Pursuant to the authority vested in the Commissioner of Health by sections 20(3)(d), 34(3)(f), 363-a (2), 365-g of the Social Services Law, sections 505.2(i), 506.5 and part 511 of Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York, are hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register.

Subdivision (i) of section 505.2 is amended to read as follows:

(i) Utilization [threshold] review. (1) [This subdivision describes the utilization threshold that t]The department has established utilization review for physician and clinic services. Part [503] 511 of this Title authorizes the department to establish a system for utilization [threshold] review for specific provider service types including physician and clinic services. Part [503]511 also describes [the application of the utilization threshold,] the services and procedures excluded from the utilization [threshold]review for all provider service types [subject to a threshold, the method for obtaining an exemption from or increase in the utilization threshold, notices, and the right to a fair hearing in certain situations.

(2) General rules. The department will pay for up to 14 physician and clinic service encounters in a benefit year. As used in this subdivision, the term clinic means hospital outpatient departments, free-standing diagnostic and treatment centers and hospital emergency rooms. As used in this subdivision, the term encounter is defined as follows:

(i) all medical care, services and supplies received during a visit with a physician, a physician's assistant, a specialist or a specialist's assistant, unless excluded by paragraph (3) of this subdivision; or

(ii) all medical care, services and supplies received during a visit to a clinic certified under Article 28 of the Public Health Law, unless excluded by paragraph (3) of this subdivision].

(2[3]) Exclusions. In addition to those services and procedures generally excluded from any utilization [threshold]review by Section [503.4]511.2 of this Title, the following services are excluded from the utilization [threshold]review established by this subdivision:

(i) Physician services.

(a) anesthesiology services; and

(b) psychiatric services.

(ii) Clinic services.

(a) mental health services, alcoholism treatment services, and [mental retardation and]developmental disability treatment services provided in clinics certified under Article 28 of the Public Health Law or Article 31 of the Mental Hygiene Law;

(b) ambulatory services ordered by a qualified practitioner;

(c) services provided in a [physically handicapped children's program]speech and hearing clinic program for children with physical disabilities; and

(d) services provided in an [physically handicapped children's]amputee center for children with physical disabilities.

[(4) The department will pay for services provided in hospital emergency rooms as emergency services; however, each encounter counts as one service unit under the utilization threshold established by this subdivision.]

Section 506.5 is amended to read as follows:

506.5 Utilization [threshold]review. (a) [This section describes the utilization threshold that the department has established for dental services and supplies.] Part [503]511 of this Title authorizes the department to establish a system for utilization [threshold]review for specific provider types, including dental services and supplies. Part [503]511 also describes the [application of utilization thresholds,] services and procedures excluded from the utilization [threshold]review for all provider service types [subject to a threshold, the method for obtaining an exemption from or increase in the utilization threshold, notices, and the right to a fair hearing in certain situations.

(b) General rule. The department will pay for up to three dental service encounters in a benefit year. For purposes of this section, each discrete visit to a dentist or to a dental clinic is one encounter, regardless of the number of services provided or procedures performed during the visit].

Part 511 is renamed to read as follows:

Part 511 - MEDICAL CARE - UTILIZATION [THRESHOLDS] REVIEW

Section 511.1 is amended to read as follows:

Section 511.1 Utilization [thresholds] review. (a) In accordance with section 365-g of the Social Services Law, the department [has established] may implement utilization [thresholds] reviews which apply to certain care, services, and supplies for medical assistance (MA) recipients. Utilization [thresholds] review [are annual service limitations which are established by the department based upon provider service type.-Utilization thresholds are designed to promote] evaluates the appropriateness [use] and quality of [services] medical assistance, and safeguards

against unnecessary utilization of care and services; [consistent with quality care.] including post-payment review process to develop and review beneficiary utilization profiles, provider services profiles and exceptions criteria to correct misutilization practice of beneficiaries and providers; and for referral to the Office of the Medicaid Inspector General where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, service or supplies.

[(b) Within a benefit year, as defined in section 511.4 of this Part, the MA program will pay for care, services and supplies provided to eligible recipients up to and including the number of service units established as a utilization threshold for the particular provider service type. A service unit is defined as one encounter, procedure, or formulary code, depending upon the provider service type.

(c) After a recipient has reached the utilization threshold established for a particular provider service type, the MA program will not pay for additional care, services or supplies for that provider service type unless one of the following conditions is satisfied:

(1) the department has exempted the recipient from the utilization threshold;

(2) the department has granted the recipient an increase in the utilization threshold;

(3) the provider certifies that the care, services, or supplies were furnished to address an urgent medical need. An urgent medical need exists when a patient has an acute or active medical problem which, if left untreated, could reasonably result in an increase in the severity of the symptoms of the problem, an increase in the patient's recovery time, or a medical emergency; or

(4) the provider certifies that the care, services or supplies were furnished to address a medical emergency. Emergency services are medical care, services or supplies provided after a sudden

onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could reasonably result in serious impairment of bodily functions, serious dysfunction of a bodily organ or body part, or would otherwise place the recipient's health in serious jeopardy.

(d) The utilization thresholds for select provider service types are set forth in sections 511.10 through 511.13 of this Part.]

Section 511.2 is repealed, and section 511.3 is renumbered as section 511.2

511.2 Excluded services. Utilization [thresholds] <u>reviews</u> do not apply to the following services:

(a) services furnished by or through a managed care program to persons enrolled in and receiving medical care from such program. Managed care programs include health maintenance organizations, preferred provider plans, physician case management programs or other managed medical care programs recognized by the Department;

(b) services otherwise subject to prior approval or prior authorization;

(c) reproductive health and family planning services including: diagnosis, treatment, drugs, supplies, and related counseling furnished or prescribed by a physician or under a physician's supervision;

(d) until September 1, 1992, services provided by or under the direction of a primary provider under the recipient restriction program, as established by section 360-6.4 of this Title;

(e) methadone maintenance treatment services;

(f) services provided by private practitioners on a fee-for-service basis to inpatients in general hospitals certified under Article 28 of the Public Health Law or Article 31 of the Mental Hygiene Law and residential health care facilities;

(g) hemodialysis services;

(h) obstetrical services provided by a physician, hospital outpatient department, or free-standing diagnostic and treatment center-certified under Article 28 of the Public Health Law; or

(i) services provided through or by referral from a preferred primary care provider designated pursuant to Section 2807(12) of the Public Health Law[.];

(j) services provided pursuant to a court order; or

(k) services provided as a condition of eligibility for any other public program, including but not limited to public assistance.

Sections 511.4, 511.5, 511.6, 511.7, 511.8, 511.9, 511.10, 511.11, 511.12, 511.13, and 511.14 are repealed.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law ("SSL") section 363-a and Public Health Law ("PHL") section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program. The State's Medicaid program includes utilization review authorized by SSL § 365-g, as amended by Chapter 55 of the Laws of 2022. The Department may promulgate regulations necessary to carry out the program's objectives, which includes the review of services for necessity and appropriateness or where there are suspected cases of fraud, waste or abuse by providers or members. The proposed amendment to the utilization regulation is within the Department's statutory rulemaking authority as it sets forth a required framework to ensure the best use of care, services, and supplies.

Legislative Objectives:

The Legislature's objective in amending SSL §365-g was to lessen the administrative burden on providers and members who would otherwise need to submit requests for overrides of service limits. This will eliminate potential barriers to care.

Needs and Benefits:

The current regulation must be amended to conform to statutory amendments to Social Services Law §365-g, as amended by Chapter 57 of the laws of 2022. §365-g as amended decreased the administrative burden on enrolled fee-for-service Medicaid members and providers by eliminating utilization thresholds as service limits, while meeting the federal regulatory requirements at 42 CFR Part 456, Subparts A and B through continued utilization

monitoring in a post-payment review process, with referral to the OHIP pre-payment Provider on Review Program, and to the Office of the Medicaid Inspector General (OMIG) where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, services or supplies by members or providers. The monitoring of service utilization has moved from a prospective to a retrospective function and removes the requirement for provider-submitted increase requests, thereby eliminating the administrative burden and interruption of service delivery to members and providers who formerly had to request increases to benefit limits upon reaching the previous utilization thresholds.

Costs to Regulated Parties:

There will be no additional costs to private regulated parties because of the proposed regulation.

Costs to State Government:

As reflected in the State's fiscal year 2022-23 budget, there is no increase in Medicaid expenditures anticipated because of the proposed regulation.

Costs to Local Government:

There will be no additional costs to local governments because of the proposed regulation.

Costs to the Department of Health:

There will be no additional administrative cost to the Department of Health.

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

The proposed regulations do not impose any reporting requirements on fiscal intermediaries or other entities. This will result in a decrease in paperwork for enrolled providers and members.

Duplication:

The proposed regulation does not duplicate any existing federal, state, or local regulations.

Alternatives:

As discussed above, the Legislature has determined that there is a need to decrease the administrative burden on those enrolled in the fee-for-service Medicaid program. Accordingly, the alternative of not taking this regulatory action was rejected.

Federal Standards:

The proposed regulations do not exceed any minimum federal standards.

Compliance Schedule:

There is no compliance schedule imposed by this amendment, which shall be effective upon publication of a Notice of Adoption.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

A Rural Area Flexibility Analysis for these amendments is not being submitted because the amendments will not impose any adverse impact or significant reporting, record keeping or other compliance requirements on public or private entities in rural areas. There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the proposed amendments.

STATEMENT IN LIEU OF

JOB IMPACT STATEMENT

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.