ACCESSING SPECIALTY CARE

What is specialty care?
Specialty care is any health care delivered by someone who specializes in one type of disease, part of the body or condition, rather than a doctor who treats all types of problems (sometimes called a “general practitioner”). Some kinds of care that are considered specialty care under Medicaid managed care include doctors who:

- Treat one kind of illness, like cancer or HIV/AIDS
- Treat one part of the body, like eye doctors and neurologists (brain and nervous system specialists)
- Use one method of treatment, like surgeons or radiologists (who use radiation)
- Treat one kind of patient, like gynecologists (women), gerontologists (elderly), or pediatricians (children)
- Specialists who are not physicians can also be considered specialty care providers, like physical therapists or psychologists. Groups of specialists may work together, at institutions like Multiple Sclerosis Centers of Excellence.

How can I get a specialist?
If you are in a managed care plan, your Primary Care Physician (PCP) is supposed to be the first person you see when you need care. Your PCP is responsible for figuring out what kind of specialist, if any, is needed for your condition at any given time. However, for some people with disabilities or chronic illnesses, the best person to be your primary care provider is a specialist. If a person has a disabling, degenerative or life-threatening condition that needs ongoing specialized medical care, Medicaid managed care plans must have a process for allowing them to see a specialist as their PCP.

Can I get a specialist as my primary care provider?
Some plans require your PCP to fill out a form that must then be approved by the Medicaid managed care plan's medical director. Some plans place time limits on how long a specialist can coordinate your care, or limits on the number of visits to the specialist. After the time limit or number of visits has been reached, you will have to have a re-evaluation in order for you to continue to see the specialist as your PCP. In most cases your PCP must request the specialist for you, and the plan’s medical director, your PCP and the specialist must all agree. Some plans require that the referral to a specialist be made as part of an overall treatment plan for you.

Examples Medicaid managed care plans give for conditions where a specialist would likely be approved are for individuals with:

- HIV
- insulin-dependent diabetes with below-the-knee amputation; secondary complications from Diabetes Mellitus
- cancer
- kidney disease requiring ongoing dialysis
- spinal cord injury
- traumatic brain injury
- cerebral palsy
- multiple sclerosis, and
- muscular dystrophy.

How often can I change to a different primary care provider (PCP)?
Some Medicaid managed care plans limit how often you can change PCPs “without cause.” They must let you switch doctors at least every six months, even without a reason. Many will let you switch more often.

This information is only for members of Medicaid managed care plans, Family Health Plus, and Child Health Plus B plans in New York. Commercial managed care plans may have different rules.
You are always allowed to change PCPs if you have a good reason (what plans call “good cause”), such as needing a doctor with more experience treating your illness or people with your disability.

**What must I do to choose and go to see a specialist?**

In any kind of managed care plan, you must have a referral from your PCP to see a specialist. Even if you have a specialist as your PCP, you will need a referral to see other kinds of specialists, with a few exceptions.

**Who are the specialists I can see without a referral?**

A few kinds of specialty care are available without a referral. For these, you can usually go to any provider in your Medicaid managed care plan without first contacting your PCP.

- **Women’s services:** You do not need a referral from your PCP to see a gynecologist or obstetrician (ob/gyn) for up to two visits per year and the required follow-up.

- **Family planning and reproductive health:** Men as well as women can go without a referral to see a family planning provider for advice on birth control (including sterilization), or to be tested for sexually-transmitted infections. Women can also receive pregnancy tests and abortions from family planning providers. Medicaid managed care plan members can go outside of their plan’s network to any family planning provider who accepts Medicaid. Family Health Plus and Child Health Plus B enrollees must see a provider in their plan’s network, unless they are in a Fidelis plan. Fidelis does not cover family planning and reproductive health, but members still have this coverage out-of-network. Fidelis Family Health Plus members may see any family planning provider who accepts Medicaid. Fidelis Child Health Plus B members must contact HealthFirst (1-800-905-5445) to get names of family planning providers they can see.

- **HIV testing and counseling:** You can get HIV testing and counseling without a PCP referral, at a family planning service provider, or from an anonymous clinic by calling the HIV Counseling Hotline at 1-800-872-2777.

- **Eye care:** You do not need a referral for an eye exam, new glasses or to have your glasses repaired under Medicaid Managed Care and Family Health Plus Plans. However, unless your eye condition has noticeably changed, you are limited to eye exams and new glasses once every two years. Under CHP B, you can get an eye examination once every twelve months, unless more frequent exams are medically necessary.

- **Mental health services:** If you have FHP, CHP B, or Medicaid managed care (but are not on SSI), you may go without a referral for one mental health visit for evaluation every year. If you need more visits, your managed care plan will tell you how to get a referral for them. If you have Medicaid managed care and receive SSI, most mental health services are “carved out” of managed care – you can use your Medicaid card and see any mental health provider who accepts fee-for-service Medicaid.

- **Substance abuse and alcohol treatment services:** If you have FHP or CHP B, you may go for one substance abuse or alcohol treatment visit for evaluation each year. If you need more visits, your plan will tell you how to get a referral for them. **FROM MCCAP GUIDE:** If you are a Medicaid managed care enrollee, you can go to an outpatient drug or alcohol treatment program for help without having to get a referral from your primary care provider or another representative of your managed care plan. These services are paid directly to your treatment provider on a fee-for-service basis. Other services, such as detoxification services and inpatient treatment services (these are usually treatment services provided in a hospital), are only available to you if you get a referral from your primary care provider or another representative of your managed care plan. Speak with a CIDNY or MCCAP counselor for
more details on what services are received through your plan and which are received through fee-for-service Medicaid.]

**Do I need to get a separate referral every time I see a specialist?**
If you need to see a particular specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time. This is called a “standing referral.” Standing referrals are available in all managed care plans. For people who have disabling, degenerative and/or life threatening conditions:

- Your PCP recommends a standing referral to the specialist
- The PCP’s recommendation has to be approved by the plan
- The PCP, the specialist and the plan all agree on this treatment.

If you have a standing referral, you will not need a new referral each time you need care as long as the visit is within the time limit or visit limits your plan has approved.

⇒ You may have to request a standing referral yourself, from either your PCP or the member services department.

**What is a “specialty care center”?**
If you have an illness or disability serious enough to require ongoing care from a “specialty care center,” you have the right to that referral. You or your PCP must request this service from your plan. A “specialty care center” is a medical center recognized as having special expertise in treating a particular condition, such as diabetes or neurological conditions.

⇒ If your health plan does not have an in-network specialty care center that can treat your condition, you should request a referral to an appropriate out-of-network center.

**What if my Medicaid managed care plan has no doctors with experience treating people with my disability?**
You have a right to a health care provider with appropriate training and experience, even if it means that your Medicaid managed care plan has to find you a provider outside their network. If no one in your plan’s network has the right training and experience for your particular health needs, the plan must give you a referral to an appropriate provider outside the plan. They must consult with that provider in developing a treatment plan. To get an out-of-network doctor:

- Your PCP requests an out-of-network doctor
- The plan must approve the request
- The out-of-network doctor must accept your Medicaid managed care plan’s fee structure
- Your PCP, your plan and the out-of-network doctor must agree on the treatment plan
- The plan may ask to redirect the request to a practice inside the network for comparable services
- Case managers may be involved in setting up arrangements and making sure appointments are made and kept.

**Can I change Medicaid managed care plans if none of my plan’s doctors can provide the specialty care I need?**
Any member of a Family Health Plus or Medicaid managed care plan can change to a different company’s Medicaid managed care plan in the first 90 days after signing up. After that, you normally have to wait 9 months before changing to a different plan. However, if you find out that you need specialty care, and your plan cannot provide it, you have “good cause” to change plans.

⇒ Make sure you find a new plan that has a specialist who can take care of you before you leave the old plan. Members of Child Health Plus B plans can change health plans at any time.

**What if my condition requires more than one accommodation?**

This information is only for members of Medicaid managed care plans, Family Health Plus, and Child Health Plus B plans in New York. Commercial managed care plans may have different rules.
You have a right to receive appropriate services, even if it takes more than one accommodation from your Medicaid managed care plan. For example, you might have a disability causing you to need ongoing health care from a specialist who is not in your plan’s network.

→ In this case, you can request (1) a standing referral to a provider who (2) is an out-of-network specialist.

How can a case manager help me access specialty care?
Your primary care provider makes medical decisions, such as which kind of specialist you should see. In some Medicaid managed care plans, case managers help to carry out those decisions by keeping track of your referrals, helping you to make and keep appointments, keeping track of you if you go into the hospital, and explaining to you what lab tests and x-rays mean. They can also arrange for your different doctors and other providers to talk to each other about your case.

What are my rights to challenge my plan’s refusal to give me a referral for specialty care?
If you have Family Health Plus or Medicaid (either fee-for-service or managed care), you can appeal a denial of services (such as a request for a referral) by requesting a fair hearing. Fair hearings are not available to members of Child Health Plus B (see below for how to appeal in CHP B).

→ Make sure you file your request for an appeal within 60 days of the date on your denial or reduction of services notice.

→ If you are already getting services and want to avoid having them reduced while you wait for a fair hearing, you must request a fair hearing within 10 days of the date on your denial or reduction notice AND ask to receive “aid-to-continue” while your case is being appealed.

→ You can bring an advocate and/or witnesses, such as caseworkers, relatives, friends, and/or doctors, to the hearing to help make your case.

Managed care organizations, including Medicaid managed care, Family Health Plus and Child Health Plus B plans, must have a way that you can ask them to reconsider your request.

→ Find out from the member services department or from your member handbook how to “appeal” the decision to deny you specialty care. If the plan has turned you down because the services were not considered “medically necessary,” and you do not win your appeal, you can go on to an “external” appeal. This means your case will be decided by impartial experts from outside of your plan. (See “The Appeals Process in Managed Care” fact sheet for further information.) If you request a Fair Hearing and an external appeal at the same time, and they result in opposite decisions, the Fair Hearing decision will overrule the external appeal decision.

For additional information about your rights or for assistance accessing health care:
CIDNY’s Managed Care Consumer Assistance Program: (212) 674-2300 or (212) 674-5619 (TTY)