Guide to Medicaid Managed Care

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Medicaid Managed Care

Most, but not all Medicaid beneficiaries in New York State must now join a Medicaid managed care plan. N.Y. Soc. Servs. L. §364-j. In regular Medicaid beneficiaries can go to any doctor who takes Medicaid. This is called fee-for-service because the doctor or provider gets a fee every time the beneficiary gets a service. In Medicaid managed care, beneficiaries must join a managed care plan and can only see the doctors and other health providers in their plan's network. In addition, they will be assigned a primary care provider and must go to this provider in order to get a referral for specialty care and hospitalizations. In managed care, the plan is paid a capitated rate (flat monthly fee) to provide for nearly all of the beneficiary's health care needs.

Beneficiaries must keep their regular Medicaid card. They will need it to get prescriptions and other important benefits that are not covered ("**carved out**") by their Medicaid managed care plan. See 364-j(3)(e); see also Appendix K of the Medicaid Managed Care Model Contract for a list of which services are covered by the managed care plans and those that remain covered by regular Medicaid.

Medicaid recipients in 42 upstate counties and New York City are generally required to join a managed care plan. In New York City and some upstate counties, recipients receive mandatory enrollment packets from New York Medicaid Choice a private company contracted to handle managed care enrollments and disenrollments. Generally individuals receiving mandatory packets will be randomly assigned into a Medicaid managed care plan if they do not choose a plan within 60 days (90 days for SSI recipients and those who are SSI related). Upstate districts who do not contract with NY Medicaid Choice do their own enrollments but the timelines are the same, 60 days for non-SSI related recipients and 90 days for those who receive SSI or who are SSI related.

Once enrolled in a plan, enrollees should get a member handbook explaining how managed care works. recipients have 90 days to change plans. If they do not switch within 90 days, they are "**locked-in**" the assigned plan and cannot get out for the following 9 months, unless they have good cause to do so. After the lock-in period ends, recipients can change plans for any reason at any time. Enrollees are supposed to receive notice of this right 60 days prior to the end of the lock-in period.

Who Does Not Have to Join a Managed Care Plan?

Two groups of people do not have to join. People who are exempt or excluded. See N.Y. Soc. Servs. L. §364-j(3); NYS DOH Operational Protocol, Chapter 2.

Exempt

People who can decide if they want to join are exempt from Medicaid managed care. See N.Y. Soc. Servs. L. §364-j(3)(a)-(c), (g).

Excluded

People who cannot join a Medicaid managed care plan are excluded. See N.Y. Soc. Servs. L. §364-j(3)(d), (f).

Who Is Exempt from Medicaid Managed Care?

There are four categories of exemptions from managed care. Some recipients do not have to join managed care plans if they can prove joining will impose **barriers to accessing care**. Recipients in this category must prove one of the following to obtain an exemption:

- a managed care provider is not geographically accessible;
- if pregnant, their provider does not participate with any Medicaid managed care plans;
- they have a chronic medical condition and are being treated by a specialist who does not participate with any Medicaid managed care plans;
- they cannot be served by a managed care provider due to a language barrier
- they have been seeing their primary care provider for more than one year and that provider does not participate in any Medicaid managed care plans.

See N.Y. Soc. Servs. L. §364-j(2)(b); 18 NYCRR 360-10.15(a)

The following recipients are statutorily exempt because of the treatment programs they participate in or they are in a special category:

- live in an alcohol/substance abuse program or a facility for the mentally retarded;
- are mentally retarded and get care from an intermediate care facility (or have health needs like a person in a facility);
- have a developmental or physical disability and receives home and community based waiver services (or have health needs like a person receiving these services) ;
- are in the "Care-at-Home" program (or have health needs like a person in that program);
- are Native American; or
- are enrolled in the Medicaid Buy-in Program for Working People with Disabilities (MBI-WPD) and are not required to pay premium.

See N.Y. Soc. Servs. L. §364-j(2)(c).

Recipients who are homeless and living in a shelter and children in foster care are **automatically exempt** if their participation is voluntary in their local district. However, treatment of children in foster care is not uniform throughout the state. Some counties mandate enrollment in Medicaid managed care while others exclude this population entirely. N.Y. Soc. Servs. L. § 364-j(2)(f).

Finally, some recipients are **exempt until the commissioner of health and, in some instances, the commissioner of mental health determines that the managed care program is ready for them to be mandatorily enrolled**. N.Y. Soc. Servs. L. § 364-j(2)(g). This group includes:

- individuals who are dually eligible for Medicaid and Medicare if they are enrolled in a Medicare managed care plan;
- SSI recipients (this exemption no longer applies in 16 counties and New York City);
- HIV+ recipients; and
- adults with serious and persistent mental illness and children with serious emotional disturbances (this exemption no longer applies in 16 counties and New York City).

New mandatory categories – **SSI recipients**, including adults with serious and persistent mental illness (**SPMI**) and children with serious emotional disturbance (**SED**), are no longer exempt from Medicaid managed care.

Proposed mandatory categories

Dual Eligibles
Dual eligibles can receive Medicare services on either a fee-for-service basis as original Medicare Parts A & B, or through Medicare managed care plans which are currently called Medicare Advantage plans. If they are in original Medicare, they must also have fee-for-service Medicaid. If they are in a Medicare Advantage plan, currently they can be in fee-for-service Medicaid or they can enroll in Medicaid's companion managed care program is called Medicaid Advantage.

Individuals with Medicare and Medicaid are currently not required to enroll in Medicaid Advantage plans. However, during last year's budget negotiations the state amended the Social Services Law to allow for mandatory enrollment of dual eligibles who are enrolled in Medicare Advantage. N.Y. Soc. Servs. L. § 364-j(3)(g)(i). This year's budget attributed significant cost-savings based on mandatory enrollment of this population.

Under the amended statute, the exemption for dual eligibles enrolled in Medicare managed care plans can be eliminated if the Commissioner of SDOH finds that the program has capacity to mandate enrollment. However, since federal law does not mandate enrollment in Medicare managed care plans for Medicare beneficiaries, dual eligibles who do not want to be in Medicaid managed care can return to regular Medicare which excludes them from the Medicaid managed care program.

Individuals with HIV/AIDS
The State is currently involved in education and outreach to advocates and health care providers working with individuals with HIV/AIDS on Medicaid managed care enrollment issues. It has requested permission from the Centers for Medicare and Medicaid

Services to expand mandatory enrollment to **recipients who are HIV + or have AIDS** and do not meet other exemption criteria.

Who Is Excluded from Medicaid Managed Care?

Excluded people **cannot** join a Medicaid managed care plan even if they would like to. Beneficiaries are excluded if they:

- are in foster care (not in all counties);
- are in the Medicaid Spenddown or Excess Income program;
- live in a nursing home or a hospice, or are in a long-term home health care program, state-operated psychiatric facility, or residential treatment facility for children;
- get Medicare and are in a long-term care program;
- are an infant living with a mother in jail;
- will get Medicaid for less than 6 months (for example, they get Emergency Medicaid);
- only use Medicaid for tuberculosis (T.B.) related services;
- are a blind or disabled child and live away from their parents;
- are in Medicaid's Restricted Recipient program;
- have other insurance; or
- are an infant who weighs less than or equal to 1200 grams at birth and other infants meeting the SSI-related categories.

Enrolling and Disenrolling from Medicaid Managed Care

Enrolling Voluntarily

Beneficiaries can enroll in a Medicaid managed care plan voluntarily at any time. They can join by calling a community based facilitated enroller, a Medicaid managed care plan directly or by calling **New York Medicaid Choice** at **1-800-505-5678**. NY Medicaid Choice is a private company which has been contracted by 13 local districts and New York City to help enroll people in managed care. NY Medicaid Choice has response standards it is required to meet. They are required to answer the phone quickly and have operators who speak many languages. In counties that have not contracted with NY Medicaid Choice, recipients are enrolled into managed care plans by the local department of social services.

Disenrolling, Transferring and Exemptions

People who would like to disenroll or transfer out of their Medicaid managed care plan, or who think they should be exempt or excluded from Medicaid managed care, should call New York Medicaid Choice at: 1-800-505-5678 or the local department of social services. New York Medicaid Choice also has a designated telephone number for SSI beneficiaries: 1-800-774-4241; TTY: 1-888-329-1541.

Issues Facing Medicaid Managed Care Enrollees

Problems with the Exemption Process

Many clients do not discover they are enrolled in a managed care plan until they try to use their regular Medicaid card and it doesn't work because the client has been enrolled in managed care. Because this can be a life threatening occurrence for someone with a disability, the Department of Health has modified the exemption process for some individuals.

Special Rules for Developmentally Disabled Children

Many children with developmental disabilities are not placed in the auto-enrollment pool because their cases are pre-coded by the Office of Mental Retardation and Developmental Disabilities (OMRDD) as in receipt of services that make them automatically eligible for an exemption. Children who are pre-coded may voluntarily enroll in managed care if they wish, but are not required to take affirmative steps to opt out.

Children who do not receive OMRDD waiver services are placed in the auto-enrollment stream even though they may also be entitled to an exemption. Because many children in New York City with developmental disabilities receive care in specialized clinics and lost access to these services upon enrollment in managed care plans, a special disenrollment process was adopted by SDOH. These children are no longer required to

submit an exemption form for processing to be exempted from Medicaid managed care. Caregivers can now call NYMC and obtain immediate disenrollment from managed care while they collect the necessary documentation to support this request. The automatic exemption period is six months. During this six month period, caregivers must obtain supporting documents from their child's doctor(s) and submit them to NYMC for processing. If the exemption documents are not submitted within the six month period, the children are placed back in the auto-enrollment stream.

Note: SDOH does not believe exemption processing is a problem outside of New York City. If children with developmental disabilities in other counties are having problems obtaining exemptions, advocates should contact the **Office of Managed Care's complaint unit at 1-800-206-8125**.

Adults and Children with Developmental Disabilities

There have been significant problems with the exemption process for individuals with developmental disabilities. When the exemption form was originally developed it required doctors to complete a very confusing and burdensome set of forms to establish that their patients' needs were similar to those of other patients who have OMRDD waiver or care-at-home services in place or that their behavioral and physical health needs were similar to individuals in intermediate care facilities. In the fall of 2007, after numerous complaints from providers and advocates, SDOH reduced the required documentation for these exemptions but it also limited the criteria it considers thus making it much more difficult for doctor's to establish that their patients qualify.

Although, the exemption form has changed, the Medicaid managed care law has not. The law <u>does not</u> support the current exemption requirement which requires a doctor to certify that:

> The patient's care meets ALL of the following criteria:
> - The patient requires extensive and/or complex care in their home for at least 120 days; <u>and</u>
> - This care allows the patient to stay in the community in lieu of being in an institutional setting (such as permanent or long-term placement in a nursing home, intermediate care facility, hospital or skilled nursing facility; and
> - A physician has order these services.

Under the Medicaid managed care law, if recipients can prove either of the first two prongs they should be exempt from mandatory enrollment. **We have recently been informed by the Department of Health that the enrollment form is being modified to comply with the law. We will notify advocates when the new form is issued.**

One good outcome of the complaints filed on behalf of people with developmental disabilities is that exemptions granted on this basis are now coded in the system as permanent exemptions. This means once an exemption is granted no further documentation should be required.

Individuals who are Homeless

Individuals who are in the New York City shelter system are coded in the system as homeless and are removed from the mandatory mailing pool. While they may voluntarily enroll in a managed care plan, they are not required to submit exemption forms if they do not want to enroll. Individuals who are homeless and not in the shelter system are still entitled to an exemption but are not removed from the mandatory mailing list and must request an exemption from enrollment when they receive their mandatory enrollment package. If a homeless individual does not receive an enrollment package and is auto-assigned to a plan, they can contact NYMC or the shelter they are staying in to request an exemption.

Currently Chautauqua, Monroe, Oswego and Westchester counties mandate enrollment of homeless individuals in Medicaid managed care. In thirteen upstate counties homeless individuals are excluded from managed care, the rest of the state allows enrollment on a case by case basis.

Exemptions for People Receiving SSI

Many individuals with complex health conditions have ongoing relationships with more than one health care provider. Finding a Medicaid managed care plan that includes all of their providers in its network can be challenging. For individuals who are unable to find a plan that meets their needs, several strategies can be used to maintain fee-for-service coverage.

Chronic care exemption – individuals facing mandatory enrollment who are being treated by a specialist who does not take any Medicaid managed care plans are eligible for an exemption from managed care enrollment on this basis. Since this exemption requires that the individual be in active treatment with the provider, it is not a permanent exemption. However, depending on the type of illness or disability the individual is in treatment for, the exemption may be granted for more than one year at a time. SDOH is currently reviewing conditions that require ongoing treatment to determine which ones should be granted for longer time periods or permanently.

Good cause exemption -
There are at least two system-wide issues that should qualify mandated enrollees for good cause exemptions if your client encounters them:

Prior to initiating mandatory enrollment for individuals on SSI and those who are SSI related, SDOH compared managed care networks with specialists who accept Medicaid fee-for-service and determined that access to specialists would be as good if not better for this new group of mandatory enrollees. Unfortunately, the data was not compared with actual utilization by individuals with complex conditions so it did not reveal how many of these individuals in treatment with multiple specialists would actually be able to continue to access them all in one network.

The data also did not take into account that many clinics specializing in treating patients with developmental disabilities do not participate in any Medicaid managed care networks. In addition, the data does not consider that many primary care physicians (PCP) specialize in conditions like developmental disabilities and that many patients go to specialty clinics because of the primary care services, not the specialists. As a result of these limitations, many people with developmental disabilities lost access to PCPs who had been treating them for many years because the chronic care exemption is not available for PCPs and there is no exemption that addresses continuity of care concerns.

Good cause exemption case examples:

Ms. A
Ms. A has multiple health conditions that require ongoing treatment by her ophthalmologist, nephrologist, orthopedist and PCP. All of Ms. A's doctors participate in Medicaid managed care, but there is no plan that includes all of Ms. A's doctors in its network. Although there is no place on the exemption form to document a situation like Ms. A's, her ophthalmologist completed the section for non-participating providers and attached an accompanying explanation of Ms. A's condition and continuity of care requirements for all of her doctors.

B
B is five years old. B receives SSI. He has autism and serious behavioral issues. B does not receive home care services. The specialized clinic he attends provides primary, dental and behavioral health services. Following his mandatory enrollment into Medicaid managed care B was no longer able to see his PCP or dentist because they do not participate in any Medicaid health plans. Although behavioral health services are carved-out services for SSI recipients and B could still see his psychiatrist, the coordinated care he received for most of his life was no longer possible.

As a result of his disability, B has a very difficult time dealing with change and the loss of his doctors was devastating. Concerned that a disruption in care would cause real set backs for B, B's PCP scratched out "specialist" and wrote in "PCP" on the exemption form and described why B's coordinated care was so important to his well being.

Note: Under New York's good cause regulations, individuals are exempt if they have been under the care of a PCP for more than one year and that PCP does not participate in any Medicaid managed care plans. 18 NYCRR 360-10.15. We have been informed by the Department that the revised exemption form will include this exemption. We will notify advocates when the new form is issued.

Incorrect Exemption Denials - Exemption Application Form Modifications
The Department of Health is currently modifying the exemption application form so that it conforms to the Social Services Law and regulations. Currently the form incorrectly

requires doctors assisting patients with exemption requests based on mental retardation or developmental disabilities to attest to their patient's receipt of home care services. This requirement is not in the law and will soon be removed from the exemption application form.

Similarly, the regulations defining good cause exemptions include an exemption for individuals being treated by a primary care provider for more than one year who do not participate in any Medicaid managed care plans. 18 NYCRR 360-10.15. This exemption will also be added to the new form.

Access Issues for Medicaid Managed Care Enrollees

Accessing Medically Necessary Care

Medicaid managed care, like fee-for-service Medicaid, covers all medically necessary care. Medically necessary care is care that is "…necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap…" See Soc. Servs. Law § 365-a(2); Operational Protocol, Chapter 4; Medicaid Model Contract, Sec. 1.

While enrollees are entitled to all the services they received in regular Medicaid, enrollment in Medicaid managed care can impose barriers to accessing services in the form of prior authorization requirements, requirements to exhaust in-network options and utilization review.

Lack of Transportation

Upon enrollment in Medicaid managed care, many individuals with SSI have had problems accessing transportation to their appointments. Especially problematic is coordinating transportation to carved-out services. Transportation is included in the managed care benefit package which means carved-out services providers must contact the managed care plans for authorization for transportation for their patients. Many of these providers are unfamiliar with the individual managed care plans and their prior authorization procedures. As a result, many individuals with SSI have been unable to get to their behavioral health appointments. In response to complaints by recipients, advocates and providers, the New York City Department of Health and Mental Hygiene (CDOH) issued transportation guidance to New York City health plans and has been training providers on how to access these services for their patients. CDOH also began requiring health plans to list transportation contacts on their websites to make this service more accessible.

Lack of Case Management/ Care Coordination

Case management has been highlighted as a benefit for enrollees in the SSI mandatory enrollment materials. It is defined in the Operational Protocol as "a model through which medical, social, and other services are coordinated by one entity. The objective of

case management is to provide medically necessary quality care and to assure access and continuity of care for a patient. This responsibility includes identification of a health risk, diagnosis of disease, and development of a treatment plan."

Although the Operational Protocol and Model Contract indicate that case management should be available to assist enrollees in coordinating their health services and accessing care, the execution of this definition varies widely from plan to plan. Many enrollees, like Ms. C below, are told that case management services are not available to them. In cases where case management is provided, enrollees often experience it as utilization review rather than as assistance in obtaining medically necessary care. Although SDOH formed a Case Management Work Group several years ago to establish requirements for implementing case management and more uniformity across plans in its delivery the group has yet to issue any guidance.

Case Example:

Ms. C
Ms. C has been diagnosed with schizoaffective disorder and learning disabilities. Ms. C also has pre-diabetes, requires four dental cleanings each year and sees a dermatologist regularly. Ms. C receives SSI and was previously exempt because of her psychiatric disability.

Ms. C was placed in the mandatory enrollment stream last spring after the exemption for serious mental illness ended in New York City. After reviewing the mandatory enrollment materials, Ms. C's mother, D, did not think she qualified for an exemption so she did not request the forms. Although not all of her doctors accepted the same plan, D chose one that included the greatest number of her daughter's doctors.

Since Ms. C suffers from anxiety, becomes confused easily, has difficulty arranging appointments and is not comfortable using the telephone, D tried to obtain case management for her in the new health plan. Although she explained her daughter's disabilities and their impact on her daughter's life to the plan representatives, D was told that the plan did not provide case management services to people with needs like Ms. C's. Despite the fact that case management is described in the NY Medicaid Choice managed care enrollment materials and the new enrollee materials issued by the plan, the plan suggested that since Ms. C's behavioral health services are carved-out, she should get intensive case management through fee-for-service Medicaid.

Unable to obtain case management for her daughter, D took on the task of getting referrals to the specialists she requires. Often D made multiple calls and received conflicting information from the plan, the doctors and NY Medicaid Choice about how to obtain referrals and even about whether referrals were necessary. As a result of this misinformation, Ms. C was turned away from an appointment with one of her specialists because she did not have a referral. Since going to doctor's visits already provokes Ms. C's anxiety, being turned away by her doctor was particularly traumatic.

When D realized how difficult it was to navigate the managed care process, she knew that her daughter would never be able to get the care she requires on her own and she began to worry about her future. Several months later, worn out by the barriers imposed by managed care and concerned for her daughter's future, D requested an exemption form. Although behavioral health services are carved-out of the managed care benefits package, Ms. C's psychiatrist was willing to advocate for the exemption. Ms. C's psychiatrist completed the necessary forms and the exemption was granted.

Termination of Services Upon Enrollment

Many recipients with SSI, especially those with Certified Home Health Aid (CHHA) and private duty nursing services in place have experienced reductions and terminations of services following their enrollment in Medicaid managed care.

After receiving many complaints about these transition issues, DOH issued two policy clarifications to Medicaid managed care plans. The first, "Medicaid Managed Care and Family Health Plus Coverage Policy New Medicaid Managed Care Enrollees In Receipt of an On-going Course of Treatment" informs the plans of their obligation to cover existing courses of treatment under the Public Health Law and their managed care contracts with the state. The clarification reminds the plans that pursuant to the Public Health Law they must cover existing treatment whether the provider is in or out-of-network for up to 60 days while the plan evaluates the needs of its new enrollee and arranges for appropriate care. N.Y. Pub. Health L. § 4403(6)(f)

The second policy clarification is called "Comparison of Home Health Services (Medicaid Managed Care Benefit) and Personal Care (Home Attendant) Services." This clarification reminds the plans of their contractual obligation to cover Home Health Services and it also clarifies the difference between these services which are considered "skilled services" and Personal Care Services.

Provider Confusion

SSI recipients enrolled in Medicaid managed care must navigate two systems. "Physical health" needs are covered by their managed care plan while mental and behavioral health services remain fee-for-service. This bifurcated system has created a lot of confusion for both recipients and providers.

Since many behavioral and mental health providers do not participate in Medicaid managed care plans they are often unfamiliar with the rules. This has created real problems for new enrollees. Many behavioral and mental health providers have turned away patients when they come in with their health plan cards instead of their Medicaid benefits cards because they do not understand that regular Medicaid will continue to pay them for these visits. Similarly, some enrollees who correctly presented their regular Medicaid cards were turned away when the provider swiped the card and the code "PCP" came up indicating the person was enrolled in managed care. After receiving numerous complaints by providers, recipients and advocates, SDOH issued

"Attachment C Behavioral Health Services New York Medicaid Billing Codes" which reminds providers of the services that remain fee-for-service and how to bill for them.

Lack of Written Notice

Lack of coordination and oversight of enrollees health services when recipients transfer from fee-for-service to managed care is very problematic. Many recipients experience this transfer as a termination of services without due process protections because these services are terminated without notice. As a result, many enrollees experience health endangering gaps in coverage because they are not advised of their right to request fair hearings with aid-to-continue.

Equally alarming is the lack of accountability for this process. When complaints are filed the providers generally blame the plan saying the plan has not authorized payment for the service, the plans blame the local district saying they did not know the service was needed and the district blames the plan saying that it is no longer responsible for authorizing services.

Right to Specialty Care

In addition to the rights Medicaid managed care recipients have under Medicaid law, they also have rights as managed care enrollees under the Public Health and Insurance Laws. These laws include the right to:

- have their specialist serve as their PCP
- get a standing referral to see their specialist
- go to a non-participating doctor if their managed care plan does not have a specialist in its network who can meet their medical needs
- continue seeing their doctor for up to 90 days (or through delivery if pregnant) if she leaves the plan's network while undergoing a course of treatment.

N.Y. Pub. Health L. § 4403(6)

Disclosure

Managed care plans must tell their patients about the coverage offered, benefit packages, prior authorization rules, how to file grievances and utilization review appeals, reimbursement policies, how to change providers, get referrals, specialty care, any use of formularies and so forth. Enrollees also have a right to receive written notice of service and payment denials and of their Fair Hearing rights. N.Y. Pub. Health L. § 4408.

Protections Exist for Enrollees but Must be Enforced

Accessing Medically Necessary Care

Since cost containment is one of the goals for implementing a managed care delivery system, recipients face increased obstacles to obtaining medically necessary care. Barriers to care can come in the form of prior authorization or referral requirements, like those experienced by Ms. C above, requirements to exhaust in-network options and utilization review.

Since Medicaid managed care enrollees are entitled to all services they would receive under fee-for-service, these cost control measures often conflict with enrollees' rights. The Operation Protocol specifically refers to Soc. Servs. L § 365-a(2) in its description of covered services and the standard by which they are obtained. Medicaid managed care, like fee-for-service Medicaid covers all medically necessary care. Medically necessary care is care that is "…necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap…" This definition is also set forth in the Model Contract.

Right to Specialty Care

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- have their specialist serve as their PCP. N.Y. Pub. Health L. § 4403(6)(c);
- get a standing referral to see their specialist. N.Y. Pub. Health L. § 4403(6)(b);
- go to a non-participating doctor if their managed care plan does not have a specialist in its network that can meet their medical needs. N.Y. Pub. Health L. § 4403(6)(a);
- continue seeing their doctor for up to 90 days (or through delivery if pregnant) if she leaves the plan's network while they are undergoing a course of treatment. N.Y. Pub. Health L. § 4403(6)(e)(1).

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Fair Hearings and Plan Appeals

Managed care enrollees have the right to file grievances and appeals with their health plans, but they are not limited to the managed care appeals process. Model Contract, Sec. 25.2. Medicaid managed care enrollees are entitled to request a fair hearing whenever a benefit or service is reduced or denied by the plan. Enrollees

are also entitled to request fair hearings if requested services are not provided with reasonable promptness.

However, if the denial is from a plan provider, the enrollee must first request that the plan review the provider's decision before they are entitled to request a fair hearing. If an enrollee requests a fair hearing because of a reduction in services, they also have aid-continuing rights. Model Contract, Sec. 25.4.

If an enrollee chooses to pursue an appeal through their health plan, they may simultaneously request a fair hearing. If a plan's adverse decision is overturned during the managed care appeals process, the fair hearing request should be withdrawn because when external review and fair hearing decisions are conflicting, the fair hearing decision prevails. Model Contract, Sec. 26.3.