*** § 364-j. Managed care programs.** 1. Definitions. As used in this section, unless the context clearly requires otherwise, the following terms shall mean:

(a) "Participant". A medical assistance recipient who receives, is required to receive or elects to receive his or her medical assistance services from a managed care provider.

(b) "Managed care provider". An entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management; and:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis, including a special needs managed care plan or comprehensive HIV special needs plan; or

** (ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act; or

** NB Effective until December 31, 2027

** (ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act.

** NB Effective December 31, 2027

** (iii) is authorized to operate under section forty-four hundred three-g of the public health law.

** NB Repealed December 31, 2027

(c) "Managed care program". A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider, including as applicable, a special needs managed care plan or a comprehensive HIV special needs plan, under this section.

(d) "Medical services provider". A physician, nurse, nurse practitioner, physician assistant, licensed midwife, dentist,

optometrist or other licensed health care practitioner authorized to provide medical assistance services.

(e) "Center of excellence." A health care facility certified to operate under article twenty-eight of the public health law that offers specialized treatment expertise in HIV care services as defined by the commissioner of health.

(f) "Primary care practitioner". A physician or nurse practitioner providing primary care to and management of the medical and health care services of a participant served by a managed care provider.

(g) "AIDS". AIDS shall have the same meaning as in article twenty-seven-f of the public health law.

(h) "HIV infection". HIV infection shall have the same meaning as in article twenty-seven-f of the public health law.

(i) "HIV-related illness". HIV-related illness shall have the same meaning as in article twenty-seven-f of the public health law.

(j) "Specialty care center". 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 disease or condition for which it is accredited or designated.

(k) "Special care". Care, services and supplies relating to the treatment of mental illness, developmental disabilities, alcoholism, alcohol abuse or substance abuse, or HIV infection/AIDS.

(l) "Responsible special care agency". Whichever of the following state agencies has responsibility for the special care in question: the department of health, the office of mental health, the office for people with developmental disabilities, or the office of alcoholism and substance abuse services.

(m) "Special needs managed care plan" shall have the same meaning as in section forty-four hundred one of the public health law.

(n) "Comprehensive HIV special needs plan" shall have the same meaning as in section forty-four hundred three-c of the public health law.

(o) "Third-party payor". Any entity or program that is or may be liable to pay the costs of health and medical care of a recipient of medical assistance benefits, including insurers licensed pursuant to article thirty-two or forty-three of the insurance law, or organizations certified pursuant to article forty-four of the public health law.

(p) "Grievance". Any complaint presented by a participant or a participant's representative for resolution through the grievance process of a managed care provider.

(q) "Emergency medical condition". A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

(r) "Emergency care". Health care procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol, that are provided for an emergency medical condition.

(s) "Existing rates". The rates paid pursuant to the most recent executed contract between a local social services district or the state and a managed care provider.

(t) "Managed care rating regions". The regions established by the department of health for the purpose of setting regional premium rates for managed care providers.

(u) "Premium group". The various demographic, gender and recipient categories utilized for rate-setting purposes by the department of health.

(v) "Upper payment limit". The maximum reimbursement that the department of health may pay a managed care provider for providing or arranging for medical services to participants in a managed care program in accordance with the federal social security act and regulations promulgated thereunder.

(x) "Persons with serious mental illness". Individuals who meet criteria established by the commissioner of mental health, which shall include persons who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (i) whose severity and duration of mental illness results in substantial functional disability or (ii) who require mental

health services on more than an incidental basis.

(y) "Children and adolescents with serious emotional disturbances". Individuals under eighteen years of age who meet criteria established by the commissioner of mental health, which shall include children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (i) whose severity and duration of mental illness results in substantial functional disability or (ii) who require mental health services on more than an incidental basis.

(z) "Credentialed alcoholism and substance abuse counselor (CASAC)". An individual credentialed by the office of alcoholism and substance abuse services in accordance with applicable regulations of the commissioner of alcoholism and substance abuse services.

2. (a) The commissioner of health, in cooperation with the commissioner and the commissioners of the responsible special care agencies shall establish managed care programs, under the medical assistance program, in accordance with applicable federal law and regulations. The commissioner of health, in cooperation with the commissioner, is authorized and directed, subject to the approval of the director of the state division of the budget, to apply for federal waivers when such action would be necessary to assist in promoting the objectives of this section.

(b) The commissioner of health has authority to allow social services districts to seek an exemption from this section for up to two years if the social services district can demonstrate and the commissioner of health and the commissioner of responsible special care agencies concurs that the district has insufficient capacity to participate in the program. An exemption under this paragraph may be renewed for additional two year periods.

(c) The commissioner of health, jointly with the commissioner of mental health and the commissioner of alcoholism and substance abuse services shall be authorized to establish special needs managed care plans, under the medical assistance program, in accordance with applicable federal law and regulations. The commissioner of health, in cooperation with such commissioners, is authorized, subject to the approval of the director of the division of the budget, to apply for

federal waivers when such action would be necessary to assist in promoting the objectives of this section. With regard to such special needs managed care plans, in addition to the applicable requirements established in this section, such commissioners shall jointly establish standards and requirements to:

(i) ensure that any special needs managed care plan shall have an adequate network of providers to meet the behavioral health and health needs of enrollees, and shall review the adequacy prior to approval of any special needs managed care plan, and upon contract renewal or expansion. To the extent that the network has been determined to meet standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate;

(ii) ensure that any special needs managed care plan shall make level of care and coverage determinations utilizing evidence-based tools or guidelines designed to address the behavioral health needs of enrollees;

(iii) ensure sufficient access to behavioral health and health services for eligible enrollees by establishing and monitoring penetration rates of special needs managed care plans; and

(iv) establish standards to encourage the use of services, products and care recommended, ordered or prescribed by a provider to sufficiently address the behavioral health and health services needs of enrollees; and monitor the application of such standards to ensure that they sufficiently address the behavioral health and health services needs of enrollees.

(d) Whenever the commissioner of health makes changes to the terms, conditions or time frames contained in the model contract that serves as the basis for contracts with managed care providers in the managed care program under this section, the changes shall be posted on the department's website. The department shall post on its website any changes required to be submitted to the centers for medicare and medicaid services (CMS) for approval prior to submission of the changes. A summary of any changes shall also be published in the state register. A notification of any request for proposals issued by the department for managed care providers to participate in the managed care program shall also be published in the state register.

3. (a) Every person eligible for or receiving medical assistance under this article, who resides in a social services district providing medical assistance, which has implemented the state's managed care program shall participate in the program authorized by this section. Provided, however, that participation in a comprehensive HIV special needs plan also shall be in accordance with article forty-four of the public health law and participation in a special needs managed care plan shall also be in accordance with article forty-four of the public health law and article thirty-one of the mental hygiene law.

(d) Until such time as program features and reimbursement rates are approved by the commissioner of health, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of children and family services, and the office of alcoholism and substance abuse services, as appropriate, the following services shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies; provided, however, that no medical assistance recipient shall be required to obtain services that are certified, funded, authorized or approved by the commissioner of the office for people with developmental disabilities through a managed care program until the program features approved by the commissioner of health, in consultation with the commissioner of the office for people with developmental disabilities, include features for habilitation services as defined in paragraph c of subdivision one of section forty-four hundred three-g of the public health law:

(i) day treatment services provided to individuals with developmental disabilities;

(ii) comprehensive medicaid case management services provided to individuals with developmental disabilities;

(iii) services provided pursuant to article eighty-nine of the education law;

(iv) mental health services provided by a certified voluntary free-standing day treatment program where such services are provided in conjunction with educational services authorized in an individualized education program in accordance with regulations promulgated pursuant to

article eighty-nine of the education law;

(v) long term services as determined by the commissioner of the office for people with developmental disabilities, provided to individuals with developmental disabilities at facilities licensed pursuant to article sixteen of the mental hygiene law or clinics serving individuals with developmental disabilities at facilities licensed pursuant to article twenty-eight of the public health law;

(vi) TB directly observed therapy;

(vii) AIDS adult day health care;

(viii) HIV COBRA case management; and

(ix) other services as determined by the commissioner of health.

(d-1) Services provided pursuant to title two-A of article twenty-five of the public health law shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies.

(d-2) Services provided pursuant to a waiver, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons suffering from traumatic brain injuries, shall not be provided to medical assistance recipients through managed care programs established pursuant to this section. Services provided pursuant to a waiver, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons qualifying for nursing home diversion and transition services, shall not be provided to medical assistance recipients through managed care programs until at least January first, two thousand twenty-eight.

(d-3) Services provided in school-based health centers shall not be provided to medical assistance recipients through managed care programs established pursuant to this section.

(d-4) Notwithstanding paragraph (a) of this subdivision, the following medical assistance recipients shall not be eligible to participate in the managed care program authorized by this section or other care coordination model established by article forty-four of the public health law: any person who is permanently placed in a residential health care facility for a consecutive period of three months or more. However, nothing in this paragraph should be construed to apply to enrollees in the Medicaid Advantage Plus Program, developed to enroll persons in

managed long-term care who are nursing home certifiable and who are dually eligible pursuant to section forty-four hundred three-f of the public health law. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees.

(e) The following categories of individuals may be required to enroll with a managed care program when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioners of the office of mental health, the office for people with developmental disabilities, the office of children and family services, and the office of alcoholism and substance abuse services:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program; provided, however, nothing herein shall: (a) require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; or (b) make enrollment in a Medicare managed care plan a condition of the individual's participation in the managed care program pursuant to this section, or affect the individual's entitlement to payment of applicable Medicare managed care or fee for service coinsurance and deductibles by the individual's managed care provider.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals;

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law;

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for the developmentally disabled;

(vi) a person receiving services provided by an intermediate care facility for the developmentally disabled or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through a demonstration waiver under section eleven hundred fifteen of the federal social security act, existing waivers under section nineteen hundred fifteen (c) of the federal social security act, or who has characteristics and needs similar to such persons;

(viii) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

(ix) a person receiving services provided by a long term home health care program, or a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

(x) certified blind or disabled children living or expected to be living separate and apart from the parent for thirty days or more;

(xi) residents of nursing facilities;

(xii) a foster child in the placement of a voluntary agency or in the direct care of the local social services district;

(xiii) a person or family that is homeless;

(xiv) individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services to the person. A managed care provider is not geographically accessible if the person cannot access the provider's services in a timely fashion due to distance or travel time;

(xv) a person eligible for Medicare participating in a capitated demonstration program for long term care;

(xvi) an infant living with an incarcerated mother in a state or local correctional facility as defined in section two of the correction law;

(xvii) a person who is expected to be eligible for medical assistance for less than six months;

(xviii) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;

(xix) individuals receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;

(xx) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the local social services district;

(xxi) a person receiving family planning services pursuant to

subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of this title;

(xxii) a person who is eligible for medical assistance pursuant to paragraph (d) of subdivision four of section three hundred sixty-six of this title;

(xxiii) individuals with a chronic medical condition who are being treated by a specialist physician that is not associated with a managed care provider in the individual's social services district; and

(xxiv) Native Americans.

4. The managed care program shall provide participants access to comprehensive and coordinated health care delivered in a cost effective manner consistent with the following provisions:

(a) (i) a managed care provider shall arrange for access to and enrollment of primary care practitioners and other medical services providers. Each managed care provider shall possess the expertise and sufficient resources to assure the delivery of quality medical care to participants in an appropriate and timely manner and may include physicians, nurse practitioners, county health departments, providers of comprehensive health service plans licensed pursuant to article forty-four of the public health law, and hospitals and diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law or otherwise authorized by law to offer comprehensive health services or facilities licensed pursuant to articles sixteen, thirty-one and thirty-two of the mental hygiene law.

(ii) provided, however, if a major public hospital, as defined in the public health law, is designated by the commissioner of health as a managed care provider in a social services district the commissioner of health shall designate at least one other managed care provider which is not a major public hospital or facility operated by a major public hospital; and

(iii) under a managed care program, not all managed care providers must be required to provide the same set of medical assistance services. The managed care program shall establish procedures through which participants will be assured access to all medical assistance services to which they are otherwise entitled, other than through the managed care provider, where:

(A) the service is not reasonably available directly or indirectly from the managed care provider,

(B) it is necessary because of emergency or geographic unavailability, or

(C) the services provided are family planning services; or

(D) the services are dental services and are provided by a diagnostic and treatment center licensed under article twenty-eight of the public health law which is affiliated with an academic dental center and which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide such dental services. Any diagnostic and treatment center providing dental services pursuant to this clause shall prior to June first of each year report to the governor, temporary president of the senate and speaker of the assembly on the following: the total number of visits made by medical assistance recipients during the immediately preceding calendar year; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs that provide dental benefits as a covered service; and the number of visits made by the uninsured during the immediately preceding calendar year; or

(E) the services are optometric services, as defined in article one hundred forty-three of the education law, and are provided by a diagnostic and treatment center licensed under article twenty-eight of the public health law which is affiliated with the college of optometry of the state university of New York and which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide such optometric services. Any diagnostic and treatment center providing optometric services pursuant to this clause shall prior to June first of each year report to the governor, temporary president of the senate and speaker of the assembly on the following: the total number of visits made by medical assistance recipients during the immediately preceding calendar year; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs; the number of visits made by medical assistance recipients during the

immediately preceding calendar year by recipients who were enrolled in managed care programs that provide optometric benefits as a covered service; and the number of visits made by the uninsured during the immediately preceding calendar year; or

(E-1) the services are vision care services rendered to a student at a school based health center approved by the commissioner pursuant to this clause. The commissioner may approve up to five pilot programs at school based health centers in partnership with a charitable foundation that agrees to provide free of charge eyeglass frames and lenses at the centers pursuant to a memorandum of agreement approved by the commissioner. The commissioner may approve the rate for such vision care services at the rate for such services when provided by a federally qualified health center or when provided by another entity licensed pursuant to article twenty-eight of the public health law and eligible for the ambulatory patient group rate approved for vision care services by the commissioner; or

(F) other services as defined by the commissioner of health.

(b) Participants shall select a managed care provider from among those designated under the managed care program, provided, however, a participant shall be provided with a choice of no less than two managed care providers. Notwithstanding the foregoing, a local social services district designated a rural area as defined in 42 U.S.C. 1395ww may limit a participant to one managed care provider, if the commissioner and the local social services district find that only one managed care provider is available. A managed care provider in a rural area shall offer a participant a choice of at least three primary care practitioners and permit the individual to obtain a service or seek a provider outside of the managed care network where such service or provider is not available from within the managed care provider network.

(c) Participants shall select a primary care practitioner from among those designated by the managed care provider. In all districts, participants shall be provided with a choice of no less than three primary care practitioners. In the event that a participant does not select a primary care practitioner, the participant's managed care provider shall select a primary care practitioner for the participant, taking into account geographic accessibility.

(d) For all other medical services, except as provided in paragraph

(c) of this subdivision, if a sufficient number of medical service providers are available, a choice shall be offered.

(e) (i) In any social services district which has not implemented a mandatory managed care program pursuant to this section, the commissioner of health shall establish marketing and enrollment guidelines, including but not limited to regulations governing face-to-face marketing and enrollment encounters between managed care providers and recipients of medical assistance and locations for such encounters. Such regulations shall prohibit, at a minimum, telephone cold-calling and door-to-door solicitation at the homes of medical assistance recipients. The regulations shall also require the commissioner of health to approve any local district marketing guidelines. Managed care providers shall be permitted to assist participants in completion of enrollment forms at approved health care provider sites and other approved locations. In no case may an emergency room be deemed an approved location. Upon enrollment, participants will sign an attestation that: they have been informed that managed care is a voluntary program; participants have a choice of managed care providers; participants have a choice of primary care practitioners; and participants must exclusively use their primary care practitioner and plan providers except as otherwise provided in this section including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdivision. Managed care providers must submit enrollment forms to the local department of social services. The local department of social services will provide or arrange for an audit of managed care provider enrollment forms; including telephone contacts to determine if participants were provided with the information required by this subparagraph. The commissioner of health may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

(ii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the requirements of this subparagraph shall apply to the extent consistent with federal law and regulations. The department of health, may contract with one or more independent organizations to provide enrollment counseling and enrollment services, for participants required to enroll in managed care programs, for each social services district requesting the services of

an enrollment broker. To select such organizations, the department of health shall issue a request for proposals (RFP), shall evaluate proposals submitted in response to such RFP and, pursuant to such RFP, shall award a contract to one or more qualified and responsive organizations. Such organizations shall not be owned, operated, or controlled by any governmental agency, managed care provider, or medical services provider.

(iii) Such independent organizations shall develop enrollment guides for participants which shall be approved by the department of health prior to distribution.

(iv) Local social services districts or enrollment organizations through their enrollment counselors shall provide participants with the opportunity for face to face counseling including individual counseling upon request of the participant. Local social services districts or enrollment organizations through their enrollment counselors shall also provide participants with information in a culturally and linguistically appropriate and understandable manner, in light of the participant's needs, circumstances and language proficiency, sufficient to enable the participant to make an informed selection of a managed care provider. Such information shall include, but shall not be limited to: how to access care within the program; a description of the medical assistance services that can be obtained other than through a managed care provider; the available managed care providers and the scope of services covered by each; a listing of the medical services providers associated with each managed care provider; the participants' rights within the managed care program; and how to exercise such rights. Enrollment counselors shall inquire into each participant's existing relationships with medical services providers and explain whether and how such relationships may be maintained within the managed care program. For enrollments made during face to face counseling, if the participant has a preference for particular medical services providers, enrollment counselors shall verify with the medical services providers that such medical services providers whom the participant prefers participate in the managed care provider's network and are available to serve the participant.

(v) Upon delivery of the pre-enrollment information, the local district or the enrollment organization shall certify the participant's

receipt of such information. Upon verification that the participant has received the pre-enrollment education information, a managed care provider, a local district or the enrollment organization may enroll a participant into a managed care provider. Managed care providers must submit enrollment forms to the local department of social services. Upon enrollment, participants will sign an attestation that they have been informed that: participants have a choice of managed care providers; participants have a choice of primary care practitioners; and, except as otherwise provided in this section, including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdivision, participants must exclusively use their primary care practitioners and plan providers. The commissioner of health may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

(vi) Enrollment counselors or local social services districts shall further inquire into each participant's health status in order to identify physical or behavioral conditions that require immediate attention or continuity of care, and provide to participants information regarding health care options available to persons with HIV and other illnesses or conditions under the managed care program. Any information disclosed to counselors shall be kept confidential in accordance with applicable provisions of the public health law, and as appropriate, the mental hygiene law.

(vii) Any marketing materials developed by a managed care provider shall be approved by the department of health or the local social services district, and the commissioner of mental health and the commissioner of alcoholism and substance abuse services, where appropriate, within sixty days prior to distribution to recipients of medical assistance. All marketing materials shall be reviewed within sixty days of submission.

(viii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the commissioner of health shall establish marketing and enrollment guidelines, including but not limited to regulations governing face-to-face marketing and enrollment encounters between managed care providers and recipients of medical assistance and locations for such encounters. Such regulations shall prohibit, at a minimum, telephone

cold-calling and door-to-door solicitation at the homes of medical assistance recipients. The regulations shall also require the commissioner of health to approve any local district marketing guidelines.

(f) (i) Participants shall choose a managed care provider at the time of application for medical assistance; if the participant does not choose such a provider the commissioner shall assign such participant to a managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of this paragraph. Participants already in receipt of medical assistance shall have no less than thirty days from the date selected by the district to enroll in the managed care program to select a managed care provider and shall be provided with information to make an informed choice. Where a participant has not selected such a provider the commissioner of health shall assign such participant to a managed care provider which, if appropriate, may be a special needs managed care plan, taking into account capacity and geographic accessibility. The commissioner may after the period of time established in subparagraph (ii) of this paragraph assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants.

(ii) The commissioner may assign participants pursuant to such criteria on a weighted basis, provided however that for twelve months following implementation of a mandatory program, pursuant to a federal waiver, twenty-five percent of the participants that do not choose a managed care provider shall be assigned to managed care providers that satisfy the criteria set forth in subparagraph (i) of this paragraph, and are controlled by, sponsored by, or otherwise affiliated through a common governance or through a parent corporation with, one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(iii) For twelve months following the twelve months described in subparagraph (ii) of this paragraph twenty-two and one-half percent of the participants that do not choose a managed care provider shall be assigned to managed care providers, that satisfy the criteria set forth in subparagraph (i) of this paragraph and are controlled by, sponsored

by, or otherwise affiliated through a common governance or through a parent corporation with, one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(iv) For twelve months following the twelve months described in subparagraph (iii) of this paragraph twenty percent of the participants that do not choose a managed care provider shall be assigned equally among each of the managed care providers, that satisfy the criteria set forth in subparagraph (i) of this paragraph and are controlled by, sponsored by, or otherwise affiliated through a common governance or through a parent corporation with one or more private not-for-profit or public general hospitals or diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law.

(v) The commissioner shall assign all participants not otherwise assigned to a managed care plan pursuant to subparagraphs (ii), (iii) and (iv) of this paragraph equally among each of the managed care providers that meet the criteria established in subparagraph (i) of this paragraph; provided, however, that the commissioner shall assign individuals meeting the criteria for enrollment in a special needs managed care plan to such plan or plans where available.

(g) If another managed care provider is available, participants may change such provider or plan without cause within thirty days of notification of enrollment or the effective date of enrollment, whichever is later with a managed care provider by making a request of the local social services district except that such period shall be forty-five days for participants who have been assigned to a provider by the commissioner of health. However, after such thirty or forty-five day period, whichever is applicable, a participant may be prohibited from changing managed care providers more frequently than once every twelve months, as permitted by federal law except for good cause as determined by the commissioner of health through regulations.

(h) If another medical services provider is available, a participant may change his or her provider of medical services (including primary care practitioners) without cause within thirty days of the participant's first appointment with a medical services provider by making a request of the managed care provider. However, after that thirty day period, no participant shall be permitted to change his or

her provider of medical services other than once every six months except for good cause as determined by the commissioner through regulations.

(i) A managed care provider requesting a disenrollment shall not disenroll a participant without the prior approval of the local social services district in which the participant resides, provided that disenrollment from a special needs managed care plan must comply with the standards of the commissioner of health, the commissioner of alcoholism and substance abuse services, and the commissioner of mental health. A managed care provider shall not request disenrollment of a participant based on any diagnosis, condition, or perceived diagnosis or condition, or a participant's efforts to exercise his or her rights under a grievance process, provided however, that a managed care provider may, where medically appropriate, request permission to refer participants to a managed care provider that is a special needs managed care plan or a comprehensive HIV special needs plan after consulting with such participant and upon obtaining his/her consent to such referral, and provided further that a special needs managed care plan may, where clinically appropriate, disenroll individuals who no longer require the level of services provided by a special needs managed care plan.

(j) A managed care provider shall be responsible for providing or arranging for medical assistance services and assisting participants in the prudent selection of such services, including but not limited to:

(1) management of the medical and health care needs of participants by the participant's designated primary care practitioners or group of primary care practitioners to assure that all services provided under the managed care program and which are found to be necessary are made available in a timely manner, in accordance with prevailing standards of professional medical practice and conduct; and

(2) use of appropriate patient assessment criteria to ensure that all participants are provided with appropriate services, including special care;

(3) implementation of procedures, consistent with the requirements of paragraph (c) of subdivision six of section forty-four hundred three of the public health law for managing the care of participants requiring special care which may include the use of special case managers or the designation of a specialist as a primary care practitioner by a

participant requiring special care on more than an incidental basis;

(4) implementation of procedures, consistent with the requirements of paragraph (b) of subdivision six of section forty-four hundred three of the public health law to permit the use of standing referrals to specialists and subspecialists for participants who require the care of such practitioners on a regular basis; and

(5) referral, coordination, monitoring and follow-up with regard to other medical services providers as appropriate for diagnosis and treatment, or direct provision of some or all medical assistance services.

(k) A managed care provider shall establish appropriate utilization and referral requirements for physicians, hospitals, and other medical services providers including emergency room visits and inpatient admissions.

(l) A managed care provider shall be responsible for developing appropriate methods of managing the health care and medical needs of homeless and other vulnerable participants to assure that all necessary services provided under the managed care program are made available and that all appropriate referrals and follow-up treatment are provided, in a timely manner, in accordance with prevailing standards of professional medical practice and conduct.

(m) A managed care provider shall provide all early periodic screening diagnosis and treatment services, as well as interperiodic screening and referral, to each participant under the age of twenty-one, at regular intervals, as medically appropriate.

(n) A managed care provider shall provide or arrange, directly or indirectly (including by referral) for the provision of comprehensive prenatal care services to all pregnant participants in accordance with standards adopted by the department of health.

(o) A managed care provider shall provide or arrange, directly or indirectly, (including by referral) for the full range of covered services to all participants, notwithstanding that such participants may be eligible to be enrolled in a comprehensive HIV special needs plan or special needs managed care plan.

(p) A managed care provider shall implement procedures to communicate appropriately with participants who have difficulty communicating in English and to communicate appropriately with visually-impaired and

hearing-impaired participants.

(q) A managed care provider shall comply with applicable state and federal law provisions prohibiting discrimination on the basis of disability.

(r) A managed care provider shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act, provided that services for a substance use disorder shall be provided by a program licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services.

(s) Managed care providers shall be provided with the date of recertification for medical assistance of each of their enrolled participants in conjunction with the monthly enrollment information conveyed to managed care providers.

(t) Prospective enrollees shall be advised, in written materials related to enrollment, to verify with the medical services providers they prefer, or have an existing relationship with, that such medical services providers participate in the selected managed care provider's network and are available to serve the participant.

(u) A managed care provider that provides coverage for prescription drugs shall permit each participant to fill any mail order covered prescription, at his or her option, at any mail order pharmacy or non-mail-order retail pharmacy in the managed care provider network. If the managed care provider has designated one or more pharmacies for filling prescriptions for a particular drug or drugs, then such prescriptions may be filled, at the participant's option, at any other pharmacy in the network, if the network pharmacy chosen by the participant offers to accept a price that is comparable to that of the pharmacy designated by the managed care provider. For the purposes of this section, "mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions, and to dispense medication to patients through the use of the United States mail or other common or contract carrier services, and provides any consultation with patients electronically rather than face to face. Every non-mail-order retail pharmacy in the managed care provider's network with respect to any prescription drug

shall be deemed to be in the managed care provider's network for every covered prescription drug.

(v) A managed care provider must allow enrollees to access chemical dependence treatment services from facilities certified by the office of alcoholism and substance abuse services, even if such services are rendered by a practitioner who would not otherwise be separately reimbursed, including but not limited to a credentialed alcoholism and substance abuse counselor (CASAC).

** (w) A managed care provider shall provide or arrange, directly or indirectly, including by referral, for access to and coverage of services provided by any national cancer institute-designated cancer center licensed by the department of health within the managed care provider's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to participants in all managed care providers offering coverage to medical assistance recipients in such cancer center's service area under the prevailing terms and conditions that the managed care provider requires of other similar providers to be included in the managed care provider's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services.

** NB There are 2 par (w)'s

** NB Repealed January 1, 2028

** (w)(i) The department of health or a managed care organization contracted to provide services pursuant to this section shall establish a program for synchronization of medications. Under the synchronization program, a health care practitioner may prescribe a refill of one or more of the patient's medications for a shorter period than would ordinarily be provided, for the purpose of synchronizing refill dates of one or more of the patient's medications subject to the synchronization, when it is agreed among the recipient, the health care practitioner and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the patient for the management or treatment of a chronic illness provided that the following apply to such medications:

(A) are covered by Medicaid services or a managed care organization

contracted to provide services pursuant to this chapter;

(B) are used for treatment and management of a chronic illness that are subject to refills;

(C) are not a schedule II controlled substance, nor a schedule III controlled substance that contains hydrocodone or other opioid medication as scheduled in section thirty-three hundred six of the public health law, or a controlled substance under the federal Controlled Substances Act;

(D) meet all prior authorization criteria specific to the medications at the time of the synchronization request;

(E) are of a formulation that can be effectively and lawfully aligned over required short fill periods to achieve synchronization; and

(F) do not have quantity limits or dose optimization criteria or state or federal requirements that would be violated in fulfilling synchronization.

(ii) The department of health or a managed care organization contracted to provide services under this section shall not deny coverage for the dispensing of a medication by a pharmacy for a partial supply when it is for the purpose of synchronizing the patient's medications. When applicable to permit synchronization, the department of health or a managed care organization contracted to provide services under this title shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(iii) The dispensing fee paid to the pharmacy contracted to provide services pursuant to this section for a partial supply associated with medication synchronization shall be paid in accordance with the Medicaid state plan as approved by the Centers for Medicare and Medicaid Services.

(iv) The requirement of this paragraph applies only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(A) the prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(B) the prescriber prescribes a different drug.

(v) Nothing in this paragraph shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple

prescriptions for a covered individual.

(vi) The provisions of this paragraph are subject to compliance with all applicable federal and state laws and regulations, including the Centers for Medicare and Medicaid Services approved Medicaid state plan. The commissioner shall apply for waivers and submit state Medicaid plan amendments as are necessary to implement the program for synchronization of medications.

** NB There are 2 par (w)'s

5. Managed care programs shall be conducted in accordance with the requirements of this section and, to the extent practicable, encourage the provision of comprehensive medical services, pursuant to this article.

(a) The managed care program shall provide for the selection of qualified managed care providers by the commissioner of health to participate in the program, including comprehensive HIV special needs plans and special needs managed care plans in accordance with the provisions of section three hundred sixty-five-m of this title; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans consistent with standards set forth in this section, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks.

(b) A proposal submitted by a managed care provider to participate in the managed care program shall:

(i) designate the geographic area to be served by the provider, and estimate the number of eligible participants and actual participants in such designated area;

(ii) include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

(iii) describe the procedures for marketing in the program location, including the designation of other entities which may perform such functions under contract with the organization;

(iv) describe the quality assurance, utilization review and case

management mechanisms to be implemented;

(v) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

(vi) demonstrate financial feasibility of the program; and

(vii) include such other information as the commissioner of health may deem appropriate.

(c) The commissioner of health shall make a determination whether to approve, disapprove or recommend modification of the proposal.

(d) Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health, to qualified managed care providers pursuant to this section.

(f) The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health, and meet applicable federal law and regulations.

(g) The commissioner of health may delegate some or all of the tasks identified in this section to the local districts.

(h) Any delegation pursuant to paragraph (g) of this subdivision shall be reflected in the contract between a managed care provider and the commissioner of health.

6. A managed care provider shall not engage in the following practices:

(a) use deceptive or coercive marketing methods to encourage participants to enroll; or

(b) distribute marketing materials to recipients of medical assistance, unless such materials are approved by the department of health and, as appropriate, the office of mental health.

7. The department, the department of health or other agency of the state as appropriate shall provide technical assistance at the request of a social services district for the purpose of development and implementation of managed care programs pursuant to this section. Such assistance shall include but need not be limited to provision and analysis of data, design of managed care programs and plans, innovative payment mechanisms, and ongoing consultation. In addition, the department and the department of health shall make available materials to social services districts for purposes of educating persons eligible to receive medical assistance on how their care will be provided through managed care as required under paragraph (e) of subdivision five of this section.

8. (a) The commissioner of health shall institute a comprehensive quality assurance system for managed care providers that includes performance and outcome-based quality standards for managed care.

(b) Every managed care provider shall implement internal quality assurance systems adequate to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization, and cost of services, provided, however, that the commissioner shall waive the implementation of internal quality assurance systems, where appropriate, for managed care providers described in subparagraph (ii) of paragraph (b) of subdivision one of this section. Such internal quality assurance systems shall conform to the internal quality assurance requirements imposed on health maintenance organizations pursuant to the public health law and regulations and shall provide for:

(i) the designation of an organizational unit or units to perform continuous monitoring of health care delivery;

(ii) the utilization of epidemiological data, chart reviews, patterns of care, patient surveys, and spot checks;

(iii) reports to medical services providers assessing timeliness and quality of care;

(iv) the identification, evaluation and remediation of problems relating to access, continuity and quality of care; and

(v) a process for credentialing and recredentialing licensed providers.

(c) The department of health, in consultation with the responsible special care agencies, shall contract with one or more independent quality assurance organizations to monitor and evaluate the quality of care and services furnished by managed care providers. To select such organization or organizations, the department of health shall issue requests for proposals (RFP), shall evaluate proposals submitted in response to such RFP, and pursuant to such RFP, shall award one or more contracts to one or more qualified and responsive organizations. Such quality assurance organizations shall evaluate and review the quality of care delivered by each managed care provider, on at least an annual basis. Such review and evaluation shall include compliance with the performance and outcome-based quality standards promulgated by the commissioner of health.

(d) Every managed care provider shall collect and submit to the department of health, in a standardized format prescribed by the department of health, patient specific medical information, including encounter data, maintained by such provider for the purposes of quality assurance and oversight. Any information or encounter data collected pursuant to this paragraph, however, shall be kept confidential in accordance with section forty-four hundred eight-a of the public health law and section 33.13 of the mental hygiene law and any other applicable state or federal law.

(e) Information collected and submitted to the department of health by the independent quality assurance organization or managed care provider pursuant to this subdivision shall be made available to the public, subject to any other limitations of federal or state law regarding disclosure thereof to third parties.

(f) Every managed care provider shall ensure that the provider maintains a network of health care providers adequate to meet the comprehensive health needs of its participants and to provide an appropriate choice of providers sufficient to provide the services to its participants 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; and

(iii) there are sufficient providers in each area of specialty

practice to meet the needs of the enrolled population.

(g) The commissioner of health shall establish standards to ensure that managed care providers have sufficient capacity to meet the needs of their enrollees, which shall include patient to provider ratios, travel and distance standards and appropriate waiting times for appointments.

9. Managed care providers shall inform participants of such provider's grievance procedure and utilization review procedures under section forty-four hundred eight-a and article forty-nine of the public health law. A managed care provider or local social services district, as appropriate, shall provide notice to participants of their respective rights to a fair hearing and aid continuing in accordance with applicable state and federal law. Managed care providers shall provide notice of the name, address, phone number and website of the department of health designated independent consumer assistance program and the independent substance use disorder and mental health ombudsman established by section 33.27 of the mental hygiene law within notices of adverse grievances and appeals determinations.

10. The commissioner of health shall be authorized to establish requirements regarding provision and reimbursement of emergency care.

10-a. For managed care providers with negotiated rates of payment for inpatient hospital services under contracts in effect on April first, two thousand eight, that have a payment rate methodology for such inpatient hospital services that utilizes rates calculated by the department of health pursuant to paragraph (a) or (a-2) of subdivision one of section twenty-eight hundred seven-c for patients under the medical assistance program, such rate shall not include adjustments pursuant to subdivision thirty-three of section twenty-eight hundred seven-c of the public health law for contract periods prior to January first, two thousand ten.

12. The commissioner, by regulation, shall provide that a participant may withdraw from participation in a managed care program upon a showing of good cause.

13. (a) Notwithstanding any inconsistent provisions of this section, participation in a managed care program will not diminish a recipient's medical assistance eligibility or the scope of available medical services to which he or she is entitled. Once a program is implemented by or in the district in accordance with this section, medical assistance for persons who require such assistance, who are eligible for or in receipt of such assistance in the district and who are covered by the program shall be limited to payment of the cost of care, services and supplies covered by the managed care program, only when furnished, prescribed, ordered or approved by a managed care provider, mental health special needs plan or comprehensive HIV special needs plan and otherwise under the program, together with the costs of medically necessary medical and remedial care, services or supplies which are not available to participants under the program, but which would otherwise be available to such persons under this title and the regulations of the department provided, however, that the program may contain provision for payment to be made for non-emergent care furnished in hospital emergency rooms consistent with subdivision ten of this section.

(b) Notwithstanding any inconsistent provision of law, payment for claims for services as specified in paragraph (a) of this subdivision furnished to eligible persons under this title, who are enrolled in a managed care program pursuant to this section and section three hundred sixty-four-f of this title or other comprehensive health services plans, shall not be made when such services are the contractual responsibility of a managed care provider but are provided by another medical services provider contrary to the managed care plan.

14. The commissioner of health is authorized and directed, subject to the approval of the director of the division of budget, to make grants to social services districts to aid in the planning and development of managed care programs. The total amount expended pursuant to this section shall not exceed the amount appropriated for such purposes in any fiscal year.

15. The managed medical care demonstration program advisory council is abolished.

16. Any waiver application to the federal department of health and human services pursuant to this article and any amendments to such application shall be a public document.

17. (a) The provisions of this section regarding participation of persons receiving family assistance and supplemental security income in managed care programs shall be effective if, and as long as, federal financial participation is available for expenditures for services provided pursuant to this section.

(b) The provisions of this section regarding the furnishing of health and behavioral health services through a special needs managed care plan shall be effective if, and as long as, federal financial participation is available for expenditures for services provided by such plans pursuant to this section.

18. (a) The department of health may, where not inconsistent with the rate setting authority of other state agencies and subject to approval of the director of the division of the budget, develop reimbursement methodologies and fee schedules for determining the amount of payment to be made to managed care providers under the managed care program. Such reimbursement methodologies and fee schedules may include provisions for payment of managed care fees and capitation arrangements.

(b) The department of health in consultation with organizations representing managed care providers shall select an independent actuary to review any such reimbursement rates. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of rates including but not limited to the adequacy of the rates in relation to the population to be served adjusted for case mix, the scope of services the plans must provide, the utilization of services and the network of providers necessary to meet state standards. The independent actuary shall issue a report no later than December thirty-first, nineteen hundred ninety-eight and annually thereafter. Such report shall be provided to the governor, the temporary president and the minority leader of the senate and the speaker and the minority leader of the assembly. The department of health shall assess managed care providers under the

managed care program on a per enrollee basis to cover the cost of such report.

* (c) In setting such reimbursement methodologies, the department shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care.

* NB There are 2 par (c)'s

* (c) The department of health shall require the independent actuary selected pursuant to paragraph (b) of this subdivision to provide a complete actuarial memorandum, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates, to managed care providers thirty days prior to submission of such rates to the centers for medicare and medicaid services for approval. Managed care providers may request additional review of the actuarial soundness of the rate setting process and/or methodology.

* NB There are 2 par (c)'s

(d) The department of health shall annually provide to the temporary president of the senate and the speaker of the assembly the annual Medicaid managed care operating reports submitted to the department from managed care plans that contract with the state to manage services provided under the Medicaid program.

(e) Increased rates, terms or scope of payment for behavioral health services under this title, where payment is made by a managed care provider under this section, as a result of a rate, coverage or other change made pursuant to a law, regulation, rule or official guidance, shall be deemed in effect on the same date that such change would have taken effect if payment were made other than by the managed care provider. Where payment is not made as of the effective date, the managed care provider shall make retroactive payments to the appropriate service providers.

19. (a) The commissioner of health, in consultation with the commissioner, shall promulgate such regulations as are necessary to implement the provisions of this section provided, however, that the provisions of this subdivision shall not limit specific actions taken by the department of health or the department in order to ensure federal financial participation.

20. Upon a determination that a participant appears to be suitable for admission to a comprehensive HIV special needs plan or a special needs managed care plan, a managed care provider shall inform the participant of the availability of such plans, where available and appropriate.

21. (a) An amount equal to seven million dollars together with any matching federal and local government funds shall be made available for rate adjustments for managed care providers whose rates were set under the competitive bidding process. Such adjustment shall be made in accordance with this paragraph.

(i) Such amount shall be allocated by the department of health among the managed care rating regions based on each region's percentage of statewide Medicaid managed care enrollment as of January first, nineteen hundred ninety-seven excluding from such calculation enrollment in local social services districts that did not participate in the competitive bidding process.

(ii) From among the funds allocated in a managed care rating region, the department of health shall adjust the existing rates paid to managed care providers for each premium group for the period from January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight in a manner that raises the rates of all managed care providers in the region to the highest uniform percentage of the upper payment limit possible based on the funds available; provided, however, that no managed care provider's rate for any premium group shall be reduced as a result of such adjustment. For the purpose of calculating appropriate rate increases under this subparagraph, the department of health shall assume that, for the entire period between January first, nineteen hundred ninety-seven and March thirty-first, nineteen hundred ninety-eight, enrollment in each premium group shall be equal to enrollment in the premium group as of July first, nineteen hundred ninety-seven.

(b) In addition to the increases made available in paragraph (a) of this subdivision for the period beginning January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, an additional ten million dollars, together with any matching federal and local government funds, shall be added to provide a

uniform percentage increase, based on July first, nineteen hundred ninety-seven enrollment to the existing rates paid for all premium groups to all managed care providers whose rates were set by the competitive bidding process.

(c) In addition to the increases made available in paragraphs (a) and (b) of this subdivision for the period beginning January first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, an additional amount equal to three million dollars together with any matching federal and local government funds, shall be made available to be added to the rates of health plans operating in geographic areas where capacity is insufficient to allow attainment of enrollment goals consistent with the federal 1115 waiver known as the Partnership Plan. Such amount shall be distributed subject to a demonstration to the commissioner's satisfaction that the plan has executed a contract amendment providing for an increase in enrollment proportional to the size of the plan and the remaining unenrolled population in the county. In evaluating the plan's demonstration, the commissioner shall consider the degree to which the plan has increased the number of primary or specialty care practitioners or diagnostic and treatment centers in its network or whether the additional rate increase would permit the plan to generate greater enrollments while continuing to meet the financial requirements of the public health law or the insurance law whichever is applicable and regulations promulgated pursuant thereto.

Any amount identified in this paragraph remaining uncommitted by December thirty-first, nineteen hundred ninety-seven shall be distributed in a manner consistent with paragraph (b) of this subdivision.

(d) A plan shall be eligible for payments pursuant to paragraphs (a), (b) and (c) of this subdivision for such periods as the plan has a contract with one or more social services districts; provided, however that the plan has a contract, or has made a good faith effort to enter into a contract, in that district effective through March thirty-first, nineteen hundred ninety-eight.

(e) For the period from April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, the premium

rates paid by the department of health to all managed care providers whose rates were set under the competitive bidding process shall be equal to (i) the managed care provider's rate as of March thirty-first, nineteen hundred ninety-eight increased by a uniform trend factor; plus, (ii) four million dollars together with any matching federal and local government funds to be added as a uniform percentage increase to such provider's rate as of March thirty-first, nineteen hundred ninety-eight, based on enrollment in the premium group as of April first, nineteen hundred ninety-eight.

(f) For the period from April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, an additional amount equal to four million dollars together with any matching federal and local government funds, shall be made available for managed care rate adjustments consistent with the criteria set forth in paragraph (c) of this subdivision. Any amount identified in this paragraph remaining uncommitted by December thirty-first, nineteen hundred ninety-eight shall be added as a uniform percentage increase to the rates of all managed care providers eligible for an increase under paragraph (e) of this subdivision.

22. Chemung county demonstration project. (a) The legislature finds that the particular circumstances of Chemung county warrant authorizing this demonstration project, including the rural nature of the county, the absence of a comprehensive medicaid managed care provider serving the area at this time, patient care needs, and aspects of the health care provider base.

(b) within all or part of Chemung county (referred to in this subdivision as "the catchment area"), the department of health and the Chemung county department of social services are authorized to conduct a Medicaid research and demonstration project (referred to in this subdivision as the "demonstration project") for the purpose of testing the use of innovative administrative techniques, new reimbursement methods, and management of care models, so as to promote more efficient use of health resources, a healthier population and containment of Medicaid program costs.

(c) As part of the demonstration project, the Chemung county department of social services is authorized to contract with a managed

care provider for the purposes of, without limitation, developing and managing a provider of care network, establishing provider payment rates and fees, paying provider claims, providing care management services to project participants, and managing the utilization of project services.

(d) The demonstration project shall be consistent with the provisions of this section, except:

(i) The department may waive any rules or regulations, as necessary to implement and consistent with this subdivision.

(ii) The demonstration project shall not be subject to:

(A) paragraph (b) of subdivision four of this section;

(B) subparagraphs (i), (ii), (iii) (v) and (viii) of paragraph (e) of subdivision four of this section;

(C) paragraph (f) of subdivision four of this section;

(D) paragraph (g) of subdivision four of this section;

(E) subdivision five of this section; provided that in approving the demonstration project or modifications to it, the department shall consider the criteria in that subdivision;

(F) sections two hundred seventy-two and two hundred seventy-three of the public health law;

(G) section three hundred sixty-five-i of this title.

(iii) Notwithstanding subdivision three of this section, participation in the project shall be mandatory for all or any specified categories of persons eligible for services under this title for whom the Chemung county department of social services has fiscal responsibility pursuant to section three hundred sixty-five of this title and who reside within the demonstration project catchment area, as determined by the commissioner of health; provided, however, that eligible persons who are also beneficiaries under title XVIII of the federal social security act and persons who reside in residential health care facilities shall not be eligible to participate in the project.

(e)(i) Persons who are enrolled in or apply for medical assistance on or before the date the demonstration project takes effect shall receive sixty days written notice prior to participating in the demonstration project, including an explanation of the demonstration project and the participant's rights and responsibilities. Persons who apply for medical assistance thereafter shall receive such notice at the time of applying for medical assistance.

(ii) The demonstration project shall provide adequate services to overcome language barriers for participants.

(iii) Participants in the demonstration project whose participation in a managed care program would not otherwise be mandatory under subdivision three of this section, who, at the time they enter the demonstration project, have an established relationship with and are receiving services from one or more medical services providers that are not included in the demonstration project's provider network (an "out-of-network provider"), shall be permitted to continue to receive services from such providers until their course of treatment is complete, or in the case of a pregnant woman, while pregnant and for sixty days post-partum. Out-of-network providers that provide services pursuant to this subparagraph shall be subject to the utilization review and care management procedures prescribed by the managed care provider and shall be reimbursed at the rate that would be paid to such providers by the medical assistance program on a fee for service basis pursuant to this title, and shall accept such reimbursement as payment in full.

(f) The provisions of this subdivision shall not apply unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this subdivision.

(g) The commissioner of health is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to obtain the federal approvals necessary to implement this subdivision.

(h) The demonstration project shall terminate five years after it is approved by the department and all necessary approvals under federal law and regulations under paragraph (f) of this subdivision have been obtained, unless terminated sooner by the Chemung county department of social services.

23. (a) As a means of protecting the health, safety and welfare of recipients, in addition to any other sanctions that may be imposed, the commissioner, in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse services, where appropriate, shall appoint temporary management of a managed care

provider upon determining that the managed care provider has repeatedly failed to meet the substantive requirements of sections 1903(m) and 1932 of the federal Social Security Act and regulations. A hearing shall not be required prior to the appointment of temporary management.

(b) The commissioner and/or his or her designees, which may be individuals within the department or other individuals or entities with appropriate knowledge and experience, may be appointed as temporary management. The commissioner may appoint the superintendent of financial services and/or his or her designees as temporary management of any managed care provider which is subject to rehabilitation pursuant to article seventy-four of the insurance law.

(c) The responsibilities of temporary management shall include oversight of the managed care provider for the purpose of removing the causes and conditions which led to the determination requiring temporary management, the imposition of improvements to remedy violations and, where necessary, the orderly reorganization, termination or liquidation of the managed care provider.

(d) Temporary management may hire and fire managed care provider personnel and expend managed care provider funds in carrying out the responsibilities imposed pursuant to this subdivision.

(e) The commissioner, in consultation with the superintendent with respect to any managed care provider subject to rehabilitation pursuant to article seventy-four of the insurance law, may make available to temporary management for the benefit of a managed care provider for the maintenance of required reserves and deposits monies from such funds as are appropriated for such purpose.

(f) The commissioner is authorized to establish in regulation provisions for the payment of fees and expenses from funds appropriated for such purpose for non-governmental individuals and entities appointed as temporary management pursuant to this subdivision.

(g) The commissioner may not terminate temporary management prior to his or her determination that the managed care provider has the capability to ensure that the sanctioned behavior will not recur.

(h) During any period of temporary management individuals enrolled in the managed care provider being managed may disenroll without cause. Upon reaching a determination that requires temporary management of a managed care provider, the commissioner shall notify all recipient

enrollees of such provider that they may terminate enrollment without cause during the period of temporary management.

(i) The commissioner may adopt and amend rules and regulations to effectuate the purposes and provisions of this subdivision.

24. Claims submitted to a managed care provider for payment for medical care, services, or supplies furnished by an out-of-network medical services provider must be submitted within fifteen months of the date the medical care, services, or supplies were furnished to an eligible person to be valid and enforceable against the managed care provider. This deadline for claims submission shall not apply where the claims submission is warranted to address findings or recommendations identified in a state or federal audit except where such audit also indicates that an inappropriate provider payment was solely the fault of the out-of-network health care provider.

25. Effective January first, two thousand thirteen, notwithstanding any provision of law to the contrary, managed care providers shall cover medically necessary prescription drugs in the atypical antipsychotic therapeutic class, including non-formulary drugs, upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted.

25-a. Effective July first, two thousand thirteen, notwithstanding any provision of law to the contrary, managed care providers shall cover medically necessary prescription drugs in the anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes, including non-formulary drugs, upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted.

26. The commissioner of health shall develop a standard prior authorization request form or forms to be utilized by all managed care providers for purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits under this

title. The managed care provider shall make the standard prior authorization request form or forms available to, and shall accept it or them from, prescribing providers in paper and electronic form.

26-a. Managed care providers shall require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period, provided, however, that this subdivision shall not apply if the patient is a recipient of hospice care, has a diagnosis of cancer or sickle cell disease, or any other condition or diagnosis for which the commissioner of health determines prior authorization is not required.

26-b. Managed care providers shall not require prior authorization for any buprenorphine products, methadone or long acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder.

26-c. Managed care providers shall not require prior authorization for methadone, when used for opioid use disorder and administered or dispensed in an opioid treatment program.

** 27. The commissioner of the department of health may make any necessary amendments to a contract pursuant to this section with a managed care provider, as defined in paragraph (b) of subdivision one of this section, to allow such managed care provider to participate as a qualified health plan in a state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

** NB There are 2 sb 27's

** 27. (a) The centers for medicare and medicaid services has established an initiative to align incentives between medicare and medicaid. The goal of the initiative is to increase access to seamless, quality programs that integrate services for the dually eligible beneficiary as well as to achieve both state and federal health care savings by improving health care delivery and encouraging high-quality efficient care. In furtherance of this goal, the legislature authorizes

the commissioner of health to establish a fully integrated dual advantage (FIDA) program.

(b) The FIDA program shall provide targeted populations of medicare/medicaid dually eligible persons with comprehensive health services that include the full range of medicare and medicaid covered services, including but not limited to primary and acute care, prescription drugs, behavioral health services, care coordination services, and long-term supports and services, as well as other services, through managed care providers, as defined in subdivision one of this section, including managed long term care plans, certified pursuant to section forty-four hundred three-f of the public health law.

(c) Under the FIDA program established pursuant to this subdivision, up to three managed long term care plans may be authorized to exclusively enroll individuals with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. The commissioner of health may waive any of the department's regulations as such commissioner, in consultation with the commissioner of the office for people with developmental disabilities, deems necessary to allow such managed long term care plans to provide or arrange for service for individuals with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety. The commissioner of the office for people with developmental disabilities may waive any of the office for people with developmental disabilities' regulations as such commissioner, in consultation with the commissioner of health, deems necessary to allow such managed long term care plans to provide or arrange for services for individuals with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety.

(d) The provisions of this subdivision shall not apply unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this subdivision.

(e) The commissioner of health is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to obtain the federal approvals necessary to implement this

subdivision.

(f) Notwithstanding any inconsistent provisions of this section and sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law to the contrary, the commissioner of health and, in the case of FIDAs authorized exclusively to enroll persons with developmental disabilities, the commissioner of health and the commissioner of the office for people with developmental disabilities, may contract with FIDAs approved under this section without a competitive bid or request for proposal process, are authorized to enter into a contract or contracts under this section, provided, however, that:

(i) the department of health shall post on its website, for a period of no less than thirty days:

(A) a description of the proposed services to be provided pursuant to the contract or contracts;

(B) the criteria for selection of a contractor or contractors;

(C) the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(D) the manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) all reasonable and responsive submissions that are received from prospective contractors in a timely fashion shall be reviewed by the commissioner of health or commissioners, as applicable; and

(iii) the commissioner or, in the case of FIDAs authorized exclusively to enroll persons with developmental disabilities, the commissioner of health and the commissioner of the office for people with developmental disabilities, may select such contractor or contractors that, in their discretion, have demonstrated the ability to effectively, efficiently and economically integrate health and long term care services, and meet the standards for a certificate of authority under the public health law for the provision of services applicable to the type of managed long term care plan that such contractor proposes to operate.

(g) Nothing in this section shall be construed as requiring an individual with a developmental disability to enroll in a FIDA that is authorized to exclusively enroll individuals with developmental

disabilities.

(h) Nothing in this section shall make enrollment in a medicare managed care plan a condition of an individual's participation in the FIDA program, or affect the individual's entitlement to payment of applicable medicare managed care or fee-for-service coinsurance deductibles by the individual's FIDA plan.

** NB There are 2 sb 27's

** 28. To the extent that any provision of this section is inconsistent with any provision of section forty-four hundred three-g of the public health law, such provision of this section shall not apply to an entity authorized to operate pursuant to section forty-four hundred three-g of the public health law.

** NB Repealed December 31, 2027

29. In the event that the department receives approval from the Centers for Medicare and Medicaid Services to amend its 1115 waiver or receives approval for a new 1115 waiver prior to or following the effective date of the chapter of the laws of two thousand twenty-four that amended this subdivision, the commissioner is authorized to enter into contracts and to amend the terms of contracts awarded prior to the effective date of the chapter of the laws of two thousand twenty-four that amended this subdivision, for the purpose of assisting the department of health with implementing projects authorized under such waiver approval. Notwithstanding the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, contracts may be entered or contract amendments may be made pursuant to this subdivision until March thirty-first, two thousand twenty-seven without a competitive bid or request for proposal process; provided, however, in the case of a contract entered into after the effective date of this subdivision, that:

(a) The department of health shall post on its website, for a period of no less than thirty days:

(i) A description of the proposed services to be provided pursuant to the contract or contracts;

(ii) The criteria for selection of a contractor or contractors;

(iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(c) The commissioner of health shall select such contractor or contractors that, in such commissioner's discretion, are best suited to serve the purposes of this section.

30. Notwithstanding the provisions of section one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, in the event that the state receives prior approval and enhanced financial participation from the Centers for Medicaid and Medicare Services, Administration for Children and Families and the Federal Food and Nutrition Services for reimbursement pursuant to an A-87 cost allocation waiver for enhanced funding for integrated eligibility systems, the state is authorized to enter into contracts, and/or to amend the terms of contracts awarded prior to the effective date of this subdivision, without a competitive bid or request for proposal process, consistent with federal requirements, for the purpose of implementing projects authorized under such waiver amendment; provided, however, in the case of a contract entered into after the effective date of this subdivision, that:

(a) The office of temporary and disability assistance and the office of general services, or another state agency, shall post on its website and concurrently provide to the chair of the senate health committee and the chair of the assembly health committee, for a period of no less than thirty days:

(i) A description of the proposed services to be provided pursuant to the contract or contracts;

(ii) The criteria for selection of a contractor or contractors;

(iii) The period of time during which a prospective contractor may submit an offer, which shall be no less than thirty days after such

information is first posted on the website; and

(iv) The manner by which a prospective contractor may submit an offer, which may include submission by electronic means;

(b) All responsive and reasonable offers that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of temporary and disability assistance or other state agency; and

(c) The commissioners of the department of health, the office of temporary and disability assistance and the office of children and family services, working in cooperation with the state chief information officer and the office of general services, shall award such contract to the contractor or contractors offer that provides the best value as such term is defined in section one hundred sixty-three of the state finance law, to the state. At notification the commissioner of health shall provide this information to the chair of the senate standing health committee and the chair of the assembly health committee.

(d) All decisions made and approaches taken pursuant to this subdivision shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law.

(e) In accordance with all federal advance planning document guidance and within the parameters established by the enhanced financial participation from the centers for Medicaid and Medicare services, administration for children and families and the federal food and nutrition services for reimbursement to an A-87 cost allocation waiver for enhanced funding for integrated eligibility systems, Phase 1 will include foundational allowable shared service components required to successfully meet the requirements for non-MAGI Medicaid such as a common client portal, document management, rules engines, workflow management tools, case management, notices and training.

(f) The contract will require training to be provided at no cost to the social services districts.

(g) The contract shall require the completion of shared service components by the timelines necessary to receive the enhanced financial participation from the centers for Medicaid and Medicare services, administration for children and families and the federal food and nutrition services for reimbursement to an A-87 cost allocation waiver.

(h) The commissioner shall provide, within thirty days of award of

such contract or contracts, the chair of the senate standing committee on health and the chair of the assembly health committee with a report outlining the procurement and awards.

31. (a) The commissioner shall require managed care providers under this section, managed long-term care plans under section forty-four hundred three-f the public health law and other appropriate long-term service programs to adopt expedited procedures for approving personal care services for a medical assistance recipient who requires immediate personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively, or other long-term care, and provide such care or services as appropriate, pending approval by such provider or program.

32. (a) The commissioner, or for the purposes of subparagraph (iv) of paragraph (c) of this subdivision, the Medicaid inspector general in consultation with the commissioner, may, in his or her discretion, apply penalties to managed care organizations subject to this section and article forty-four of the public health law, including managed long term care plans, for untimely or inaccurate submission of encounter data; provided however, no penalty shall be assessed if the managed care organization submits, in good faith, timely and accurate data and a material amount of such data is not successfully received by the department as a result of department system failures or technical issues that are beyond the control of the managed care organization.

(b) The commissioner, or for the purposes of subparagraph (iv) of paragraph (c) of this subdivision, the Medicaid inspector general in consultation with the commissioner, shall consider the following when determining whether to assess a penalty against a managed care organization and the amount of such penalty:

(i) the degree to which the managed care organization submitted inaccurate data at a category of service level and the frequency of such inaccurate data submissions by the managed care organization;

(ii) the degree to which the managed care organization submitted untimely data or no data and the frequency of such untimely data submissions or failures to submit by the managed care organization; and

(iii) the timeliness of the managed care organization in curing or correcting inaccurate or untimely data.

For purposes of this section, "encounter data" shall mean all encounter records or adjustments to previously submitted records which the managed care organization has received and processed from provider encounter or claim records of all contracted services rendered to an enrollee of the managed care organization in the current or any preceding month. Any penalty assessed under this subdivision shall be calculated as a percentage of the Medicaid capitated premium calculated by the department and paid to the managed care organization.

(c) (i) Penalties assessed pursuant to this subdivision against a managed care organization other than a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law shall be as follows:

(A) for encounter data submitted or resubmitted past the deadlines set forth in the model contract, the Medicaid capitated premiums shall be reduced by one-third percent; and

(B) for incomplete or inaccurate encounter data, evaluated at a category of service level, that fails to conform to department developed benchmarks for completeness and accuracy, the Medicaid capitated premiums shall be reduced by one and one-third percent; and

(C) for submitted data that results in a rejection rate in excess of ten percent of department developed volume benchmarks, the Medicaid capitated premiums shall be reduced by one-third percent.

(ii) Penalties assessed pursuant to this subdivisions against a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law shall be as follows:

(A) for encounter data submitted or resubmitted past the deadlines set forth in the model contract, the Medicaid capitated premiums shall be reduced by one-quarter percent;

(B) for incomplete or inaccurate encounter data, evaluated at a category of service level, that fails to conform to department developed benchmarks for completeness and accuracy, the Medicaid capitated premiums shall be reduced by one percent; and

(C) for submitted data that results in a rejection rate in excess of ten percent of department developed volume benchmarks, the Medicaid

capitated premiums shall be reduced by one-quarter percent.

(iii) For incomplete or inaccurate encounter data, identified in the course of an audit, investigation or review by the Medicaid inspector general, the Medicaid capitated premiums shall be reduced by an additional one percent.

(d) (i) Penalties under this subdivision may be applied to any and all circumstances described in paragraph (b) of this subdivision until the managed care organization complies with the requirements for submission of encounter data.

(ii) No penalties for late, incomplete or inaccurate encounter data shall be assessed against managed care organizations in addition to those provided for in this subdivision, provided, however, that nothing in this paragraph shall prohibit the imposition of penalties, in cases of fraud, waste or abuse, otherwise authorized by law.

33. For services under this title provided by residential health care facilities under article twenty-eight of the public health law, the commissioner shall direct managed care organizations licensed under article forty-four of the public health law, article forty-three of the insurance law, and this section, to continue to reimburse at a benchmark rate which is to be the fee-for-service rate calculated pursuant to section twenty-eight hundred eight of the public health law. The benchmark fee-for-service rate shall continue to be paid by such managed care organizations for all services provided by residential healthcare facilities from the effective date of this subdivision at least until December thirty-first, two thousand twenty. The commissioner may require, as a condition of continuing to require payment at such benchmark rate that aggregate managed care expenditures to residential health care facilities meet the alternative payment methodology requirements set forth in attachment I of the New York State section 1115 medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall waive such requirements if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if the commissioner determines that such alternative payment methodologies significantly threaten individuals' access to residential health care facility

services; such waiver may be applied on a provider-specific or industry-wide basis. Further, such requirements may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies.

34. For purposes of recovery of overpayments pursuant to subdivision thirty-five of this section, any payment made pursuant to the state's managed care program, including payments made by managed long term care plans, shall be deemed a payment by the state's medical assistance program, provided that this subdivision shall not permit the imposition of a lien or recovery against property of an individual or estate on account of medical assistance payments where recovery is made against the individual's managed care provider or provider of medical assistance program items or services. Provided however nothing in this subdivision shall be construed to limit recoveries under other relevant sections of law.

35. Recovery of overpayments from network providers. (a) Where the Medicaid inspector general during the course of an audit, investigation, or review, or the deputy attorney general for the Medicaid fraud control unit during the course of an investigation or prosecution for Medicaid fraud, identifies medical assistance overpayments made by a managed care provider or managed long term care plan to its subcontractor or subcontractors or provider or providers, the state shall have the right to recover the overpayment from the subcontractor or subcontractors, provider or providers, or the managed care provider or managed long term care plan; provided, however, in no event shall the state duplicate the recovery of an overpayment from a provider or subcontractor.

(b) Where the state is unsuccessful in recovering an overpayment from the subcontractor or subcontractors or provider or providers, the Medicaid inspector general may require the managed care provider or managed long term care plan to recover the medical assistance overpayment identified in paragraph (a) of this subdivision on behalf of the state. The managed care provider or managed long term care plan shall remit to the state the full amount of the identified overpayment no later than six months after receiving notice of the overpayment from the state.

36. Medicaid Program Integrity Reviews. (a) For purposes of this subdivision, managed care provider shall also include managed long term care plans.

(b) The Medicaid inspector general shall conduct periodic reviews of the contractual performance of each managed care provider as it relates to the managed care provider's program integrity obligations under its contract with the department. The Medicaid inspector general, in consultation with the commissioner, shall publish on its website, a list of those contractual obligations pursuant to which the managed care provider's program integrity performance shall be evaluated, including benchmarks, prior to commencing any review. A Medicaid program integrity review of a managed care provider conducted pursuant to this subdivision, may be completed no more than annually. Reviews performed pursuant to this subdivision shall include a review of compliance with contractual standards which prevent fraud, waste, or abuse. Such standards may include but are not limited to excluded providers, restricted recipient program, reporting obligations, compliance programs, and suspension of payments. However, if the Medicaid inspector general determines that a subsequent review, pursuant to this subdivision, is necessary, a second review may occur within one year.

(c) If, as a result of his or her review, the Medicaid inspector general determines that a managed care provider is not meeting its program integrity obligations, the Medicaid inspector general may recover from the managed care provider up to two percent of the Medicaid premiums paid to the managed care provider for the period under review. Any premium recovery under this subdivision shall be a percentage of the administrative component of the Medicaid premium calculated by the department and may be recovered by the department in the same manner it recovers overpayments.

(d) The managed care provider shall be entitled to receive a draft audit report and final audit report containing the results of the Medicaid inspector general's review. If the Medicaid inspector general determines to recover a percentage of the premium as described in paragraph (c) of this subdivision, the managed care provider shall be entitled to notice and an opportunity to be heard in accordance with section twenty-two of this chapter.

37. Managed care providers shall report to the department all sources and amounts of income, payments, and financial benefits related to the provision of pharmacy benefits, including, but not limited to, any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits whether such income, payments, or financial benefits are received directly by the managed care provider or passed through from a pharmacy benefit manager or other entity. Managed care providers shall also report to the department the amounts of any administrative fees paid to cover the cost of providing pharmacy benefit management services. The reporting required in this subdivision shall be supplemental to and included with other existing reporting requirements, including but not limited to any quarterly reporting requirements.

** 38. (a) When a patient's health care provider prescribes an opioid dependence agent or opioid antagonist that is not on the statewide formulary of opioid dependence agents and opioid antagonists, the prescriber shall consult with the managed care plan to confirm that in his or her reasonable professional judgment, the patient's clinical condition is consistent with the criteria for approval of the non-preferred or non-formulary drug. Such criteria shall include:

(i) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(ii) the patient has tried the preferred drug and has experienced unacceptable side effects;

(iii) the patient has been stabilized on a non-preferred drug and transition to the preferred or formulary drug would be medically contraindicated; or

(iv) other clinical indications identified by the committee for the patient's use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, elderly, chronically ill, persons with mental health conditions, persons affected by HIV/AIDS and pregnant persons with a substance use disorder.

(b) The managed care plan shall have a process for a patient, or the patient's prescribing health care provider, to request a review for a prescription drug that is not on the statewide formulary of opioid

dependence agents and opioid antagonists, consistent with 42 C.F.R. 438.210(d), or any successor regulation.

(c) A managed care plan's failure to comply with the requirements of this subdivision shall be subject to a one thousand dollar fine per violation.

** NB There are 2 sb 38's

** 38. Penalties for the submission of misstated cost reports. (a) For purposes of this subdivision, managed care provider shall also include managed long-term care plans.

(b) The Medicaid inspector general may, in his or her discretion and in consultation with the commissioner, impose a penalty on a managed care provider whose filed cost report contained a misstatement of fact including:

(i) unsubstantiated or improper costs;

(ii) number of member months;

(iii) number of events.

For purposes of this paragraph, number of events shall include, but not be limited to understated births or deliveries.

(c) (i) For misstatements found in subparagraph (i) of paragraph (b) of this subdivision, the penalty shall be equal to the amount of the misstatement multiplied by two.

(ii) For misstatements found in subparagraph (ii) of paragraph (b) of this subdivision, the penalty shall be the amount of the premium capitation paid by the department for the region per member month.

(iii) For misstatements found in subparagraph (iii) of paragraph (b) of this subdivision, the penalty shall be the amount of the supplemental capitation paid by the department for the region per member event.

(d) Any penalty imposed under this subdivision may be recovered by the department in any manner authorized by law.

(e) The managed care provider against whom a penalty is imposed pursuant to this subdivision shall be entitled to notice and an opportunity to be heard in accordance with section twenty-two of this chapter.

** NB There are 2 sb 38's

39. Medicaid fraud, waste and abuse prevention. (a) For purposes of

this subdivision, managed care provider shall also include managed long-term care plans.

(b) Managed care providers shall adopt and implement policies and procedures designed to detect and prevent fraud, waste and abuse. This shall include the adoption and implementation of a compliance program as required by section three hundred sixty-three-d of this title and the terms of the contract between the managed care provider and the state, and for managed care providers with an enrolled population of one thousand or more persons in the aggregate in any given year, the establishment of a special investigation unit which will have primary responsibility for implementing the managed care provider's policies and procedures to detect and prevent fraud, waste and abuse, as it relates to the managed care provider's participation in the medical assistance program.

(c) The managed care provider shall coordinate its fraud, waste and abuse prevention activities with the Medicaid inspector general and the department of health. The Medicaid inspector general, in consultation with the department of health, may promulgate regulations establishing standards and requirements for the operation of managed care provider fraud, waste and abuse prevention activities, including requirements for special investigation units. The provisions of this subdivision notwithstanding, the managed care provider shall continue to comply with all the requirements of section forty-four hundred fourteen of the public health law.

40. (a) The commissioner shall be entitled to penalize managed care providers for failure to meet the contractual obligations and performance standards of the executed contract between the state and a managed care provider in place at the time of the failure.

(b) The commissioner shall have sole discretion in determining whether to impose a penalty for noncompliance with any provision of such contract.

(c) (i) Penalties imposed by this subdivision against a managed care provider shall be from two hundred fifty dollars up to twenty-five thousand dollars per violation depending on the severity of the noncompliance as determined by the commissioner.

(ii) The commissioner may elect, in their sole discretion, to assess

penalties imposed by this section from, and as a set off against, payments due to the managed care provider, or payments that become due any time after the assessment of penalties. Deductions may continue until the full amount of the noticed penalties are paid in full.

(iii) All penalties imposed by the commissioner pursuant to this subdivision shall be paid out of the administrative costs and profits of the managed care provider. The managed care provider shall not pass the penalties imposed by the commissioner pursuant to this subdivision through to any medical services provider and/or subcontractor.

(d) For the purposes of this subdivision a violation shall mean a determination by the commissioner that the managed care provider failed to act as required under the contract between the state and the managed care provider in place at the time of the failure, or applicable federal and state statutes, rules or regulations governing managed care providers. Each instance of a managed care provider failing to furnish necessary and/or required medical services or items to each enrollee shall be a separate violation and each day that an ongoing violation continues shall be a separate violation.

(e) No penalties shall be assessed pursuant to this subdivision without providing an opportunity for a formal hearing conducted in accordance with section twelve-a of the public health law.

(f) Nothing in this subdivision shall prohibit the imposition of damages, penalties or other relief, otherwise authorized by law, including but not limited to cases of fraud, waste or abuse.

(g) The commissioner may promulgate any regulations necessary to implement the provisions of this subdivision.

* NB Repealed March 31, 2029 (per ch. 165/1991)

* NB Repealed March 31, 2029 (per ch. 710/1988)