicating in English and to communicate appropriately with visually-impaired and hearing-impaired participants.

(q) A managed care provider, comprehensive HIV special needs plan and mental health special needs plan shall comply with applicable state and federal law provisions prohibiting discrimination on the basis of disability.

(r) A managed care provider, comprehensive HIV special needs plan and mental health special needs plan shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act.

(s) Managed care providers shall be provided with the date of recertification for medical assistance of each of their enrolled participants in conjunction with the monthly enrollment information conveyed to managed care providers.

(t) Prospective enrollees shall be advised, in written materials related to enrollment, to verify with the medical services providers they prefer, or have an existing relationship with, that such medical services providers participate in the selected managed care provider's network and are available to serve the participant.

5. Managed care programs shall be conducted in accordance with the requirements of this section and, to the extent practicable, encourage the provision of comprehensive medical services, pursuant to this article.

(a) The managed care program shall provide for the selection of qualified managed care providers by the commissioner of health and, as

appropriate, mental health special needs plans and comprehensive HIV special needs plans to participate in the program, provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans consistent with standards set forth in this section, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks.

(b) A proposal submitted by a managed care provider to participate in the managed care program shall:

(i) designate the geographic area to be served by the provider, and estimate the number of eligible participants and actual participants in such designated area;

(ii) include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

(iii) describe the procedures for marketing in the program location, including the designation of other entities which may perform such functions under contract with the organization;

(iv) describe the quality assurance, utilization review and case management mechanisms to be implemented;

(v) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

(vi) demonstrate financial feasibility of the program; and

(vii) include such other information as the commissioner of health may deem appropriate.

(c) The commissioner of health shall make a determination whether to approve, disapprove or recommend modification of the proposal.

(d) Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health or the local department of social services in a city with a population of over two million may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health or the local department of social services in a city with a population of over two million, to qualified managed care providers pursuant to this section.

(f) The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health or the local department of social services in a city with a population of over two million, and meet applicable federal law and regulations.

(g) The commissioner of health may delegate some or all of the tasks identified in this section to the local districts.

(h) Any delegation pursuant to paragraph (g) of this subdivision shall be reflected in the contract between a managed care provider and the commissioner of health.

6. A managed care provider, mental health special needs plan or comprehensive HIV special needs plan provider shall not engage in the following practices:

(a) use deceptive or coercive marketing methods to encourage

participants to enroll; or

(b) distribute marketing materials to recipients of medical assistance, unless such materials are approved by the department of health and, as appropriate, the office of mental health.

7. The department, the department of health or other agency of the state as appropriate shall provide technical assistance at the request of a social services district for the purpose of development and implementation of managed care programs pursuant to this section. Such assistance shall include but need not be limited to provision and analysis of data, design of managed care programs and plans, innovative payment mechanisms, and ongoing consultation. In addition, the department and the department of health shall make available materials to social services districts for purposes of educating persons eligible to receive medical assistance on how their care will be provided through managed care as required under paragraph (e) of subdivision five of this section.

8. (a) The commissioner of health shall institute a comprehensive quality assurance system for managed care providers that includes performance and outcome-based quality standards for managed care.

(b) Every managed care provider shall implement internal quality assurance systems adequate to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization, and cost of services, provided, however, that the commissioner shall waive the implementation of internal quality assurance systems, where appropriate, for managed care providers described in subparagraph (ii) of paragraph (b) of subdivision one of this section. Such internal quality assurance systems shall conform to the internal quality assurance requirements imposed on health maintenance organizations pursuant to the public health law and regulations and shall provide for:

(i) the designation of an organizational unit or units to perform continuous monitoring of health care delivery;

(ii) the utilization of epidemiological data, chart reviews, patterns of care, patient surveys, and spot checks;

(iii) reports to medical services providers assessing timeliness and quality of care;

(iv) the identification, evaluation and remediation of problems relating to access, continuity and quality of care; and

(v) a process for credentialing and recredentialing licensed providers.

(c) The department of health, in consultation with the responsible special care agencies, shall contract with one or more independent quality assurance organizations to monitor and evaluate the quality of care and services furnished by managed care providers. To select such organization or organizations, the department of health shall issue requests for proposals (RFP), shall evaluate proposals submitted in response to such RFP, and pursuant to such RFP, shall award one or more contracts to one or more qualified and responsive organizations. Such quality assurance organizations shall evaluate and review the quality of care delivered by each managed care provider, on at least an annual basis. Such review and evaluation shall include compliance with the performance and outcome-based quality standards promulgated by the commissioner of health.

(d) Every managed care provider shall collect and submit to the department of health, in a standardized format prescribed by the department of health, patient specific medical information, including encounter data, maintained by such provider for the purposes of quality assurance and oversight. Any information or encounter data collected

pursuant to this paragraph, however, shall be kept confidential in accordance with section forty-four hundred eight-a of the public health law and section 33.13 of the mental hygiene law and any other applicable state or federal law.

(e) Information collected and submitted to the department of health by the independent quality assurance organization or managed care provider pursuant to this subdivision shall be made available to the public, subject to any other limitations of federal or state law regarding disclosure thereof to third parties.

(f) Every managed care provider shall ensure that the provider maintains a network of health care providers adequate to meet the comprehensive health needs of its participants and to provide an appropriate choice of providers sufficient to provide the services to its participants by determining that:

(i) there are a sufficient number of geographically accessible participating providers;

(ii) there are opportunities to select from at least three primary care providers; and

(iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrolled population.

(g) The commissioner of health shall establish standards to ensure that managed care providers have sufficient capacity to meet the needs of their enrollees, which shall include patient to provider ratios, travel and distance standards and appropriate waiting times for appointments.

9. Managed care providers shall inform participants of such provider's grievance procedure and utilization review procedures required pursuant to sections forty-four hundred eight-c and forty-nine hundred of the public health law. A managed care provider or local social services district, as appropriate, shall provide notice to participants of their respective rights to a fair hearing and aid continuing in accordance with applicable state and federal law.

10. The commissioner of health shall be authorized to establish requirements regarding provision and reimbursement of emergency care.

* 11. Notwithstanding section three hundred sixty-six of this chapter or any other inconsistent provision of law, participants in the managed care program under this section who have lost their eligibility for medical assistance before the end of a six month period beginning on the date of the participant's initial selection of or assignment to a managed care provider shall have their eligibility for medical assistance continued until the end of the six month enrollment period, but only with respect to family planning services provided pursuant to subparagraph (iii) of paragraph (a) of subdivision four of this section and any services provided to the individual under the direction of the managed care provider. Provided further, however, a pregnant woman with an income in excess of the medically needy income level set forth in section three hundred sixty-six of this title, who was eligible for medical assistance solely as a result of paragraph (m) or (o) of subdivision four of such section, shall continue to be eligible for medical assistance benefits only through the end of the month in which the sixtieth day following the end of her pregnancy occurs except for eligibility for Federal Title X services which shall continue for twenty-four months therefrom, and provided further that the services are reimbursable by the federal government at a rate of ninety percent; provided, however, that nothing in this subdivision shall be deemed to affect payment for such services if federal financial participation is not available for such care, services and supplies solely by reason of

the immigration status of the otherwise eligible woman.

* NB Effective until July 1, 2007

* 11. Notwithstanding section three hundred sixty-six of this chapter or any other inconsistent provision of law, participants in the managed care program under this section who have lost their eligibility for medical assistance before the end of a six month period beginning on the date of the participant's initial selection of or assignment to a managed care provider shall have their eligibility for medical assistance continued until the end of the six month enrollment period, but only with respect to family planning services provided pursuant to subparagraph (iii) of paragraph (a) of subdivision four of this section and any services provided to the individual under the direction of the managed care provider. Provided further, however, a pregnant woman with an income in excess of the medically needy income level set forth in section three hundred sixty-six of this title, who was eligible for medical assistance solely as a result of paragraph (m) or (o) of subdivision four of such section, shall continue to be eligible for medical assistance benefits only through the end of the month in which the sixtieth day following the end of her pregnancy occurs except for eligibility for Federal Title X services which are eligible for reimbursement by the federal government at a rate of ninety percent which shall continue for twenty-four months therefrom; provided, however, that such ninety percent limitation shall not apply to those services identified by the commissioner as services, including treatment for sexually transmitted diseases, generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement; and provided further, however, that nothing in this subdivision shall be deemed to affect payment for such Title X services if federal financial participation is not available for such care, services and supplies.

* NB Effective July 1, 2007

12. The commissioner, by regulation, shall provide that a participant may withdraw from participation in a managed care program upon a showing of good cause.

13. (a) Notwithstanding any inconsistent provisions of this section, participation in a managed care program will not diminish a recipient's medical assistance eligibility or the scope of available medical services to which he or she is entitled. Once a program is implemented by or in the district in accordance with this section, medical assistance for persons who require such assistance, who are eligible for or in receipt of such assistance in the district and who are covered by the program shall be limited to payment of the cost of care, services and supplies covered by the managed care program, only when furnished, prescribed, ordered or approved by a managed care provider, mental health special needs plan or comprehensive HIV special needs plan and otherwise under the program, together with the costs of medically necessary medical and remedial care, services or supplies which are not available to participants under the program, but which would otherwise be available to such persons under this title and the regulations of the department provided, however, that the program may contain provision for payment to be made for non-emergent care furnished in hospital emergency rooms consistent with subdivision ten of this section.

(b) Notwithstanding any inconsistent provision of law, payment for claims for services as specified in paragraph (a) of this subdivision furnished to eligible persons under this title, who are enrolled in a managed care program pursuant to this section and section three hundred sixty-four-f of this title or other comprehensive health services plans, shall not be made when such services are the contractual responsibility

of a managed care provider but are provided by another medical services provider contrary to the managed care plan.

14. The commissioner of health is authorized and directed, subject to the approval of the director of the division of budget, to make grants to social services districts to aid in the planning and development of managed care programs. The total amount expended pursuant to this section shall not exceed the amount appropriated for such purposes in any fiscal year.

15. The managed medical care demonstration program advisory council is abolished.

16. Any waiver application to the federal department of health and human services pursuant to this article and any amendments to such application shall be a public document.

17. The provisions of this section regarding participation of persons receiving family assistance and supplemental security income in managed care programs shall be effective if, and as long as, federal financial participation is available for expenditures for services provided pursuant to this section.

18. (a) The department of health may, where not inconsistent with the rate setting authority of other state agencies and subject to approval of the director of the division of the budget, develop reimbursement methodologies and fee schedules for determining the amount of payment to be made to managed care providers under the managed care program. Such reimbursement methodologies and fee schedules may include provisions for payment of managed care fees and capitation arrangements.

(b) The department of health in consultation with organizations representing managed care providers shall select an independent actuary to review any such reimbursement rates. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of rates including but not limited to the adequacy of the rates in relation to the population to be served adjusted for case mix, the scope of services the plans must provide, the utilization of services and the network of providers necessary to meet state standards. The independent actuary shall issue a report no later than December thirty-first, nineteen hundred ninety-eight and annually thereafter. Such report shall be provided to the governor, the temporary president and the minority leader of the senate and the speaker and the minority leader of the assembly. The department of health shall assess managed care providers under the managed care program on a per enrollee basis to cover the cost of such report.

19. (a) The commissioner of health, in consultation with the commissioner, shall promulgate such regulations as are necessary to implement the provisions of this section provided, however, that the provisions of this subdivision shall not limit specific actions taken by the department of health or the department in order to ensure federal financial participation.

20. Upon a determination that a participant appears to be suitable for admission to a comprehensive HIV special needs plan or a mental health special needs plan, a managed care provider shall inform the participant of the availability of such plans, where available and appropriate.

21. (a) An amount equal to seven million dollars together with any matching federal and local government funds shall be made available for rate adjustments for managed care providers whose rates were set under the competitive bidding process. Such adjustment shall be made in accordance with this paragraph.

(i) Such amount shall be allocated by the department of health among

the managed care rating regions based on each region's percentage of statewide Medicaid managed care enrollment as of January first, nineteen hundred ninety-seven excluding from such calculation enrollment in local social services districts that did not participate in the competitive bidding process.

(ii) From among the funds allocated in a managed care rating region, the department of health shall adjust the existing rates paid to managed care providers for each premium group for the period from January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight in a manner that raises the rates of all managed care providers in the region to the highest uniform percentage of the upper payment limit possible based on the funds available; provided, however, that no managed care provider's rate for any premium group shall be reduced as a result of such adjustment. For the purpose of calculating appropriate rate increases under this subparagraph, the department of health shall assume that, for the entire period between January first, nineteen hundred ninety-seven and March thirty-first, nineteen hundred ninety-eight, enrollment in each premium group shall be equal to enrollment in the premium group as of July first, nineteen hundred ninety-seven.

(b) In addition to the increases made available in paragraph (a) of this subdivision for the period beginning January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, an additional ten million dollars, together with any matching federal and local government funds, shall be added to provide a uniform percentage increase, based on July first, nineteen hundred ninety-seven enrollment to the existing rates paid for all premium groups to all managed care providers whose rates were set by the competitive bidding process.

(c) In addition to the increases made available in paragraphs (a) and (b) of this subdivision for the period beginning January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, an additional amount equal to three million dollars together with any matching federal and local government funds, shall be made available to be added to the rates of health plans operating in geographic areas where capacity is insufficient to allow attainment of enrollment goals consistent with the federal 1115 waiver known as the Partnership Plan. Such amount shall be distributed subject to a demonstration to the commissioner's satisfaction that the plan has executed a contract amendment providing for an increase in enrollment proportional to the size of the plan and the remaining unenrolled population in the county. In evaluating the plan's demonstration, the commissioner shall consider the degree to which the plan has increased the number of primary or specialty care practitioners or diagnostic and treatment centers in its network or whether the additional rate increase would permit the plan to generate greater enrollments while continuing to meet the financial requirements of the public health law or the insurance law whichever is applicable and regulations promulgated pursuant thereto.

Any amount identified in this paragraph remaining uncommitted by December thirty-first, nineteen hundred ninety-seven shall be distributed in a manner consistent with paragraph (b) of this subdivision.

(d) A plan shall be eligible for payments pursuant to paragraphs (a), (b) and (c) of this subdivision for such periods as the plan has a contract with one or more social services districts; provided, however that the plan has a contract, or has made a good faith effort to enter

into a contract, in that district effective through March thirty-first, nineteen hundred ninety-eight.

(e) For the period from April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, the premium rates paid by the department of health to all managed care providers whose rates were set under the competitive bidding process shall be equal to (i) the managed care provider's rate as of March thirty-first, nineteen hundred ninety-eight increased by a uniform trend factor; plus, (ii) four million dollars together with any matching federal and local government funds to be added as a uniform percentage increase to such provider's rate as of March thirty-first, nineteen hundred ninety-eight, based on enrollment in the premium group as of April first, nineteen hundred ninety-eight.

(f) For the period from April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, an additional amount equal to four million dollars together with any matching federal and local government funds, shall be made available for managed care rate adjustments consistent with the criteria set forth in paragraph (c) of this subdivision. Any amount identified in this paragraph remaining uncommitted by December thirty-first, nineteen hundred ninety-eight shall be added as a uniform percentage increase to the rates of all managed care providers eligible for an increase under paragraph (e) of this subdivision.

22. Chemung county demonstration project. (a) The legislature finds that the particular circumstances of Chemung county warrant authorizing this demonstration project, including the rural nature of the county, the absence of a comprehensive medicaid managed care provider serving the area at this time, patient care needs, and aspects of the health care provider base.

(b) within all or part of Chemung county (referred to in this subdivision as "the catchment area"), the department of health and the Chemung county department of social services are authorized to conduct a Medicaid research and demonstration project (referred to in this subdivision as the "demonstration project") for the purpose of testing the use of innovative administrative techniques, new reimbursement methods, and management of care models, so as to promote more efficient use of health resources, a healthier population and containment of Medicaid program costs.

(c) As part of the demonstration project, the Chemung county department of social services is authorized to contract with a managed care provider for the purposes of, without limitation, developing and managing a provider of care network, establishing provider payment rates and fees, paying provider claims, providing care management services to project participants, and managing the utilization of project services.

(d) The demonstration project shall be consistent with the provisions of this section, except:

(i) The department may waive any rules or regulations, as necessary to implement and consistent with this subdivision.

(ii) The demonstration project shall not be subject to:

(A) paragraph (b) of subdivision four of this section;

(B) subparagraphs (i), (ii), (iii) (v) and (viii) of paragraph (e) of subdivision four of this section;

(C) paragraph (f) of subdivision four of this section;

(D) paragraph (g) of subdivision four of this section;

(E) subdivision five of this section; provided that in approving the demonstration project or modifications to it, the department shall consider the criteria in that subdivision;

(F) sections two hundred seventy-two and two hundred seventy-three of the public health law;

(G) section three hundred sixty-five-i of this title.

(iii) Notwithstanding subdivision three of this section, participation in the project shall be mandatory for all or any specified categories of persons eligible for services under this title for whom the Chemung county department of social services has fiscal responsibility pursuant to section three hundred sixty-five of this title and who reside within the demonstration project catchment area, as determined by the commissioner of health; provided, however, that eligible persons who are also beneficiaries under title XVIII of the federal social security act and persons who reside in residential health care facilities shall not be eligible to participate in the project.

(e)(i) Persons who are enrolled in or apply for medical assistance on or before the date the demonstration project takes effect shall receive sixty days written notice prior to participating in the demonstration project, including an explanation of the demonstration project and the participant's rights and responsibilities. Persons who apply for medical assistance thereafter shall receive such notice at the time of applying for medical assistance.

(ii) The demonstration project shall provide adequate services to overcome language barriers for participants.

(iii) Participants in the demonstration project whose participation in a managed care program would not otherwise be mandatory under subdivision three of this section, who, at the time they enter the demonstration project, have an established relationship with and are receiving services from one or more medical services providers that are not included in the demonstration project's provider network (an "out-of-network provider"), shall be permitted to continue to receive services from such providers until their course of treatment is complete, or in the case of a pregnant woman, while pregnant and for sixty days post-partum. Out-of-network providers that provide services pursuant to this subparagraph shall be subject to the utilization review and care management procedures prescribed by the managed care provider and shall be reimbursed at the rate that would be paid to such providers by the medical assistance program on a fee for service basis pursuant to this title, and shall accept such reimbursement as payment in full.

(f) The provisions of this subdivision shall not apply unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this subdivision.

(g) The commissioner of health is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to obtain the federal approvals necessary to implement this subdivision.

(h) The demonstration project shall terminate five years after it is approved by the department and all necessary approvals under federal law and regulations under paragraph (f) of this subdivision have been obtained, unless terminated sooner by the Chemung county department of social services.

23. (a) As a means of protecting the health, safety and welfare of recipients, in addition to any other sanctions that may be imposed, the commissioner shall appoint temporary management of a managed care provider upon determining that the managed care provider has repeatedly failed to meet the substantive requirements of sections 1903(m) and 1932 of the federal Social Security Act and regulations. A hearing shall not

be required prior to the appointment of temporary management.

(b) The commissioner and/or his or her designees, which may be individuals within the department or other individuals or entities with appropriate knowledge and experience, may be appointed as temporary management. The commissioner may appoint the superintendent of insurance and/or his or her designees as temporary management of any managed care provider which is subject to rehabilitation pursuant to article seventy-four of the insurance law.

(c) The responsibilities of temporary management shall include oversight of the managed care provider for the purpose of removing the causes and conditions which led to the determination requiring temporary management, the imposition of improvements to remedy violations and, where necessary, the orderly reorganization, termination or liquidation of the managed care provider.

(d) Temporary management may hire and fire managed care provider personnel and expend managed care provider funds in carrying out the responsibilities imposed pursuant to this subdivision.

(e) The commissioner, in consultation with the superintendent with respect to any managed care provider subject to rehabilitation pursuant to article seventy-four of the insurance law, may make available to temporary management for the benefit of a managed care provider for the maintenance of required reserves and deposits monies from such funds as are appropriated for such purpose.

(f) The commissioner is authorized to establish in regulation provisions for the payment of fees and expenses from funds appropriated for such purpose for non-governmental individuals and entities appointed as temporary management pursuant to this subdivision.

(g) The commissioner may not terminate temporary management prior to his or her determination that the managed care provider has the capability to ensure that the sanctioned behavior will not recur.

(h) During any period of temporary management individuals enrolled in the managed care provider being managed may disenroll without cause. Upon reaching a determination that requires temporary management of a managed care provider, the commissioner shall notify all recipient enrollees of such provider that they may terminate enrollment without cause during the period of temporary management.

(i) The commissioner may adopt and amend rules and regulations to effectuate the purposes and provisions of this subdivision.

* NB Repealed March 31, 2009