

2 Provider Rights and Responsibilities

2.1 Provider Rights

Health Plus participating providers acting within the lawful scope of their license have the right to advise or advocate for members on the following issues without restriction or incrimination from Health Plus:

1. Health status, medical care or treatment options (including sufficient information to enable the member to decide among various treatment options, and information regarding alternative treatments that may be self-administered).
2. Risks, benefits, and consequences of various treatment options.
3. The opportunity to refuse treatment and/or express preferences for future treatment options.

2.2 Health Plus's Responsibilities to Providers

Health Plus recognizes its obligation to assure providers the following:

- comprehensive plan orientation and training programs
- respectful communication from knowledgeable plan staff
- thirty (30) day prior written notification of changes in plan policy or procedure
- timely payment for covered services rendered to members
- timely response to questions or concerns
- assistance with complex member issues
- timely resolution of grievances and appeals
- constructive feedback on performance and utilization

2.3 Provider Responsibilities

Health Plus participating providers' responsibilities include (but are not limited to):

2.3.1 Provide Quality Care:

- Provide care within scope of practice (as defined by Health Plus) and in accordance with Health Plus access, quality and participation standards.
- Adhere to Health Plus's clinical guidelines.
- Participate in Health Plus quality improvement initiatives and other activities associated with meeting regulatory requirements and upholding contractual obligations.
- Provide optimal care to members without regard to age, race, sex, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status, or marital status.
- Comply with the Americans with Disabilities Act (ADA) guidelines set forth by the New York State Department of Health (i.e. wheelchair access).

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- Give members complete and accurate information concerning a diagnosis, treatment plan, or prognosis in terms they can understand (eliminating both language and cultural barriers), and without regard to plan coverage.

If there is no office staff member, friend or relative who speaks the member's language, Health Plus's multi-lingual staff and facilitated connection with the AT&T Language Bank can assist with translation.

- Provide sufficient information to enable members to give informed consent prior to the initiation of any treatment or procedure.
- Inform members of appropriate follow-up and self-care measures relevant to their condition.
- Advise members of non-covered treatments or services and their cost prior to rendering them.

2.3.2 Maintain Proper Billing Practices:

- Submit claims for reimbursement of covered services provided to members. Claims must be accurate and conform to the standards described in Chapter 10 (see section 10.3: Definition of a Clean Claim).

Health Plus members must never be billed for covered services. Providers are prohibited from requesting any monetary compensation from members or their responsible relatives, except for applicable co-payments.

If a service is not covered by Health Plus, participating providers must inform members **prior to rendering services** that they will be billed as a private pay patient if they elect to receive the service. If the member consents to receive the service and be billed as a private pay patient, providers should maintain documentation of this consent in the member's medical record.

- Advise members of their right to contact Health Plus Member Services if they have concerns about a non-covered service or wish to file an appeal.

2.3.3 Maintain Member Confidentiality:

- Maintain members' Protected Health Information (PHI) strictly confidential, in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards.
- Provide necessary member PHI to Health Plus (in compliance with HIPAA standards) when required for payment, treatment, quality assurance, regulatory, data collection and reporting activities.

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2.3.4 Notify Health Plus when Changing or Updating Information:

Send a letter, fax or e-mail to the Health Plus Provider Relations Department **60 days in advance** of a:

- Change in tax or billing information (a new W-9 must be filed)
- Change in office location (address)
- Request for panel closure

Address: 335 Adams Street, Suite 2600, Brooklyn, NY 11201

Fax: (718) 504-9602

E-mail: Providers@healthplus-ny.org

2.3.5 Avoid Fraud, Abuse, and Unacceptable Practices:

Fraud and abuse is broadly defined as intentional deception or misrepresentation resulting in an unauthorized benefit.

The following is a list of examples of fraudulent, abusive, and unacceptable practices that are prohibited by Health Plus:

1. Submission of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled (i.e. upcoding or bundling of charges).
2. Billing for services not rendered.
3. Billing for a service before it is rendered.
4. Denying services based on a member's inability to pay a co-payment.
5. Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law).
6. Submission of false information to obtain authorization for the provision of services.
7. Ordering or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies.
8. Practicing fraudulently beyond the scope of one's license, or after one's license has been suspended or revoked.
9. Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to members.
10. Offering or accepting inducements to influence members to use or avoid using a particular service.
11. Submitting bills or accepting payment for care, services or supplies rendered by a provider who has been disqualified from participation in the Medicaid program.

Providers who suspect fraud and abuse by another provider or a member should contact the Health Plus Provider Care Center at: 1-800-450-8753.

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In addition, providers may call the New York State Medicaid Helpline: 1-877-87FRAUD.

If the suspected fraud involves a CHP member, providers may call the New York State Department of Insurance Fraud Bureau at 1-888-FRAUDNY (1-888-372-8369).

2.3.6 Follow Medicaid Managed Care Marketing Guidelines:

- a. Permit Health Plus to conduct marketing activities at provider office locations or facilities.
- b. Prominently display a list of all managed care plan affiliations.
- c. Speak to patients about plan affiliations, encouraging them to select the plan that best meets their needs, without promoting one plan over another.
- d. Avoid offering material or financial gain to potential members as an inducement to enroll in Health Plus or any other Medicaid managed care plan.
- e. Avoid paying or accepting a payment, commission, or bonus from Health Plus or any other Medicaid managed care plan to increase the numbers of Medicaid-eligible members enrolled in that particular plan.
- f. Avoid targeting individuals and families who are already enrolled in managed care plans in an attempt to persuade them to switch plans.

2.4 24 Hour Access and Appointment Availability Standards

2.4.1 24 Hour Access Standards

All participating primary care physicians (PCPs) and OB/GYNs are required to provide access to covered medical services 24 hours a day, 7 days a week. In practice, this means:

- Member telephone calls should be answered by a live answering service that is able to connect the member with his or her physician or with a covering provider within 30 minutes. In the event that the member cannot receive a return phone call, the answering service must keep the member “on hold” until he or she can be connected directly with a physician.
- For physicians whose phone is answered after hours by an answering machine, the outgoing message must instruct members to call the 1-800 number on the back of their health plan ID card in urgent situations. A sample message might state:

“If you are a member of a health plan and this is an urgent call, please call the 1-800 number on the back of your health insurance card.”

Otherwise, the message must refer the member to a phone number answered by a live person capable of offering the member information and referrals as necessary.

On-call providers must return calls within 30 minutes.

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2.4.2 Health Plus Appointment Availability Standards

For:	Members should be seen:
Emergency Care	Immediately upon presentation
Urgent Care	Within twenty-four (24) hours of request
Non-urgent "Sick" Visit	Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated
Routine Non-Urgent Preventive Appointment (Well Visit)	Within four (4) weeks of request
Specialist Referral (Non-Urgent)	Within four (4) to six (6) weeks of request
Initial Family Planning Visit	Within two (2) weeks of request
Initial Prenatal Visit	Within three (3) weeks during 1st trimester Within two (2) weeks during 2nd trimester Within one (1) week during 3rd trimester
Initial PCP Visit for Newborns	Within two (2) weeks of hospital discharge
Well Child Care	Within four (4) weeks of request
Adult Baseline and Routine Physicals (adults age 21 and older)	Within ninety (90) days of enrollment
Mental Health or Substance Abuse Assessment for Work Preparedness (as requested by HRA)	Within ten (10) days of member request
Mental Health or Substance Abuse Visit Following ER Visit or Hospital Discharge	Within five (5) days of request or as clinically indicated
Non-urgent Mental Health or Substance Abuse Visit	Within two (2) weeks of request

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2.4.3 Missed Appointments

Health Plus members should be asked for a contact telephone number and given a reminder card when they make an appointment. Participating providers should follow up with members who miss scheduled appointments by documenting the “no show” in the member’s medical record and attempting to reach the member by telephone.

2.5 Continuity of Care for New Members

Non-network providers may continue to render care to new Health Plus members for up to 60 (sixty) days after their effective date of enrollment if one of the following applies:

- The member has a life threatening, chronic, degenerative and/or disabling disease or condition.

-or-

- The member has entered the second trimester of pregnancy at the time of enrollment. In this instance, the new member is eligible to continue receiving care from her existing provider for the period including the delivery and up to 60 (sixty) days postpartum.

2.6 Termination of Provider Agreements

2.6.1 Voluntary Terminations

Providers who wish to end their contractual relationship with Health Plus are governed by the terms of their individual agreements. All providers voluntarily terminating their affiliation with Health Plus are required to give the plan ninety (90) days prior written notice of their intended termination.

2.6.2 Non-Renewals

If either Health Plus or a participating provider decides not to renew a provider agreement, this is not considered a termination. Nevertheless, the party initiating the non-renewal is required to give 90 (ninety) days written notice prior to the expiration of the contract.

When Health Plus does not renew a provider’s contract due to issues of professional competence or conduct, this is considered a **termination**. Such actions are reportable to the National Practitioner Data Bank (NPDB) and New York State professional disciplinary agencies.

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2.6.3 Continuity of Care When a Provider Leaves the Network

Terminating and non-renewing providers are required to continue caring for members for up to ninety (90) days from the date of written member notification. Health Plus will send a notice of the intended termination to all members on the provider's panel with information on obtaining care and services during the 90-day transitional period and thereafter.

For members who have entered the second trimester of pregnancy, the transitional period includes the delivery and sixty (60) days of postpartum care related to the delivery.

Providers offering transitional care must agree to:

1. Continue to accept Health Plus reimbursement rates in effect prior to the transitional period.
2. Adhere to Health Plus's medical policies and procedures, including referrals, prior authorization requirements and treatment regimen(s) approved by the plan.

2.6.4 Terminations for Cause

Health Plus will not terminate a contract or refuse to renew a contract solely because a health care provider has:

- Advocated on behalf of an member
- Filed a complaint against Health Plus
- Appealed a decision by Health Plus
- Provided information to members regarding treatment
- Complained to a government agency about Health Plus's policies or practices

When Health Plus decides to terminate a provider's contract (for reasons other than those that require immediate termination), the provider will be offered a hearing and appeals process. The provider will receive a written notice, to include:

- The reasons for the proposed termination
- Information about the right to request a hearing or review before a panel appointed by Health Plus
- Notice that the provider has 30 days from receipt of the notice to request a hearing
- Notice that Health Plus will schedule the hearing within thirty (30) days of receiving the provider's request

2.6.5 Provider Hearings

Hearing panels are comprised of a minimum of three individuals appointed by Health Plus. At least one of these persons is required to be of the same discipline or specialty as the provider under review. If the panel consists of more than three members, then at least one-third of them must be clinical peers of the provider being reviewed.

Health Plus hearing panels must render timely written decisions, outlining one of three possible outcomes:

1. Reinstatement
2. Reinstatement with provisions set forth by Health Plus
3. Termination

If the Hearing Panel decides to terminate the provider, the termination will become effective 30 days from the date the provider receives the notice of termination from Health Plus. In no event will the termination become effective prior to 60 days from the date the provider received the original notice of proposed termination.

2.6.6 Immediate Termination

In the following situations, Health Plus will immediately and automatically terminate a provider, without a professional review or hearing:

- a) Imminent harm to member care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice.

-or-

- b) Health Plus learns or confirms from an official source that the provider has had his or her license suspended or revoked by New York State, or has been excluded from the Medicaid or Medicare programs.

In the above instances, the Health Plus Chief Medical Officer (CMO) will notify the provider in writing of the immediate termination.

2.6.7 Health Plus's Duty to Report

Health Plus is legally obligated to notify the appropriate New York State professional disciplinary agency within 30 days of the following:

- A health care provider is terminated for reasons related to alleged physical or mental impairment, professional misconduct, or the impairment of the safety or welfare of a Health Plus member.
- Health Plus voluntarily or involuntarily terminates a contract, employment agreement or any other affiliation with an organization in lieu of imposing disciplinary measures.
- Health Plus terminates a health care provider contract pursuant to a determination of fraud or in the case of imminent harm to member health.

National Practitioner Data Bank (NPDB)

Health Plus will report the following to the NPDB within 15 days of final action:

- Adverse actions resulting from professional review that last more than 30 days and are related to professional competence or conduct.
- Voluntary termination of contract by a provider while under, or to avoid investigation by Health Plus.

