ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 91 ADM-47

DIVISION: Medical Assistance

TO: Commissioners of Social Services

DATE: November 27, 1991

SUBJECT: Statewide Managed Care Program: Social Services District Guidelines and Procedures

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SUGGESTED DISTRIBUTION:
Medical Assistance Staff
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ATTACHMENTS:
I. Chapter 165 of the Laws of 1991
II.A Requirements for Participation in the Preferred Physicians and Children Program (PPAC)
II.B Requirements for Participation as a Preferred Primary Care Provider (PPCP)
III. Major Public Hospitals in New York State
IV. Managed Care Plan Requirements
V. Managed Care Grant Funding Requirements And Application
VI. Managed Care Program Regulations

(No Attachments are available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR Part 360-10	SSL 364-j SSL 367 (a)(6) PHL (b) (i) & (ii) PHL 4403-a (7)		91 LCM -135

TABLE OF CONTENTS

I. PURPOSE

This Administrative Directive describes the process for social service districts to establish managed care programs pursuant Chapter 165 of the Laws of 1991 (Chapter 165). The purpose of the Administrative Directive is to provide the LDSS with information on the new statute, and to outline the procedures the LDSS must follow to develop and implement managed care programs which are authorized under Chapter 165, including requirements for preparing and submitting managed care plans to the New York State Department of Social Services (Department).

II. BACKGROUND

On June 12, 1991 Governor Cuomo signed Chapter 165 (see Attachment I). The intent of this statute is to increase the enrollment of Medicaid Assistance (MA) recipients in managed care programs throughout New York State. This increased enrollment will result from expanding existing LDSS managed care programs and developing new managed care programs across the State.

The new statute expands upon previous statutory authority designed to foster MA managed care program development at the local level, including the Medicaid Reform Act (Chapter 904 of the Laws of 1984) and the MA managed care demonstration provisions of Chapter 710 of the Laws of 1988. As of October, 1991, there were 36 managed care contracts, with 85,327 enrollees in 20 districts, established under these initiatives.

Managed care is a comprehensive and coordinated system of medical and health care delivery encompassing preventive, primary and specialty services, as well as acute in-patient care. Although there are a variety of managed care financing and delivery models, they all share several common characteristics which clearly distinguish them from the traditional, episodic MA fee-for-service program.

For example, managed care links each MA recipient in a formal relationship to a primary care practitioner. The practitioner may be a private physician in solo or group practice, on staff in a neighborhood health center, or associated with a health maintenance organization (HMO), etc. Regardless of the setting, however, the practitioner is the focal point of the managed care system. This practitioner is responsible for the delivery of primary care, and also coordinates and case manages most other medically necessary services. Other features of managed care programs are accessibility to 24-hour, seven day per week primary care and continuity of care.

III. PROGRAM IMPLICATIONS

A. Summary of Key Legislative Provisions

Chapter 165 includes a number of key provisions which will have a significant impact on social services district managed care program activity.

1. The Department must designate annually up to 20 districts which must develop and submit managed care plans for approval by the Department, until all non-exempt LDSS have been designated. Any social services district or group of districts which has not been designated may submit a managed care plan at any time. (Managed care plan requirements are found in Attachment IV of this Administrative Directive.)

2. There are no longer any limits on the number of MA recipients who can be required to enroll in mandatory managed care programs.

3. There are no restrictions on the aid category of MA recipients who may be enrolled in mandatory managed care programs. Recipients in all categories of MA eligibility, including ADC, HR, SSI and MA-Only, may be required, at the social services district's discretion, to enroll in a managed care program.

4. Enrollment goals are established for LDSS managed care programs approved by the Department:

   - o 10 percent of the social services district's MA population who are not exempt or excluded from participating in the managed care program within one year of managed care plan approval;

   - o 25 percent of the district's MA population who are not exempt or excluded from participating in the managed care program within three years of managed care plan approval, and

   - o 50 percent of the district's MA population who are not exempt or excluded from participating in the managed care program within five years of managed care plan approval.

   (However, if the social services district's reasonable efforts fail to achieve these enrollment goals, the Department may not impose a penalty.)

5. The Department is authorized to make grants to districts of up to $150,000 per county (up to $750,000 in New York City) in State Fiscal Year (SFY) 1991-1992 to aid social services districts in planning and developing managed care programs. In SFY `91-`92, $2 million has been appropriated for this purpose. Up to an additional $150,000 may be provided, subject to the availability of federal financial participation (FFP). There is no required local share funding for these grants.

B. Managed Care Program Components

A managed care program is a program in a social services district in which MA recipients receive MA services directly and indirectly (including by referral) from a managed care provider, including case management. Participation in a managed care program does not diminish a recipient's MA eligibility or the scope of available MA services to which she or he is entitled.

1. PARTICIPANTS

Eligible Enrollees

MA recipients in all aid categories are eligible to participate in a social services district's voluntary or mandatory managed care program.

Exemptions and Exclusions from Enrollment

An MA recipient will not be required to participate in a managed care program if there is no geographically accessible managed care provider or for other reasons, including good cause reasons, identified in 18 NYCRR Subpart 360-10 (Subpart 360.10). These regulations are in Attachment VI. For example:

- The MA recipient has received on-going medical care and services from a primary health care practitioner who does not participate in the managed care program, for at least a one year period before the social service district's determination that the recipient is eligible for the managed care program. In order to qualify for this exemption, the primary care practitioner must have hospital admitting privileges and/or be able to manage the recipient's care in a hospital.

- The MA recipient cannot be served by a managed care program participating physician due to a language barrier, and he or she has a relationship with a primary care practitioner who speaks his or her language.

- The MA recipient is enrolled in an HMO under a health insurance program other than MA.

- The MA recipient is enrolled in the Recipient Restriction Program.

- The MA recipient is enrolled in the Physically Handicapped Children's Program.

- An MA recipient will not be required to participate in a managed care program if the recipient is receiving services provided by a residential health care facility, Long Term Home Health Care Program (LTHHCP), hospice, State hospital for the mentally-ill, residential treatment facility for children and youth or institution operated by the Veteran's Administration.

- An MA recipient will be excluded from participating in a managed care program if the recipient has a disability, chronic infirmity or condition, is receiving services from a certified home health agency (CHHA), and has medical needs which are more appropriately met outside of the managed care program. This determination is to be made by the social services district, in consultation with the CHHA providing services to the recipient, pursuant to Subpart 360-10.

Withdrawal from Participation

A participant may withdraw from participation in the managed care program for good cause reasons as defined Subpart 360-10. Good cause includes prior transfer for good cause among managed care providers.

2. PROVIDERS

Managed Care Providers

Managed care providers may actually deliver services or may arrange for the delivery of services (directly or by referral), including case management.

Providers eligible to be designated as managed care providers include:

- physicians licensed under the Education Law and qualified to participate in the MA program (operating in solo or group practice, or in institutional settings);

- nurse practitioners licensed under the Education Law and qualified to participate in the New York State MA program (MA Program);

- HMOs certified under Article 44 of the Public Health Law;

- prepaid health service plans (PHSPs) certified under Section 4403-a of the Public Health Law;

- physician case management program (PCMP) providers authorized under the Medicaid Reform Act (Section 364-f of the Social Services Law);

- county health departments;

- diagnostic and treatment centers licensed under Article 28 of the Public Health Law;

- general hospitals licensed under Article 28 of the Public Health Law; and

- facilities licensed under Article 31 of the Mental Hygiene Law.

Managed Care Provider Qualifications

To be designated as a managed care provider, a provider must meet certain standards for the delivery of primary care relating to such factors as continuity of care, 24-hour accessibility and in-patient admitting privileges. For example, HMOs must be certified by the New York State Department of Health (DOH), physicians should meet standards similar to those established for the Preferred Physicians and Children Program (PPAC), and Article 28 clinics and outpatient departments should be eligible for designation by DOH as Preferred Primary Care Providers (PPCP). (See Attachments II A and II B for PPAC and PPCP provider standards and qualifications.)

Multiple Providers

If a major public hospital, as defined under Article 28 of the Public Health Law, is designated by a social services district as a managed care provider, the district must designate at least two other managed care providers which are not major public hospitals or facilities operated by major public hospitals. A list of these hospitals is in Attachment III.

In districts with a general population over 350,000, where one managed care provider is a general hospital (as defined in Public Health Law), there must be at least one other managed care provider which is not a general hospital.

In districts with a general population over 350,000, a MA recipient must be provided with a choice of at least three managed care providers in a mandatory managed care program. In a mandatory managed care program in a social services district with a general population less than 350,000, it is recommended that the district include at least two managed care providers in its managed care program. The program needs to encompass as broad a range of primary care and other medical services as possible, since federal waivers to establish a mandatory managed care program will be contingent upon demonstration of adequate provider availability and accessibility. (See Section VI.A of this Administrative Directive for a further discussion of federal waivers.)

Managed Care Provider Responsibilities

A managed care provider arranges for access to, and enrollment of, primary care practitioners and other medical services providers. The managed care provider must possess the expertise and enough resources to assure the delivery of quality medical care to enrollees in an appropriate and timely manner.

The managed care provider must provide or arrange for medical services and assist enrollees to select medical services prudently, including:

1) management of the medical and health care needs of enrollees by the enrollee's designated primary care practitioner or group of practitioners to assure that all medically necessary services are available in a timely manner, and

2) referral, coordination, monitoring and follow-up with regard to other medical service providers as appropriate for diagnosis and treatment, or directly providing some or all medical services.

A managed care provider must establish appropriate utilization and referral requirements for physicians, hospitals and other medical service providers, including requirements for emergency room visits and in-patient admissions.

Primary Care Practitioners

A primary care practitioner is a physician or nurse practitioner who provides primary care to, and manages the medical and health care services of, an enrollee of a managed care program. The primary care practitioner may practice in a private, solo or group setting, may be associated with an HMO or may practice in a clinic or out-patient department. In certain types of managed care programs (e.g., PCMP models), the primary care practitioner may also act as the managed care provider.

Enrollees select a primary care practitioner (e.g.,physician or nurse practitioner) from among those designated by the managed care provider. Enrollees must be provided with a choice of no less than three primary care practitioners.

The primary care practitioner must manage the medical and health care needs of enrollees, to assure that all services which are found to be medically necessary are made available in a timely manner.

Primary care physicians are those who are licensed under the Education Law, who are qualified to participate in the MA program, and who specialize in: internal medicine, pediatrics, family practice, general practice, or obstetrics/gynecology.

Primary care practitioners may also include nurse practitioners licensed under Education Law, who are qualified to participate in the MA program, and who specialize in: internal medicine, pediatrics, family practice, general practice, or obstetrics/gynecology.

Other Medical Service Providers

Medical service providers include physicians, nurse practitioners, nurse midwives, dentists, optometrists, or other licensed practitioners qualified to provide services under the MA program. For all covered medical services, the managed care provider must offer a choice of medical service providers if enough are available.

3. MANAGED CARE SERVICES

A managed care provider may be responsible for any services covered under the MA program except:

a. residential health care facility services;

b. LTHHCP services, and

c. hospice services

At a minimum, managed care providers must be responsible for primary care services, including adhering to the Child/Teen Health Plan visit schedule and examination content standards for children 21 years of age or younger.

Enrollees must have access to family planning services from either providers affiliated with the managed care provider, or directly on a fee-for-service basis from other qualified MA providers not affiliated with the managed care provider.

Under a managed care program, not all managed care providers must provide the same set of MA services. A managed care program must include procedures through which enrollees will be assured access to all MA services to which they are otherwise entitled where the service is not available from the managed care provider (e.g., dentistry, transportation, etc.), or necessary because of an emergency or geographic unavailability

4. PARTICIPANT SELECTION OF MANAGED CARE PROVIDER

In mandatory managed care programs, MA recipients must have a minimum of 21 days from the date selected by the district to enroll in a managed care program to select a managed care provider. If there is a choice of managed care providers, the recipients must be provided with informational materials which are clear, reasonably understandable and in a culturally appropriate form to assure that they can make an informed choice. The recipient's ability to make a knowledgeable choice is a key factor in the success of a managed care program, whether voluntary or mandatory.

If a recipient does not select a managed care provider or there is only one provider designated by the districts, the recipient may be assigned to a provider by the districts. If there is more than one managed care provider, the districts must equitably assign recipients among all participating managed care providers. However, assignment should be used only as a last resort if a recipient refuses or fails to choose a provider.

In certain types of managed care programs, enrollees must be permitted to change providers for any reason; in others there may be restrictions on provider changes. The ability to restrict provider changes depends upon the type of managed care provider and/or federal authority. Restrictions are permitted if the managed care provider is a federally-qualified HMO, an HMO which has been designated as a competitive medical plan (CMP) for Medicare contracting, or has been certified by DOH as a PHSP. Restrictions on provider changes also are permitted if federal Section 1115 waivers have been approved. For example, if the federal Health Care Financing Administration (HCFA) grants a waiver, provider change restrictions are permitted if the managed care program uses a physician case management model, or the managed care provider is a federally-qualified HMO. However, restriction on provider changes in HMOs which are only State-certified (and not federally-qualified) is <u>not</u> permitted, pursuant to federal statute.

If a managed care provider may not restrict the enrollee's right to change providers, the enrollee must be permitted to leave the provider at any time (subject to Welfare Management System (WMS) constraints), for any reason. If the managed care provider may restrict the enrollee's right to change providers, enrollees are permitted to change providers within 30 days of their first enrollment with a managed care provider. In the next five months, the enrollee may not change to a different managed care provider, except for good cause as defined in Subpart 360-10. After this initial six-month period, the enrollee may again change managed care providers without cause. This restricted period is generally referred to as "lock-in".

Disenrollment

In a voluntary managed care program, disenrollment also may be restricted. For example, if the MA recipient is enrolled with a managed care provider which is a federally-qualified HMO, an HMO with CMP designation or a PHSP, enrollees may disenroll within the first 30 days without cause. Within the next five months, the enrollee may only disenroll for good cause (as defined in Subpart 360-10). After this initial six-month period, the enrollee may disenroll for any reason. (Note: This restriction on disenrollment also is generally referred to as "lock-in".) MA recipients enrolled with a State-certified HMO must be permitted to disenroll without cause at any time. There may be a restriction on disenrollment with other types of managed care providers in voluntary programs if a federal Section 1915 waiver has been approved (e.g., PCMP model programs).

All mandatory managed care programs will require a federal Section 1915 waiver. In mandatory managed care programs, enrollees may only disenroll for good cause as defined in Subpart 360-10. Provider changes also may be limited. For example, if a mandatory managed care program includes one federally-qualified HMO, a PCMP and two State-certified HMOs, there can be an enrollment lock-in period for enrollees of the federally-qualified HMOs and the PCMP. However, after the first six months of enrollment, the enrollee can change providers without cause, but must remain in the managed care program. If the MA recipient is an enrollee of a state-certified HMO, the enrollee may change providers at any time for any reason, but must remain in the managed care program.

Note: See Section VI.A. of this Administrative Directive for a further discussion of federal waivers.

5. FINANCIAL MODELS

A variety of financial models may be used to reimburse providers in the managed care program. However, the model selected must be both financially feasible and cost-effective. The two models most frequently employed use a full capitation/comprehensive benefit approach or a partial capitation/limited benefit approach, although the district may propose enhanced fee-for-service or other reimbursement methods.

Under the full capitation/comprehensive benefit model, a managed care provider (generally an HMO or PHSP) receives a monthly prepaid rate per enrollee, sufficient to cover a wide range of services, including in-patient hospital. The provider assumes a level of financial risk (within certain limits which can be negotiated) for all covered services, and is responsible for controlling use of unnecessary and duplicative services.

In the partial capitation/limited benefit model, the providers are generally primary care physicians who receive payments for providing primary care services, although partial capitation arrangements can involve other types of providers (e.g., clinics), and could cover specialty, as well as, primary care. Non-primary care services are paid on a fee-for-service basis, subject to referral and authorization by the primary care practitioner who serves as a case manager.

Attachments IV.A, IV.B and IV.C of this Administrative Directive provide examples of benefit packages for each of the three financial models.

6. GUARANTEED ELIGIBILITY

A managed care program may include provisions for guaranteed eligibility; however, guaranteed eligibility may only be provided to ADC and SSI enrollees if FFP is available. Currently, FFP is available only for enrollees of HMOs which are federally-qualified or have been designated as CMPs (for Medicare contracting purposes), or PHSPs certified by the Department of Health. HR enrollees will be provided with guaranteed eligibility to the extent that it is available to ADC and SSI enrollees. That is, if a managed care provider includes a guaranteed eligibility provision for ADC and SSI enrollees, then guaranteed eligibility will also be available to HR enrollees. If the managed care provider does not include a guaranteed eligibility provision for ADC and SSI enrollees, guaranteed eligibility will not be available for HR enrollees.

If guaranteed eligibility is available, enrollees will be entitled to six months guaranteed eligibility coinciding with the first six months of their enrollment period. The six-month guarantee period will begin on the effective date of the recipient's enrollment with the initial managed care provider. If an enrollee loses MA eligibility before the end of the six month period, she or he will continue to be eligible to receive only services provided under the direction of the managed care provider and family planning services from any qualified MA provider.

HR recipients who lose their MA eligibility due to failure or refusal to comply with work sanctions will not be entitled to guaranteed eligibility.

7. PAYMENT FOR COVERED SERVICES

Once a MA recipient is enrolled in a managed care program, MA reimbursement is available only for: 1) services provided by or through the managed care provider, and 2) services not covered by the managed care program, but required to be available under the MA program. There is no federal or State reimbursement for payments made to another medical service provider for services which are the contractual responsibility of the managed care provider. The managed care plan may contain provisions for: 1) payment for non-emergent care furnished in hospital emergency rooms or 2) denial of payment for non-emergent care furnished in hospital emergency rooms, or 3) for reduced payments for such care (i.e., "triage" payments).

Payment for Acute Hospital Services

In cases where managed care providers assume financial responsibility for hospital acute care services, payment to hospitals for in-patient services are to be made in accordance with the State case payment system unless an HMO or other managed care provider seeks authorization from Department of Health for an alternate payment arrangement. There are two approaches to an alternate payment method. First, Chapter 165 requires the Department of Health to establish through regulation an alternate payment method, such as a per diem payment method, which a managed care provider may use. However, the managed care provider must insure that aggregate payment to a hospital is justified, based upon lower costs to the hospital, and that the payments are equivalent to costs. Mandatory adjustments in hospital payment such as capital reimbursement, and bad debt and charity care allowance are to be received fully by a hospital under an alternate payment arrangement. Another way for managed care providers to pursue an alternate payment method is to enter into a mutually agreed-upon payment method with one or more hospitals. The actual method of payment and payment amount can be negotiated between the managed care provider and hospital so long as both are consistent with State hospital payment law and regulations. Such negotiated arrangements must be submitted to the Department of Health for approval.

8. CO-PAYMENTS

Payments for unauthorized emergency room visits for enrollees mandated to be in a managed care program must be reduced by statutorily established co-payment amounts (see Attachment I), but no provider may deny services to an enrollee based on an enrollee's inability to pay the co-payment.

The co-payment will apply to all enrollees except:

o children under the age of 18:

o pregnant women;

- o enrollees who have been required to spend all of their income for medical expenses on residential care, except their personal needs allowances, and

- o and any other enrollees excluded by federal law or regulations.

Co-payments may not exceed the following:

State's payment for services	Maximum Co-payment
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

9. SPECIAL CARE

a. Special Care Provisions of Managed Care Plans

Districts or groups of districts may develop managed care plans with special care provisions for MA recipients. Special care is defined as care, services and supplies relating to the treatment of mental illness, mental retardation, developmental disabilities, alcoholism and alcohol abuse, and substance abuse.

A managed care program which includes special care must provide participants who require special care on more than an incidental basis with a managed special care provider to arrange access to special care providers.

b. Managed Special Care Providers

A managed special care provider is an entity that provides, directly or indirectly (including by referral), either special care services or special care services in conjunction with MA services as part of the managed care program.

Qualifications and standards for managed care special providers are being developed in regulation, in consultation with the responsible special care agencies. The responsible special care agency (RSCA) is whichever of the following State agencies is responsible for the special care in question: the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Division of Alcoholism and Alcohol Abuse, or the Division of Substance Abuse Services.

A managed special care provider must possess the expertise and enough resources to assure the delivery of quality special care to participants in an appropriate and timely manner, and must apprise the participant's managed care provider of special care provided to the participant if the managed special care provider is not the participant's managed care provider.

c. Managed Special Care Plans

A managed care plan that covers special care in addition to meeting the requirements for managed care plans (identified in Section IV of this Administrative Directive) must be developed in conjunction with the local mental hygiene director and the community services board, and include a provider network adequate to meet the needs of participants who need special care. Regulations for special care are currently under development by the Department and the RSCAs.

Review Criteria

The managed special care provisions of a managed care plan will be reviewed by the Department according to the criteria identified in Section IV, C,2; "Review Criteria for Managed Care Plans", of this Administrative Directive. Provisions of a managed care plan that include special care will also require the approval of the responsible special care agency (RSCA). The RSCA may partially approve a managed care or special care plan when this would promote the objectives of Chapter 165.

Review Process

Upon receipt of the special care provisions of a managed care plan, the Department will submit the provisions to the RSCA. Within 60 days of reviewing the special care provisions of the plan, the RSCA will inform the Department of its approval or disapproval of the provisions. Upon this recommendation, the Department will notify the social services district whether it is required to submit an amendment to the special care provisions of its plan.

If the Department requires an amendment of the special care provisions, the social services district must submit an amended plan addressing the reasons for disapproval within 90 days of the district's receipt of the disapproval.

Upon receipt of the amended special care provisions form the social services district, the Department will submit the amendment to the RSCA. Within 30 days of receiving the amended special care provisions, the RSCA will inform the Department of its approval or disapproval of the provisions.

Within 60 days of the Department's receipt of the amended provisions, it will notify the social services district of its approval or disapproval.

10. UTILIZATION THRESHOLDS

All enrollees of a managed care program approved by the Department will be exempt from MA utilization thresholds.

IV. REQUIRED ACTION

A. District Designation by the Department

Beginning in October, 1991, and annually thereafter, the Department must designate up to twenty districts which must develop and submit managed care plans to the Department. In subsequent years, the Department will designate up to twenty additional districts per year, until all non-exempt districts have been designated.

The list of designated districts will be issued in mid-October of each year in the form of a Local Commissioner's Memorandum. Additionally, districts which have been designated will be notified individually by the Department in writing.

Priority Ranking of LDSS for Designation

Designation will be based upon a priority ranking of districts according to criteria established by the Department in regulation (Subpart 360-10). General criteria, such as provider availability and geographic accessibility, implementation potential and potential cost-effectiveness will be applied. Other mandated criteria under Chapter 165 will also be considered:

1) the size of the social service district's MA population;
2) high average cost per client;
3) MA population not enrolled in a managed care program;
4) low community health center utilization;
5) high utilization rates for emergency rooms;
6) high number and duration of in-patient hospital admissions, and
7) high number of physician visits.

B. District Exemption from Managed Care Plan Submission

Any social services district which has been designated to submit a managed care plan may seek an exemption from the plan submission requirement for up to two years from the date of the social services district's initial designation. To secure an exemption, the social services district must demonstrate, subject to the Department's approval, that: 1) it will be unable to achieve savings through managed care, or 2) that quality of care cannot be maintained through managed care. A district may request the Department to renew an exemption for additional two year periods.

To request an exemption, the social services district must submit a written request to the Department within 60 days of its receipt of notification of its designation. The request must describe in detail:

1) the reason(s) the exemption is sought;
2) the information used and the activities undertaken by the social services district to determine that an exemption would be required;
3) the duration of the requested exemption, and
4) the likelihood that renewal of the exemption would be requested in subsequent years.

Within 30 days of the Department's receipt of the exemption request, the Department will approve or disapprove the request in writing. If the request is disapproved, the Department will explain the reasons for disapproval.

If a request for an exemption has been denied, the social services district must submit a managed care plan pursuant to the district's initial designation by the Department. A social services district will have 180 days from receipt of the Department's exemption disapproval to submit its managed care plan.

C. Managed Care Plan Submission

In addition to those districts required to submit managed care plans as a result of designation by the Department, any other district may submit a managed care plan for approval by the Department. Two or more districts which share a common medical marketing area are encouraged to submit a multi-district managed care plan.

Districts which have been designated must submit managed care plans to the Department within 180 days of the date upon which they were designated by the Department. A social services district or group of social services districts which has not yet been designated may submit a managed care plan at any time. The specific requirements for submitting a managed care plan and the content of the plan are in Attachment IV.

The managed care plan submitted by the social services district must include, at a minimum, a provider network which is adequate to meet the medical and health care needs of 10 percent of the district's MA population which is not exempt or excluded from participating in managed care. At this point, the social services district will not be required to submit a managed care plan which includes a provider network adequate to meet the needs of 50 percent of the social services district's MA population which is not exempt or excluded from participating in managed care. However, if the managed care plan submitted by the social services district does <u>not</u> include such a network, the managed care plan must generally describe how the social services district proposes to recruit and establish enough providers with the capacity to furnish the necessary services within five years of when the Department approves the managed care plan.

Additionally, if the social services district's managed care plan does not include a sufficient provider network to meet the third and fifth year enrollment goals, the district will be required to submit amendments to its plan as it expands its managed care provider network to meet the needs of its MA population required to be enrolled (i.e, 25 percent by Year Three of program operations, and 50 percent of the MA population by Year Five of program operations). The first amendment, describing the social services district's provider network and plans for enrollment of 25 percent (or 50 percent) of its MA recipients not exempt or excluded from participating in managed care, must be submitted to the Department within 24 months of when the Department initially approves the managed care plan. If this first

amendment does not describe the provider network and specific plans for enrollment of 50 percent of the social services district's MA recipients not exempt or excluded from participating in managed care, a second amendment identifying the district's proposed network and specific plans must be submitted within 48 months of when the Department initially approved the social services district's managed care plan.

All managed care plan amendments identified above must contain the information identified in Attachment IV, "Managed Care Plan Requirements" of this Administrative Directive.

1. Review/Approval Process for Managed Care Plans

Review

All managed care plans, whether from designated districts or from other districts, will be subject to the same review and approval process.

Within 90 days of receipt of a managed care plan by a social services district, the Department will approve, disapprove or request modification of the managed care plan. This review will be conducted in consultation with the Department of Health. (Note: the Department may approve part of a managed care plan if such approval would promote the objectives of Chapter 165.) If the Department disapproves or requests modification of the managed care plan or any portion of the plan, the Department will provide a written notice to the social services district detailing the reasons for the disapproval or requested modifications.

Within 90 days of the receipt of this notice, the social services district must modify the managed care plan to address the deficiencies and resubmit the modified plan to the Department.

If within 30 days of submission of the modified managed care plan, the Department determines that the modified plan has not adequately addressed the deficiencies, the Department may require further modification of the plan within a time period specified by the Department.

Approval

If the Department has granted <u>full approval</u> of the social services district's managed care plan, the district will be expected to implement its managed care program so as to achieve its first year enrollment goal within 12 months from the plan's approval.

In certain circumstances, the Department may grant a conditional approval of the district's managed care plan, e.g., if the State Division of the Budget has not approved the proposed reimbursement rates, or if final provider contracts are not executed. If the Department conditionally approves the managed care plan, it will specify the reasons for the conditional approval and identify the time period within which the conditions must be met. Once these conditions are addressed, and the Department grants full approval of the social services district's managed care plan, the district will be expected to implement its managed care program so as to achieve its first year enrollment goal within 12 months from the date of the plan's full approval.

2. Review Criteria for Managed Care Plans

In determining the adequacy of a social services district's managed care plan, the Department will consider the extent to which the proposed managed care program will achieve social service district's enrollment goals, and if the plan describes a program which:

- o is reasonably related to specific problems which the managed care program is designed to address, including reasonable estimates of the program's local cost-effectiveness;
- o includes enough managed care providers, and an adequate network of primary care practitioners and other medical service providers, which are geographically accessible to the MA target population (to be determined in consultation with the Department of Health);
- o includes adequate grievance procedures;
- o adequately assures the continuity and quality of care for enrollees (to be determined in consultation with the Department of Health);
- o adequately documents community participation in the development of the managed care plan;
- o includes appropriate procedures to enroll MA recipients, including providing enough information for recipients to make an informed choice of managed care and primary care practitioners;
- o provides adequate access to emergency medical care and services (if covered under the plan) and establishes adequate procedures between managed care providers and hospitals to assure appropriate use of such services (to be determined in consultation with the Department of Health);
- o provides enough documentation that managed care providers, qualified primary care practitioners and medical services providers were given the opportunity to participate in the managed care program;
- o assures the provision of preventive care services in accordance with the Child/Teen Health Plan; and

- o adequately describes how managed care providers will be enrolled in the managed care program.

Note: The Department may approve a managed care plan that may not achieve the program's enrollment goals, but would improve the quality and cost-effectiveness of care.

D. Failure to Submit a Managed Care Plan by a Designated Social Services District or Disapproval of a Plan from a Designated District.

If a social services district which has been designated to submit a managed care plan does not submit a plan or has failed to adequately modify the plan to obtain the Department's approval, the Department may, in consultation with the Department of Health, develop a managed care plan for the social services district. If the Department determines that the managed care plan will provide a cost-effective means to enhance quality and availability of health care for MA recipients, and the plan can be effectively implemented in the social services district, the Department may authorize and direct the social services district to provide all necessary assistance to assure that the plan is timely implemented in the social services district.

E. Managed Care Grant Funding

Chapter 165 authorizes the Department, subject to approval of the State Division of the Budget, to make grants to social services districts of up to $150,000 in SFY '91-'92 to aid in the planning and development of managed care programs. Where a social services district is comprised of more than one county (i.e., New York City), the district may receive up to $150,000 for each county. Up to an additional $150,000 may be provided, subject to the availability of FFP.

Any social services district or group of districts which has been designated to submit a managed care plan by the Department may request grant funding. Any social services district or group of districts which voluntarily has submitted a managed care plan (before designation) also may request grant funding.

The specific details of the grant process and funding requirements are in Attachment V of this Administrative Directive.

V. SYSTEMS IMPLICATIONS

A. Provider Enrollment in the Medicaid Management Information System (MMIS)

All managed care providers must be enrolled in MMIS, whether the provider is fully-capitated (HMO or PHSP), partially-capitated with referral provisions (e.g., a PCMP), or is participating in an enhanced fee-for-service model. All providers will be enrolled under Category of Service 0220-Capitation Provider. If providers are already enrolled in MMIS under another Category of Service, they must also enroll with a separate MMIS provider identification number for Category of Service 0220.

B. MA Recipient Enrollment

MA recipients will be enrolled in the Prepaid Capitation Program (PCP) Subsystem of WMS. Training and technical assistance will be provided by Department staff in the enrollment/disenrollment processes and all related WMS, MMIS, Electronic Medicaid Eligibility Verification System (EMEVS) and fiscal agent issues.

C. Billing and Payment

Payment for services for managed care enrollees will be through the MMIS fiscal agent. Fully-capitated (HMO or PHSP) and partially-capitated (e.g., PCMP) type programs, will be paid once-a-month per enrollee. Payment amounts will be based upon the enrollee's actuarial class (age, sex, aid category). The option exists for the Department to generate the monthly claims for the HMO and partially-capitated PCMP models.

However, managed care providers must be aware that the Department-generated claim includes only enrollees who are eligible with the proper type of coverage, and an active PCP Subsystem entry at the point of the WMS pulldown. Cases that have not yet been recertified by pulldown, for example, will not be included on that claim. Therefore, the managed care providers also must be able to claim in those situations. The Department cannot generate claims for the enhanced fee-for-service model providers.

Billing instructions will be provided by the Department after providers are enrolled.

VI. ADDITIONAL INFORMATION

A. Federal Waivers

Any social services district which proposes to enroll federally-participating MA recipients on a mandatory basis will require federal waivers for its managed care plan from HCFA. Chapter 165 authorizes the Department to request waivers of certain provisions of the Social Security Act under Section 1915 of Title XIX, relating to freedom of choice, statewideness and comparability of services for the managed care program. The need for federal waivers will depend on whether or not a social services district will mandate enrollment in managed care plans, and the type(s) of managed care providers that will be involved. It is, therefore, important for the social services district to identify and describe in as much detail as possible these components of its managed care plan. The Department will assess the need for federal waivers for the social services district's managed care plan. If federal waivers are necessary, the Department will provide technical assistance to the districts to address the requirements of a federal waiver request.

Waiver applications will be submitted to HCFA by the Department once a social service district's managed care plan has been approved. Past experience indicates that it may take from 6 to 12 months to prepare and secure final HCFA approval of the waivers. Therefore, when preparing the managed care plan, the districts should allow for this additional time in their workplans and enrollment projections. For example, if a managed care plan is submitted by April 1,1992, fully approved by the Department by July 1, 1992, and a waiver request submitted by September 1, 1992, a district should not project mandatory enrollment to begin until September 1, 1993. In the interim, however, a social services district would be encouraged to implement its program on a voluntary basis.

B. Technical Assistance

Social services districts will receive technical assistance with development of their managed care plans, and with development of the models of health care which will be used to implement these plans. Technical assistance will be available from the Department, as well as the Department of Health and any other State agencies as necessary. The kinds of technical assistance which will be offered to the LDSS are as follows:

1. The Department will develop and distribute a managed care policy and procedure manual. This manual will identify State policies and procedures, and include examples of managed care materials (e.g., enrollment/disenrollment forms, referral forms, marketing brochures, grievance procedures, county staffing plans, etc.) currently used.

2. Other technical assistance in managed care plan development will be provided as necessary:

   - o identifying appropriate managed care program models for service delivery and financing;
   - o identifying and recruiting providers;
   - o developing reimbursement models/methods;
   - o facilitating contract negotiation with providers, including rate and benefit package negotiation;
   - o developing organizational structures within the districts;
   - o developing appropriate quality assurance mechanisms;
   - o developing appropriate marketing strategies/preparing marketing materials;
   - o assisting the district to develop procedures for processing enrollment/ disenrollments/ case transitions /roster reconciliations;
   - o facilitating provider enrollment; and
   - o training district staff in enrollment/disenrollment mechanisms, general problem identification and resolution WMS/PCP interface, provider relations.

3. Technical assistance/liaison with operational programs:

   - o overall provider monitoring;
   - o systems issues: data entry, systems interface, problem identification/resolution;
   - o provider relations, including claiming/billing; and
   - o quality assurance/grievance resolution oversight.

C. Reporting

Upon approval of a social services district's grant funding request and/or managed care plan, the district must submit quarterly program reports to the Department. The specific format of these reports will be determined by the Department at a later date. Before implementation of the managed care program, the social services district will be required to address in the reports such issues as progress to date, status of key milestones, and problems encountered. Once the social services district's managed care program has been implemented, the district will be required to report on enrollment levels, grievances, changes in provider participation, etc.

D. Evaluation

All social services districts with approved managed care plans will be required to participate in Department activities to evaluate their managed care program, and activities related to reporting to the Governor and the Legislature.

VII. EFFECTIVE DATE

This Administrative Directive is effective November 1, 1991, retroactive to June 12, 1991.

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Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance