

4. PARTNERSHIP PLAN SERVICES

This chapter describes the Medicaid services covered under The Partnership Plan. The chapter includes a description of those services included in the capitated benefits package, services that remain available on a fee-for-service basis, and services for which members may self-refer.

Standard MCO Capitated Benefits Package

Medicaid managed care enrollees are entitled to the same benefits and coverages as are available under the fee-for-service program. The capitated health care benefits package is comprehensive for HMOs and PHSPs. Emphasis is on primary, preventive, and acute episodic care. MCOs must provide all services included in the capitated benefit package, to the extent that such services are medically necessary. “Medically necessary” is defined in Social Services law as medical, dental, and remedial care, services and supplies which are necessary to prevent, diagnose, and correct or cure conditions in the person that may cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity or threaten some significant handicap [see Social Services Law 365-a (2)]. Also, by statute, EPSDT and family planning services are “deemed” medically necessary and therefore are, by definition, covered.

The prepaid benefit package is identical for all enrollees, except those for whom the MCO receives a “physical health services only” capitation rate, i.e. the SSI population. These clients do not receive the behavioral health (mental health and chemical dependence) benefits through their MCO, but instead receive this care through existing special care providers under the fee-for-service program. Detoxification and medically supervised inpatient/outpatient withdrawal services are covered under the Managed Care benefit package for SSI enrollees when medically necessary. MCOs are responsible for participating in the coordination of physical and behavioral health services for members receiving a “health only” benefit. HIV SNP SSI enrollees receive inpatient and outpatient mental health and inpatient chemical dependency through the plan (except for uninfected SSI children¹). The Medicaid Managed Care Benefit Package is fully described in Appendix K of the Medicaid Managed Care/Family Health Plus Model Contract. The Model Contract is available at www.nyhealth.gov/health_care/providers/index.htm.

All capitated services covered under the managed care plan’s benefit package must be authorized by the enrollee’s MCO for any enrollee seeking such care. Non-capitated services are separately authorized and reimbursed based on medical necessity criteria at payment rates established by the State. Long-term care services are provided for those individuals who are categorically eligible for Medicaid under current program rules. These services are not the responsibility of managed care plans.

Accessibility

¹ Whose mental health and chemical dependency benefits will be carved out of the benefit package consistent with mainstream managed care for SSI recipients. Providers will have to check with the MCO to determine the status of these children.

MCOs must provide 24-hour/day, seven days a week access to health care services. Emergency services may be obtained from any provider, and MCOs are required to reimburse hospitals providing such services to their enrollees at the Medicaid rate, unless the hospital and the MCO have negotiated a rate. The State monitors 24-hour access through its complaint and grievance process and its “undercover” appointment availability studies. MCOs are also required to monitor access within their network using such procedures as they deem necessary, but to include after-hours monitoring of access to PCPs and services. In no event may a PCP or MCO “sign out” (i.e., automatically refer calls) to an emergency room.

In addition to providing all capitated benefits, MCOs must continue to furnish ongoing services (in or out-of-network) to new members, until such time as the MCO is able to arrange a first visit with a physician. In meeting this obligation, MCOs may require providers to obtain prior authorization and to submit clinical encounter data as a condition of payment. MCOs must negotiate mutually agreed upon reimbursement rates with out-of-network providers, keeping in mind that Medicaid managed care enrollees may not be “balance billed”.

MCOs are also required to permit all members to obtain second opinions within the MCO's network of providers for diagnosis of a condition, treatment or surgical procedures.

Coordination of Care

In general, Primary Care Providers (PCPs) are responsible for coordinating care for managed care enrollees. More particularly, PCPs must perform the following:

- Deliver medically necessary primary care services, including C/THP screening services for children and adolescents and a behavioral health screening for all members as appropriate.
- Provide health counseling and advice.
- Make referrals for specialty care and other medically necessary services, whether or not they are included in the MCO’s prepaid benefit package.
- Coordinate each patient’s overall course of care with out-of-network providers to the extent possible, including explaining treatment options and plans to the enrollee and/or the enrollee’s family.
- Maintain a current medical record for the member.

PCP Selection and Assignment

MCOs must offer enrollees a choice of at least three PCPs within distance and travel time standards. Individuals who fail to select a PCP will be assigned one; however, such assignment will occur no later than 30 days after written notification of enrollment has been made and only

after the MCO has made all reasonable efforts to contact the individual in person, by telephone or by mail and inform the individual of his/her right to choose a PCP. “Reasonable efforts” means at least three attempts, with more than one method of contact being employed. Should an assignment be necessary, MCOs will, to the extent they have information available to them, assign PCPs based on geographic proximity, language needs, and other special health care needs. Enrollees may change PCPs within thirty days of their first appointment without cause. Enrollees are permitted to change PCPs no more than once every six months except with good cause. Enrollees may change PCPs at any time in the event of the following:

- Enrollee is unable to schedule an appointment within the State-mandated time frames (see Model Contract, Section 15.2).
- Enrollee moves, and the PCP is no longer accessible within the time and distance standards prescribed by the State.
- Enrollee and the PCP agree a change is in the patient’s best interest.

In general, MCOs must limit their PCPs to the following primary care specialties:

- Family Practice
- General Practice
- General Pediatrics
- General Internal Medicine

Exceptions to these limits are described below.

Providers

MCOs, at their option, may permit providers to serve as PCPs, subject to SDOH qualifications. MCOs also must permit direct access for female members to in-network qualified providers of services (i.e. obstetricians, gynecologists, family practitioners, certified midwives or nurse practitioners) pursuant to Public Health Law Section 4406 b(1). These requirements are described in all approved Member Handbooks.

Specialists

Individuals with a life-threatening condition or disease, or a degenerative and disabling condition, either of which requires specialized medical care over a prolonged period of time, may receive a principal provider referral to a specialist with expertise in treating the disease or condition. Any specialist agreeing to serve as an enrollee's principal provider shall be responsible for, and capable of, providing and coordinating the enrollee's primary and specialty care. See Chapter 26 for further discussion of the role of specialists as PCPs.

If the MCO or primary care provider, in consultation with the MCO medical director and a specialist with expertise in serving the enrollee's condition or disease, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the MCO shall permit a standing referral and direct access to the specialist. Thereafter, for the approval period, the specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such other referrals, procedures, tests, and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

Only MCO network specialists may function as primary care providers under these provisions. The only exception is if an MCO determines that it does not have a health care provider with appropriate training and expertise in its network to meet the particular needs of an enrollee. In such cases, the MCO shall make a referral to an appropriate non-network provider, pursuant to a treatment plan approved by the MCO.

Nurse Practitioners

MCOs may use nurse practitioners as PCPs, subject to their scope of practice limitations under New York State Law.

Physician Assistants

MCOs may use physician assistants to provide primary care services subject to their scope of practice limitations. Under New York State law, physician assistants require the supervision of a physician, and can only be considered a PCP in conjunction with a supervising physician.

Medical Residents

MCOs may use Year One, Two, Three and Four resident physicians who are enrolled in "upweighted" or "designated priority" primary care training programs as part of their PCP delivery system subject to the following guidelines:

The capacity of each resident will be calculated in accordance with the methodology specified in Appendix I of the Medicaid Managed Care Model Contract.

Residents comprising a team must share the caseload in a manner that assures care coordination.

Residents must comply with all MCO requirements for prior authorization, utilization review, and quality assurance and medical management of MCO members.

Members must be granted access to the attending physician if they request an appointment with this individual.

A 16 hour per week attending may have no more than 4 residents on his/her team. Attendings spending 24 hours per week in patient care/supervisory activity at the continuity site may have 6 residents per team. Attendings spending 32 hours per week may have 8 residents per team. Two or more attendings may join together to form a larger team as long as the ratio of attending to residents does not exceed 1:4 and all attendings comply with the 16 hour minimum.

Responsibility for the care of the enrollee remains with the attending physician. All attending/resident teams must provide adequate continuity of care, 24-hour/7-day coverage and maintain appointment and availability access which meets the standards in the Plan Qualification document.

Residents may participate in the specialty care of Medicaid managed care patients in all settings supervised by fully licensed and HMO/PHSP credentialed specialty attending physicians.

PCP Teams

MCOs with clinic provider sites may designate teams of physicians/nurse practitioners to serve as PCPs for members receiving primary care at those sites. Such teams may include no more than three practitioners and, when a member chooses or is assigned to a team, one of the practitioners must be designated as “lead provider” for that member.

Partial Capitation Plans

New York State, through legislation, has provided for the continuation of four partial risk programs in five counties (Broome, Chemung, Erie, Schuyler, and Steuben). Of these four programs, the Broome MAX program is a PCCM model in which the PCPs are reimbursed on a fee-for-service basis for services. In the other three programs, the PCP is paid a capitation payment for primary and preventive services. These programs will remain a managed care selection alternative for populations eligible or required to enroll in managed care under The Partnership Plan. In the future, in counties with insufficient managed care alternatives, the State may also authorize additional primary care partial capitation programs.

The participation requirements for primary care partial capitation programs are appended to this document as Appendix 4.1. In these programs the PCP acts as the locus of care for the enrollee. The PCP is responsible for the medical case management and coordination of most of the services needed by the enrollee. Enrollees are not permitted to receive capitated services from a provider other than their PCP. The PCP receives a monthly capitation payment for each enrollee. In accordance with federal regulations the capitation rates must be approved as actuarially sound by the State’s actuarial consultant.

The State does not expect significant growth in the partial capitation model overall since The Partnership Plan emphasizes fully capitated MCOs. However, the State incorporated the primary care partial capitation model under the demonstration for two key reasons:

- Prevent disruption of care for existing enrollees

Approximately 20,000 Medicaid beneficiaries in New York were enrolled in primary care partial capitation programs and, accordingly, the State wanted to ensure that these individuals' existing relationships with their PCPs were not disrupted, given that they were already receiving health care under a 'managed' approach.

- Provide a managed care option in rural areas without adequate HMO or PHSP coverage

Even as fully capitated MCOs develop throughout New York, there continue to be 'gaps' in coverage, particularly in the more rural areas of the State. Therefore the State will, on a very limited basis, continue to approve primary care partial capitation models in areas where this model is necessary to ensure that some form of managed care is available as an alternative to the fee-for-service program. New primary care partial capitation programs will also be required to meet the participation standards outlined in Appendix 4.1.

4. FHPLUS SERVICES

FHPlus provides a comprehensive prepaid benefit package consisting of primary, preventive, specialist and inpatient health care services. Unlike the Partnership Plan, there are no partial capitation plans, fee-for-service wraparounds, stop-loss limits or extended benefits. The FHPlus benefit package is fully described in Appendix K of the Medicaid Managed Care/Family health Plus Model Contract. The Model Contract is available at www.nyhealth.gov/health_care/providers/index.htm.

Accessibility, Self-Referral Services (in-network), Public Health-Related Services, Coordination of Care, and PCP Selection and Assignment are the same for both programs.

Pursuant to subsequent changes in State law, co-payments are required for certain services:

- Pharmacy
 - \$6 for brand name prescriptions
 - \$3 for generic prescriptions
- Clinic - \$5 per visit
- Physician - \$5 per visit
- Dental - \$5 per visit with a \$25 annual cap
- Lab Tests - \$.50
- X-rays (ordered ambulatory only) - \$1
- Inpatient Hospital - \$25 per stay
- Non-Urgent Emergency Room - \$3
- Diabetic Supplies and Smoking Cessation Materials - \$.50

Exceptions: Co- payments cannot be applied to:

- People under 21 Years of Age
- Pregnant Women
- Emergency Services
- Family Planning Services and Supplies
- Mental Health Clinics
- Chemical Dependence Clinics
- Psychotropic Drugs
- Tuberculosis Drugs
- People Living in an Institution
- People Living in a Community Residence

Enrollees who cannot afford to pay may not be denied a service based on their inability to pay.