EmblemHealth

Chapter 5: Member Policies and Rights

Chapter Summary

EmblemHealth is committed to serving our members in a culturally competent and nondiscriminatory manner. We expect our network providers to treat all members with respect and dignity and to honor the rights set out in this chapter. We also expect our members to fulfill their responsibilities to you.

This chapter describes our members' rights and responsibilities, including member copay policy procedures and privacy rights.

Member Rights and Responsibilities

It's important for providers to be familiar with and meet expectations set out in all our Member Rights and Responsibilities.

- Enhanced Care (Medicaid Managed Care) Members
- Enhanced Care Plus (HARP) Members
- Child Health Plus (CHPlus) Members
- Commercial Members

Providers should be aware of who may and may not consent for care. See Public Health Law section 2504.

Member Copay Policy and Procedures

Some plans require members to pay a set portion of the providers' fee as a copay. The office visit copay is part of the provider's payment. It is the provider's responsibility to collect the amount specified on the member's ID card. Copays should be collected at the time of service. Under normal circumstances, EmblemHealth will not reimburse providers for copays that were not collected from the member. See COVID-19 exceptions.

If the provider's contracted fee is less than the copay amount, the provider cannot charge the member more than the contracted fee. If already collected, providers must refund the difference to the member.

Some plans have a deductible for in-network services. The copay collected at an office visit may be a payment towards the member's deductible. A true copay will not apply until after the deductible is met. See the remittance statement for the member's actual out-of-pocket responsibility.

Copay amounts are listed on the member's ID card. It can also be obtained from the member's Benefit Summary on our secure provider portal at emblemhealth.com/providers under the Member Management tab and Eligibility drop-down, or from our Customer Service department as listed in the Directory chapter.

Important things to note:

- Copays may not be collected from Medicare members for services defined by the Centers for Medicare & Medicaid Services (CMS) as Medicare Preventive Services .
- Dual Eligible SNP members' cost-share may not be greater than what the New York State Medicaid program requires of its enrollees for members with full Medicaid benefits.
- Medicaid members do not have copays for the following services:
  - Emergency room visits
  - Family planning services, drugs, and supplies
  - Mental health visits
  - Chemical dependency visits
  - Drugs to treat mental illness
  - Drugs to treat tuberculosis
  - Prescription drugs for residents of adult care facilities
- The following Medicaid members do not have copays for any services:
  - Children under age 21
  - Pregnant women (through 60 days postpartum)
  - Permanent residents of nursing homes
  - Residents of community-based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability
  - Those who are financially unable to make copays at any time and who tell the provider they are unable to pa
  - Those in a Comprehensive Medicaid Case Management (CMCM) or service coordination program
  - Those in an New York State Office of Mental Health (OMH) or New York State Office for People With Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) waiver program
  - Those in a New York State Department of Health (NYSDOH) HCBS waiver program for persons with traumatic brain injury (TBI)
- Medicaid members cannot be denied health care services based on their inability to pay the copay at the time of service. However, providers may bill these members or take other action to collect the owed copay amount.
- Members with Medicaid only have pharmacy copays and an annual $200 maximum copay obligation.
- Child Health Plus (CHPlus) members do not have copays.
- Copays may not exceed the amount payable under the contracted fee schedule.
- The Patient Protection and Affordable Care Act provides members with access to covered preventive services without having to pay a copay or coinsurance or meet a deductible.

Nondiscrimination

Network providers represent and warrant to EmblemHealth they will not discriminate against members with respect to the

availability or provision of health services based on a member's:

- Age
- Amount of payment
- Color
- Creed
- Disability
- Ethnicity
- Gender
- Gender identity or expression
- Health literacy
- HIV status
- Language
- Marital status
- National origin
- Need for health services
- Place of residence
- Plan membership
- Race
- Religion
- Sex
- Sexual orientation
- Source of payment
- Veteran status
- Or any factor related to a member's health status including, but not limited to:
  - Claims experience
  - Evidence of insurability (including conditions arising out of acts of domestic violence)
  - Genetic information or type of illness or condition
  - Health care needs
  - Medical history
  - Mental or physical disability or medical condition or handicap or other disability
  - Or on any other basis otherwise prohibited by state or federal law.

Member Privacy Rights

EmblemHealth is committed to protecting and securing our members' personal information. Our Notice of Privacy Practices describes how members' medical information may be used and disclosed, and how our members can get access to this information.

The member handbook tells members how to consent to the collection, use, and release of protected health information (PHI), how to obtain access to their medical records, and what we do to protect access to their PHI.

Confidentiality of Personal Information
We want members to know that EmblemHealth makes the protection of PHI a high priority. Our members entrust us with personal, sensitive, and highly confidential information. Our employees and other authorized individuals working for us are accountable for exercising a high degree of care in safeguarding the confidentiality of PHI.

Our employees and other authorized individuals are prohibited from:

Accessing or trying to access PHI, except on a "need to know" basis and only when authorized to do so.

- Disclosing PHI to any person or organization within or outside of EmblemHealth, unless that person or organization has a "need to know" and is authorized to receive that information.

Confidentiality of Health Information for Minors Enrolled in Medicaid Managed Care Plans
EmblemHealth suppresses all Explanation of Benefits (EOBs) for Medicaid minors 0 – under 18 years of age, except for dental-related services and situations where the member may be financially responsible. NYSDOH requires Medicaid Managed Care Plans, including EmblemHealth, to establish an effective, uniform, and systemic mechanism to comply with confidentiality protections for health care services provided to minors who are enabled by statute to consent to their own heath care.

Authorization to Release Information
The member or qualified person must give authorization before any PHI can be released to an outside organization or agency, unless release of that information is legally required or permitted.

Special restrictions apply to the release of information relating to substance use disorders (alcohol and drug), mental health, psychotherapy notes, genetic information (including genetic test results), HIV/AIDS, and sexually transmitted disease(s).

In many cases, routine consent for release of information is obtained on the enrollment application. The consent authorizes the use of PHI for general treatment, coordination of care, quality assessment, utilization review, and fraud detection. The consent also authorizes the use of PHI for oversight reviews, such as those performed by the State or for accreditation purposes. In addition, it covers future routine use of such information.

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA permits the disclosure of information for payment, treatment, and health care operations. HIPAA requires providers to take reasonable and appropriate measures to protect member/patient information. Examples of measures considered reasonable and appropriate to safeguard the patient chart include:

- Limiting access to certain areas.
- Ensuring the area is supervised.
- Escorting non-employees in the area.
- Placing the chart in a box next to the exam room with the front cover facing the wall so PHI is not visible to anyone who walks by.

An office sign-in sheet may not display medical information (e.g., information about symptoms or treatment). Messages on home answering machines should be limited to the member's name and information necessary to confirm an appointment, or simply request a returned call.

Confidentiality of Behavioral Health, Substance Use, and HIV-related Information
Providers must develop policies and procedures to assure confidentiality of behavioral health (BH), substance use (SU), and HIV-related information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors.
- Identification of staff allowed access and limits of access.
- Procedures to limit access to trained staff (including contractors).
- Protocols for secure storage (including electronic storage).
- Procedures for handling requests for information.
- Protocols to protect members from discrimination.