

# ACCESS TO CARE AND DELIVERY SYSTEM

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# ACCESS TO CARE AND DELIVERY SYSTEM

This chapter outlines EmblemHealth policies and procedures for the provision of medical care to our members, including participation requirements, role of primary care providers and provider termination procedures.

## ACCESSIBILITY AND TIMELINESS OF CARE

All EmblemHealth plan members are entitled to:

- An initial assessment of their health care status performed within 90 days of enrollment (For Medicaid members over age 21, within 12 weeks [84 days])
- Information regarding health care needs that require follow up
- Self-care training (as necessary)

## OFFICE HOURS

Health care professionals must notify EmblemHealth (and the HIP Network Services IPA, Inc., if applicable) within five business days after any change in office address, telephone number and/or office hours.

From time to time, regulatory agencies will audit Plans' directories for accuracy and may impose fines and/or penalties when information is found to be inaccurate. Any fines/penalties received by the Plan **or negative financial impact experienced by the Plan** due to a Practitioner's failure to notify the Plan of any required change listed above will be levied to the Practitioner in the amount equal to the fine/penalty.

Health care professionals doing business as primary care physicians must maintain office hours not less than two (2) days per week, eight hours per day, at each primary care office.

## TELEPHONE RESPONSE

Telephone response to member calls to the office should be handled by the physician or designated office staff (as appropriate to the situation) while adhering to the following guidelines:

- Emergency conditions should receive immediate response
- Urgent conditions should be responded to within four hours
- Semi-urgent conditions should be responded to during the current day
- Routine conditions should be responded to within two working days
- After hours calls where the nature is unclear should receive response within 30 minutes

## UPDATE YOUR PRACTICE RECORDS

Your practice information appears in our network directories (including our online **Find a Doctor** tool) and is used in claims processing. Keeping your information up to date helps ensure that patients can locate your practice and we process your claims accurately. You must report

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updates to your practice information whenever change occurs in the following:

- Ability to accept new members
- Age-range limitations applicable to the health care professional
- Add or delete a provider from your practice
- Email address
- Fax number
- Hospital affiliations
- IRS taxpayer identification number (TIN)
- Languages spoken in your office
- Medicaid Number is assigned
- Medicare Number is assigned
- National Provider Identifier (NPI) number is assigned
- Office hours
- Opening or closing a primary care panel
- Practice address
- Practice phone number used for scheduling patient appointments
- Billing information
- Specialties
- Wheelchair accessibility has been added to a practice location
- When an OB/GYN opts to see GYN-only patients

**Unless you're part of a group that has arranged to submit changes via a spreadsheet/ dataset process, providers, and their staff, can access and update their practice records on our secure provider website. For changes that cannot be processed online, mail or fax your changes to our Provider Modifications team:**

*Provider Modifications Team*  
*EmblemHealth*  
*55 Water Street, 6th Floor*  
*New York, New York, 10041-8190*

Fax: **1-877-889-9061** 

Providers must inform EmblemHealth as soon as possible or within five (5) business days after any change to office address, telephone number, office hours, specialty, languages spoken, hospital affiliation, addition or termination of an individual provider in a medical group. Updates to your practice information will be posted to the EmblemHealth website within 15 days. In general, some updates, such as to your license number, specialty or school, will be verified by our Credentialing department and may take longer to appear.

**Note:** Removing an individual provider from a service location will not affect previously submitted claims. EmblemHealth will continue to process claims with a Date of Service on or before the provider's termination date for that location.

EmblemHealth may terminate a provider if he/she fails to notify EmblemHealth of any required

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changes in a timely manner (subject to any applicable reconsideration or hearing rights required by state or federal law).

From time to time, regulatory agencies will audit the Plans' directories for accuracy and may impose fines and/or penalties when information is determined to be inaccurate. Any fines/penalties received by the Plan due to a Practitioner's failure to notify the Plan of any required change listed above will be levied to the Practitioner in the amount equal to the fine/penalty.

## Change of Ownership

A change of ownership (CHOW) cannot be performed online; a CHOW is treated like a new enrollment. When a change of ownership occurs, providers must contact EmblemHealth. The appropriate contact information can be located in the **EmblemHealth Contact Information** section of the Directory chapter.

## Know Your Network Participation

The provider profile also lists your network affiliations. If the network information on the member's ID card matches your network affiliations, then you are in-network for that member's benefit plan. See the **Provider Networks and Member Benefit Plans** chapter for a listing of all networks and plans.

Note: Some government program cards don't have network names; however, they are easily identified by the plan name. Digital representations of our most common member ID cards are located in the **Member Identification Cards** section of the Your Plan Members chapter.

Ask to see a member's ID card at each appointment, emergency visit or inpatient stay. However, the provision of service should not be conditioned solely on the presentation of a member ID card because a member's enrollment status can change due to various reasons. Sign in to our secure provider website to check your patients' eligibility status.

Keeping your information current ensures we send your claims payments and other important correspondence to the correct address. It also helps our members contact you at your current location. We recommend that you periodically review the information we have on file for you and encourage you to share your network participation and any changes with your staff on a regular basis.

## EMBLEMHEALTH ACCESS STANDARDS

### Revised June 6, 2018

Practitioners are expected to adhere to EmblemHealth's appointment availability and 24-hour access standards for primary care physicians, OB/GYNs, Oncologists, specialists and mental health and substance abuse practitioners (as appropriate). These standards are based on industry, Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access standards.

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## **Appointment Availability Standards**

Practitioner offices will schedule appointments in a timely and efficient manner. Member visits to see a practitioner shall be scheduled based on EmblemHealth's **Appointment Availability Standards During Office Hours & After Office Hours Access Standards**, which is available at the end of this chapter.

Starting January 1, 2019, new access to care standards will be introduced to meet the needs of Medicaid children. See **Appointment Availability Standard by Service Type for Medicaid Children's Health and Behavioral Health Benefits**.

Customer Service will maintain and monitor standards for customer telephone access.

EmblemHealth conducts semi-annual appointment availability surveys by calling practitioner offices to determine the next available appointment for a given type of service. This determines both individual practitioner and overall network compliance with these standards as part of our Quality Management program. Noncompliant practitioners are notified and resurveyed approximately six months after the initial survey. Practitioners that are not compliant with these standards upon resurvey will be forwarded to our Recredentialing Committee for review and action.

## **24-hour Access Standards**

All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner. If an answering machine is used, it must provide an option for the member to directly contact the practitioner or covering practitioner in case of emergencies. An answering machine cannot simply refer the member to an emergency room unless it is a life-threatening issue.

## **Annual Practitioner Surveys for Appointment Availability and 24-hour Access**

EmblemHealth conducts annual surveys for appointment availability, by calling practitioner offices during office hours to determine the next available appointment for a given type of service, and 24-hour access by calling after-hours telephone numbers. These surveys determine both individual practitioner and overall network compliance with these standards as part of our Quality Management program.

Noncompliant practitioners are notified by letter that they failed one or more components of the survey. Practitioners that fail the survey are automatically included in the next survey administration. Practitioners who are not compliant with the standards and fail when they are re-surveyed will be forwarded to our Credentialing/Recredentialing Committee (CRC) for review and action.

The NYSDOH may also conduct surveys of your appointment availability and after-hours access.

## **Covering Practitioners**

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Covering practitioners should be contracted and credentialed by EmblemHealth's companies. Practitioners must provide EmblemHealth with a list of the covering physicians and notify us of any changes. If the covering practitioner in the coverage group does not participate with the EmblemHealth plan, the network practice must inform that practitioner of our policies and procedures. Out-of-network practitioners are prohibited from balance billing and they must clearly identify the name of the practice/practitioner for whom they are covering. Patients should be instructed by the covering physician to follow up with their PCP. Only one visit will be approved for the covering practitioner's services, unless the office is closed for more than 24 hours. If a practice is closed for an extended period of time, the practice must notify the Provider Relations department and any members that may be affected by the closure.

## **Urgent Care Access**

For urgent conditions that do not meet the layperson's definition of an emergency, EmblemHealth maintains a network Urgent Care Centers for all plan members. To access a list of participating urgent care centers, use the **Find a Doctor** tool on our website at [www.emblemhealth.com/find-a-doctor](http://www.emblemhealth.com/find-a-doctor).

## **Retired as of 5/31/2018**

Practitioners are expected to adhere to EmblemHealth's appointment availability and 24-hour access standards for primary care physicians, OB/GYNs, specialists and mental health and substance abuse practitioners (as appropriate). These standards are based on industry, Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access standards.

## **Appointment Availability Standards**

Practitioner offices will schedule appointments in a timely and efficient manner. Member visits to see a practitioner shall be scheduled based on EmblemHealth's **Appointment Availability Standards During Office Hours & After Office Hours Access Standards**, which is available at the end of this chapter.

Customer Service will maintain and monitor standards for customer telephone access.

EmblemHealth conducts semi-annual appointment availability surveys by calling practitioner offices to determine the next available appointment for a given type of service. This determines both individual practitioner and overall network compliance with these standards as part of our Quality Management program. Noncompliant practitioners are notified and resurveyed approximately six months after the initial survey. Practitioners that are not compliant with these standards upon resurvey will be forwarded to our Recredentialing Committee for review and action.

## **24-hour Access Standards**

All practitioners will provide access to medical advice or treatment when not in the office in the form of 24-hour coverage, seven days a week, 365 days a year. This 24-hour access will include:

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- An answering service or machine with an appropriate message explaining:
  - That patients should go to the emergency room if they reasonably believe that their health is in serious jeopardy if they do not seek immediate medical treatment.
  - How to access medical attention outside of an ER for conditions that are not life- or limb-threatening.
- Coverage by another practitioner in the event the practitioner is unavailable. Please see the **Claims** chapter for details on covering practitioners.
- A method to communicate issues, calls and advice from covering practitioners to the PCP and the member's file.

Covering practitioners should be contracted and credentialed by EmblemHealth's companies. Practitioners must provide EmblemHealth with a list of the covering physicians and notify us of any changes. If the covering practitioner in the coverage group does not participate with the EmblemHealth plan, the network practice must inform that practitioner of our policies and procedures. Out-of-network practitioners are prohibited from balance billing and they must clearly identify the name of the practice/practitioner for whom they are covering.

Patients should be instructed by the covering physician to follow up with their PCP. Only one visit will be approved for the covering practitioner's services, unless the office is closed for more than 24 hours. If a practice is closed for an extended period of time, the practice must notify the Provider Relations department and any members that may be affected by the closure.

Members also have access to urgent care centers. See the **Care Management** chapter for more information.

EmblemHealth conducts semi-annual surveys of 24-hour access by calling after-hours telephone numbers to determine whether members can reach a live voice and be connected either directly to their practitioner or to an answering machine/voice-mail system that asks the caller to leave a name and phone number so the call can be returned immediately. Noncompliant practitioners are notified and resurveyed approximately six months after the initial survey. Practitioners that are not compliant with these standards upon resurvey will be forwarded to our Recredentialing Committee for review and action.

## CUSTOMER SERVICE

EmblemHealth provides member services through our Customer Service. Customer Service Advocates assist members with questions about services, benefits, enrollment and other issues. Our computerized Member Contact System enables same-day responses to most member requests. If a member's inquiry cannot be resolved during the initial call on the same day, then a Customer Service Advocate strives to call the member back within 48 hours.

Provider Customer Care Advocates are dedicated on a full-time basis to assist providers with questions about EmblemHealth, participation status, contract questions and to provide education and educational material.

We are committed to encouraging and rewarding superior service and recognize that

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cooperation is an essential component of the provision of quality medical care.

**Customer Service will maintain and monitor standards for customer telephone access.**

## MEDICAL CARE DELIVERY SYSTEM

Medical care for EmblemHealth plan members is provided by a network of thousands of contracted practitioners (including multi-specialty practices) that provide care both in medical centers and in their own offices within the community.

We have contracted with an extensive and comprehensive array of facilities and ancillary clinicians to ensure a full continuum of care including an extensive network of prestigious teaching and community hospitals, skilled nursing facilities and freestanding ambulatory care centers.

EmblemHealth will maintain a network of practitioners adequate to meet the comprehensive and diverse health needs of its enrollees. Practitioner selection is based on meeting our minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act and cultural and linguistic competency.

In the event that a participating practitioner is not available with the skills required to meet a member's needs or is not available within a reasonable distance from the member's place of residence, EmblemHealth, when appropriate, will arrange and authorize the use of a nonparticipating practitioner at no additional out-of-pocket expense to the member.

## BEHAVIORAL HEALTH SERVICES

EmblemHealth has engaged Beacon Health Options to administer behavioral health services for most of its members under two programs. Members of plans underwritten by HIP or HIPIC and ASO plans administered by VHMS have their behavioral health services administered by Beacon Health Options under the Emblem Behavioral Health Services Program (EBHSP). GHI-underwritten plan members by have their behavioral health services administered by Beacon Health Options under the EmblemHealth Behavioral Management Program (BMP). For more information, please see the **Behavioral Health Services** chapter.

## THE PRIMARY CARE PRACTITIONER / PRIMARY CAREGIVER

EmblemHealth-contracted Primary Care Practitioners (PCPs) are responsible for supervising and coordinating medically necessary health care of their patients including, but not limited to:

- Providing health counseling and advice
- Baseline and periodic health examinations
- Diagnosing and treating conditions not requiring the services of a specialist
- Arranging inpatient care, specialist consults and laboratory/radiological services when medically necessary and in a timely manner

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- Coordinating the findings of consultants and laboratories and interpreting such findings to the member and the member's family (subject to HIPAA Privacy Rules)
- Maintaining a current medical record for each patient

PCPs are required to follow the standards of care contained in this manual and the administrative guidelines posted to our website, which are reflective of professional and generally accepted standards of medical practice. One of the first and most important decisions any member makes is the selection of a PCP. It is equally important for PCPs to establish a meaningful professional and lasting relationship with their patients. **A PCP cannot be his/her own or his/her family's primary care physician.**

If a member is using a behavioral health clinic that also provides primary care services, the member may select the lead provider to be their PCP.

Credentialed advanced nurse practitioners (ANPs) may act as primary caregivers, maintaining their own panel of EmblemHealth members and issuing referrals for specialty care. All ANPs functioning as primary caregivers must maintain a current collaborative relationship with an EmblemHealth physician who is participating in the same networks and coverage arrangement for hospital admissions at an EmblemHealth contracted hospital. ANPs may submit to EmblemHealth either a written collaborative agreement or the **NYS Education Department Collaborative Relationships Attestation Form (NP-CR)**. See the **Credentialing Chapter** for more information. In general, NPs and PAs are paid for covered services at 85 percent of what a physician is paid.

For more information on how to become credentialed with EmblemHealth as a primary caregiver, please sign in to our secure provider website at [www.emblemhealth.com/providers](http://www.emblemhealth.com/providers) and send us an email via our Message Center.

EmblemHealth encourages new members to contact their PCP within 90 days of enrollment for an initial evaluation. If the initial contact with the practitioner is for an acute visit, the practitioner should recommend that the member return for a general health assessment based on age, state of health and the member's last health assessment.

Each time a member needs to see a specialist, it is the PCP's/primary caregiver's responsibility to identify and refer the member to a participating practitioner and to give the member an appropriate referral, either for a consult only or for specific medical services. If the PCP or primary caregiver anticipates the need to refer a member for services that require a referral, prior approval, or the use of a non-participating provider, the request must be approved by EmblemHealth in advance.

All members have direct access to OB/GYN care without a referral or prior approval, as required by New York State law.

## **Primary Care Practitioner Responsibilities**

Primary care practitioners (PCPs) are responsible for providing primary care services and managing all necessary health care services for the members assigned to them. Coordinating all care and maintaining an overall picture of member health is key to helping members stay healthy while effectively managing appropriate use of health care resources.

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When providing primary health care services and coordination of care, the PCP must:

- Provide for all primary health care services that do not require specialized care. These include, but are not limited to:
  - Routine preventive health screenings.
  - Physical examinations.
  - Routine immunizations.
  - Child/Teen Health Plan Services (C/THP) screenings for children and adolescents (required for Medicaid members; as appropriate for other members).
  - Reporting communicable and other diseases as required by Public Health Law.
  - Behavioral health screening (as appropriate).
  - Routine/urgent/emergent office visits for illnesses or injuries.
  - Clinical management of chronic conditions not requiring a specialist.
  - Hospital medical visits (when applicable).
  - Maintain appropriate coverage for members 24 hours a day, seven days a week, three hundred and sixty-five days a year as noted in the above section on 24-hour access.
- Refer all members for services in accordance with EmblemHealth's referral policies and procedures. See the **Care Management** chapter of this manual for more details.
- Provide services of available allied health professionals and support staff in your office.
- Provide supplies, laboratory services and specialized or diagnostic tests that can be performed in the office.
- Assure members understand the scope of referred specialty or ancillary services and how/where the member should access the care.
- Communicate conditions, treatment plans and approved authorizations for services to member and appropriate specialists.
- Consult and coordinate with members regarding specialist recommendations.
- Comply with the New York State "Vaccine for Children Program," as appropriate, and with New York State and New York City requirements for reporting communicable diseases.

## **EmblemHealth Medicaid and Child Health Plus Participating Practitioners**

Practitioners treating members enrolled in Medicaid or Child Health Plus shall have no more than 1,500 members on their panel or 2,400 for a physician practicing in combination with a registered physician assistant or certified nurse practitioner. Advanced nurse practitioners credentialed as primary caregivers shall have no more than 1,000 members on their panel.

These member-to-practitioner ratios are based on the assumption that the practitioner works 40 hours per week and therefore must be prorated for practitioners working less than 40 hours per week. The ratios apply to practitioners, not to each of their practice locations.

## PRIMARY CARE PHYSICIAN SELECTION, ASSIGNMENT AND CHANGE POLICY FOR MEMBERS WHOSE BENEFIT DESIGN REQUIRES THE SELECTION OF A PCP

When EmblemHealth members first enroll, they choose where they want to receive medical care. Members can choose any participating primary care physician (PCP) with an open panel.

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Members who fail to select a PCP within a given period of time are assigned to a PCP and notified of the assignment in writing.

Members who subsequently wish to transfer to another network PCP may do so at any time for any reason by calling our Customer Service departments or by logging on to our Web site, [www.emblemhealth.com](http://www.emblemhealth.com). PCP changes take effect immediately upon request.

When members transfer from one network PCP practice to another, the PCP who previously treated the member is required to forward a copy of the member's medical record to the new PCP, allowing for continuity of care. The original record should be retained and treated as a terminated record.

Note that Medicaid members that are in the Restricted Recipient Program have restrictions on when they can change PCPs out of good cause reasons such as:

- Provider no longer wishes to be the RRP member's provider;
- Provider closed/moved servicing location or moved to a location that is beyond 30 minutes or 30 miles from RRP member's home;
- Provider no longer participates in HIP's network;
- Member moved beyond 30 minutes or 30 miles from RRP provider;
- Other circumstances exist that make it necessary to change providers, including but not limited to good cause reasons for changing PCPs as provided by applicable statute and regulations.

## REMOVAL OF A MEMBER FROM A PCP PANEL / DISCONTINUATION OF SPECIALTY CARE SERVICES

A PCP or Primary Caregiver may request removal of a member from his/her panel or a specialty care practitioner may request to discontinue treating a member if:

- The member repeatedly fails to keep appointments
- The member repeatedly disregards the practitioner's medical advice
- The member exhibits continual abusive behavior toward the practitioner or his/her office staff
- The practitioner is unable to establish a mutually beneficial relationship with the member

The practitioner should provide at least 90 days prior written notice to Provider Relations that he/she will not continue as the member's physician. Provider Relations will coordinate with the Customer Service department to notify the member.

## MEDICAL RECORDS TRANSFER

The medical records transfer procedure ensures that the new PCP will have a continuous medical record of the member. See the **Medical Record Guidelines** chapter of this manual for more details.

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## MEDICAL SPECIALISTS

EmblemHealth contracted specialist physicians agree to see members referred by a participating primary care physician except when members are seeking services to which they are permitted to self-refer or when a member's benefit design does not require the selection of a PCP. (See the **Direct Access** section of this chapter.)

Specialists should make note of the scope of the referral and refer the member back to the referring PCP for continuation of care.

In order to ensure continuity of care, the specialist must communicate with the PCP, if applicable, regarding the consultation, findings and recommended treatment plan.

When a member has been referred to a specialist, the specialist is responsible for diagnosing the member's clinical condition and/or managing treatment of the condition, up to the number of visits identified on the referral authorization. The scope of the services rendered is limited to those related to the clinical condition for which the primary care practitioner referred the member.

### **Age range now assigned to internal medicine clinicians:**

Internists in the Prime Network and Premium Networks who have not specified an age range for members will have their records updated to reflect members aged 18 and over. If you treat members in a different age range, e.g. 21 and over, you may request a change via the Provider/Practice Profile or, if you are part of a group that is delegated for credentialing, submit it via the monthly file process.

When providing specialty care, the practitioner must:

- Keep the PCP informed of the member's general condition with prompt verbal or written consult reports
- Obtain PCP authorization for subsequent referrals for tests, hospitalization or additional covered services
- Provide only those services authorized by a PCP and/or the medical director (or his or her designee) and emergency care
- Deliver all medical health care services available to members with self-referral benefits

**Note:** OB/GYN specialists may see members without referral from a PCP consistent with § 4406-b of the New York State Public Health Law. OB/GYN specialists must be available after hours for emergency care of pregnant enrollees.

For information on specialists functioning as PCPs, see the **Specialists as PCPs** subsection in the **Care Management** chapter.

**Note:** Qualified providers of OB/GYN care are required to provide HIV pre-testing counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychological support and case management for medical, social and addictive services. See **Direct Access (Self-Referral) Services**.

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## New policy for specialty designations

In order to improve our members' experience while seeking care, and to reduce inappropriate calls to your office, we will periodically update our directories to change the OB/GYN specialty designation to GYN (gynecology) for those who have not submitted a claim for obstetric services in the prior 24 months. Please let us know if you stopped practicing obstetrics less than two years ago and we will update our records accordingly.

## ROUTINE VOLUNTARY HIV TESTING

In New York State, voluntary HIV testing is part of routine medical care. Additionally, New York State public health law requires most medical facilities to offer voluntary HIV testing to patients of all ages. With limited exceptions, the law applies to anyone receiving treatment for a condition that is not life-threatening, whether in a hospital, emergency room or primary care setting such as a doctor's office or outpatient clinic.

For a summary of changes to simplify HIV testing consent and improve linkage to care, please see **New York State HIV Testing Law Update: May 2014**.

### Consent Still Required

The amended law allows patients to give verbal consent for a rapid HIV test, which produces results within an hour. Consent must be documented in the patient's medical record, and the practitioner must counsel the patient on the following seven points about HIV:

1. HIV is the virus that causes AIDS. HIV can be passed through:
  - Unprotected sex (vaginal, anal or oral sex without a condom) with a person who has HIV.
  - Shooting drugs with needles, or "works," of a person who has HIV.
  - Pregnancy, birth or breastfeeding.
2. Treatments are available to help people living with HIV stay healthy. Getting tested early can help patients get the most from their health care benefits.
3. HIV testing is important for women before or during pregnancy. Treatment can reduce the chance that a woman with HIV will pass the virus to her infant.
4. Many resources are available in New York to help people living with HIV meet their medical, social and legal needs.
5. HIV testing is confidential. A doctor can share HIV test results with other practitioners only when the information is needed for the patient's health care. The names of people who have HIV or other STDs, such as syphilis and gonorrhea, are confidentially sent to the State Health Department. This helps the State Health Department plan services for people with HIV.
6. If test results show that a patient has HIV, the doctor will talk with the patient about urging sex and needle-sharing partners to get tested for HIV. Counselors from the Health Department's Partner Assistance Program (PNAP) or Contact Notification Assistance Program (CNAP in New York City) can help notify partners without revealing the patient's name.
7. HIV testing is voluntary. The practitioner must ask the patient to sign a consent form for HIV testing, and the patient should read this form carefully. The practitioner will answer any questions the patient has about HIV testing.

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Patients must still provide written consent for HIV tests that require more time, but the process has been simplified. Consent for HIV testing can now be included in a patient's general consent for routine medical care as long as the consent form permits patients to opt out of HIV testing.

### Treating HIV/AIDS

We post clinical practice guidelines for the treatment of HIV/AIDS on our Web site. To review these guidelines, visit Clinical Corner at [www.emblemhealth.com](http://www.emblemhealth.com). In addition, New York State Quality Assurance Reporting Requirements (QARR) include four quality measures for HIV/AIDS Comprehensive Care. Recommended treatment and preventive criteria for people living with HIV/AIDS are:

- Two outpatient visits occurring at least 182 days apart (every six months) for each patient age 2 and older.
- Two annual viral load tests conducted at least 182 days apart for each patient age 2 and older.
- One annual screening for syphilis for each patient age 19 and older.
- One annual screening for cervical cancer for each female patient age 19 to 64.

Documentation of these measures must be included in the patient's medical records and will be reviewed as necessary.

## HEPATITIS C TESTING

Effective **January 1, 2014**, a hepatitis C screening test must be offered to every individual born between 1945 and 1965 when one of the following criteria is met:

- Inpatient of a hospital
- Receiving primary care services in the outpatient department of a hospital
- In a freestanding diagnostic and treatment center
- From a physician, physician assistant or nurse practitioner providing primary care regardless of setting type

If the test is reactive, follow-up health care including an HCV RNA test must be offered onsite or by referral.

For more information on hepatitis C, please visit the New York State Department of Health website at [https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis\\_c/provider.htm](https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis_c/provider.htm).

## REQUESTING INFORMATION FOR CONTINUITY OF CARE

The PCP will request all pertinent medical records from any other health practitioner from whom the member is receiving care. The following information will be requested:

- Patient's name, EmblemHealth ID number and birth date
- The problem or reason for visit, as stated by the patient
- The duration of the problem

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- Findings on physical examination
- Diagnosis or assessment of the patient's condition
- Therapeutic or preventive services recommended or prescribed, if any, or that none were indicated
- Dosage and duration information regarding any prescription given
- Follow-up plan, or that no follow up was planned
- Childhood immunization records

## TRANSITIONAL CARE FOR NEW MEMBERS

We make every effort to assist new members whose current providers are not participating with one of our plans. See the **Continuity/Transition of Care - New Members** section of the **Care Management** chapter for information on transition of care.

## TRANSITIONAL CARE WHEN PRACTITIONERS LEAVE THE EMBLEMHEALTH NETWORK

Upon a practitioner's termination from EmblemHealth, EmblemHealth shall:

- Make a good faith effort to notify affected enrollees of a practitioner's termination 30 days prior to the effective date
- Provide the affected practitioner with a written notice explaining the reasons for the termination or suspension as well as the right to a notice and hearing (See the **Termination and Appeal** section of the **Credentialing** chapter.)

We make every effort to assist members whose physicians end their participation with one of our plans. Members who wish to continue seeing their current health care provider for a limited time must contact or have their provider contact their plan/managing entity. See the **Continuity of Care - When Providers Leave the Network** subsection of the **Care Management** chapter on transitional care.

If the physician is a PCP and the member opts to stay with the PCP, the member must notify Customer Service of the new PCP who will manage their care following the 90-day transition period. If the physician leaving the network is a specialist and the member opts to stay with the specialist for the 90-day transition period, the member should obtain a referral to a new specialist for care following the 90-day transition period.

## NEWBORN ACCESS TO CARE

### **EmblemHealth Medicaid Newborns**

Newborn children of mothers enrolled in EmblemHealth's Medicaid plans will be automatically enrolled in the Medicaid program of the mother's plan, and shall receive all benefits and services of that plan beginning on the newborn's date of birth, even if the newborn has not yet been enrolled.

All members should call our Customer Service department to provide their newborn's name,

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sex, date of birth, birth weight and birth hospital so that we can complete the enrollment process. Once enrolled, the newborn is issued a member ID card.

Note that enrollment could be delayed for a number of reasons. Therefore, if a newborn presents for care without an ID card, but the mother was an active Medicaid member on the date of the baby's birth, care must be rendered. Practitioners should call EmblemHealth's Customer Service Department to verify eligibility.

## **EmblemHealth Child Health Plus**

**Note:** If a Child Health Plus member gives birth, the parent must complete an application for the newborn. There is no automatic enrollment in Child Health Plus. The parent can contact Customer Service for information on how to apply.

## MEDICALLY FRAGILE CHILDREN ACCESS TO CARE

EmblemHealth contracts with health care professionals and facilities that have expertise in caring for medically fragile children, to ensure that they, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child, or seek authorization care for out-of-network providers when participating providers cannot meet the child's needs.

EmblemHealth will authorize services in accordance with established time frames in the Medicaid Managed Care Model Contract; OHIP Principles for Medically Fragile Children (Attachment G); under EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning.

## DIRECT ACCESS (SELF-REFERRAL) SERVICES

### **EmblemHealth Members**

EmblemHealth members can self-refer for the following services to network practitioners when covered by their benefit plan:

- Chiropractic services\*
- Preventive and primary care services from the member's PCP
- Preventive obstetric and gynecological care including mammography screenings and cervical cytology screenings
- Ob-gyn Care: Prenatal care, two routine visits per year and any follow-up care, acute gynecological condition
- One mental health visit and one substance abuse visit with a participating provider per year for evaluation.
- Vision Care
  - Refractive eye exams from an optometrist or ophthalmologist
  - Eyeglasses (within benefit limits)
  - Diabetic eye exams from an ophthalmologist

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- HIV pre-test counseling with clinical recommendation of testing required for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. (This requirement is applicable to all qualified providers of OB/GYN care whether the member directly accesses care or is referred by another provider. See the section titled **Medical Specialists** for more information.)
- Emergency Care: Members should call 911.

\*EmblemHealth Medicaid and Child Health Plus members do not have chiropractic coverage. See below for more details.

## Medicare Members

Medicare members may self-refer to a participating clinician for certain EmblemHealth-covered services and certain Medicare-covered services at designated frequencies and ages:

- Annual mammography screening
- Annual routine eye exam
- Colorectal screening
- Four routine podiatry visits (VIP HMO, VIP Essential HMO, and VIP High Option HMO only)
- Glaucoma screening, if at high risk
- HIV screening
- Influenza and pneumococcal vaccine
- Initial chiropractic assessment
- Initial mental health consultation
- Nutritionist and social worker visit
- Prostate cancer screening

Female members may self-refer to a participating women's health care specialist for the following routine and preventive health care services:

- Pelvic exam
- Screening Pap test
- Bone mass measurement, if at risk

Members may also self-refer to a Medicare-certified hospice program.

## EmblemHealth Medicaid and Child Health Plus Members

In addition to the above services to which all members have direct access, there are some services to which members in state sponsored programs (Medicaid and Child Health Plus) may also self-refer. Unless otherwise indicated, members in all state sponsored programs may self-refer to the following services:

- Unlimited behavioral health and substance use assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization, HCBS services)
- **Dental Services** - Primary and preventive services from the member's assigned network dentist or to a dental clinic operated by an academic dental center.
- **Orthodontic services (Medicaid only)** - For orthodontic services, Medicaid members may also self-refer to Academic Dental Clinics affiliated with Article 28 Academic Centers, Medicaid

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fee-for-service dentists.

- **Nonemergency transportation services (Medicaid members)** - See the **Transportation Services** section of this chapter for more details.
- **Family planning and reproductive health services** include:
  - Access to birth control
  - Sterilization procedures
  - Medically necessary abortions
  - Screening for anemia, cervical cancer, sexually transmitted diseases, breast disease, pelvic abnormality and pregnancy

Medicaid members can obtain these services from a participating practitioner or any Medicaid fee-for-service provider. Participating practitioners must bill EmblemHealth and not Medicaid FFS for family planning services. If the member is assigned to a Managing Entity, the participating practitioner must bill the Managing Entity at the address on the back of the member's ID card. However, all Child Health Plus members must self-refer to a participating clinician for family planning/reproductive health services.

All members must use network physicians for all other gynecologic and obstetric care, including hysterectomies, routine Gynecological exams, prenatal and postpartum care.

Federal regulations require patient notification for hysterectomy and sterilization procedures. The patient or their representative must sign the required consent form for the service to be deemed a covered service under the Medicaid plan. This form must also accompany manual claim submissions as proof of consent. If the required form is not received, then the claim will be returned requesting the required form. Once the form is received, then the claim will be considered eligible and processed.

Claims for hysterectomy procedures must be submitted along with a copy of the completed and signed Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113. When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, LDSS-3134, is required and must be attached to the claim. Both forms can be obtained from the New York State Department of Health's website at **Local Districts Social Service Forms**.

- **Assessments for Foster Care Children (Medicaid)** - EmblemHealth requires a 30-day obligation to complete a comprehensive physical that includes a behavioral health assessment and an assessment of exposure to any infectious disease. Foster Care children are not eligible for CHPlus.

Starting in 2019, EmblemHealth will manage the delivery of expanded behavioral and physical health services for this population. Please see the end of this chapter for a copy of **Foster Care Initial Health Services**. This table outlines the time frames for initial health activities, to be completed within 60 days of placement. These assessments are a critical component to the development of a **comprehensive plan of care**.

- **Child Protective Services (Medicaid)** - EmblemHealth physicians shall comply with agencies such as Child Protective Services (CPS) or any other court-ordered services. This compliance

## ACCESS TO CARE AND DELIVERY SYSTEM

includes, but is not be limited to, the provision of medical information to the CPS agency's investigation and any subsequent amendments thereto. If the child is referred by a court order for covered medical services, these services must be provided whether or not they are covered by the plan. Clinicians that are not currently participating with EmblemHealth will be reimbursed at the Medicaid fee schedule. For CHPlus, court-ordered services are only covered if they are medically necessary and covered by the plan.

- **Immunizations** - Members can obtain immunization services from an EmblemHealth network practitioner. However, immunizations provided to all Child Health Plus members and to Medicaid children under 19 years of age must be given with vaccines obtained through the Vaccines for Children Program. See the **Pharmacy** chapter of this manual for more details.

In addition, Medicaid members can obtain immunization services from a public health agency clinic. Public health agencies are required to make reasonable efforts to contact the member's PCP to ascertain the member's immunization status prior to service delivery. If the public health agency clinic is unable to verify the immunization status from the PCP or learns that immunization is needed, it is authorized to render the service as appropriate and bill EmblemHealth or the responsible full risk provider.

- **Tribal Health Center Services** - Native Americans enrolled in EmblemHealth's Medicaid plan are free to access primary care services through their tribal health center without a referral or prior approval. EmblemHealth network PCPs must develop a relationship with tribal health center PCPs to ensure coordination of patient care.

- **Tuberculosis (TB) screening, diagnosis and treatment**, administered by EmblemHealth participating practitioners or from public health agency facilities. Public health agencies are required to notify EmblemHealth or the member's PCP of the presentation of TB in order to verify previous TB treatments and bill for the services rendered.

EmblemHealth does not cover, and Medicaid FFS should be billed for, the following TB-related services:

- Direct observed therapy (DOT) due to noncompliance with TB care regimens
- HIV counseling and testing during a TB-related visit at a public health clinic
- Testing for chlamydia

EmblemHealth participating practitioners and laboratories must report TB and STD cases to the local public health agency. State and local departments of health will be available to offer technical assistance in establishing TB reporting policies.

- **HIV counseling and testing services** administered by:
  - EmblemHealth network practitioners
  - Anonymous HIV counseling and testing centers
  - For Medicaid members, any Medicaid fee-for-service practitioner as part of a family planning encounter
  - For New York City Medicaid members, any New York City Department of Health and Mental Hygiene clinic
- **HIV / AIDS treatment services** administered by EmblemHealth network practitioners
- **Emergency care** - EmblemHealth covers emergency care for Medicaid and Child Health Plus members in all 50 United States, Washington D.C., Canada, the United States Territories of the Virgin Islands, Puerto Rico, Guam, American Samoa, the Northern Mariana Islands and

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American territorial waters. Members that have a condition meeting the definition of emergency while in one of these areas can go to the nearest emergency room or call 911. Emergency care services are covered in Mexico for Child Health Plus members.

## Medicaid Pregnant Members Only

- **HIV pre-test counseling services with a clinical recommendation of testing**

Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.

## EMBLEMHEALTH NEIGHBORHOOD CARE

The mission of EmblemHealth Neighborhood Care is to reinforce a holistic approach to health and wellness and help health plan and community members take a more active role in their mental and physical well-being. EmblemHealth Neighborhood Care offers our plan members and other community members a place to go to get the personalized, one-on-one support of experts in clinical, benefits and health management solutions. Neighborhood Care does not provide medical services. Instead, our role is to help practitioners manage patient care by supporting the primary practitioner-patient relationship.

Using the EmblemHealth Neighborhood Care Provider Recommendation Form, providers can recommend that a plan member visit a local Neighborhood Care site for the services listed below (see the forms at the end of this chapter and at [emblemhealth.com](http://emblemhealth.com)):

- In-person EmblemHealth customer service (billing, claims)
- Health plan navigation
- Care management and coordination (for EmblemHealth plan members)
- Assistance with DME fulfillment
- Health and wellness resources
- Fitness and wellness classes
- Health care education
- Behavioral health care
- Medication support
- Disease and condition self-management

The Neighborhood Care team of professionals consists of:

- **Site Managers:** Site managers oversee the staff and operations of the site and also function as customer care navigators to help make appropriate connections for customers. They also work with community partners and care providers to develop health and educational programming relevant to the site to address the needs specific to the community.
- **Customer Care Navigators:** Customer Care Navigators help connect EmblemHealth members to health and wellness services, care coordination and customer service, and community resources. They also make warm connections to sales partners to help visitors determine their eligibility for health care, choose a health plan and complete health plan

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enrollment.

- **Social Workers:** Certified Social Workers assist members with matters such as housing, financial assistance, education and career guidance and specialized health services. They also help make connections to community resources.

Neighborhood Care locations:

## Manhattan

**EmblemHealth Neighborhood Care – Harlem (AdvantageCare Physicians next door)**

215 W 125 Street | 866-469-0999

**EmblemHealth Neighborhood Care – Chinatown**

87 Bowery | 855-283-2151

**EmblemHealth Neighborhood Care at AdvantageCare Physicians Express**

52 Duane Street 212-423-3901

## Queens

**EmblemHealth Neighborhood Care – Cambria Heights (AdvantageCare Physicians next door)**

206-20 Linden Blvd | 866-539-0999

**EmblemHealth Neighborhood Care at AdvantageCare Physicians Flushing Medical Office**

140-15 Sanford Ave Suite A, Area G | 800-447-0752

## Brooklyn

**EmblemHealth Neighborhood Care – Crown Heights (AdvantageCare Physicians next door)**

546 Eastern Parkway | 855-283-2156

**EmblemHealth Neighborhood Care at AdvantageCare Physicians Brooklyn Heights Medical Office**

195 Montague Street, Floor 2 | 212-423-3901

**EmblemHealth Neighborhood Care – Bensonhurst at EmblemHealth sales office**

2482 86th Street | 800-447-0856

Visit the EmblemHealth Neighborhood Care website at [emblemhealth.com/community](https://emblemhealth.com/community) for more details.

## TRANSPORTATION SERVICES

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Emergency transportation services for EmblemHealth members with conditions that meet the definition of emergency can call 911 for emergency transportation. Non-emergency transportation for EmblemHealth Medicaid and Medicaid Advantage members should be arranged according to the instructions in the **Transportation** chapter.

### TELEHEALTH SERVICES

EmblemHealth members enrolled in either a Medicaid or Medicare-Medicaid plan are able to access telehealth services from approved home health care agencies as a covered benefit if the members are assessed by the home health care agency on an individual basis and the members meet specific criteria.

To be eligible, the member must have conditions needing frequent monitoring and be at-risk of acute or long-term care facility admission. (Congestive heart failure, asthma, cardiac conditions, chronic obstructive pulmonary disease (COPD), HIV and diabetes are the most frequent diagnoses for those currently receiving telehealth services. However, this is not an exhaustive list of conditions for which telehealth may be indicated. Each case is assessed individually to determine the appropriateness of telehealth monitoring.) Telehealth services may only be provided during an episode of home care. They must be an adjunct to nursing care and they do not replace physician-ordered nursing visits.

The home health care agency must submit a doctor's order to EmblemHealth along with the member's assessment in order to obtain prior approval to provide telehealth services to the member as a covered benefit.

EmblemHealth will cover telehealth services if they are deemed medically necessary. If a member enrolls in EmblemHealth while in receipt of telehealth services through Medicaid fee-for-service, we provide transitional care while we conduct our own assessment of the individual's care needs. Our review may include review of the original assessment or we may request a new assessment.

Only home care agencies approved by Medicaid as providers of telehealth are authorized to provide telehealth monitoring.

The home health care agency may then bill using HCPCS code T1014 for either the nursing visit or the installation, but not both. Authorization is given for 30 days. On day 30, another 30 days may be requested. If longer than 60 days are needed, the member must be reassessed.

The risk assessment tool completed by the home care agency incorporates the following information. The member:

- Is at risk for hospitalization or emergency care visits
- Lives alone
- Has a documented history of, or is at risk of, requiring unscheduled nursing visits or interventions
- Has a history of non-compliance in adhering to disease management recommendations
- Requires ongoing symptom management related to dyspnea, fatigue, pain, edema, or

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- medication side effect or adverse effects
- Resides in a medically under-served, rural or geographically inaccessible area
- Requires frequent physician office visits
- Has difficulty traveling to and from home for medical appointments
- Has the functional ability to work with the telehealth monitoring equipment in terms of sight, hearing, manual dexterity, comprehension and ability to communicate

## DISCLOSURE AND REPORTING RESPONSIBILITIES

EmblemHealth shall not prohibit or restrict any practitioner from disclosing to any member, patient or designated representative any information that the practitioner deems appropriate regarding a condition or course of treatment with a member including the availability of other therapies, tests, medications, etc., regardless of benefit coverage limitations. EmblemHealth shall not prohibit or restrict a health care professional, acting within the lawful scope of practice, from advocating on behalf of an individual who is a patient and enrolled under EmblemHealth. Practitioners shall not be prohibited from discussing the risks, benefits and consequences of treatment (or absence of treatment) with the member, patient or designated representative. Patients shall have the opportunity to refuse treatment and to express preferences about future treatment decisions.

### **EmblemHealth Medicaid and Child Health Plus Responsibilities to Government Agencies**

Any activities and reporting responsibilities delegated to a subcontractor, including a practitioner, shall be performed pursuant to standards set forth by the SDOH. In the event such policies and procedures are not complied with and the practitioner does not meet the SDOH requirements, EmblemHealth and/or SDOH may revoke the delegation in whole or in part. SDOH may also impose other sanctions if the practitioner's performance does not satisfy standards set forth in the agreement between EmblemHealth and SDOH for the Medicaid program. As required, the practitioner shall take any necessary corrective action(s) with respect to any delegated activities and responsibilities.

Subcontractors, including practitioners, shall perform all work and render all services in accordance with the terms of the agreement between EmblemHealth and SDOH for Medicaid. Practitioners agree to comply with and be bound by the confidentiality provisions set forth in the above referenced agreement. Any obligations and duties imposed on sub-contactors, including participating practitioners, do not impair any rights accorded to LDSSs, SDOH, the New York City Department of Health and Mental Hygiene (NYCDOHMH) or DHHS.

## CONTRACTED VENDORS

EmblemHealth contracts with vendors to provide services to EmblemHealth plan members. These vendors are considered network providers. Prior approval, if required, must be obtained directly from these vendors. For a listing of EmblemHealth network vendors, please go to the **Directory** in this manual. More information about each vendor is organized by subject or specialty in the various chapters of this manual.

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## PHYSICIAN INCENTIVE PROGRAM

In the event EmblemHealth elects to operate a physician incentive plan, no specific payment will be made directly or indirectly to a network practitioner or group as an inducement to reduce or limit medically necessary services furnished to a member. All practitioner agreements will include language requiring that the practitioner submit incentive plan information to EmblemHealth in an accurate and timely manner and in the format requested by the NYSDOH.

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

Please see the end of this chapter for a copy of our **Appointment Availability Standards During Office Hours & After Office Hours Access Standards**.

## DENTAL SERVICE - DENTAQUEST

As of January 1, 2017, DentaQuest manages the dental benefits for members in the VIP Prime; Medicare Essential; Enhanced Care Prime; Prime; Premium (aka Vytra Premium); and Select Care Networks. This also includes those using the out of area benefits (via Careington) through our Preferred/Plus Dental Network. Go to [dentaquest.com](http://dentaquest.com) for more details, or call DentaQuest at 1-844-822-8108, Monday to Friday from 8 am to 5 pm.

## FORMS

See the following pages for the EmblemHealth Neighborhood Care Provider Recommendation Forms for the **Cambria Heights** and **Harlem** locations



# Access, Availability & After Hours Coverage Standards

The access to care standards in the following tables are monitored using random audits. We want you to pass if you are selected for one! Below are avoidable mistakes that count as audit failures. Please take the time to periodically review these common mistakes and the standards that follow with your appointment schedulers.

**TIP: Successful practices conduct their own secret shopper audits!**

## Don't Fail! Avoid These Mistakes

	Routine and Non-Urgent "Sick" Appointments	After Hours Access
Failure reasons if no "live voice" reached:	<ul style="list-style-type: none"> <li>No answer</li> <li>On hold for &gt;10 minutes</li> <li>Answering machine/voicemail</li> <li>Answering service</li> <li>Wrong telephone number</li> <li>Telephone number is not in service</li> <li>Constant busy signal</li> </ul>	<ul style="list-style-type: none"> <li>No answer</li> <li>No answer at the after-hours number</li> <li>Wrong telephone number</li> <li>Telephone number is not in service</li> <li>Constant busy signal</li> <li>Answering machine/voicemail with no instruction on how to access non-emergency after-hours care (Messages that instruct patients to go directly to the hospital are counted as failures.)</li> <li>Answering machine/voicemail with instruction to leave message for provider but the call-back time was unspecified</li> </ul>
Failure reasons if a "live voice" is reached, but an appointment cannot be made:	<ul style="list-style-type: none"> <li>Staff inaccurately states that the health care professional is:                             <ul style="list-style-type: none"> <li>Not accepting new patients</li> <li>Not a plan participant</li> <li>Restricted to specialty care or changed specialty</li> </ul> </li> <li>Staff not scheduling appointments at this time</li> <li>Staff requires previous medical records before appointment can be made</li> <li>Health care professional requires a referral</li> <li>Health care professional not at site and no alternative provider available</li> <li>Health care professional will not see patient because the pregnancy is too far along</li> <li>Health care professional must see Social Worker/Case Manager before a medical appointment can be made</li> <li>Caller told they must complete a health questionnaire/registration form before medical appointment can be made</li> <li>Caller instructed to go to Emergency Room</li> </ul>	<ul style="list-style-type: none"> <li>Health care professional does not participate with caller's health plan</li> <li>Health care professional no longer at site</li> <li>Health care professional is not covered by an answering service</li> <li>On hold for &gt;10 minutes</li> <li>Caller told to call back the next day for an appointment</li> <li>Hospital/facility staff could not identify the requested health care professional</li> </ul>

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# Appointment Availability Standards During Office Hours & After Office Hours Access Standards

Standards	Definition	Scheduled Appointment Time Frame
Emergency Care (Emergent) <sup>1</sup>	Emergency care is medical care given for a condition that, without immediate treatment, could result in placing the member's life or general health in severe jeopardy, or cause severe impairment in one or more bodily function(s), or cause severe dysfunction of one or more body organ(s) or parts. Examples of emergency conditions include seizure, stab/gunshot wounds, diabetic coma, cardiac arrest, meningitis, and obvious fracture (bone showing through skin).	Requires <b>immediate</b> face-to-face medical attention. If a practitioner or covering practitioner is not immediately available, the member or representative should call <b>911</b> .
Urgent Care	Urgent care is medical care given for a condition that, without timely treatment, could be expected to deteriorate into an emergency or cause prolonged, temporary impairment in one or more bodily function(s), or development of a chronic illness or need for a more complex treatment. Examples of urgent conditions include abdominal pain of unknown cause, unremitting new symptoms of dizziness (cause unknown), and suspected fracture.	Requires timely face-to-face medical attention within <b>24 hours</b> of member notification of the existence of an urgent condition.
Non-Urgent Sick Visit	Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.	Requires face-to-face medical attention within <b>48 to 72 hours</b> of member notification of a non-urgent condition, as clinically indicated.
Routine Primary Care	Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/ reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis, and chronic low back pain.	Requires a face-to-face visit within <b>4 weeks</b> of member request.
Preventive Care/Routine Physical Exam	Preventive care or services are rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.	Requires a face-to-face visit within <b>4 weeks</b> of member request.
Routine Specialty Care	Specialty care is medical care given by a specialist. Examples include podiatry and neurology.	Requires a face-to-face visit within <b>4 weeks</b> of member request.
Oncology Specialist Visit	Initial oncology visit for medical care when the patient has a positive test result and is requesting an initial visit.	Requires appointment within <b>3 business days</b> of member request.
Assessment Regarding Ability to Perform/Return to Work	An appointment for assessment of the member's mental health/medical status needs as related to recommendation regarding member's capability to perform or return to work.	Requires appointment within <b>2 business days</b> of member request.
Initial Family Planning/Reproductive Health Visits	Family planning/reproductive health services include screening and treatment services to prevent, diagnose, alleviate, or ameliorate sexually transmitted diseases, anemia, cervical cancer, glycosuria, proteinuria, hypertension, and breast disease. Also includes routine gynecological examinations, pregnancy testing, and HIV counseling and testing.	Requires a face-to-face visit within <b>2 weeks/14 days</b> of member request.

<sup>1</sup> Emergency Care (Emergent): "Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

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## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

Standards	Definition	Scheduled Appointment Time Frame
Initial Prenatal Visit	Initial prenatal visit is medical care given for a condition in which the patient has tested positive for pregnancy and is requesting an initial visit.	Requires appointment scheduled within <b>3 weeks</b> for first trimester, <b>2 weeks</b> for second trimester, and <b>1 week</b> for third trimester. A schedule of follow-up appointments is given to the patient based on American College of Obstetricians and Gynecologists guidelines and practitioner risk assessment.
Postpartum Visit	During the postpartum visit, an assessment of the mother's blood pressure, weight, breasts, abdomen, and a pelvic exam is conducted to determine the mother's physical health status and general well-being following childbirth.	Requires a face to face visit within <b>21 – 56 days</b> following delivery.
Routine GYN Visit	Routine GYN care is a situation in which a short delay in treatment would not result in deterioration to a more severe level or cause need for more complex treatment. Examples include routine pap smear, and refill of oral contraceptives.	Requires a face-to-face visit within <b>4 weeks</b> of member request.
Pediatrician Conference	A prenatal visit (during 3rd trimester) is recommended for parents who are at high risk, for first-time parents, and for those who request a conference.	Requires appointment scheduled within <b>10 days</b> of member request or as clinically indicated.
Follow-Up Visit for Breast- Fed Infants	Follow-up visit for a breast-fed infant is medical care given for a condition in which delay of treatment could result in failure to thrive, dehydration, and/or malnutrition.	Requires face-to-face medical attention within <b>48 to 72 hours</b> of discharge.
Initial Newborn PCP Visit	An appointment for assessment of a newborn's physical status to ascertain the general well- being of the child and to promote early detection of immediate medical needs and promote early educational opportunities.	Requires appointment within <b>2 weeks</b> of hospital discharge.
Routine Well-Child Visits	Well-child services are those provided to members under 21 years of age that are essential to: a) prevent, diagnose, prevent the worsening of, alleviate, or ameliorate the effects of an illness, injury, disability, disorder, or condition; b) assess the overall physical, cognitive, and mental growth and developmental needs of the child; and c) assist the child to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.	Requires well-child services within <b>4 weeks</b> of member request.
Any Other Condition		Up to medical judgment of the practitioner.

Standards	Definition and Benchmark
Geographic (GEO) Access Standards for All Physicians	Members must be offered a choice of at least three (3) PCPs, three (3) OB/GYNs, and three (3) high-volume specialists within program distance/travel time standard. Normal condition/primary road – 30 miles/30 minutes. Rural areas – 60 miles/60 minutes.
Office Waiting Time Standard	Members with appointments should be seen within 15 minutes, but no later than 30 minutes, of their scheduled appointment time or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and alternatives offered to the patient.
24-Hour Accessibility	All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner. If an answering machine is used, it must provide an option for the member to directly contact the practitioner or covering practitioner in case of emergencies. An answering machine cannot simply refer the member to an emergency room unless it is a life-threatening issue.

# ACCESS TO CARE AND DELIVERY SYSTEM

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

### Behavioral Health Standards

Standards	Definition	Scheduled Appointment Time Frame
Emergency Care (Emergent)	An emergency appointment for life- threatening mental health or substance abuse conditions (suicidal intent) or for non-life-threatening mental health or substance abuse conditions that nevertheless necessitate immediate intervention, i.e., psychosis.	Requires <b>immediate</b> face-to-face medical care. The member or representative should call <b>911</b> .
Urgent Care	An urgent appointment for an acute mental health or substance abuse condition, or a condition that may become an emergency if not treated, i.e., acute major depression and acute panic disorder.	Requires appointment scheduled within <b>24 hours</b> .
Follow-Up for Emergency/ Hospital Discharge	An appointment for a follow-up visit related to an emergency room or hospital discharge for evaluation of acute mental health condition.	Requires appointment scheduled within <b>5 days</b> of member request or as clinically indicated, but no later than <b>7 days</b> post discharge.
Routine Care	An appointment for specific mental health or substance abuse concerns that are not of an urgent nature, i.e., marital problems, tensions at work, and general anxiety disorder.	Requires appointment within <b>10 business days</b> of member request.
Average Speed to Answer	The amount of time it takes for a live voice to answer the telephone in the Mental Health Department.	Telephone call answered by a live voice within <b>30 seconds</b> .
Call Abandonment	The number of calls that went unanswered by a “live voice” and ultimately voluntarily disconnected in the Mental Health Department.	Less than <b>5 percent</b> .

# ACCESS TO CARE AND DELIVERY SYSTEM

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

### Appointment Availability Standards for Medicaid Behavioral Health Providers

Service Type		Urgent	Non-Urgent MH/ SUD		Pursuant to Emergency or Hospital Discharge	Pursuant to Incarceration Release
MH or SUD Outpatient Clinic/ PROS Clinic	<b>Emergency</b>	Within 24 hrs	Within 1 wk of request	<b>BH Specialist</b>	Within 5 days of request	Within 5 days of request
ACT		Within 24 hrs for AOT		N/A	Within 5 days of request	
PROS		Within 24 hrs	Within 2 wks of request	Within 2 wks of request	Within 5 days of request	Time frame to be determined
Continuing Day Treatment				2-4 wks		Time frame to be determined
IPRT				2-4 wks		
Partial Hospitalization					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
OASAS Outpatient Clinic		Within 24 hrs	Within 1 wk of request		Within 5 days of request	Time frame to be determined
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hrs				
Stabilization Treatment Services in OASAS Certified Residential Settings		Within 24 hrs				
Opioid Treatment Program		Within 24 hrs			Within 5 days of request	
Rehabilitation Services for Residential SUD Treatment Supports				2-4 wks	Within 5 days of request	
<b>Home and Community-Based 1915(I)-Like Services</b>						
Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, and Family Support and Training	N/A	N/A	Within 2 wks of request		Within 5 days of request	Within 5 days of request
Short-Term and Intensive Crisis Intervention/Respite	Immediately	Within 24 hrs	N/A		Immediate	
Educational and Employment Support Services, including Pre- Vocational Services	N/A		Within 2 wks of request		N/A	
Peer Supports	N/A	Within 24 hrs for symptom management	Within 1 wk of request		Within 5 days of request	

KEY  
MH - Mental Health  
PROS - Personalized Recovery Oriented Services  
ACT - Assertive Community Treatment  
AOT - Assisted Outpatient Treatment  
BH - Behavioral Health

IPRT - Intensive Psychiatric Rehabilitation Treatment Programs  
CPEP - Comprehensive Psychiatric Emergency Program  
OASAS – Office of Alcoholism and Substance Abuse Services  
SUD - Substance Use Disorder

# ACCESS TO CARE AND DELIVERY SYSTEM

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

Standards	Definition and Benchmark
Appointment Waiting Time	Providers must have policies and procedures addressing members who present for unscheduled, non-urgent care with the aim of promoting access to appropriate care.
Travel Time Standards for Primary Care	Travel time/distance to primary care sites shall not exceed 30 minutes from the member's residence in metropolitan areas or 30 minutes/30 miles from the member's residence in non-metropolitan areas. Transport time and distance in rural areas to primary care sites may be greater than 30 minutes/30 miles from the member's residence if based on the community standard for accessing care, or if by member's choice. The member may, at their discretion, select a participating primary care physician (PCP) located farther from their home as long as they are able to arrange and pay for transportation to the PCP themselves. In the case of a Restricted Enrollee, the member can select a Restricted Recipient Program (RRP) PCP further from their home as long as they are able to arrange and pay for transportation to the RRP PCP themselves.
Travel Time Standards for Other Providers	Travel time/distance to specialty care, hospitals, mental health, lab, and x-ray providers shall not exceed 30 minutes/30 miles from the member's residence. Transport time and distance in rural areas to specialty care hospitals, mental health, lab, and x-ray providers may be greater than 30 minutes/30 miles from the member's residence if based on the community standard for accessing care, or if by member's choice.

# ACCESS TO CARE AND DELIVERY SYSTEM

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

### Appointment Availability Standards by Service Type for Medicaid Children's Health and Behavioral Health Benefits

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2–4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community SelfAdvocacy Training and Support			Within 5 business days of request		Within 5 business days of request
Habilitation			Within 2 weeks of request		

# ACCESS TO CARE AND DELIVERY SYSTEM

## APPOINTMENT AVAILABILITY STANDARDS DURING OFFICE HOURS & AFTER OFFICE HOURS ACCESS STANDARDS

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

### Foster Care Initial Health Services

The following series of assessments are required to form a complete picture of a foster child's health needs and should be used as the basis for developing a comprehensive Plan of Correction. This table outlines the time frames for initial health activities, to be completed within 60 days of placement. An "X" in the Mandated Activity column indicates that the activity is required within the indicated time frame.

Time Frame	Activity	Mandated Activity	Mandated	Who Performs
			Time frame	
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child Welfare Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X		Mental health practitioner
30 days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	X	X	Health Practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Child Welfare Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in followup assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child Welfare Caseworker or health staff

# ACCESS TO CARE AND DELIVERY SYSTEM

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Group Health Incorporated (GHI), Health Insurance Plan of Greater New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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# ACCESS TO CARE AND DELIVERY SYSTEM



Use this form to recommend a visit to EmblemHealth Neighborhood Care. Please check off the areas you think would be most beneficial.

## How can we help your patient?

Member's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician/Group address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

We have a menu of ways we can help. This is not the full scope of what we can do — it's just enough to give you an idea about how we can create connections between your patient's needs and the community or EmblemHealth resources available to achieve your treatment goals.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <b>Health and Wellness Resources</b><br>Health risk surveys<br>Fitness resources<br>Nutrition resources<br>Smoking cessation resources<br>Weight management resource<br>Preventive care                           | <input type="checkbox"/> <b>Health Care Education</b><br>Health care reform<br>Insurance 101<br>Medicaid 101<br>Medicare 101     | <input type="checkbox"/> <b>Behavioral Health</b><br>Links to community/social resources<br>Find Behavioral Health specialists<br>Family or Caregiver support<br>Self-management support |
| <input type="checkbox"/> <b>Medication Support</b><br>Drug interactions<br>How to fill prescriptions<br>(Prescription required)<br>Medication adherence<br>Medication reconciliation   | <input type="checkbox"/> <b>Self-Management Support</b><br>COPD and respiratory diseases<br>Diabetes<br>Heart disease<br>Obesity | <input type="checkbox"/> <b>Health Plan Support</b><br>Benefits<br>Claims issues<br>Eligibility and coverage<br>Formulary questions  |
| <input type="checkbox"/> <b>Care Management for EmblemHealth members</b><br>Find in-network specialist providers (Referral from a doctor is needed)<br>Durable medical equipment<br>Home health assistance and eligibility<br>Other: _____ |  |  |
| <input type="checkbox"/> <b>Comments:</b> _____<br>_____<br>_____<br>_____   |  |  |

### Internal use only:

CH01, CH02, CH03, CH04, CH05, CH06, CH07, CH08, CH09, CH10 Other \_\_\_\_\_

**EmblemHealth Neighborhood Care**, 206-20 Linden Boulevard, Cambria Heights, NY 11411, **1-866-539-0999**

Coverage underwritten by Group Health Incorporated (GHI) and HIP Health Plan of New York (HIP).

EMB\_EM\_FLY\_11255\_Provider-Office\_Recommendation\_Pad\_Cambria-Hts 4/13

## EMBLEMHEALTH NEIGHBORHOOD CARE OFFERS...



We offer face-to-face support and personal attention from solution experts and clinical staff, right in the heart of the neighborhood.

These services are part of your EmblemHealth benefits and are offered at no cost to you.

- Find a doctor who meets your needs.
- Arrange needed health care services.
- Make the most of your benefits.
- Solve claims issues.
- Take your medicines in the right way.
- Understand what your doctor wants you to do.
- Live better with long-term illness.
- Connect with community resources.
- Join health and wellness programs.



**Open To Everybody:** While the services listed above are for EmblemHealth customers, we welcome all members of the community to take classes, use our health and wellness library, discover possible health risks and learn a healthy weight range for their height.



[www.ehnc.com](http://www.ehnc.com)

**Be sure to visit us at 206-20 Linden Boulevard, Cambria Heights, NY 11411**

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- Health and Wellness Resources**
  - Health risk surveys
  - Fitness resources
  - Nutrition resources
  - Smoking cessation resources
  - Weight management resource
  - Preventive care

- Health Care Education**
  - Health care reform
  - Insurance 101
  - Medicaid 101
  - Medicare 101

- Behavioral Health**
  - Links to community/social resources
  - Find Behavioral Health specialists
  - Family or Caregiver support
  - Self-management support

- Medication Education**
  - Drug interactions
  - How to fill prescriptions (Prescription required)
  - Medication adherence
  - Medication reconciliation

- Self-Management Support**
  - COPD and respiratory diseases
  - Diabetes
  - Heart disease
  - Obesity

- Health Plan Support**
  - Benefits
  - Claims issues
  - Eligibility and coverage
  - Formulary questions

- Care Management for EmblemHealth members**
  - Find in-network specialist providers (Referral from a doctor is needed)
  - Durable medical equipment
  - Home health assistance and eligibility
  - Other: \_\_\_\_\_

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Internal use only:**  
CH01, CH02, CH03, CH04, CH05, CH06, CH07, CH08, CH09, CH10 Other \_\_\_\_\_

**EmblemHealth Neighborhood Care**, 215 West 125 Street, New York, NY 10027, **1-866-469-0999**

Coverage underwritten by Group Health Incorporated (GHI) and HIP Health Plan of New York (HIP).

MB\_EM\_FLY\_11255\_Provider-Office\_Recommendation\_Pad\_Harlem 4/13



## EMBLEMHEALTH NEIGHBORHOOD CARE OFFERS...



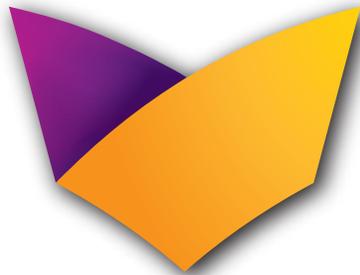
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**Be sure to visit us at 215 West 125th Street, New York, NY 10027**