

7 OB/GYN AND FAMILY PLANNING

7.1 SCOPE OF SERVICE

Within the SHP health care delivery system, the OB/GYN Specialist Provider is a participating provider who has agreed to provide obstetric and/or gynecological services to SHP Medicaid, Family Health Plus and Child Health Plus

Participating OB/GYNs deliver services to members on a “self-referral” basis. A Referral Voucher Form (RVF) is not required for a Member to obtain OB/GYN services as per NYS regulations.

Suffolk Health Plan includes Family Planning and Reproductive Health services in its Benefit Package. Family Planning and Reproductive Health services mean the offering, arranging and furnishing of those health services which enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies.

All SHP members of reproductive age, including minors who may be sexually active, at the time of Enrollment may self-refer to family planning and reproductive health services.

7.1.1 Cost Sharing

Providers may not bill any SHP member for any service covered by the SHP. Our payment is payment in full for all services with the exception of any applicable permitted deductible, co-insurance or co-payments. When providing services not covered by SHP, the provider must advise the member prior to initiating the service that the service is not covered by SHP, the specific cost of the service and that the service will be the financial responsibility of the member; and **obtain the written consent of the member authorizing the provider to render the non-covered service**. SHP will bear no financial responsibility for services not covered by the Plan.

7.2 ROLE OF THE OB/GYN

The OB/GYN must:

1. Adhere to New York State Department of Health Prenatal Care Assistance Program (PCAP) guidelines (Refer to Appendix for details).
2. **Notify SHP of all pregnancies** and coordinate care for these members. Use the Prenatal Notification Form and fax to 1-877-267-7900 or call 1-800-250-5007 and ask for the Maternity Case Manager
3. Educate pregnant women and families with children under twenty-one (21) about the C/THP program and its importance to a child's or adolescent's health.

4. Educate pregnant members on their responsibility to follow the appropriate prenatal visit schedule.
5. Conduct outreach (e.g., by mail and telephone) to ensure members are kept current with respect to their prenatal visit schedules, and conduct follow-up with members who miss or cancel appointments.
6. Educate, screen and treat members for sexually transmitted diseases, and report information to the local health department in accordance with existing State and local laws and regulations.
7. Report other communicable diseases to the New York State Department of Health in compliance with the New York State Sanitary Code. The diseases and conditions that must be reported include AIDS, Parasitic diseases, Tuberculosis, Vaccine preventable diseases, Other reportable diseases, Poisonings (drugs, lead or other toxic agents), Injuries (animal bites and falls), outbreaks. . For assistance, call the New York State Department of Health Communicable Disease Program at 518-473-4439. or 866-881-2809 after hours for the current reportable disease list.
8. Encourage Medicaid members to attend enhanced services which promote wellness and prevent illness including general health education classes, smoking cessation classes, childbirth education classes, parenting classes, nutrition counseling, and extended care coordination for pregnant women, as per PCAP guidelines.
9. Permit direct access for female members to obstetrics and gynecology services pursuant to Public Health Law Section 4406 b(1) and, communicate patient updates to the PCP if care exceeds two (2) visits;
10. Follow New York State Department of Health appointment scheduling standards:
 - emergency care immediately upon presentation at a service delivery site,
 - urgent medical or behavioral problems within 24 hours,
 - non-urgent "sick visits" within 48 to 72 hours, as clinically indicated,
 - routine, non-urgent or preventive care visits within 4 weeks,
 - specialist referrals (not urgent) within four (4) to six (6) weeks of request'
 - adult baseline and routine physicals within 12 weeks of enrollment (adults older than 21),
 - well child care within four (4) weeks of request,
 - initial prenatal visits within 3 weeks during the first trimester, 2 weeks during the second trimester and 1 week thereafter,
 - initial visit for newborns to their PCP within 2 weeks of hospital discharge,
 - initial family planning visits within 2 weeks of request,

- mental health or substance abuse follow-up visits pursuant to an emergency or hospital discharge with a Participating Provider within 5 days, or as clinically indicated,
 - non-urgent mental health or substance abuse visits within 2 weeks of request, and
 - visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a member's ability to perform work when requested by LDSS within ten (10) days of request by the MMC Enrollee
11. Comply with the SHP 1 hour office wait time standard for members in provider offices. If you are delayed you must provide an explanation and offer the member the opportunity to reschedule the appointment.
 12. Serve as an after hours "on-call" telephone resource to members with medical problems.
 13. Have a coverage system in place for twenty-four (24) hours a day, seven (7) days a week access, that meets New York State Department of Health requirements and instruct members on what to do to obtain services after office/center operating hours. (Refer to Appendix for details). If your after hours call system is an answering machine it must direct the member to a live voice. Your answering machine may not direct members to the ER.
 14. Screen all pregnant members and conduct ongoing risk assessments for both maternal and fetal risk at subsequent prenatal follow-up visits for all pregnant women, as per PCAP guidelines. Risk assessments include genetic, nutritional, psychosocial, historical and emergency obstetrical, medical-surgical risk factors, and HIV counseling and testing. Psychosocial assessments include economic, social, psychological and emotional problems as well as past domestic violence or sexual assault.
 15. Develop and/or coordinate programs of nutrition screening and counseling as required by NYSDOH regulations.
 16. Provide HIV pretest counseling with clinical recommendation of testing to all pregnant women. Those women and their newborns must have access to services for the positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. Call SHP's Care Management Department for case management services at 1-800-250-5007.
 17. Provide services to the HIV+ population as per AIDS Institute guidelines and protocols, as well as address the HIV prevention needs of uninfected members and newborns:
 - provide patients with HIV related education and risk reduction information;
 - promote early identification and prevention of HIV to members,

- inform members of the availability of both in-plan HIV counseling and testing services, as well as those services available from New York State-operated Anonymous Counseling and Testing Programs
 - inform pregnant women where they and their newborns can obtain access to services for positive management of HIV disease, psychosocial support and case management for case management for medical, social and addictive services
 - assure timely and accurate required reporting
 - use AIDS Institute protocols and procedures for patient evaluation
 - encourage early entry into treatment, paying special attention to HIV+ women who are pregnant, and
 - participate in case management activities to ensure that all necessary services are furnished on a timely basis.
18. SHP protects the rights of its members, and expects all Providers to protect the rights of their patients, to:
- a. Receive information about SHP and managed care;
 - b. Be treated with respect and due consideration for his or her dignity and privacy; Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand or if the member is not able to understand this information provide it to their designee on the member's behalf.
 - c. Participate in decisions regarding his or her health care, including the right to refuse treatment;
 - d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in Federal regulations on the use of restraints and seclusion; and
 - e. If the privacy rule, as set forth in 45CFR Parts 160 and 164, subparts A and E, applies, request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.
 - f. SHP members have the right to all of the above without any adverse regard from any Provider.
19. Maintain a separate **legible centralized** medical record for each pregnant member for the provision of prenatal care and other services with dated and signed entries that completely describe all encounters. The medical record for *adult* members should indicate that the PCP has discussed the preparation of an Advanced Health Care Directive. It must be clearly indicated if the discussion occurred and that the member does or does not have an Advanced Health Directive. All medical records must be retained for a period of ten years as indicated in your provider contract. In addition, SHP requires that all medical records be accessible to SHP for Utilization

Review and Quality Assurance purposes as well as to the Centers for Medicaid and Medicare Services (CMS) and the New York State Department of Health. **Detailed Medical Record Guidelines are available in Appendix Tab #11.**

20. Providers may not bill any SHP member for services covered by the SHP. Our payment is payment in full for all services with the exception of any applicable co-insurance or co-payments or permitted deductibles. When providing services **not covered** by SHP, the provider must advise the member prior to initiating the service that the service is not covered by SHP, the specific cost of the service and that the service will be the financial responsibility of the member; and obtain the written consent of the member authorizing the provider to render the non-covered service. **SHP will bear no financial responsibility for services not covered by the Plan.**
21. Providers should report services using the CMS1500 universal claim form (or UB04). The claim form must include CPT-4 codes (including preventive care CPT codes where appropriate), place of service codes, appropriate ICD-9-CM codes for each service (i.e. well visit service codes should have well visit diagnosis codes), the Provider name, and the correct SHP provider ID number. Submit claims to:

**Suffolk Health Plan
PO Box 6008
Hauppauge, NY 11788-9007**

7.2.1 Transition of Care-Provider Left Network

Consider a Member's request for Continuation of Care should you leave the SHP network. A transition period begins on the date the provider's contractual obligation to provide services with SHP terminates and ends no later than ninety (90) days thereafter, or for pregnant members, a transitional period to include postpartum care directly related to the delivery if the Member has entered the second trimester of pregnancy.

This request is conditional on whether you agree to continue to adhere to SHP's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by SHP, adhere to SHP's Quality Assurance requirements, to accept SHP's reimbursement as payment in full, and if your termination from the network is not the result of the suspension or revocation of your license to practice medicine in the State of New York. The request for Continuation of Care should come from the Member.

7.2.2 Transition of Care- New Member

If a member is being treated by a non-participating provider for a life threatening disease or condition or disease or a degenerative or disabling disease or condition, SHP will allow the member to continue treatment with the non-participating provider for a transition period of up to sixty (60) days.

If the member has entered the second trimester of pregnancy at the effective date of enrollment, SHP will allow the continued use of the non-participating provider for a transitional period which shall include the provision of postpartum care directly related to the delivery.

7.2.3 CHILD TEEN HEALTH PROGRAM /ADOLESCENT PREVENTIVE SERVICES

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health.

Suffolk Health Plan (SHP) and our Participating Providers are required to provide the Child Teen Health Program (C/THP) services and be compliant with the Early Periodic Screening and Diagnostic Testing (EPSDT) requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found.

The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

SHP is required to educate participating providers about the program and their responsibilities under it.

SHP and SHP Participating Providers must provide C/THP services to Enrollees under twenty-one (21) years of age when:

1. The care or services are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition.
2. The care or services are essential to the overall physical, cognitive and mental growth and developmental needs of the Enrollee.
3. The care or service will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for individuals of the same age as the Enrollee.

4. SHP shall base its determination on medical and other relevant information provided by the member's PCP, other health care providers, school, local social services, and/or local public health officials that have evaluated the member.

SHP complies with the C/THP program standards and SHP Participating Providers are required to do at least the following with respect to all Enrollees under age 21:

1. Educate Enrollees who are pregnant women or are parents of Enrollees under age 21 about the program and its importance to a child's or adolescent's health.
2. Educate Participating Providers about the program and their responsibilities under it.
3. Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure children are kept current with respect to their periodicity schedules.
4. Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments.
5. Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.
6. Achieve and maintain an acceptable compliance rate for screening schedules during the contract period.
7. In addition to C/THP requirements, SHP requires that Participating Providers comply with the American Medical Association's Guidelines for Adolescent Preventive Services which require annual well adolescent preventive visits which focus on health guidance, immunizations, and screening for physical, emotional, and behavioral conditions.

7.3 FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

Family planning services mean the offering, arranging and furnishing of those health services which enable individuals, including minors who may be sexually active to prevent or reduce the incidence of unwanted pregnancies. Such services include professional medical counseling services, prescription drugs, nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner or physician's assistants, and sterilization. Family planning services do not include hysterectomy procedures. Offering of and arranging for family planning means providing services under the medical assistance program.

Medicaid Managed Care (MMC) Members may receive such services from any qualified Medicaid provider (Free Access), regardless of whether the provider is a SHP Participating or Non-Participating Provider, without referral from the member's PCP and without approval from SHP.

Family Health Plus (FHP) Members may receive such services from **any SHP Participating Provider** without referral from the member's PCP and without approval from the SHP.

SHP Members should be informed that they have the right to:

- Obtain Family Planning and Reproductive Health services and supplies without referral or approval.
- Obtain full range of Family Planning and Reproductive Health services, including HIV counseling and testing when performed as part of a Family Planning and Reproductive Health encounter, from the SHP's Participating Provider without referral, approval or notification.

Family Planning and Reproductive Health services include the following medically-necessary services, related drugs and supplies which are furnished or administered under the supervision of a physician, licensed midwife or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit for the purpose of:

- A) Contraception, including all FDA-approved birth control methods, devices such as insertion/removal of an intrauterine device (IUD) or insertion/removal of contraceptive implants, and injection procedures involving Pharmaceuticals such as Depo-Provera;
- B) Emergency contraception and follow up; Sterilization; Screening, related diagnosis, and referral to a Participating Provider for pregnancy;
- C) Medically-necessary induced abortions, which are procedures, either medical or surgical, that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration.
- D) Family Planning and Reproductive Health services include those education and counseling services necessary to render the services effective.
- E) Family Planning and Reproductive Health services include medically-necessary ordered contraceptives and pharmaceuticals:
- F) When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit:

- Screening, related diagnosis, ambulatory treatment and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology.
- Screening, related diagnosis and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease.
- Screening and treatment for sexually transmissible disease.
- HIV testing and pre- and post-test counseling.

The cost of the member's Family Planning and Reproductive care will be fully covered. If the patient to whom you provide Family Planning and Reproductive care is a SHP member, remember to bill SHP for these services. (Some providers are billing Medicaid directly for these types of services provided to SHP members and this is not allowed).

7.4 CONSENT REQUIREMENTS FOR HYSTERECTOMY AND STERILIZATION

SHP Participating Providers must comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR Part 441, sub-part F.

7.4.1 STERILIZATION

Sterilization is defined as any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. Medicaid and therefore SHP will reimburse for sterilization procedures and hysterectomies only if all the following requirements are met;

- A) Sterilization of a mentally competent individual aged 21 or older.
- The individual is at least 21 years old at the time consent is obtained;
 - The individual is not a mentally incompetent individual;
 - The individual has voluntarily given informed consent in accordance with all the requirements prescribed in §§441.257 and 441.258; and
 - At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
- B) Mentally incompetent or institutionalized individuals.

- Federal Financial Participation is not available for the sterilization of a mentally incompetent or institutionalized individual.

7.4.2 HYSTERECTOMY

Hysterectomy is defined as a medical procedure or operation for the purpose of removing the uterus.

- 1) Federal Financial Participation (FFP) is not available in expenditures for a hysterectomy if—
 - a) It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
 - b) If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.
- 2) Federal Financial Participation (FFP) is available in expenditures for a hysterectomy not covered by paragraph (a) of section 1 only under the conditions specified in paragraph (3), (4), or (5) of this section.
- 3) Federal Financial Participation (FFP) is available if—
 - a) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
 - b) The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.
- 4) Effective on March 8, 1979 or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available if—
 - a) The individual—
 - i) Was already sterile before the hysterectomy; or
 - ii) Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible; and
 - b) The physician who performs the hysterectomy—
 - i) Certifies in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or
 - ii) Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. He or she must also include a description of the nature of the emergency.

- 5) Effective March 8, 1979, or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available for hysterectomies performed during a period of an individual's retroactive Medicaid eligibility if the physician who performed the hysterectomy certifies in writing that—
 - a) The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing; or
 - b) One of the conditions in paragraph (d)(1) of this section was met. The physician must supply the information specified in paragraph (d)(2) of this section.

7.4.3 ADDITIONAL CONDITION FOR FFP (Federal Financial Participation).

FFP is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met. This documentation must include a consent form, an acknowledgement of receipt of hysterectomy information or a physician's certification under §441.255(d)(2), as applicable.

With regard to the requirements of §441.255(d) for hysterectomies performed from March 8, 1979 through November 2, 1982, FFP is available in expenditures for those services if the documentation showing that the requirements of that paragraph were met is obtained by the Medicaid agency before submitting a claim for FFP for that procedure.

7.4.4 INFORMED CONSENT

An individual has given informed consent only if—

- (1) The person who obtained consent for the sterilization procedure offered to answer any questions that the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:
 - (i) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
 - (ii) A description of available alternative methods of family planning and birth control.
 - (iii) Advice that the sterilization procedure is considered to be irreversible.

- (iv) A thorough explanation of the specific sterilization procedure to be performed.
 - (v) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
 - (vi) A full description of the benefits or advantages that may be expected as a result of the sterilization.
 - (vii) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in §441.253(c).
- (2) Suitable arrangements were made to insure that the information specified in paragraph (a)(1) of this section was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;
 - (3) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;
 - (4) The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;
 - (5) The consent form requirements of §441.258 were met; and
 - (6) Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.
- 2) Informed consent may not be obtained while the individual to be sterilized is—
- (1) In labor or childbirth;
 - (2) Seeking to obtain or obtaining an abortion; or
 - (3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

7.5 SPECIAL REFERRALS

Special referrals are authorized and dispensed when certain cases arise.

7.5.1 Referrals to Non-participating Providers

If Suffolk Health Plan (SHP) determines that it does not have a health care provider with appropriate training and experience in its network to meet the particular health care needs of an enrollee, SHP shall make a referral to an appropriate provider outside of its network, pursuant to a treatment plan approved in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

7.5.2 Standing Referral

An enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. As long as the following conditions are met:

- SHP or the primary care provider in consultation with the medical director of the organization and specialist, if any, determine that such a standing referral is appropriate.
- Treatment plan approved by SHP in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

SHP is not required nor are our members permitted to elect a non-participating specialist, unless the member requires a provider with a specialty that we do not have in our network.

7.5.3 Specialist as a PCP

SHP has a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, 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;

may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If SHP, or primary care provider in consultation with a medical director and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, SHP shall refer the enrollee to such specialist.

In no event shall SHP be required to permit an enrollee to elect to have a non-participating specialist. Such referral shall be pursuant to a treatment plan approved by SHP, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee.

Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such 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.

If an organization refers an enrollee to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

If SHP authorizes the transfer of primary care responsibilities to a specialist, the specialist then coordinates the member's care, completes referrals for needed services, and is responsible for all preventive care and health education activities as outlined in **Section 5.3**.

All members who have requested to have a specialist serve as their PCP are considered for possible enrollment in SHP's Case Management services (see Section 12 for further information). Members whose request, to have the Specialist act as their PCP, is approved are automatically enrolled in Case Management.

7.5.4 Referral to a Specialty Care Center

SHP has a procedure by which an enrollee 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,

may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If SHP, or the primary care provider or the specialist designated in consultation with a medical director, determines that the enrollee's care would most appropriately be provided by such a specialty care center, SHP shall refer the enrollee to such center.

In no event shall SHP be required to permit an enrollee to elect to have a non-participating specialty care center, unless SHP does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network.

Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health maintenance organization, in consultation with the primary care provider, if any, or a designated specialist, and the enrollee or the enrollee's designee.

If SHP refers an enrollee to a specialty care center that does not participate in its network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

For purposes of this paragraph, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

7.6