- ❖ If an enrollee has not seen the assigned PCP and has seen multiple unassigned PCPs, the enrollee will be assigned to the PCP with the most visits.
    - o If the enrollee has the same number of visits with multiple unassigned PCPs, the enrollee will be assigned to the most recently visited PCP.
- ❖ If the enrollee has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, the MCO will reassign that enrollee appropriately, even if the unassigned PCP's panel shows that it is closed. The enrollee-PCP relationship takes priority over a closed panel.

An enrollee will also be eligible for reassignment to another PCP under the following conditions:

- ❖ if they have not visited any PCP within the previous 12 months.
- ❖ If they are under 4 years of age and have not visited a PCP within the previous 6 months.
- ❖ If they have not visited a PCP within 6 months of giving birth.

All reassignments shall be prospective. An enrollee who has been reassigned may be transferred to another PCP upon enrollee request and in accordance with the Contract.

Provider Notification

MCOs must publish the results of the claims analysis to their provider portals on the 15th calendar day of the second month of each quarter. If the due date falls on a weekend or a State-recognized holiday, the results shall be published on the next business day.

The results shall identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only considering this data is subject to change via the dispute protocol below.

The results of the analysis shall be published in a format that is able to be downloaded/exported into Excel. The PCP is allowed 15 business days to review before any enrollees are reassigned.

MCOs must also include a protocol for provider disputes with the results from the claim analysis. To dispute the reassignment of the enrollee(s) from the PCP, the provider must provide documentation (e.g., medical record, proof of billed claim, etc. for at least one date of service) that they have seen the enrollee(s) during the previous 12 months.

MCOs must incorporate a flag for providers to identify new enrollees on their rosters/panels easily and a flag to indicate if the enrollee was auto-assigned or not. This flag is for all enrollees, not just reassigned enrollees.

Enrollee Notification

MCOs must incorporate the process for notifying the affected enrollees within the policy.

~~LDH Notification~~

~~In accordance with the standard reporting deadlines established in the Contract, MCOs shall report the following to LDH on a quarterly basis:~~

- ~~Number of PCPs included in the analysis.~~
- ~~Number of PCPs with at least one enrollee reassigned from their panel.~~

- ~~Number of PCPs with at least one enrollee reassigned to their panel.~~
- ~~The name of any PCP that had no changes to their panel from the reassignment analysis.~~

Referral System for Specialty Health Care

The MCO shall have a referral system for MCO enrollees requiring specialty healthcare services to ensure that services can be furnished to enrollees promptly and without compromise to care. The MCO shall provide the coordination necessary for referral of MCO enrollees to specialty providers. The MCO shall assist a PCP or enrollee with getting an appointment with the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services, and follow up are included in the PCP's enrollee medical record. The MCO must assist the PCP or enrollee with making an appointment. Contact information for accessing referral system services should be clearly outlined in provider and enrollee materials.

The MCO shall submit referral system policies and procedures for review and approval within 30 calendar days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:

- When a referral from the enrollee's PCP is and is not required;
- Process for enrollee referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the enrollee;
- Process for providing a standing referral when an enrollee with a condition requires on-going care from a specialist;
- Process for assisting PCPs find specialists when their attempts have been unsuccessful. This process shall include a form that can be faxed or securely e-mailed to the MCO, with a 72 hour turnaround to the provider;
- Process for referral for specialty care for an enrollee with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;
- Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or an enrollee of the provider's family has a financial relationship; and
- Processes to ensure monitoring and documentation of specialty healthcare services and follow up are included in the PCP's enrollee medical record.

There must be written evidence of the communication of the patient results/information to the referring physician by the specialty healthcare provider or continued communication of patient information between the specialty healthcare provider and the primary care provider; and

Process for referral of enrollees for State Plan services that are excluded from MCO covered services and that will continue to be provided through fee-for-service Medicaid.

The MCO shall develop electronic, web-based referral processes and systems.

ACCESS TO MEDICATION ASSISTED TREATMENT

The MCO shall refer to the *Reporting* section of this Manual for required MAT reporting.