§ 4403. Health maintenance organizations; issuance of certificate of authority. 1. The commissioner shall not issue a certificate of authority to an applicant therefor unless the applicant demonstrates that:

(a) it has defined a proposed enrolled population to which the health maintenance organization proposes to provide comprehensive health services and has established a mechanism by which that population may advise in determining the policies of the organization;

(b) it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan;

(c) it is financially responsible and may be expected to meet its obligations to its enrolled members. For the purpose of this paragraph, "financially responsible" means that the applicant shall assume full financial risk on a prospective basis for the provision of comprehensive health services, including hospital care and emergency medical services within the area served by the plan, except that it may require providers to share financial risk under the terms of their contract, it may have financial incentive arrangements with providers or it may obtain insurance or make other arrangements for the cost of providing comprehensive health services to enrollees; any insurance or other arrangement required by this paragraph shall be approved as to adequacy by the superintendent as a prerequisite to the issuance of any certificate of authority by the commissioner;

(d) the character, competence, and standing in the community of the proposed incorporators, directors, sponsors or stockholders, are satisfactory to the commissioner;

(e) the prepayment mechanism of its comprehensive health services plan, the bases upon which providers of health care are compensated, and the anticipated use of allied health personnel are conducive to the use of ambulatory care and the efficient use of hospital services;

(f) acceptable procedures have been established to monitor the quality of care provided by the plan, which, in the case of services provided by non-participating providers, shall be limited to the provision of reports to the primary care practitioner responsible for supervising and coordinating the care of the enrollee;

(g) approved mechanisms exist to resolve complaints and grievances initiated by any enrolled member; and

(h) the contract between the enrollee and the organization meet the requirements of the superintendent as set forth in section forty-four hundred six of this article, as to the provisions contained therein for health services, the procedures for offering, renewing, converting and terminating contracts to enrollees, and the rates for such contracts including but not limited to, compliance with the provisions of section one thousand one hundred nine of the insurance law.

2. The commissioner may adopt and amend rules and regulations pursuant to the state administrative procedure act to effectuate the purposes and provisions of this article. Such regulations may include rules and procedures addressing the provision of emergency services, including patient notification, obtaining authorization for treatment, transfer of patients from one facility to another and emergency transportation arrangements.

3. Nothing contained in this section shall preclude any person or persons in developing a health maintenance organization from contacting potential participants to discuss the health care services such organization would offer, prior to the granting of a certificate of authority.

4. Nothing in this article shall preclude any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or which would authorize enrollees to receive assistance from federal funds.

5. (a) The commissioner, at the time of initial licensure, at least every three years thereafter, and upon application for expansion of service area, shall ensure that the health maintenance organization maintains a network of health care providers adequate to meet the comprehensive health needs of its enrollees and to provide an appropriate choice of providers sufficient to provide the services covered under its enrollee's contracts by determining that (i) there are a sufficient number of geographically accessible participating providers; (ii) there are opportunities to select from at least three

primary care providers pursuant to travel and distance time standards, providing that such standards account for the conditions of accessing providers in rural areas; (iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrollment population; (iv) there is no exclusion of any appropriately licensed type of provider as a class; and (v) contracts entered into with health care providers neither transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of this section, nor penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(b) The following criteria shall be considered by the commissioner at the time of a review: (i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; (iii) the availability of appropriate and timely care that is in compliance with the standards of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance and regulations issued under those Acts, which shall include an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services; (iv) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity; and regulations to be promulgated by the commissioner. The commissioner shall determine standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services and propose regulations, in consultation with the superintendent of financial services, the commissioner of the office of

mental health and the commissioner of the office of addiction services and supports by December thirty-first, two thousand twenty-three.

(c) Each organization shall report on an annual basis the number of enrollees and the number of participating providers in each organization.

6. (a) If a health maintenance organization determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the health maintenance organization shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(b) A health maintenance organization shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the health maintenance organization, or the primary care provider in consultation with the medical director of the organization and specialist if any, determines that such a standing referral is appropriate, the organization shall make such a referral to a specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(c) A health maintenance organization shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to

a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the health maintenance organization, or primary care provider in consultation with a medical director of the organization and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the organization shall refer the enrollee to such specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee. Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If an organization refers an enrollee to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(d) A health maintenance organization shall have a procedure by which an enrollee with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the health maintenance organization, or the primary care provider or the specialist designated pursuant to paragraph (c) of this subdivision, in consultation with a medical director of the organization, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the organization shall refer the enrollee to such center. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialty care center, unless the organization does not have an appropriate

specialty care center to treat the enrollee's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health maintenance organization, in consultation with the primary care provider, if any, or a specialist designated pursuant to paragraph c of this subdivision, and the enrollee or the enrollee's designee. If an organization refers an enrollee to a specialty care center that does not participate in the organization's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network. For purposes of this paragraph, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph a of subdivision two of section forty-four hundred six-d of this chapter, the health maintenance organization shall provide written notice to the enrollee of the provider's disaffiliation and permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of: (i) ninety days from the later of the date of the notice to the enrollee of the provider's disaffiliation from the organization's network or the effective date of the provider's disaffiliation from the organization's network; or (ii) if the enrollee is pregnant at the time of the provider's disaffiliation, the duration of the pregnancy and post-partum care directly related to the delivery.

(2) During the transitional period the health care provider shall: (i) continue to accept reimbursement from the health maintenance organization at the rates applicable prior to the start of the transitional period, and continue to accept the in-network cost-sharing from the enrollee, if any, as payment in full; (ii) adhere to the organization's quality assurance requirements and to provide to the organization necessary medical information related to such care; and

(iii) otherwise adhere to the organization's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization.

* (f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance organization, the organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to sixty days from the effective date of enrollment, if (i) the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition or (ii) the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to otherwise adhere to the organization's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization. In no event shall this paragraph be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

* NB Effective until January 1, 2027

* (f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance organization, the organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's

current health care provider during a transitional period of up to ninety days from the effective date of enrollment. If the enrollee is pregnant at the effective date of enrollment, the transitional period shall include the provision of care for the duration of the pregnancy and postpartum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees: (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to otherwise adhere to the organization's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization. In no event shall this paragraph be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

* NB Effective January 1, 2027

7. A health maintenance organization that requires or provides for designation by an enrollee of a participating primary care provider shall permit the enrollee to designate any participating primary care provider who is available to accept such individual, and in the case of a child, shall permit the enrollee to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the health maintenance organization.

* 8. Notwithstanding any provision of law to the contrary, a health maintenance organization may expand its comprehensive health services plan to include services operated, certified, funded, authorized or approved by the office for people with developmental disabilities, including habilitation services as defined in paragraph (c) of

subdivision one of section forty-four hundred three-g of this article, and may offer such expanded plan to a population of persons with developmental disabilities, as such term is defined in the mental hygiene law, subject to the following:

(a) Such organization must have the ability to provide or coordinate services for persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities. Such criteria shall include, but not be limited to, adequate experience providing or coordinating services for persons with developmental disabilities;

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such organization lacks the experience required in paragraph (a) of this subdivision, the organization shall have an affiliation arrangement with an entity or entities that are non-profit organizations or organizations whose shareholders are solely controlled by non-profit organizations with experience serving persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria including, but not limited to, residential, day, and employment services such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

(a-2) Each enrollee shall receive services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known and the individual's needs. With respect to an individual receiving non-residential services operated, certified, funded, authorized or approved by the office for people with developmental disabilities prior to enrollment in the organization, such guidelines shall require the organization to contract with the current provider of such non-residential services at the rates established by the office for ninety days, in order to ensure continuity of care. With

respect to an individual living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the organization, the organization shall contract with the provider of residential services for that residence at the rates established by the office for people with developmental disabilities for so long as such person lives in that residence pursuant to an approved plan of care;

(b) The provision by such organization of services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to the joint oversight and review of both the department and the office for people with developmental disabilities. The department and such office shall require such organization to provide comprehensive care planning, assess quality, meet quality assurance requirements and ensure the enrollee is involved in care planning.

(c) Such organization shall not provide or arrange for services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until the commissioner and the commissioner of the office for people with developmental disabilities approve program features and rates that include such services, and determine that such organization meets the requirements of this paragraph and any other requirements set forth by the commissioner of the office for people with developmental disabilities;

(d) An otherwise eligible enrollee receiving services through the organization that are operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall not be involuntarily disenrolled from such organization without the prior approval of the commissioner of the office for people with developmental disabilities. Notice shall be provided to the enrollee and the enrollee may request a fair hearing regarding such disenrollment;

(e) The office for people with developmental disabilities shall determine the eligibility of individuals receiving services operated, certified, funded, authorized or approved by such office to enroll in such a plan and shall enroll individuals it determines eligible in an organization chosen by such individual, guardian or other legal representative;

(f) The office for people with developmental disabilities, or its

designee, shall complete a comprehensive assessment for enrollees that receive services operated, certified, funded, authorized or approved by such office. This assessment shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee as such needs relate to such enrollee's health, safety, living environment and wishes, to the extent such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person-centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The initial assessment shall be completed by such office or its designee other than the organization and shall be completed, in consultation with the prospective enrollee's health care practitioner as necessary. Reassessments shall be completed by the office or its designee, which may be the organization. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made.

(f-1) Such organization shall provide the department and the office for people with developmental disabilities with a description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice.

(g) No person with a developmental disability shall be required to enroll in a comprehensive health services plan as a condition of receiving medical assistance and services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until program features and reimbursement rates are approved by the commissioner and the commissioner of the office for people with developmental disabilities and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons with developmental disabilities pursuant to this article operating in the person's county of residence to meet the needs of persons with developmental disabilities, and that such plans meet the standards of this section.

(h) Organizations providing services operated, certified, funded,

authorized or approved by the office for people with developmental disabilities shall be subject to all requirements applicable to DISCOs operating under section forty-four hundred three-g of this article with respect to quality assurance, grievances and appeals, informed choice, participating in development of plans of care and requirements with respect to marketing, to the extent that such requirements are not inconsistent with this section.

(i) The provisions of this subdivision shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided hereunder to recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, as may be necessary to ensure such federal financial participation. To the extent that the provisions of this subdivision are inconsistent with other provisions of this article or with the provisions of section three hundred sixty-four-j of the social services law, the provisions of this subdivision shall prevail.

* NB Repealed December 31, 2027

9. A health maintenance organization shall have procedures for coverage of medically fragile children including those necessary to implement section forty-four hundred six-i of this article.