Provider Manual

Chapter 6: 2022 Provider Networks and Member Benefit Plans

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Overview

Underwriting Companies

EmblemHealth's Companies

Members with EmblemHealth plans underwritten or administered by one of the EmblemHealth companies listed below follow the policies, processes, and administrative guidelines set out in this provider manual, EmblemHealth's website and provider portal, and third-party websites for special programs for applicable members.

Health Insurance Plan of Greater New York (HIP) underwrites EmblemHealth's HMO and POS plans, including those branded HIP, GHI HMO, and Vytra. HIP offers commercial, Medicaid/HARP, Medicare, and Medicare Special Needs Plans (SNPs). HIP also underwrites the City of New York Gold plan and many of our plans offered to individuals and small groups on the New York State of Health Marketplace and directly through our company.

EmblemHealth Insurance Company (formerly HIP Insurance Company of New York (HIPIC)) underwrites some of EmblemHealth's commercial EPO and PPO plans including our popular EmblemHealth Value EPO plan and some of our Bridge Program plans.

EmblemHealth Plan, Inc. (formerly Group Health Incorporated (GHI)) underwrites some of EmblemHealth's commercial EPO and PPO plans including the PPO plans for New York City employees as well as plans for large employer groups and some of our Bridge Program plans.

ConnectiCare's Companies

Members with ConnectiCare plans underwritten or administered by one of the

ConnectiCare companies listed below follow the policies, processes, and administrative guidelines set out in the ConnectiCare Provider Manual, ConnectiCare's website and provider portal, and third-party websites for special programs for applicable members.

ConnectiCare, Inc.

ConnectiCare Insurance Company Inc.

ConnectiCare of Massachusetts, Inc.

ConnectiCare Benefits, Inc.

Know Your Networks

You can help your patients keep their costs down by using in-network services and providers. To do this, you need to understand:

- Your own network participation.
  Knowing your network participation is critical. It will determine whether you are in-network for our members and our affiliates' members and which facilities and health care professionals you may coordinate with in the care of your EmblemHealth members.
    - Use the online Find a Doctor to see your contracted networks, then see the **2022 Summary of Companies, Lines of Business, Networks & Benefit Plans** and **2023 Summary of Companies, Lines of Business, Networks & Benefit Plans** to see which of those networks is used by our affiliates. Also see if the networks are used by the Bridge Program.

- How to identify your patient's network.

- Look at the **member ID card.**
- Use the provider portal's Member Management – Eligibility search to see a virtual copy of the Member's ID Card.

Summary of Companies, Line of Business, Networks and Benefit Plans

The **2022 Summary of Companies, Lines of Business, Networks & Benefit Plans** and **2023 Summary of Companies, Lines of Business, Networks & Benefit Plans** summarizes how our provider networks and member benefit plans relate to our underwriting companies. You can print this page as a reference tool for your staff. Check the boxes to show them which networks your contract covers. The blank spaces allow you to customize for each practice location.

As a reminder, providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers are also deemed in-network and participating for our ConnectiCare affiliates where access to the EmblemHealth network has been granted.

Member Benefit Summaries

The benefits available to our members are provided in accordance with the terms of the members' benefit plans. Below, are links to sample benefit summaries for the following types of plans:

- **Commercial**

- **Medicaid, HARP and CHPlus**
- **Medicare Advantage**
- **Medicare Supplement**

Note: These sample benefit summaries are provided for informational use only. They do not constitute an agreement, do not contain complete details of the plan benefits and cost-sharing, and the benefits may vary based on riders purchased. View a member's actual Benefit Summary on our secure **provider portal** under the Member Management tab and Eligibility drop-down.

Commercial and Child Health Plus Networks

EmblemHealth Plan, Inc. (Group Health Incorporated (GHI)) Commercial Networks

Commercial Networks Covered by Agreements with EmblemHealth Plan, Inc.

EmblemHealth Plan, Inc. contracts cover participation in the CBP, Tristate, and/or National Networks. These networks as used to support EPO and PPO plans typically allow members to self-refer to network specialists for office visits. However, preauthorization is still required before certain procedures can be performed.

In addition, **Bridge Program** members may access the National Network's providers. See the Bridge Program page for details on identifying the applicable utilization management, claims submission, fee schedule, and other operational processes that apply.

For announcements about our Commercial plans, see our dedicated Commercial Networks and Benefit Plans **resource hub.**

Sample Plan Description

Health Essentials Plus EPO

Health Essentials Plus EPO is a unique EmblemHealth EPO plan designed for people seeking health coverage primarily for catastrophic injury or illness. Its core benefits are hospital and preventive care services and three additional office visits.

The Health Essentials plan features:

- Network hospital or ambulatory surgical center benefits
    - Inpatient and outpatient hospital services provided in and billed by a network hospital or facility
    - Well-baby and well-child care provided by a network practitioner
    - Emergency room services (provided in and billed by a hospital or facility)
    - Inpatient and outpatient mental health and chemical dependency services provided in and billed by a network hospital or facility
- Covered preventive care services consistent with guidelines of the Patient Protection and Affordable Care Act
    - Preventive care services covered at 100% when provided by a network practitioner
    - Sick visits not covered
- Pharmacy benefit
    - $15 generic drug card

Note: Except for preventive care services provided by network practitioners, services billed by a practitioner are not covered under this plan except for three (3) office visits.

HIP Commercial Networks

Commercial Networks Covered by Agreements with Health Insurance Plan of Greater New York (HIP) (doing business as HIP Health Plan and HIP Health Plan of New York), HIP Network Services, IPA, and EmblemHealth Insurance Company (fka HIP Insurance Company of New York)

Prime Network

The Prime Network includes a robust network of practitioners, hospitals, and facilities in 28 New York state counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings (Brooklyn), Montgomery, Nassau, New York (Manhattan), Orange, Otsego, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester.

For Large Group members, New Jersey QualCare HMO Network services a variety of HMO and POS plans. ConnectiCare Network services a variety of HMO, POS, and EPO plans.

Small Group members also have access to providers in New Jersey via QualCare's network, and Connecticut via ConnectiCare's network.

Select Care Network

The Select Care Network is in the following 28 New York state counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings (Brooklyn), Montgomery, Nassau, New York (Manhattan), Orange, Otsego, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester.

The Select Care Network, a subset of our Prime Network, is tailored to help keep costs

down and supports an integrated model of care. Providers in the Select Care Network are chosen on measures such as geographic location, hospital affiliations, and sufficiency of services. The network includes a full complement of physicians, hospitals, community health centers, facilities, and ancillary services. Urgent care and immediate care are also available.

EmblemHealth offers multiple Large Group, Small Group, and Individual plans on the Select Care Network. Individual plans are offered both on and off the **NY State of Health: The Official Health Plan Marketplace**. EmblemHealth Silver Value and EmblemHealth Gold Value plans, both non-standard plans, provide a specific number of primary care physician (PCP) visits at no cost before the deductible. The plans offer acupuncture, dental, and vision benefits for adults and children.

Millennium Network

The Millennium Network is in the nine New York downstate counties: Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, Richmond (Staten Island), Rockland, Suffolk, and Westchester.

Providers in the Millennium Network are chosen on measures such as geographic location, hospital affiliations, and sufficiency of services. The network includes a full complement of physicians, hospitals, community health centers, facilities, and ancillary services. Urgent care and immediate care are also available.

EmblemHealth offers certain Large Group plans, multiple Small Group plans and an Individual plan, Silver Bold, on the Millennium Network. This plan is offered both on and off the **NY State of Health: The Official Health Plan Marketplace**. EmblemHealth Silver Bold, a non-standard plan, provides a specific number of primary care physician (PCP) visits at no cost before the deductible. These plans offer acupuncture, dental, and vision benefits for adults and children.

HIP Commercial Plan Covered Services

Our HMO plans only offer in-network coverage for non-emergent services. Most plans require referrals and preauthorization for certain services and have a deductible that

applies to in-network services. If you see a member who is NOT in a plan associated with your participating network(s) without preauthorization, the member may incur a surprise bill or avoidable expenses. When scheduling appointments, be sure to check your participation in the member's plan at that location. If you do not participate in their plan, refer them back to their PCP or our online directory, Find-A-Doctor at **Find-A-Doctor**, to find a provider in their network.

Individual and Small Group Standard plans follow the plan designs established by New York State, and Nonstandard plans can change the cost-sharing required in any benefit cate.

Wellness Visits:
Large Group and Small Group plan members are eligible for an annual wellness visit once every benefit plan year. Individual plan members are eligible for an annual wellness visit once every calendar year. Sign in to **Provider Portal** to check the member's Benefit Summary under the Member Management tab and Eligibility drop-down.

Telemedicine:
EmblemHealth Individual and Small Group plans, and the Essential Plan offer telemedicine services at no cost. EmblemHealth Basic plan offers telemedicine at 0% after deductible.

HIP Commercial Plan Descriptions

Child Health Plus
Child Health Plus (CHPlus) is a New York state-sponsored program that provides uninsured children under 19 years of age with a full range of health care services for free or for a low monthly cost, depending on family income. In addition to immunizations and well-child care visits, CHPlus covers pharmaceutical drugs, vision, dental, and mental health services. There are no copays for any covered services and members may visit any of our Prime Network providers who see children.

Medicaid Managed Care/HARP/Essential Plan

Our Medicaid, HARP, and Essential Plan members all utilize the Enhanced Care Prime Network. This network covers the following eight counties in New York: Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk, and Westchester.

For announcements and requirements for our Medicaid, HARP and Child Health Plus Programs, see our dedicated State-Sponsored Programs resource hub.

Required Training for Providers

Providers and their staff, who have regular and substantial contact with EmblemHealth Enhanced Care (Medicaid Managed Care) and Enhanced Care Plus (HARP) members, are required to certify completion of cultural competency training. To certify completion of cultural competency training, please see **Cultural Competency Training Certification**.

All Enhanced Care Prime Network providers are required to complete an initial orientation and training on the expanded children's benefit and populations, including:

1. Training and technical assistance to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and utilization management requirements.
2. Training on processes for assessment for HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and Plan of Care development and review.

For training opportunities, please visit our **Learning Online** webpage.

Medicaid Recertification

It's important that you and your staff remind Medicaid members to recertify with their Local Department of Social Services or the health exchange two (2) months prior to their Eligibility End Date. If members do not recertify by the Eligibility End Date, they will lose eligibility for Medicaid, lose their health insurance coverage, and will have to reapply for Medicaid.

To help ensure Medicaid members retain their coverage and don't lose access to valuable care, the Medicaid Recertification or Eligibility End Date is included on the Health Care Eligibility Benefit Inquiry and Response (270/271) report for those members close to their recertification dates. The recertification date is also on the PCP Member Panel Report available on our Provider Portal. See the video and user guide for PCP Member Panels under the Member Management section on the portal's training materials page.

Members requiring assistance with recertification should contact our Marketplace Facilitated Enrollers at **888-432-8026**.

Medicaid and Health and Recovery Plan (HARP) Benefits

See **Appendix K** of the **Medicaid Managed Care Model Contract** for a listing of covered services. The benefit information provided in Appendix K does not list every service that is covered or list every limitation or exclusion.

Medicaid Benefits: Our Medicaid members are entitled to a standard set of benefits. They may directly access certain services without a required referral. A list of these services can be found in the Direct Access (Self-Referral) Services section of the **Access to Care and Delivery System** chapter.

HARP Benefits: EmblemHealth offers a Health and Recovery Plan (HARP) designed to meet the unique needs of our eligible MMC members living with serious mental illness and/or substance use disorder. The plan includes access to home and community-based

services (HCBS) and support from their assigned Health Home. Below is a list of covered HCBS for HARP members only. (See the **HCBS manual** for full details.)

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Habilitation Services
- Family Support and Training
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Peer Supports
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment (ISE)
- Ongoing Supported Employment
- Care Coordination

Adult Behavioral Health Covered Services

EmblemHealth covers the following behavioral health benefits for its MMC members aged 21 and older who reside in the EmblemHealth MMC service area:

- Medically supervised outpatient withdrawal services
- Outpatient clinic and opioid treatment program services
- Outpatient clinic services
- Comprehensive psychiatric emergency program services

- Continuing day treatment
- Partial hospitalization
- Personalized recovery-oriented services
- Assertive community treatment
- Intensive and supportive case management
- Health home care coordination and management
- Inpatient hospital detoxification
- Inpatient medically supervised inpatient detoxification
- Rehabilitation services for residential substance use disorder treatment
- Inpatient psychiatric services

For more information on the Behavioral Health Services Program, please see the **Behavioral Health Services** chapter.

Health Home Program

Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical health and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high-need Medicaid members with chronic conditions. A listing of EmblemHealth network Health Homes that support our Medicaid and HARP benefit plans are listed in the **Directory** chapter.

Under the federal Patient Protection and Affordable Care Act, New York state has developed a set of Health Home services for Medicaid members. To be eligible for Health Home services, the member must be enrolled in Medicaid and must have:

- Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes), or
- One single qualifying chronic condition: HIV/AIDS, or
- Serious Mental Illness (SMI) (Adults), or
- Serious Emotional Disturbance (SED) or Complex Trauma (Children)

If a Medicaid member has HIV or SMI, he or she does not have to be determined to be at risk of another condition to be eligible for Health Home services. Substance use disorders (SUD) are considered chronic conditions, but the presence of SUD by itself does not qualify a member for Health Home services. Members with SUD must have another chronic condition to qualify.

The Health Home Program is offered at no cost to all eligible EmblemHealth Medicaid members. Once the member agrees to enroll, they will be designated to a Health Home. The Health Homes, and/or affiliated Care Management Agency (CMA), will assign them a care coordinator and begin providing services. EmblemHealth also notifies providers that their patient has been identified for this program.

The following services are available through the Medicaid Health Home Program:

- Comprehensive case management with an assigned, personal care manager
- Assistance with getting necessary tests and screenings
- Help and follow-up when leaving the hospital and going to another setting
- Personal support and support for their caregiver or family
- Referrals and access to community and social support services

More information on the NYS Medicaid Health Home Program can be found on the **NYSDOH website**. See our **guide** for Health Home assistance with submitting claims.

Medicaid members who are not eligible to participate in the Medicaid Health Home

Program may still meet our criteria for case management services. If you think a member would benefit from case management, please refer the patient to the program by calling **800-447-0768**, Monday through Friday, from 9 a.m. to 5 p.m. ET.

Children's Health and Behavioral Health Benefits

EmblemHealth manages the delivery of expanded behavioral and physical health services for Medicaid-enrolled children and youth under 21 years of age (see the table of **Medicaid State Plan and Demonstration Benefits**). This includes medically fragile children, children with behavioral health diagnosis(es), and children in foster care with developmental disabilities. Benefits include HCBS designed to provide children/youth access to a vast array of habilitative services (additional details can be found in the **Children's HCBS Provider Manual** and **Children's Health and Behavioral Health Services Billing and Coding Manual**. All HCBS are available to any child/youth determined eligible. Eligibility is based on Target Criteria, Risk Factors, and Functional Limitations. Health Homes provide care management to children/youth eligible for HCBS.

Health Home Care Management for Children

Children eligible for HCBS are enrolled in Health Home. Unless the child or guardian opts out, the Health Home provides care coordination of the children's HCBS. Health Homes administer all HCBS assessments through the Uniform Assessment System, which has algorithms (except for the foster care developmentally disabled (DD) and the Office for People with Developmental Disabilities (OPWDD) care at home medically fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria. Health Homes ensure the child meets all other eligibility criteria for HCBS (i.e., a child must live in a setting that meets HCBS settings criteria to be eligible for HCBS, such as Target and Risk criteria for Level of Care and Level of Need populations). The Health Homes develop one comprehensive plan of care that includes HCBS, as well as all the other services the member needs (e.g., health, behavioral health, specialty services, other community and social supports, etc.).

EmblemHealth collaborates with Beacon Health Options, Health Homes, and HCBS providers to gather information to support the evaluation of the member's level of care; adequacy of service plans; provider qualifications; member health and safety; financial accountability and compliance, etc. EmblemHealth utilizes aggregated data from its care management and claims systems to identify trends and opportunities for improving member care.

Health Home care management not only provides comprehensive, integrated, child, and family-focused care management, but also ensures the efficient and effective implementation of the expanded array of State Plan services and HCBS. See the **Health Homes Serving Children** homepage for more information. Additional strategies to promote behavioral health-medical integration for children, including at-risk populations, include:

- Provider access to rapid consultation from child and adolescent psychiatrists
- Provider access to education and training
- Provider access to referral and linkage support for child and adolescent patients

Identifying Members

Medicaid Managed Care (MMC): EmblemHealth Enhanced Care

EmblemHealth's Medicaid Managed Care plan is called EmblemHealth Enhanced Care. The plan name "Enhanced Care" can be found in the upper right corner of the member's ID card.

Health and Recovery Plan (HARP): EmblemHealth Enhanced Care Plus

EmblemHealth's Health and Recovery Plan (HARP) is called EmblemHealth Enhanced Care Plus. The plan name "Enhanced Care Plus" can be found in the upper right corner of the member's ID card.

Homeless and HARP Members Enrolled with EmblemHealth

Since homeless and HARP members may present with unique health needs, we have identified which of our Medicaid Managed Care (MMC) members are homeless and/or HARP members. See the respective columns on the PCP Member Panel Report found under the Member Management tab in our secure Provider Portal. See the video and user guide for PCP Member Panels under the Member Management section on the portal's training materials page..

A homeless indicator is present on eligibility extracts. The homeless indicator "H" is included if the member is homeless, and blank if the member is not homeless.

Restricted Recipients

EmblemHealth is also required to identify members already enrolled who need to be restricted. EmblemHealth member ID cards have an "R" after the plan name on the front of the card so providers will know that they are restricted (i.e., Enhanced Care - R or Enhanced Care Plus - R). See the PCP Member Panel Report found under the Member Management tab in our secure Provider Portal. See the video and user guide for PCP Member Panels under the Member Management section on the portal's training materials page.

Restricted Recipient Program

MMC and HARP members are placed in the Restricted Recipient Program (RRP) when a review of their service utilization and other information reveals they are:

- Getting care from several doctors for the same problem

- Getting medical care more often than needed
- Using prescription medicine in a way that may be dangerous to their health
- Allowing someone else to use their plan ID card
- Using or accessing care in other inappropriate ways

RRP members are restricted to certain provider types (dentists, hospitals, pharmacies, behavioral health professionals, etc.) based on a history of overuse or inappropriate use of specific services. Members are further restricted to using a specific provider of that type. EmblemHealth is required to continue the Medicaid Fee-for-Service (FFS) program restrictions for MMC and HARP members until their existing restriction period ends.

The Office of the Medicaid Inspector General (OMIG) is responsible for sending notification of previous Managed Care Organization's restriction for a new member to EmblemHealth within 30 days. Neither the provider nor member may be held liable for the cost of services when the provider could not have reasonably known the member was restricted to another provider. See above for instructions on identifying restricted recipients.

To report suspicious activity, please contact EmblemHealth's Special Investigations Unit in one of the following ways:

Email:
KOfraud@emblemhealth.com

Toll-free hotline:
888-4KO-FRAUD (888-456-3728)

Mail:

EmblemHealth
Attention: Special Investigations Unit
55 Water Street
New York, NY 10041

A trained investigator will address your concerns. The informant may remain anonymous. For more information, please see the **Fraud and Abuse** chapter.

Mandatory Enrollment of the New York City Homeless Population

According to the New York State Department of Health (NYSDOH), all of New York City's homeless population must be enrolled into MMC.

Primary Care Services Offered in Homeless Shelters

Homeless members can select any participating PCP. We have expanded our provider network to include practitioners who practice in homeless shelters to improve access to care for our members with no place of usual residence. A PCP practicing at a homeless shelter is available only to members who reside in that shelter.

Permanent Placement in Nursing Homes

The MMC nursing home benefit includes coverage of permanent stays in residential health care facilities for Medicaid recipients aged 21 and over who reside in the EmblemHealth MMC service area. Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

If a Medicaid member needs long-term residential care, the facility is required to request increased coverage from the Local Department of Social Services (LDSS) within 48 hours of a change in a member's status via submission of the DOH-3559 (or equivalent). The facility must also submit a completed Notice of Permanent Placement Medicaid Managed Care (MAP form) within 60 days of the change in status to the LDSS. The facility must notify EmblemHealth of the change in status. If requested, the facility must submit a copy of the MAP form to EmblemHealth for approval prior to the facility's submission of the MAP form to the LDSS.

Payment for residential care is contingent upon the LDSS' official designation of the member as a Permanent Placement Member.

Veterans Nursing Homes

Eligible Veterans, Spouses of Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans' nursing home. If EmblemHealth does not have a Veterans' home in their provider network and a member requests access to a Veterans' home, the member will be allowed to change enrollment into an MMC plan that has the Veterans' home in their network. While the member's request to change plans is pending, EmblemHealth will allow the member access to the Veterans' home and pay the home the Medicaid daily benchmark rate until the member has changed plans.

NYSDOH Medicaid Provider Non-Interference

Medicaid providers and their employees or contractors are not permitted to interfere with the rights of Medicaid recipients in making decisions about their health care coverage. Medicaid providers and their employees or contractors are free to inform Medicaid recipients about their contractual relationships with Medicaid plans. However, they are prohibited from directing, assisting, or persuading Medicaid recipients on which plan to join or keep.

In addition, if a Medicaid recipient expresses interest in a Medicaid Managed Care

program, providers and their employees or contractors must not dissuade or limit the recipient from seeking information about Medicaid Managed Care programs. Instead, they should direct the recipient to New York Medicaid Choice, New York state's enrollment broker responsible for providing Medicaid recipients with eligibility and enrollment information for all Medicaid Managed Care plans. For assistance, please call New York Medicaid Choice: **800-505-5678**, Monday to Friday, 8:30 a.m. to 8 p.m. ET, and Saturday from 10 a.m. to 6 p.m. ET.

Any suspected violations will be turned over to the New York Office of the Medicaid Inspector General (OMIG) and potentially the federal Office of Inspector General (OIG) for investigation.

Essential Plan Benefits

The Essential Plan is a low-cost plan for adult individuals available on the NY State of Health Marketplace. Premiums for the Essential Plan are either $0 or $20.

As with Qualified Health Plans (QHPs), the Essential Plan includes all benefits under the 10 categories of the Affordable Care Act (ACA)-required Essential Health Benefits with no cost-sharing (no deductible, copay, or coinsurance) on preventive care services, such as screenings, tests, and shots. For more information, please see the **Preventive Health Guidelines** located on our **Health and Wellness** webpage.

Unlike QHP Standard Plans, some Essential Plan members are also eligible for adult vision and dental benefits for a small additional monthly cost. The Aliessa population (New York's legally residing immigrant population) receives six additional benefits at no extra cost. These include: dental, vision, non-emergency transportation, non-prescription drugs, orthopedic footwear, and orthotic devices.

Essential Plan Eligibility

The Essential Plan covers adult individuals only. If eligible, spouses and children must

enroll into Essential Plan separately under an individual policy. To qualify for the Essential Plan, individuals must:

- Be a New York state resident.
- Be between the ages of 19 and 64 (U.S. citizens) or 21 to 64 (legally residing immigrants).
- Not be eligible for Medicare, Medicaid, Child Health Plus, affordable health care coverage from an employer, or another type of minimum essential health coverage.
- Be either:
    - A U.S. citizen (residing in New York) with an income between 138% and

Medicare Networks

Medicare Networks

EmblemHealth's company, Health Insurance Plan of Greater New York (HIP), underwrites the Medicare plans associated with the VIP Prime Network, VIP Bold Network, and VIP Reserve Network.

EmblemHealth's company, EmblemHealth Plan, Inc. (fka Group Health Incorporated (GHI)), underwrites plans associated with the Medicare Choice PPO Network.

Provider Obligations/Responsibilities

For information about provider obligations and responsibilities, see **Medicare Advantage Required Provisions** in the **Required Provisions to Network Provider Agreements** chapter. Also see the **EmblemHealth Medicare Advantage Plans** page for participation requirements and key information for managing these members.

See the **ConnectiCare Medicare Advantage Plans** page for participation requirements and key information for managing our affiliate's members who have access to EmblemHealth's network.

Maximum Out-of-Pocket Threshold

The MOOP for each benefit plan is shown in the **2022 Summary of Companies, Lines of Business, Networks & Benefit Plans**, **2023 Summary of Companies, Lines of Business, Networks & Benefit Plans** and in the member's Benefit Summary on our secure Provider Portal under the Member Management tab and Eligibility option on the drop-down menu.

Transferability of Maximum Out-of-Pocket (MOOP): If a member makes a mid-year change from one EmblemHealth Medicare plan to another, the MOOP accumulated thus far in the contract year follows the member and counts toward the MOOP in the new EmblemHealth Medicare plan.

Preventive/Wellness Visit and Physical Exam

"Welcome to Medicare" Preventive Visit: Our Medicare plans cover a one-time, "Welcome to Medicare" preventive visit, which is available for members who are new to Medicare. This visit includes a health review, education, and counseling about preventive services (including screenings and vaccinations) and referrals for care, if necessary.

Members must have the "Welcome to Medicare" preventive visit within 12 months of enrolling in Medicare Part B. When making their appointment, they should let you know they are scheduling their "Welcome to Medicare" preventive visit. Providers may bill for this service using HCPCS code G0438 for this initial visit.

Annual Wellness Visit: This benefit is covered once every 12 months. Following their "Welcome to Medicare" physical exam, members enrolled in Medicare Part B must wait 12 months before having their first annual wellness visit. A Health Assessment (HA) is used as part of the annual wellness visit. This is a great opportunity for members and

providers to review and discuss management of chronic health conditions such as diabetes and hypertension, and complete preventive steps such as flu shots, breast cancer screenings, and others. Providers may bill for this service using HCPCS code G0439 for subsequent visits.

Annual Physical Exam: Most EmblemHealth Medicare plans cover an annual physical exam once every calendar year at no cost to the member. The annual physical exam may include updating medical history, and measurement of vital signs, including height, weight, body mass index, blood pressure, visual acuity screen, and other routine measurements. This benefit may not cover some services like lab tests and tests to diagnose or treat a condition. Members may have to pay for those tests, even when they are done during an annual physical exam.

Medicare Preventive Services: The **Medicare Preventative Services chart** features services that the Centers for Medicare & Medicaid Services (CMS) has determined should be provided to all Medicare recipients with no cost-sharing. This requirement applies to Original Medicare as well as to all our Medicare plans when provided on an in-network basis. For HMO members, including Dual Eligible members, Medicare-required covered services that are not available in-network and receive preauthorization from our plan or the member's assigned managing entity, as applicable, are allowed at $0 cost-sharing, as well.

Special Needs Plans

Our Medicare Dual Special Needs Plans (DSNPs) are designated Medicare Advantage plans with custom-designed benefits to meet the needs of a specific population. Enrollment in an SNP is limited to Medicare beneficiaries within the target SNP population. The target populations for EmblemHealth SNPs are individuals who live within the plan service area, eligible for Medicare Part A and Part B, and eligible for Medicaid.

SNP Coinsurance and Copay

Our HMO DSNP members are members with Medicaid, including full dual benefit eligibles, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs), which means they receive help from New York State Medicaid to pay their cost-sharing. As a result, providers who see these Dual Eligible members must verify Medicaid eligibility and bill New York State Medicaid, Medicaid Managed Care (including EmblemHealth Enhanced Care or Enhanced Care Plus), or Medicaid Managed Long Term Care plan for any applicable member cost-sharing. Providers can find information about the secondary coverage during eMedNY eligibility verification. EmblemHealth VIP Solutions (HMO D-SNP) members may not be eligible for full Medicaid or QMB and may pay cost-sharing for covered services.

SNP Interdisciplinary Team

Practitioners are important members of the SNP interdisciplinary team. They participate in one of our regularly scheduled care coordination or case rounds meetings to discuss their patient's plan of care and health status. Practitioners also share their progress with the team to ensure we are meeting our SNP program goals.

Our SNP goals are to:

- Improve access to medical, mental health, social services, affordable care, and preventive health services.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.
- Improve beneficiary health outcomes.

The SNP interdisciplinary team provides the framework to coordinate and deliver the plan of care and to provide appropriate staff and program oversight to achieve the SNP goals. The care management staff assumes a key role in developing and implementing the individualized care plan, coordinating care, and sharing information with the interdisciplinary care team, and with the practitioners, member, their family, or caregiver.

SNP Required Training for EmblemHealth Practitioners, Providers, and Vendors

Each year, all Medicare providers are required to complete the Special Needs Plan (SNP) Model of Care (MOC) training for each of the Dual Eligible SNPs in which they participate, as mandated by the Centers for Medicare & Medicaid Services (CMS). For training presentations and other learning opportunities, please visit our **Learning Online** webpage.

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ALSO OF INTEREST

The Bridge Program

Commercial Networks and Plans

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