Provider Network Data System (PNDS)

Overview

New York State Department of Health
Office of Health Insurance Programs
Bureau of Outcomes Research

OPEN Data NY

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General Description

The Provider Network Data System (PNDS) was implemented by the New York State Department of Health in December of 1996 to gather information about the provider and service networks contracted to managed care plans operating in New York State. The primary purpose for the PNDS is to collect data needed to evaluate the provider networks including physicians, hospitals, labs, home health agencies, durable medical equipment providers, etc., for all types of managed care plans in New York State, including HIV SNPs, FHP Buy-In, PACE, and Non-PACE MLTC plans.

Data Collection Methodology

PNDS data is submitted through an Internet connection to the Health Commerce System (HCS), also known as the Health Provider Network (HPN), a secure Intranet site requiring an ID and password. Managed care plans electronically submit provider network data quarterly (Medicaid, Child Health Plus, Family Health Plus and HIV Special Needs Plan (SNP) networks) or annually (Commercial managed care networks).

Medicaid submissions are a snapshot of the week in which the last day of the calendar quarter falls. Quarters end March 31, June 30, September 30, and December 31. The snapshot week includes the last day wherever it falls in the week. Annual submissions are only for the week including December 31. This submission includes the plan's entire network.

Statistical and Analytic Uses

1. Provider Eligibility Assessment

PNDS data is matched against information on professional licensing, Office of Professional Medical Care sanctions, and Medicaid and Medicare provider eligibility, to assure that only qualified providers are delivering health care to plan members. Facilities are checked for valid operating certificate numbers and that

operating certificate numbers match the type of facility indicated.

2. Comprehensive Services Assessment

The Department of Health conducts network assessments to assure that comprehensive health services are available as required under Section 4403 of the Public Health Law. The Office of Health Insurance Programs, Bureau of Managed Care Certification and Surveillance uses data from the PNDS to assess whether a managed care plan has contracted with an appropriate range of primary care practitioners, clinical specialists and service facilities (hospitals, labs, etc.) within the managed care plan's service area. Evaluations are completed on plans serving Commercial, Medicaid, Child Health Plus, HIV Special Needs Plan (SNP) and Family Health Plus populations.

3. Access and Travel Assessment

Managed care plans serving Medicaid recipients are evaluated against established access and travel standards using PNDS data.

4. Finding a Plan Provider

Customized directories of providers by county are created from PNDS data.

5. Capacity Analysis

PNDS data is used to calculate the potential capacity of a managed care plan's primary care providers. The calculation estimates the number of full time equivalent primary care providers and assumes that each FTE can serve up to 1,500 Medicaid members.

6. Investigation of Fraud

Data from PNDS is matched with Medicaid Encounter Data System data to identify Medicaid providers who have been identified as unable to participate in Medicaid managed care but had an encounter with a patient during the quarter. The file of identified providers is sent to the Bureau of Certification and Surveillance for action.

7. County Network Review

PNDS data is provided to county Departments of Social Services for use in local