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**Your Right to Specialist Care:**

**A Survey of HMOs in New York**

**May 2002**

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# Your Right to Specialist Care: Are New York HMOs Following the Law?

## Executive Summary

*Your Right to Specialist Care: A Survey of HMOs in New York* is the fourth in a series of reports that examine compliance by New York HMOs with New York's Managed Care Bill of Rights. The current report investigates how well HMOs are following New York laws on access to specialty care.

One of the most important provisions of the 1996 law is the requirement that all managed care organizations, including HMOs, provide referrals to specialists when a consumer's health condition warrants as follows:

- *Standing referrals:* Advance approval for a series of referrals to a specialist for ongoing care;
- *Out-of-network referral:* Referral to an out-of-network specialist when the managed care plan does not have a qualified provider within the network;

When the consumer has a life-threatening or disabling and degenerative disease or condition and needs ongoing care over a long period of time:

- *Specialist as Primary Care Provider:* A referral to a specialist who will then act as a primary care provider and coordinate the consumer's care;
- *Specialty Care Center:* A referral to a center that specializes in the consumer's disease or condition, such as a cancer institute.

Each of these referrals – according to New York law – requires a treatment plan approved by the HMO, the providers

involved (primary care provider and specialist) and the consumer.

PPEF surveyed 26 HMOs in New York to test how well they were complying with the law on access to specialist care. The survey had two parts. In the first part, PPEF staff posing as prospective enrollees attempted to get information on how to obtain a standing referral. HMOs were given two grades, from A to F, on this part of the survey.

Consumers who were enrolled in an HMO, and who had a chronic disease, conducted the second part of the survey. The surveyors asked for different types of specialist referrals and reported on the responses of HMOs to their requests.

### Results

**Prospective Enrollee Survey of Access to Standing Referrals:** Most HMOs in New York are doing a good or adequate job providing information to prospective consumers about how to receive a standing referral, to a specialist. However, most HMOs in New York are failing to provide proper information to consumers about how to file an appeal if the referral is denied.

All but two of the plans provided the legally required information to a prospective enrollee about how to access a standing referral when the caller asked questions about the procedure. The two plans that received a grade of F – HMO-CNY (now part of Excellus) and Oxford – did not respond at all to callers. Both of these plans appear to be in violation of the compliance agreements they signed with the New York

State Attorney General's office in 1998, obligating them to provide information to prospective consumers.

Among the 24 other plans, two received a partial A – Preferred Care and Premier Care – for allowing consumers to see some specialists without any referral. Twelve plans received a grade of B; these plans transferred authority to make a referral to the patient's primary care provider (PCP). Twelve plans got a C; they complied with the law's requirements on providing information about the referral process.

Plans did not do nearly as well informing consumers about how to appeal if a referral is denied. Almost half of the plans (12 out of 26) received a failing grade (F); these plans said that no appeal was possible or failed to mention how to appeal. However, under New York law, a consumer may appeal any dispute with a plan.

Eleven plans got a grade of D because they did not provide adequate information or information consistent with New York law about the appeal process.

Two plans received a C; Health Now provided correct information about how to appeal and Univera indicated the denial letter would include the appeal procedure. One plan got a B; Capital District Physicians' Health Plan informed the consumer that a second opinion was available if a referral was denied by a PCP and that all denials could be appealed. The two As were for the plans that – for most specialty care– do not require referrals.

**Survey by HMO Members with Chronic Illness:** Volunteers who are members of HMOs and who have a chronic disease (or a family member with a chronic disease) called their HMO and sought information on specialist referrals.

The responses of HMOs to questions about referrals to a specialist as PCP, and referrals to a specialty care center, varied

widely. In some cases, getting approval for the specialist as PCP was a simple matter. In other cases, plans indicated that it would be difficult or impossible to get certain types of specialist referrals.

## Conclusions

The results of our survey demonstrate that New Yorkers are not able to consistently exercise their legal right to access specialty care from an HMO. Most telling was the experience of two HMO enrollees who were denied access to a specialist on a first call, but were granted access on a second call, after they received counseling from PPEF staff on their rights.

This is not to say that all plans are failing to meet their obligations; several of the consumers who called their HMO were able to receive accurate information about access to specialty care. However, others were told that specialty care services were not available. For several plans, the responses and assistance provided varied from one call to the next, even when the same questions were asked of the same plan. The survey responses confirm anecdotal evidence that consumers do not get consistent answers from member services representatives.

Overall, the plans generally were able to answer questions about standing referrals to a specialist. Their responses about other types of referrals varied widely, from clear explanations about how to obtain a particular type of referral, to claims that it was not possible to get a specific type of specialist referral.

Our survey found that many plans have delegated decisions on standing referrals to the primary care provider. This delegation improves access to specialty care. In two instances, the HMOs had gone one better, by not requiring a referral for most types of specialty care.

However, delegating decisions to a PCP does not remove the legal obligation of the plan to allow consumers to appeal a decision by the PCP to deny access to the specialist. Most plans failed to provide acceptable, or legally correct, information to consumers on how to appeal when the PCP or plan denies access to a specialist.

### **Recommendations:**

PPEF recommends that consumers and advocates:

- Call the HMO again on another day to get a different representative if you don't get an adequate response the first time you ask for a referral.
- Ask to speak to a supervisor if the member services representative does not give a positive response on how to access specialist care referrals.
- Have your member handbook ready when you call and read the sections about specialist referrals if the plan's representative doesn't know what you're asking about.
- Be persistent and follow the appeals procedure if you are denied a specialist referral.
- If your PCP has the full authority to decide referrals and denies your request, ask for a second opinion from another PCP.
- Speak to your specialist about the rationale for any specialist referral you want.

PPEF recommends that the New York State Department of Health improve regulation of access to specialty care:

- Require each HMO to establish detailed procedures for referrals to specialists, including timeframe for decision-making.

- Allow plans to permit enrollees to seek specialty care without a referral.
- Allow primary care providers to make referrals on their own, so long as the enrollee, specialist and plan medical director are consulted before a PCP makes a final decision to deny a referral.
- Require plans that give the PCP full authority to make referrals to have a clear procedure and timeframe for providing written denial notice and how to appeal the PCP's denial of a referral.
- Establish standards to interpret the law's requirement for involving the specialist in making decisions about specialty care referrals.
- Require plans to use medical necessity as the criterion to determine access to a particular type of specialist; access to specialist as PCP; access to a specialty care center; and going outside the HMO's network when there is no qualified provider within the network.

# Your Right to Specialist Care: Are New York HMOs Following the Law?

## Introduction

In 1996 New York passed what has become known as the Managed Care Consumers' Bill of Rights. This law provides specific protections for health insurance consumers. In the fall of 1997, six months after the law took effect, PPEF published the first in a series of reports on compliance with the Managed Care Consumers' Bill of Rights. Subsequent reports were published in 1998 and in 2000. This report, *Your Right to Specialist Care: A Survey of HMOs in New York* is the fourth in the series examining compliance with the law. *Your Right to Specialist Care: A Survey of HMOs in New York* breaks new ground by examining more than the basic provisions of the law. This report assesses whether health plans provide adequate and accurate information to consumers about obtaining ongoing care from a specialist.

### Referrals to specialists

Historically, Health Maintenance Organizations (HMOs) have required their members to obtain health care through a gatekeeper, a primary care provider (PCP), to whom a member must go for a referral each time the consumer needs care from a specialist. Traditional HMOs also limit their members to obtaining care from a defined set of health care providers who are included in the plan's network. Consumers' disenchantment with these HMO restrictions created a market force that resulted in the development of many different types of managed care plans. Newer models of managed care, such as Preferred Provider Organizations (PPOs), allow consumers to see some or all specialists in the plan's network without prior approval from a PCP. Point of Service (POS) plans and PPOs allow consumers to see specialists out of the network without a referral but require that the consumer pay significantly higher out of pocket costs.

One of the most important provisions of the 1996 law is the requirement that all managed care organizations, including HMOs, provide referrals to specialists that expand the limits normally placed on consumers in managed care plans. These specialist referrals are available when a consumer's health condition warrants it:

- *Standing referrals*: A series of referrals to a specialist for ongoing care, so that the consumer need not continually return to the primary care provider each time a visit to the specialist is needed;
- *Out-of-network referral*: Referral to an out-of-network specialist when the managed care plan does not have a provider in its network with the expertise and

skill the consumer needs to treat their health condition, at no additional cost to the consumer;

*When the consumer has a life-threatening or disabling and degenerative disease or condition and needs ongoing care over a long period of time:*

- *Specialist as Primary Care Provider:* A referral to a specialist who will then act as a primary care provider and coordinate the consumer's care;
- *Specialty Care Center:* A referral to a center that specializes in the consumer's disease or condition, such as a cancer institute.

Each of these referrals – according to New York law – requires a treatment plan approved by the HMO, the providers involved (primary care provider and specialist) and the consumer. For those with chronic health conditions, access to these types of referrals can be a lifesaver. For example, a person with HIV/AIDS will likely receive the best care from a specialist who has experience with HIV/AIDS rather than from a typical primary care provider (PCP) who may have only limited experience in treating people with HIV/AIDS. Further, the law requires that managed care plans disclose to all enrollees and to anyone considering enrolling in the plan (prospective enrollees), in the plan's member handbook or subscriber contract, not only that these referrals are available, but also, the procedures a consumer must use for accessing these referrals.

### Results of earlier surveys

These specialty care provisions are part of a body of information that plans must disclose to their enrollees and to prospective enrollees who request the information. In 1998 PPEF undertook an extensive survey of health plan member materials to determine whether health plans provide the information to consumers that the law requires. The report of that survey, *Your Right to Know about Managed Care: Are New York HMOs and Insurers Following the Law? Part 2: Information Disclosure*, evaluated member handbooks and contracts of all of the HMOs and many of the other major health insurance plans in New York State.

Four categories of information were assessed to determine whether the health plan included the information and whether the information included was accurate. The PPEF report also assessed the clarity with which the information was presented. One category PPEF surveyed was managed care plans' descriptions of access to the four types of referrals to specialty care.

In that 1998 report PPEF found that one-half of the HMOs surveyed failed to provide the required information regarding access to specialty care. Most commonly, plans neglected to describe any procedures for accessing this care. And this was true even though PPEF considered procedures as vague as "contact member services or your PCP to find out how to get this referral" as complying with the law.

New York State Department of Health confirmed that, in the department's view, HMOs had fulfilled the law's requirement regarding procedures as long as the plan listed a toll-free phone number or asked the enrollee to contact their PCP. The Department's assumption was that, once an enrollee contacted member services, the details of how to obtain the special referrals and what a consumer could expect from the plan would be forthcoming.

### Concerns about access to specialist care

Meanwhile, advocates for those with serious and chronic illnesses were concerned that their clients were not, in many cases, able to actually access these specialty care referrals. Either HMOs could not provide detailed information about these referrals or the plan member services representative provided inaccurate information or, in some cases, were not even aware of these referrals.

Unlike other provisions in the Managed Care Consumer's Bill of Rights, which clearly spell out time frames and other requirements, the specialty care provisions merely state that the plan must provide "the procedures for requesting and obtaining such a referral." Since the statute is silent about the criterion plans should use in determining access to specialist referrals, there is no guarantee that medical necessity will be the governing principle that guides decision-making. The vagueness in the statute itself left little recourse to consumers who needed to know what to do about seeking specialty care. As a result, PPEF decided to undertake an ambitious survey to find out whether health plans do have procedures that member services representatives can explain to consumers. This report describes the findings of that survey.

## **Methodology**

To determine what explanations HMOs provide to consumers about how to access specialist care, PPEF reached out to organizations that serve those with serious and chronic illnesses or disabilities. These are the consumers most in need of information and access to these types of referrals. Our first outreach effort was to New Yorkers for Accessible Health Coverage (NYFAHC), a coalition of voluntary health organizations working for people with serious and chronic illnesses and disabilities.

### Survey design

NYFAHC members and staff agreed to assist with the survey design and to help recruit consumers enrolled in HMOs who had health conditions that made them eligible for one or more of these types of referrals. With input from NYFAHC, PPEF designed the survey questionnaires. These interview scripts were developed with commonsense as a guide as to what kinds of information a consumer would need to have to obtain one of these

referrals. Another source for questions were the relevant sections of PPEF's 2000 publication, *Best Practices Member Handbook: How New York HMOs are Providing Information to consumers Required Under the Managed Care Consumers' Bill of Rights*. The *Handbook* is an amalgam of descriptions from existing member materials and information that PPEF added, when no existing member materials met the standard, to exemplify best practices.

### Surveyors

To recruit HMO members as volunteer surveyors, PPEF contacted organizations around New York State. PPEF's intent was to attempt to recruit appropriate volunteer surveyors who were enrolled in most, if not all, of the HMOs operating in New York State. PPEF was able to recruit surveyors from many areas of the State, from Buffalo to Long Island, but PPEF was not successful in recruiting surveyors enrolled in every HMO in the State.

The law requires HMOs to provide information about access to specialist care to prospective enrollees as well as enrollees. In previous surveys, PPEF's experience has been that plans are more forthcoming in providing information to enrollees than to prospective enrollees. Therefore, PPEF conducted a two-part survey. To provide consistent methodology, PPEF staff surveyed all of the HMOs' member service departments, posing as prospective enrollees, and asked the questions in the standing referral survey. The report card in the results section of this report is based on the surveys conducted by the PPEF staff. In the second part of the survey actual HMO members contacted their own plans asking about access to specialist care. Calls from enrollees provided additional information about how plans provide access to specialists. Using both volunteer surveyors and PPEF staff, PPEF was able to obtain answers to the survey questions from 26 HMOs operating in New York State as of July 2001.

### Study questions

Using the above methodology, PPEF sought to answer the following study questions:

1. What information do HMOs provide consumers about how to obtain a standing referral for specialist care?
2. What information do HMOs give consumers about how to appeal a denial of a request for a standing referral to a specialist?
3. What information do HMOs give consumers about access to other types of specialist referrals?

## Results

### Standing Referrals and Appeal of Denials

PPEF staff was able to contact all but two of the plans to conduct the survey asking for information about how to obtain a standing referral to a specialist. Two of the plans received failing grades because staff surveyors were not able to reach a person to conduct the survey, even though they made multiple attempts trying to get through the automated attendant system, or waited on hold for more than 15 minutes. The responses to these staff-conducted surveys form the basis for the report card included below.

### Grading criteria

Plans received two separate grades: one grade based on the description of how to obtain a standing referral and the second grade based on the description of the appeal process if a standing referral is denied.

The highest grades were assigned to those plans whose policies exceeded the requirements in the Managed Care Consumers' Bill of Rights law. The very highest grade, A, was given to plans that do not require any referral because they allow consumers direct access to specialists; this high grade recognizes that there are no barriers for consumers seeking access to specialist care. The second highest grade, B, went to the plans that exceed the requirements of the law by giving the PCP full authority to make standing referrals so that there are fewer procedures to navigate when a consumer seeks a standing referral. A passing grade of C was assigned to plans meeting the legal requirement of explaining their referral process. A barely passing grade of D went to those plans that could give partial explanations about their process for obtaining a standing referral. Failures were given when no information was available about the referral process.

The highest grade for appealing a denial, A, went to plans that exceed the requirements of the law by never denying referrals because they give the consumer direct access to specialists without requiring a referral. The next highest grade "B" went to plans that exceed the managed care law requirements by describing all avenues a consumer could use to get an undesirable decision overturned, including what to do in the event that a PCP with full authority to make standing referrals denied the consumer's request. Plans earning a "B" noted that a consumer could seek a second opinion if the PCP denies the referral and also mentioned other appeal rights. A passing grade of "C" was assigned to those plans that could provide information about their appeal process in the event that a standing referral was denied. The grade "D" was assigned to those plans that could not adequately explain their appeal process and a failing grade went to both those plans that indicated that, contrary to law, no appeal was possible and to plans that failed to explain to the caller that they had appeal rights.

## Grading Criteria for Standing Referrals and Appeal Process

Obtaining Standing Referral	Appealing Denial of Standing Referral
<b>A</b> – Patient can go directly to specialist without referral (exceeds requirements of Managed Care law)	<b>A</b> – No appeal procedure needed because no referral required to access specialist (exceeds requirements of Managed Care law)
<b>B</b> – PCP* has complete authority to provide standing referral (exceeds requirements of Managed Care law)	<b>B</b> – Can ask for second opinion if PCP* has full authority to provide standing referral and denies referral and also can still make appeal (exceeds requirements of Managed Care law)
<b>C</b> – Adequate explanation of process for obtaining a standing referral	<b>C</b> – Adequate explanation of appeals process
<b>D</b> – Inadequate explanation of process for obtaining a standing referral	<b>D</b> – Inadequate and/or partially correct explanation of appeals process
<b>F</b> – No information provided on how to obtain a standing referral	<b>F</b> – Patient cannot appeal denial or no information provided on how to appeal a denial
*PCP – Primary Care Provider	

### Standing referrals

All but two of the plans provided the legally required information to a prospective enrollee about how to access a standing referral when the caller asked questions about the procedure. The two plans that got F's – HMO-CNY (now part of Excellus) and Oxford – did not respond at all to callers despite multiple attempts. Both of these plans appear to be in violation of the compliance agreements they signed with the New York State Attorney General's office in 1998 obligating them to provide information to prospective consumers.

Among the other plans, two received a partial A – Preferred Care and Premier Care – for allowing consumers to see some specialists without any referral\*. These two plans received two sets of grades since access to different types of specialists was handled so differently. Twelve plans received a grade of B; these plans transferred authority to make a referral to the patient's primary care provider (PCP). Twelve plans got a C; they complied with the law's requirements on providing information about the referral process.

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\* Referrals were required for a limited number of specialists such as allergist, dermatologist, cardiologist, mental health, and physical therapy.

<b>Report Card: Standing Referrals and Appeals Process</b>		
<b>Name of Plan</b>	<b>Standing Referral</b>	<b>Appeals Process</b>
Aetna US Healthcare	B	F
AmeriChoice	C	F
Atlantis Health Plan, Inc.	B	D
Blue Choice (now part of Excellus)	C	D
CDPHP	B	B
Cigna	B	F
Community Blue (part of HealthNow NY)	C	D
Empire BC & BS/ Empire HealthChoice	B	F
GHI	C	D
Health Now (part of HealthNow NY)	C	C
HIP	B	F
HMO Blue (now part of Excellus)	C	D
HMO-CNY (now part of Excellus)	F	F
Independent Health Association, Inc.	B	F
MagnaHealth of NY	C	F
Managed Health	B	D
MDNY Health Care	B	F
MVP Health Plan	C	D
Oxford	F	F
Physicians Health Service of NY	C	D
Preferred Care*	A	A
	C	D
Premier Health Plan*	A	A
	C	D
United Health Care of NY	B	F
United Health Care of Upstate	B	F
Univera Healthcare (now part of Excellus)	C	C
Vytra	B	D
* The plan received one set of grades for allowing consumers to go directly to many specialists without requiring a referral. The second set of grades is for the remaining specialists that still require a referral.		

### Appeal process when standing referral denied

While most plans did a good job establishing an easy referral process, or explaining the referral process, most did a poor job explaining the process of appealing a denial of care. Almost half of the plans (12 out of 26) received a failing grade (F); two plans said that no appeal was possible and another 10 plans failed to provide even cursory information about how to appeal a denial. One plan indicated that it would deny a claim from a specialist only in the event that the specialist was outside its network. The major reason these plans did not provide information about their appeals procedures was based on their insistence that the PCP had total authority to make this decision; they failed to acknowledge that the consumer could appeal if the PCP denied the referral. However, ***under New York law, a consumer may appeal any dispute with a plan.***

Eleven plans got a grade of D because they did not provide adequate information or the information was partially contrary to New York legal requirements for the appeal process. This number included the two plans that require a referral for a limited number of specialist services. One plan indicated that claims would be denied only when the specialist was outside its network. Many of the plans told the surveyor that decisions about standing referrals would be made based on medical necessity and later indicated that an appeal should be made under the plan's grievance procedure. ***However, under New York law, denials based on medical necessity are appealed through the utilization review (UR) process, which is distinct from the grievance process and offers consumers considerably more protections.*** Under the UR process, medical decisions are reviewed by qualified clinicians based on clinical criteria and UR decisions made be appealed to a review agent that is independent of the patient's insurer through New York's external review law.

Two plans received a C; Health Now provided correct information about how to appeal and Univera indicated that the written notice of denial would tell the consumer how to appeal a denial. One plan got a B; Capital District Physicians' Health Plan informed the consumer that a second opinion was available if a referral was denied and that all denials could be appealed. The two As were for the plans that – for most specialty care– do not require referrals.

An area of concern is the impact of transferring all decisions about standing referrals to the PCP. While it is commendable that many HMOs now see decisions about standing referrals as a medical decision that rests solely with the PCP, there was evidence that some of these same HMOs indicated that they have no further responsibility for how the consumer accesses specialist care. Most troubling were the responses from plans that said they had no responsibility for telling consumers how to appeal a denial of a standing referral because that decision is the sole responsibility of the PCP. Just as troubling were the two plans that said there was nothing the consumer could do if the standing referral was denied or said that only the PCP could appeal the denial. ***The law still makes the plan responsible for the appeals process; as long as the PCP has the ability to deny a referral the plan has the legal obligation to inform the consumer why the referral was denied and how to file an appeal.***

### Involvement of specialist

The law requires that an HMO consult with the PCP *and* the specialist in making decisions about referrals for specialist care. In an ideal world, collaborative discussions between the PCP, the patient and the specialist would determine for each individual which provider, the PCP or the specialist, is best in meeting ongoing needs for primary care as well as specialist care. The plan's medical director could be involved in seeking resolution of any disagreements between the PCP and the specialist in favor of best meeting the patient's needs.

The findings of this survey indicate that many HMOs have decided to give the PCP responsibility for determining whether the specialist would be involved in making the decision for a standing referral for ongoing care by a specialist. Some plans give the PCP full authority for determining standing referrals to a specialist and others require the PCP to notify the plan about any standing referrals and secure an authorization code number for the specialist to use in billing. This latter procedure was described as an administrative procedure rather than a medical approval. In both cases, the plan representatives indicated that they do not interfere with the PCP's medical decision about standing referrals.

At first blush these “we’re-only-the-insurance-plan-and-we-don’t-make-medical-decisions” approaches to standing referrals sound like the best possible world for the patient. However, *if the PCP denies care, the HMOs may have failed to assure that the perspective of the specialist was included in the decision-making process. This is a legal obligation of the plan under New York law.*

The scope of this study does not provide any information about whether the HMOs have given the PCPs guidelines on how to involve specialists in making decisions about referrals. It is impossible to determine from this study whether the failure to consult the specialist could result in less than optimum care for the patient. It is also beyond the scope of this study to determine what factors might influence the PCP's decision about whether to consult with the specialist or not before determining whether to authorize a standing referral. *However, we note that HMOs have often established financial incentives for PCPs that could result in penalizing PCPs who make referrals to specialists.*

<b>Role of Specialist in Determining Standing Referral</b>	<b>Plans</b>	
Nothing needed from specialist	AmeriChoice Atlantis Blue Choice GHI HIP MagnaHealth of NY MDNY Health Care	Preferred Care Premier Health Plan United Healthcare of NY United Healthcare of Upstate Univera Healthcare Vytra
Copy of medical records from specialist to be submitted to the HMO	Health Now (sometimes) HMO Blue MVP Health Plan	
Primary care provider handles specialist	Cigna Community Blue Empire BC & BS/Empire HealthChoice Independent Health Association, Inc.	
Specialist sends the primary care provider's referral with the claim form to the HMO	CDPHP Managed Health	
No information available regarding the role of the specialist	Aetna US Healthcare HMO-CNY (unable to contact a representative) Oxford (unable to contact a representative) Physicians Health Service of NY	

### Customer access and service

Almost all of the plans were easy to access via a toll-free number. For these plans, someone answered the phone and engaged in conversation with the surveyor. Most responders were business-like; a few went out of their way to be helpful and informative and they willingly answered all questions posed by the surveyor. A small number of those surveyed were rude and a few were reluctant or suspicious when asked more than a couple of questions. In two cases, no one answered the phone and the surveyor was unable to talk to a representative despite being shuttled through endless automated telephone attendants, put on hold for 15 minutes or more, or leaving messages as instructed by the automated answering system.

### Surveys by HMO Members with Chronic Illness

Volunteers who are members of HMOs and who have a chronic disease (or a family member with a chronic disease) called their HMO and sought information on specialist referrals. In every attempt, volunteer surveyors were able to talk to a person, although they often had to wait on hold. The volunteers were also able to reach the two plans that did not respond to calls made by prospective enrollees.

The responses of HMOs to questions about referrals to a specialist as PCP and referrals to a specialty care center varied widely. In some cases, getting approval for the specialist as PCP was a simple matter, as long as the specialist participated in the HMO's network of providers and had the appropriate credentials to be recognized as a PCP. Such a credentialing requirement does not exist in the law, so these plans did not really meet their legal requirements for providing this type of specialist referrals. In other cases plans indicated that it would be difficult or impossible to get certain types of specialist referrals.

During this study, at least two volunteer surveyors were deeply disappointed by their HMO's response that they could not have the type of specialist referral (standing, out-of-network, specialist as PCP, specialty care center) they had inquired about. After PPEF staff counseled these HMO participants about which specialist referrals the law said they could have, the surveyors called a second time and were successful in getting the information they wanted. When another volunteer surveyor was told that there was no such thing as a "standing referral," he was able to quickly change his request to ask for a referral to a specialist as PCP and get information on how to apply for this type of referral.

In some surveys the HMO specified that the specialist's records for that patient must be submitted to the plan as well as information from the PCP. This requirement was most common for all types of specialist referrals other than standing referrals. Decisions about referrals to out-of-network specialists were sometimes linked to geography, such as whether an in-network specialist was available within thirty miles of the consumer.

## Conclusions and Recommendations

The results of our survey demonstrate that New Yorkers are not able to consistently exercise their legal right to access to specialty care from an HMO. Most telling was the experience of two HMO enrollees who were denied access to a specialist when each made a call to their HMO. When the enrollee then received counseling from PPEF staff on their rights, and how to press their point with their HMO, the HMO did approve access to specialty care. ***It is simply not acceptable that consumers must have the benefit of a detailed knowledge of their rights, and consumer advocacy training, to readily access specialty care.***

This is not to say that all plans are failing to meet their obligations; several of the consumers who called their HMO were able to receive accurate information about access to specialty care. However, others were told that specialty care services were not available. For several plans, the responses and assistance provided varied from one call to the next, even when the same questions were asked of the same plan. The survey responses confirm anecdotal evidence that consumers do not get consistent answers from member services representatives.

Overall, the plans generally were able to answer questions about standing referrals to a specialist. Their responses about other types of referrals varied widely, from clear

explanations about how to obtain a particular type of referral, to claims that it was not possible to get a specific type of specialist referral.

Two plans failed to even answer their phones in response to calls from a prospective enrollee. These plans appear to be in violation not only of the law but also of agreements the plans signed with the New York State Attorney General.

Many HMOs have relaxed the rules on prior-approval for some specialty care, due to widespread concern by both consumers and practitioners that such prior-approval was blocking access to needed care. Our survey found that many plans have delegated decisions on standing referrals to the primary care provider. This delegation improves access to specialty care. As a result, we found that virtually every plan that answered their phone could provide acceptable or better information to prospective consumers on how to access standing referrals. In two instances, the HMOs had gone one better, by not requiring a referral for most types of specialists.

However, delegating decisions to a PCP does not remove the legal obligation of the plan to allow consumers to appeal a decision by the PCP to deny access to the specialist. ***Most plans failed to provide acceptable, or legally correct, information to consumers on how to appeal when the PCP or plan denies access to a specialist. This is an area of major concern to consumers.***

The survey also reveals a continued ambiguity in New York law with regard to referrals and utilization review. HMOs told surveyors that a referral would be decided based on medical need but then frequently told the surveyor that an appeal of a denial would be made under the grievance process when in fact all medical necessity denials are to be done through the utilization review process. The grades for these plans reflect the inherent conflict in their statements.

The confusion occurs because referrals may be denied for reasons relating to the contract or medical necessity. For example, if an HMO restricts patients to receiving care from a provider in the HMO's network, that denial would be made for contractual reasons and go through the grievance process. On the other hand, if a patient believes that there is not a provider in the HMO's network who is qualified to provide the care they need, that is a dispute over medical necessity. The provisions in the specialty care section of the law are really driven by concerns about medical necessity: would the patient get better care from a specialist serving as a PCP?; does a patient with a serious disease need the services of a specialty care center?; is there a provider in the HMO's network who has sufficient experience performing a rare operation to safely treat the patient? So in these cases a dispute over a denial should be handled through the utilization review process, which includes access to an external review.

It is worth noting that there is an important difference between standing referrals and the other referrals included in the access to specialty care provisions. The standing referral provision is not a denial of a referral; it is a denial of the ability to see a specialist without receiving a referral before each visit. On the other hand the other three provisions – a

specialist as PCP; access to a specialty care center; going outside the network because there is not a qualified provider within the HMO's network – are issues of the medical needs of the patient.

The NYS Department of Health (DOH) should resolve the ambiguity about referrals and medical necessity. For consumers, disputes about referrals for specialty care are best determined based on the medical needs of the patient, which is the entire thrust of the utilization review process. Therefore, DOH should deem referral determinations to be based on medical necessity and appeals should be resolved through the utilization review process. Medical necessity should be the criterion for determining access to specialist as PCP; access to a specialty care center; and going outside the HMO's network when there is no qualified provider within the network. In addition, medical necessity should be the criterion for determining access to a particular type of specialist when there is a dispute as to whether a provider has the right experience, training, or specialty to provide appropriate care.

On the other hand, the grievance process can handle denials of standing referrals since the primary purpose of this type of referral is decreasing the effort associated with obtaining repeated referrals to see the same specialist.

If the DOH fails to recognize this distinction, then the Legislature should clarify the law.

### **Recommendations to consumers and advocates:**

Given the uneven response of plans, we recommend that consumers and advocates:

- Call the HMO again on another day to get a different representative if you don't get an adequate response the first time you ask for a referral.
- Ask to speak to a supervisor if the member services representative does not give a positive response on how to access specialist care referrals.
- Have your member handbook ready when you call and read the sections about specialist referrals if the plan's representative doesn't know what you're asking about.
- Be persistent and follow the appeals procedure if you are denied a specialist referral.
- If your PCP has the full authority to decide referrals and denies your request, ask for a second opinion from another PCP.
- Speak to your specialist about the rationale for any specialist referral you want.

The Public Policy and Education publishes a detailed guide to consumer rights under New York's managed care laws. *The Consumers' Guide to New York's Managed Care Bill of Rights* is free to consumers and may be ordered by emailing: [ppef@citizenactionny.org](mailto:ppef@citizenactionny.org); or by calling: (518) 465-4600.

## **Recommendations to New York State Department of Health:**

The New York State Department of Health should issue regulations on access to specialty care. These regulations should take into account recent changes in plan practices with regard to referrals. The regulations should:

- Require each HMO to establish procedures for referrals to specialists, including timeframe for decision-making. New York law specifically requires that HMOs establish procedures for access to specialty care. However, the Department of Health has not required HMOs to establish such procedures; it has accepted the most minimal procedures that clearly fail to meet the details of the law, which instructs plans to involve several parties, including the enrollee, primary care provider, specialist and the plan's medical director, in such decisions.
- Allow plans to permit enrollees to seek specialty care without a referral.
- Allow primary care providers to make referrals on their own, so long as the enrollee, specialist and plan medical director are consulted before the PCP makes a final decision to deny a referral.
- Require plans that give the PCP full authority to make standing referrals to have a clear procedure and timeframe for providing a written denial notice and how to appeal the PCP's denial of a referral.
- Establish standards to interpret the law's requirement for involving the specialist in making decisions about specialty care referrals.
- Require plans to use medical necessity, and therefore the utilization review process, as the criterion for determining access to a particular type of specialist; access to specialist as PCP; access to a specialty care center; and going outside the HMO's network when there is no qualified provider within the network. These disputes are best determined based on the medical needs of the patient, which is the entire thrust of the utilization review process. On the other hand, the grievance process can handle denials of standing referrals.