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Managed Care Laws, Rules & Regulations

What Providers Need to Know

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Presenters

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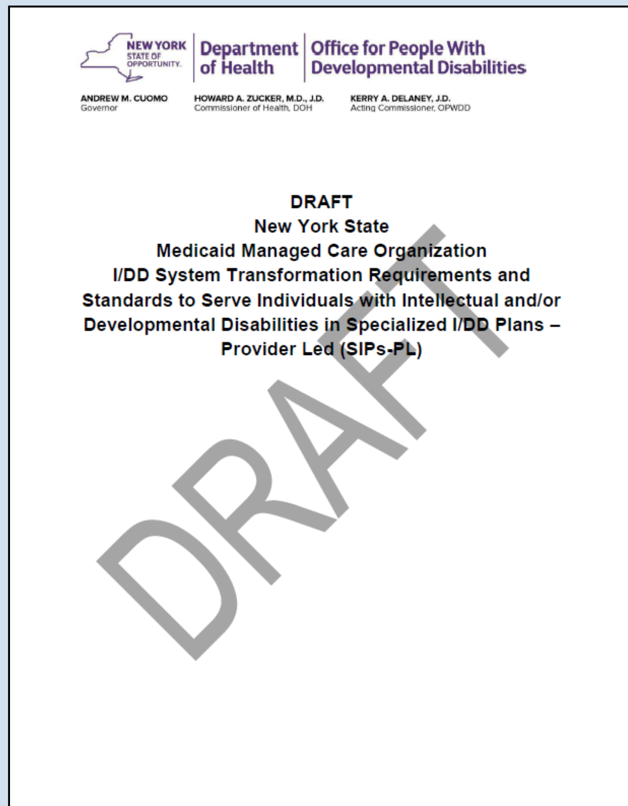
Plan standards

The state will set standards for SIP-PLs and SIP-Ms through plan standards and qualifications, model contract and other regulatory guidance documents.

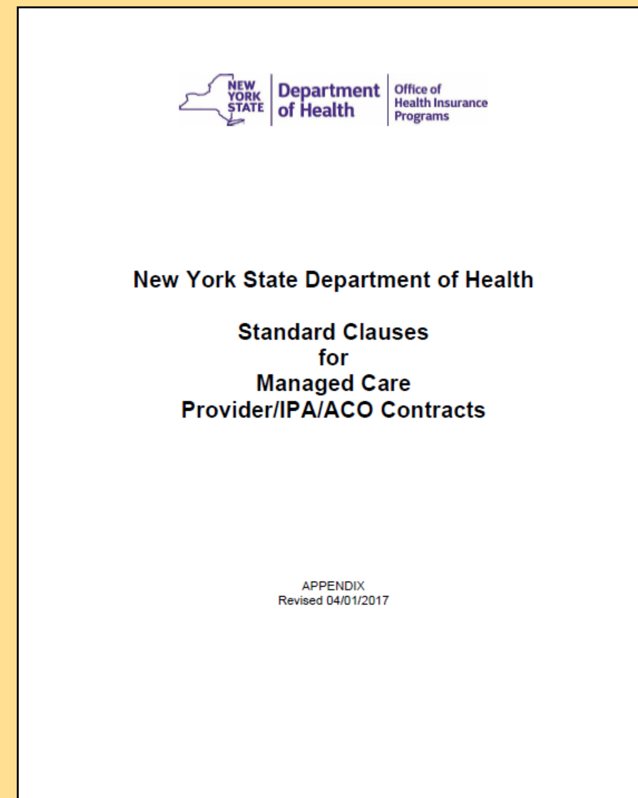

NEW YORK STATE OF OPPORTUNITY. | Department of Health | Office for People With Developmental Disabilities

ANDREW M. CUOMO, Governor | HOWARD A. ZUCKER, M.D., J.D., Commissioner of Health, DOH | KERRY A. DELANEY, J.D., Acting Commissioner, OPWDD

DRAFT
New York State
Medicaid Managed Care Organization
I/DD System Transformation Requirements and Standards to Serve Individuals with Intellectual and/or Developmental Disabilities in Specialized I/DD Plans – Provider Led (SIPs-PL)

DRAFT

A final version is anticipated in 2019


NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Department of Health

Standard Clauses
for
Managed Care
Provider/IPA/ACO Contracts

APPENDIX
Revised 04/01/2017

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Main Sources of Legal Requirements

Underpinning these policies are state and federal statutes and regulations that provide a roadmap for managed care plans and the providers contracting with them.

The **federal government** sets minimum standards for Medicaid managed care programs through regulation.

Medicaid managed care plans are also **subject to State law**, including the Insurance and Public Health Laws, which provide certain standards for insurers.

Areas of focus for today's webinar:

- Utilization review
- Appeals and grievances
- External appeals
- Fair hearings
- Prompt pay law
- Network adequacy
- Provider credentialing

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Utilization Review

New York State law sets standards for utilization review (UR) by insurers, including Medicaid managed care plans

When engaging in UR, insurers are required to use medical professionals to oversee the process and reach medical necessity determinations.

- The insurer must have a medical director or clinical director that typically manages the type of service he or she is reviewing.
- Where the insurer reaches an adverse determination, it must be made by a licensed health care practitioner. For some services (including mental health and substance use disorder services), it must be a practitioner that specializes in or is experienced in the delivery of the services.
- This statute could be amended to require similar credentials for those reviewing I/DD services.

Citations: Articles 49 of the Public Health and Insurance Laws; 42 C.F.R. § 438.210.

Utilization Review

The statute requires that insurers reach determinations in certain timeframes

Prior Authorization	Concurrent Review	Retroactive Review
▪ *Standard*: 3 business days from receipt of the necessary information, but not more than 14 days ▪ *Expedited*: 72 hours	▪ *Standard*: One business day from receipt of the necessary information, but not more than 14 days ▪ *Expedited*: One business day from receipt of the necessary information, but not more than 72 hours	▪ 30 days from receipt of the necessary information for all retroactive reviews

Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal.

Citations: Articles 49 of the Public Health and Insurance Laws; 42 C.F.R. § 438.210.

Appeals and Grievances

Providers and patients are afforded the opportunity to file grievances and appeals with managed care plans

- What is the difference between appeals and grievances?
  - **Appeal**: A review of a plan's adverse benefit determination, which includes the denial of limited authorization of a requested service, reduction, suspension or termination of a previously authorized service, the denial of payment for services, or the failure to provide services in a timely manner.
  - **Grievance**: An expression of dissatisfaction about any matter other than an adverse benefit determination, including the quality of care or services provided, aspects of interpersonal relationships (such as rudeness of a provider or employee), or failure to respect the member's rights regardless of whether remedial action is requested.

Citations: Articles 49 of the Public Health and Insurance Laws; 42 C.F.R. §§ 438.400, 402, 404, 408.

Appeals: Timelines for filing and resolution

Timeframes for Filing Appeals

- State law requires that ***members and their representatives be given a minimum of 45 days to file an appeal***, but the State can require additional time in the contract with plans
- ***Of note for providers***: State law provides that, in the event that an adverse determination is rendered without attempting to discuss the matter with the provider who specifically recommended the service, procedure or treatment, the provider must be given the opportunity to request a reconsideration of the adverse determination.

Timeframes for Insurers Reaching a Determination on the Appeal

- Plans are required to ***reach a decision on standard appeals with within 30 days***.
- Plans are required ***to reach a decision on expedited appeals within two business days, but no longer than 72 hours.***

If the plan fails to reach a determination on the appeal within the above timeframe, the adverse determination is automatically overturned.

Citations: Articles 49 of the Public Health and Insurance Laws; 42 C.F.R. §§ 438.400, 402, 404, 408.

Fair Hearings

Under federal and state law, all Medicaid beneficiaries are entitled to fair hearings by administrative law judges (ALJs) of final adverse determinations

- These protections are extended to Medicaid managed care enrollees.
- Members are given 120 days to seek a fair hearing and can be entitled to aid continuing, which allows them to receive services that the plan was seeking to reduce or terminate until the ALJ directs otherwise.

Citations: 42 CFR §§ 438.402 and 408; Social Services Law § 365-a.

External Review

Members and their providers, in certain instances, have the right to request an external appeal by DFS of final adverse determinations based on lack of medical necessity, experimental or investigational treatment, a clinical trial or, in certain instances, out-of-network services.

Who can appeal?

- A provider's ability to appeal on their own behalf is limited to cases of concurrent and retrospective adverse determinations
- Generally, members are required to exhaust the plan's initial internal appeal process before requesting an external appeal

Timeframes to request an external appeal

- A provider appealing on their own behalf must file a request with DFS within 60 days from the date of the final adverse determination
- A member or the member's designee (which could be their provider) must file a request with DFS within four months from the date of the final adverse determination

More information: https://www.dfs.ny.gov/complaints/file_external_appeal

Citation: Articles 49 of the Public Health and Insurance Laws.

Prompt Pay Law

Medicaid managed care plans are required to promptly pay claims.

Medicaid managed care plans are required to pay "clean" claims that are submitted electronically within 30 days and paper claims within 45 days.

- If the claim is incomplete or the insurer's obligation to pay is "not reasonably clear," the insurer must notify the member or provider within 30 calendar days of receiving the claim

Enforcement mechanisms and provider protections

- For claims that are not timely paid, the insurer is obligated to pay the provider interest (12%) on the claim.
- DFS also has the ability to levy penalties against insurers that fail to meet the prompt pay obligations.
- The law also provides a private right of action against insurers by providers.

Citations: Insurance Law § 3224-a; *Maimonides Med. Ctr. v First United Am. Life Ins. Co.*, 116 AD3d 207 [2d Dept 2014].

Network Adequacy and Provider Credentialing

Federal regulations require that states develop and enforce network adequacy standards for managed care plans

- Provider-specific network adequacy standards are required for certain types of providers (such as hospitals, pharmacies behavioral health and primary care) and states are permitted to set specific requirements for other provider types.
- Certain rights extend to "health care professionals" relating to the opportunity to submit applications to health plans and to avoid arbitrary terminations (PHL §4406-D)—but these limited protections do not extend to facilities or service providers.

Citations: 42 CFR §§ 438.68; 438.214.

Network Adequacy and Provider Credentialing

Network adequacy standards must take into account:

- Anticipated enrollment
- Expected utilization
- Characteristics and health care needs of specific populations covered in the plan contract
- The numbers and types of network providers required to furnish the contracted services
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees
- The ability of network providers to communicate with limited English proficient enrollees in their preferred language
- The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities
- The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions

Citations: 42 CFR §§ 438.68; 438.214.

Questions