STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

May 28, 2009

Dear Colleague:

The Department has updated the enclosed transitional care policy to clarify the responsibilities of health plans for providing continuity of care for new members who are receiving an ongoing course of treatment as of the effective date of enrollment.

This document does not reflect a change in policy. Rather, it clarifies existing policy in the following areas:

- Transitional care requirements are applicable to both Medicaid managed care and Family Health Plus (FHPlus) enrollees;
- Transitional care for new enrollees undergoing a course of treatment with a ***non-participating*** provider is required for a period of up to 60 days from the date of enrollment, consistent with statute;
- Transitional care for new enrollees undergoing a course of treatment with a ***participating*** provider is required until the health plan's approved treatment plan is in place;
- While health plans must ensure that transitional care services are provided in accordance with the contract and this policy document, the terms of provider contracts and/or applicable plan policies and procedures control with respect to reimbursement of participating providers for transitional care services.

Please share this policy with all appropriate staff.

Questions should be directed to Vida Wehren of my staff at (518) 473-0122.

Sincerely,

Jay Laudato
Director
Division of Managed Care

cc: LDSS Managed Care Coordinators
Ms. Simon
Ms. Wehren

Medicaid Managed Care and Family Health Plus Coverage Policy
New Managed Care Enrollees
In Receipt of an On-Going Course of Treatment

This policy clarifies the responsibility of health plans to ensure continuity of care for new health plan members with serious health problems who receive a complex mix of health care services prior to enrollment in managed care. While many new Medicaid managed care enrollees may have chronic health problems and qualify for exemptions, the presence of chronic illness and the ongoing need for health care services such as home health and private duty nursing services does not disqualify these enrollees from enrollment in Medicaid managed care. These enrollees are entitled to the full package of medically necessary Medicaid managed care services for the period they are enrolled in a health plan.

Public Health Law, Section 4403, and the corresponding section in the Medicaid Managed Care/Family Health Plus model contract (15.6) anticipate circumstances where the disruption of a new member's relationship with a non-participating provider would have a significant negative impact for a new member with a life threatening disease or condition or a degenerative or disabling disease or condition. Health plans routinely apply section 15.6 to new Medicaid members who are in an on-going course of treatment from non-participating physicians and outpatient clinics.

This policy clarifies that:

- Section 15.6 contract requirements apply to the full range of services in the managed care benefit package, including home health and, for Medicaid managed care only, private duty nursing services;
- Health plans must ensure all new Medicaid managed care and FHPlus enrollees continuity of care regardless of provider status (participating or non-participating); and
- Health plans should have mechanisms to assure timely access to medically necessary services pending a managed care approved plan of care.

This policy applies to all new Medicaid managed care and Family Health Plus enrollees who are in an ongoing course of treatment as of the effective date of enrollment.

Policy Clarification

Non-Participating Providers

Under State law and the contract, health plans must permit a new enrollee to continue an ongoing course of treatment during a transitional period of up to sixty (60) days from the effective date of enrollment if the new enrollee has an existing relationship with a non-participating health care provider, elects to continue to receive care from the non-participating provider, and has a life threatening disease or condition or a degenerative or

disabling disease or condition. Transitional care services must be provided for up to 60 days or until the plan has assessed the member's needs and an approved treatment plan is put into place. The plan's obligation to ensure the continued provision of services, including services authorized under Medicaid fee-for-service or by another Medicaid managed care or Family Health Plus plan, during the sixty (60) day transition period applies even if the non-participating provider fails to notify the plan or request authorization. The plan should also ensure that reimbursement issues do not interfere with continuity of care. In the absence of a negotiated rate, the Department suggests that plans reimburse non-participating providers at the Medicaid fee-for-service rates.

Participating Providers

To prevent disruptions in service, health plans must have policies and procedures for their participating providers to ensure new enrollees continued receipt of services, including services authorized under Medicaid fee-for-service or another Medicaid managed care or Family Health Plus plan, until a managed care plan's approved treatment plan can be put in place. Plan policies and procedures for participating providers must include a mechanism to secure prior authorization within a reasonable period after the effective date of enrollment and assure continuity of care during the transitional period. These policies and procedures should recognize that services such as home health and private duty nursing services may be in place on the effective date of enrollment and, thus, may not always be prior authorized in accordance with customary plan procedures. While plans must ensure that services are provided during the transitional period, and are liable for payment of services during the grace period between enrollment and the date that providers may reasonably be expected to obtain prior authorization, the terms of provider contracts, and/or pertinent policies and procedures, control with respect to reimbursement beyond the grace period.

Management of New Enrollee Health Care

The Department recognizes the challenges of providing health care services to new enrollees with complex health care needs and plans of care established before enrollment in a health care plan. Plans may want to consider using requests for the provision of these services to new enrollees as triggers for greater plan management, including case management services. In addition, the Department encourages plans to develop mechanisms to identify these new enrollee authorization requests to avoid denials of care that may disrupt the delivery of important health care services. Finally, the Department also encourages plans to take full advantage of the Medicaid fee-for-service claims history files for SSI enrollees. These files are provided to assist health plans in managing patient care needs while facilitating continuity of care.[1]

[1]The description of the claim file sharing initiative, a data element dictionary for the claim extract file, and a 100 record sample file, are currently available for download on the MEDS II Home Page on the Health Provider Network (HPN) under the Data Share section. Plans with questions about the contents of the test file, or an interest in

Provider Responsibilities

All providers must routinely check the individual's Medicaid eligibility and plan enrollment status, request plan service authorizations and provide health documentation requested by plans. Providers should check the individual's Medicaid eligibility, aid category, managed care enrollment status, and health plan on ***the first day of every month*** that services are rendered.

Member Rights

Health Plan Members' Rights to a Fair Hearing

In accordance with the requirements outlined in Section 25 of the Medicaid Managed Care/Family Health Plus Model contract, health plan members may request a fair hearing when a health plan denies a request for services or reduces, suspends or terminates a treatment or plan benefit service currently being provided. The health plan may have to continue the provision of services if ordered by the NYS Office of Administrative Hearings in the circumstances listed in Section 25 of the Model Contract.

Grievances and Appeals

In addition to a Fair Hearing, members also have the right to appeal a health plan determination to deny a request for benefit services or to reduce, suspend or terminate a plan benefit service.

External Appeals

Members are eligible to request an External Appeal when one or more covered health care services have been denied by the health plan on the basis that the service(s) is not medically necessary or is experimental or investigational, and if a fair hearing determination has not been rendered.

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requesting the Medicaid fee-for-service claims history files routinely, should contact Mary Beth Conroy at (518) 486-9012 or email omcmeds@health.state.ny.us.