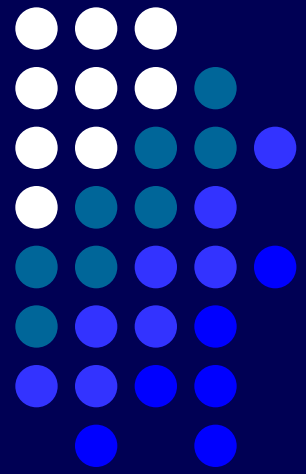
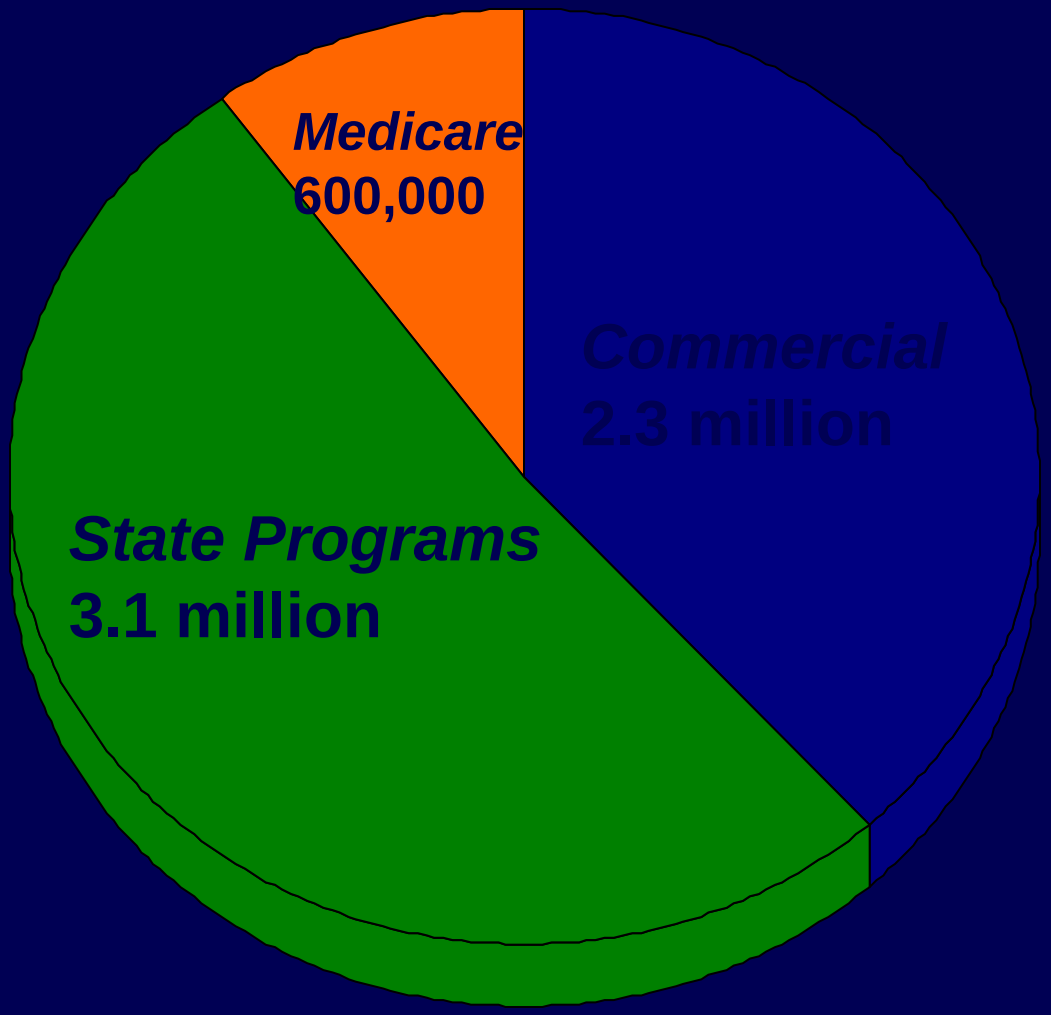
MRT Managed Long Term Care Workgroup

Consumer Rights in Managed Care

September 28, 2011



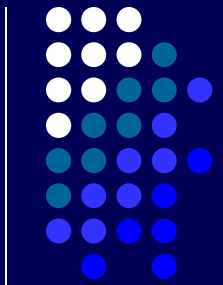
Nearly 31% of New Yorkers are enrolled in a managed care plan



- 2.3 million commercial enrollees receive coverage through their employer or purchase it directly
- 3.1 million enrollees of state health insurance programs including Medicaid Managed Care, Family Health Plus and Child Health Plus
- 600,000 Medicare beneficiaries

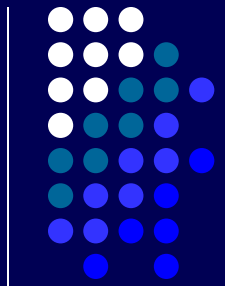
NYS Consumer Rights

PHL §§ 4403, 4408, 4902, 4903, & 4904



- Right to information about Health Plans
  - Benefit description
  - Referral and authorization requirements
  - Provider network
- Access to Needed Care
  - Right to out of network care
  - Prudent layperson emergency care
  - Transitional care
  - Access to specialty care & specialty care centers
- Right to complain, grieve and appeal
  - Notification of denials of treatment and grievance outcomes
  - Clinical rationale for the denial
  - Appeal of denials & timeframes for responding
  - If appeal timeframes not met, the denial is reversed

Service Authorizations



- New, review and notice in
  - Expedited, 3 bd from request
  - Standard, 3 bd from all info and no more than 14 days from request
- Concurrent, review and notice in
  - Expedited, 1 bd from all info and no more than 3 business days from request
  - Standard, 1 bd from all info and no more than 14 days from request
  - Home health care following inpatient admission on Friday or day before holiday, 72 hours after all info, no more than 3 bd of request
- All may be extended up to 14 days if:
  - plan needs more info and in member's best interest to extend
  - Enrollee or provider requests extension
- Verbal and written notice made to enrollee and provider

Retrospective Review

- Review and determine 30 days after all information
- Claim denials noticed on day of denial
- Written notice to provider and enrollee
  - Notice only provider for certain administrative issues: duplicate claim, unbundling of global codes, up-coding, in excess of contracted rate, etc
- Cannot deny prior authorized service on retrospective review unless information that changes decision was not shared with MCO
- Cannot deny claim for prior authorized service unless at time of claim:
  - not eligible for coverage
  - Untimely claim submission
  - benefit exhausted
  - Confirmed fraud or abuse
  - Authorization based on inaccurate or incomplete information

Action Appeals

- No less than 60 business days to file
- Plan determines in:
  - Expedited, 2 bd of all info and no more than 3 bd from appeal
  - Standard, no later than 30 days from appeal
- All may be extended up to 14 days if:
  - plan needs more info and in member’s best interest to extend
  - Enrollee or provider requests extension
- Notice to enrollee and provider:
  - Expedited verbal notice at time of decision, written in 24 hours.
  - Standard written notice within 2 business days of decision.

Notices

- Notice whether approved or denied
- Written adverse determination content includes
  - Reason
  - clinical rationale in terms specific enough to judge basis for appeal
  - Internal plan appeal rights and time frames
  - Fair hearing rights and form
  - External appeal rights, if applicable
  - Right to complain to DOH
  - Translations, formats for special needs, and assistance with appeal process available from plan

Fair Hearings

Issued When:

- Reduction, Denial, or Termination of Treatment
- Notice issued by plans when action is taken
- Notices must be issued 10 days in advance of action for aid continuing.
- Denial of an exclusion/exemption

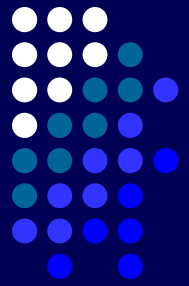
Fair Hearings

- Enrollee will have right to aid to continue if
  - Fair hearing is filed timely
  - Involves termination, reduction, suspension of previously authorized service
  - Service ordered by provider
  - Original authorization has not expired
- If requested, services continue until
  - Enrollee withdraws fair hearing
  - Fair hearing decision
  - Original service authorization expires

42 CFR 438.420

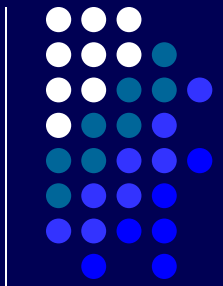
External Appeal affords providers and consumers an independent review

PHL Article 49 Title 2



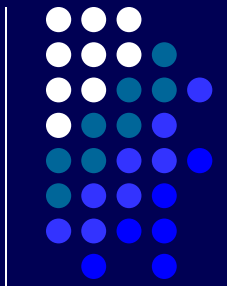
- Jointly administered by SDOH and SID
- Decisions made by independent agents
- Appeals available for denials based on:
  - Medical necessity
  - Experimental treatment for life threatening or disabling condition
  - Out-of-network service materially different from service in network
- 1070 external appeals filed in 2010
  - 413 (39%) fully or partially reversed

DOH Managed Care Hot Line available to assist providers and enrollees



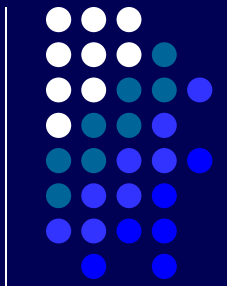
- Call 1-800-206-8125 with complaints relating to:
  - Quality of care
  - Plan operations
  - Any issue of dissatisfaction
  - Questions about Medicaid fair hearing rights
- 916 complaints filed in 2010
  - 25% substantiated
  - Major areas of complaints were:
    - Billing disputes
    - Denial of clinical treatment
    - Access to referrals

Medicaid Managed Care Enrollment Process



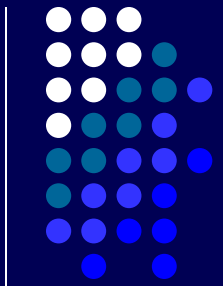
- Provides Education on plan options
  - FE's trained to educate and assist in choice
  - Maximus has toll free # to assist with education and questions
- Consumers have choice of a managed care plan operating in the county
- Consumers have the right to apply for exclusions and exemptions

Medicaid Managed Care Enrollment Process



- New applications
  - Medicaid/FHPlus Application amended to strengthen choosing on application
- Choice must be made during the application process, section I
  - If eligible for exemption/exclusion, must self identify
  - If no choice is made or exemption/exclusion request, auto-assignment will occur using current AA algorithm

Medicaid Managed Care Enrollment Process



- Newly targeted for mandatory enrollment
  - New populations being added through expansions
  - Recipients in new mandatory counties during phase-in

Notice and materials sent to potential enrollee

- Allows for 30 days to choose plan
  - Enrollment education packet will be sent
  - Plan choice can be by mail, phone, or in person
- If plan not chosen, current AA algorithm followed

Plan Enrollment

- **Guarantee**
  - Enrollee receives MCO benefit for six months from enrollment eff. date if eligibility lost
- **Lock-in**
  - First 90 days – switch plans for any reason
  - Next nine months – locked in unless good cause
- **PCP choice**
  - Recipient can choose a PCP from Plan
  - If a PCP is not chosen, one is assigned

Fair Hearings

- If exemption/exclusion denied (A/C if applicable)