

26. MCO NETWORK REQUIREMENTS AND REFERRAL AUTHORIZATION POLICIES

The first section of this chapter discusses MCO Provider Network requirements under The Partnership Plan. The second section provides a description of the referral authorization policies, procedures, and requirements in effect, including policies relating to standing referrals to specialists. The Chapter also describes policies when a provider leaves an MCO's network. It also describes State monitoring activities specifically related to behavioral health services (general monitoring activities are discussed in Chapter 20, "Quality Assurance Monitoring Plan").

MCO Provider Network Requirements

MCOs must maintain provider networks with adequate numbers of primary care providers, specialists, subspecialist physicians, and tertiary and ancillary providers to meet the medical needs of the enrolled population. The RFP used by the State during the 1996 procurement (see Appendix 3.1) delineated these requirements in detail. The following limitations are in place for PCPs enrolling Medicaid clients:

Individual providers with office-based practices:	1,500 enrollees: 1 PCP
• practicing with a Physician Extender (Nurse Practitioner or Physician Assistant):	2,400 enrollees: 1 PCP & PE
• practicing with a Medical Resident:	up to 3,000 enrollees: 1 PCP & 1 MR
• Nurse Practitioners	1,500 enrollees: 1 NP

Provider Network Data System (PNDS)

MCOs are required to submit to the Division of Managed Care and Program Evaluation's the Provider Network Data System (PNDS), all contracted healthcare providers that participate in Medicaid Managed Care and/or Family Health Plus on a quarterly basis. This system captures detailed provider data, including location of provider, office hours, language capability, specialty and panel size. The current system was initiated in December 1996, and has been further developed since then.

MCO data is submitted electronically through the Department's Health Provider Network (HPN), a restricted access internet site. Upon intake, MCO's data is immediately checked by intake software for critical errors and matched against State licensing and eligibility databases. If the data does not meet a certain threshold, the entire file is rejected. Upon completion of this process, the MCO receives a report of either a successful submission or rejection. The report will also include a list of data errors and/or provider record rejections, if any. The Provider

Network data is used for other purposes in the Department within the Division of Managed Care and Program Evaluation, and at the local government level. For example, data from the provider network system is used to assess a plan's network, evaluate geographic distribution of providers, form the basis for access and availability studies, determine primary care capacity, and calculate provider turnover rates and provider ratios.

MCO Referral Procedures

MCOs must have written policies and procedures for the processes by which members may receive referrals for specialty care. While the State does not intend to interfere with the day-to-day operations of its MCO contractors, it has established guidelines for these referral policies as follows:

- MCO Primary Care Providers have the ability to make referrals they deem appropriate to network specialists without undue restrictions.
- Enrollees may appeal to the MCO for reconsideration of a decision by their PCP not to make a specialist referral on their behalf.
- The timeframe for receiving a referral should be reasonable and appropriately related to the degree of urgency associated with the need for a specialist evaluation.
- Members must be permitted to obtain a second opinion from an in-network provider for diagnosis of a condition, treatment or surgical procedures.

The New York State Managed Care Reform Act and the Managed Care Omnibus Act, both effective in 1997, expanded protections for all managed care members enrolled in MCOs certified to operate in New York State. Subsequently, MCOs implemented additional referral procedures as described below.

All of the referral options discussed below require approval by the MCO and are made pursuant to a treatment plan which is approved by the MCO in consultation with the PCP, the specialist or specialty care center, and the enrollee (or the enrollee's designee).

Out-of-Network Referrals

MCOs are required to include the full continuum of specialists and sub-specialists in their networks. However, if the MCO does not have a health care provider with the appropriate training and experience in its network to meet the particular health care needs of an enrollee, the MCO must make an out-of-network referral to an appropriate provider.

In addition, if the MCO refers a member to a non-participating specialist provider or specialty center, the treatment shall be provided at no additional cost to the enrollee had the enrollee received care from in-network providers.

Specialists as PCPs

For enrollees diagnosed with a life threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, MCOs must have a procedure in place that allows for a referral to a specialist with appropriate expertise who will be responsible for both the primary and specialty care of the enrollee, or to a specialty care center which has expertise in treating the specific condition/disease.

Standing Referrals to Specialists

If a member requires ongoing care from a specialist, the plan must have a procedure to allow a standing referral to a specialist provider. If the MCO or the PCP, in consultation with the plan medical director and the specialist, if any, determines that such a standing referral is appropriate, the MCO shall authorize such a referral. In making this decision, the MCO Medical Director and PCP shall take into consideration the frequency of specialist visits required. Standing referrals are generally limited to network providers unless the plan is unable to arrange for appropriate specialty care in-network.

Referral to Specialty Care Centers

All MCOs are required to have a procedure to allow a member with a life-threatening or a degenerative and disabling condition or disease which requires specialized medical care over a prolonged period of time to request a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition

Identification of Special Needs Populations

MCOs are required to provide training and support to their network PCPs on the appropriate mechanisms for identifying and referring persons with special needs, including HIV counseling and testing and identifying persons with mental health and/or substance abuse problems for treatment. MCOs must ensure that their network PCPs have the skills and training necessary to identify mental health and substance abuse problems through the use of recognized screening tools and methods. The State has made available to MCOs screening instruments recommended by the Office of Alcohol and Substance Abuse Services (OASAS). While plans are not required to use OASAS-sponsored instrument, they must utilize policies, procedures, and screening and placement tools available which are consistent with OASAS or nationally recognized standards.

During the qualification process, MCOs are required, to describe the methods and procedures employed by the organization in meeting the needs of persons with mental health or substance abuse problems. The individual responses of the MCOs are encompassed in their proposals to the State, which are available for CMS review.

To facilitate the care of members with special needs, MCOs must meet all of the following requirements:

- Networks which include individual practitioners (psychiatrists, psychologists, psychiatric nurse practitioners, clinical nurse specialists, social workers,) and OMH- and OASAS-licensed programs and clinics;
- Capacity to provide culturally and linguistically appropriate services, including therapy services in languages other than English;
- Satisfactory methods for identifying persons requiring such services and encouraging self-referral and early entry into treatment;
- Satisfactory case management systems to ensure all required services – including emergency services – are furnished on a timely basis;
- Satisfactory systems for coordinating service delivery between physical health, substance abuse, and mental health providers.

MCOs are also required to participate in the local planning process for serving persons with mental health or chemical dependence problems, to the extent requested by the LDSS.

The State, through the Division of Managed Care and Program Evaluation (DMCPE) Medical Director, has developed a program to monitor the utilization of behavioral health services by MCO enrollees. Following the receipt of proposals from MCOs during the 1996 procurement, the Department did an extensive analysis of the utilization and unit cost projections made by the health plans for behavioral health services. This analysis forms the baseline from which the SDOH can monitor plans' actual experience relative to their projections. The DMCPE Medical Director has collaborated with MCOs, NCQA, IPRO, and behavioral health providers regarding the design of the overall behavioral health monitoring effort. The monitoring program includes assessing access and availability and appropriateness of care. The monitoring program is described in Appendix 9.2 of this document.

Transitional Care

If an enrollee's health care provider leaves an MCO's network of providers for reasons other than a reason for which a provider would receive a hearing, the MCO shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health provider during a transitional period of: (a) up to ninety days from the date of notice to the enrollee of the provider's separation from the MCO network, or; (b) if the enrollee has entered the second trimester of pregnancy at the time of the provider's separation, for a transitional period that includes the provision of post-partum care directly related to the delivery.

This care will be authorized by the MCO during the transitional period only if the health care provider agrees to: (a) continue to accept as payment in full the rates which were applicable prior to the start of the transitional period; (b) adhere to the MCO's quality assurance requirements and provide to the MCO necessary medical information related to such care, and; (c) otherwise

adhere to the MCO's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the MCO. After the 90 day period expires or after the final post partum care visit has occurred, enrollees will have to choose another participating provider within the MCO. The only exceptions to this requirement are: the existing PCP is the only geographically accessible PCP for that enrollee, or; a language barrier exists and the enrollee has an established relationship with a non-participating PCP who has the language capability to serve the enrollee and no participating plan offers a PCP who has the language capability to serve the enrollee (see Chapter 2)

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MCO Provider Network Requirements

The network ratios used to determine network capacity includes FHPlus enrollees.

The Provider Network Data System (PNDS) and MCO Referral Procedures are the same for FHPlus.