Chapter 37: Required Provisions to Network Provider Agreements

Chapter Summary

In this chapter, you will find mandatory contract language required by the State of New York and the Centers for Medicare & Medicaid Services, including the Managed Care Law of 2009, the New York State Department of Health (NYSDOH) Standard Clauses, the Special Provisions Related to Medicaid Members, and the Medicare Advantage Addendum.

- Managed Care Law of 2009
- Medicare Advantage/Medicare-Medicaid Required Provisions
- NYSDOH Standard Clauses for Managed Care Provider/IPA Contracts Appendix Effective: April 1, 2017
- Provision Related to Medicaid, Managed Long Term Care and Family Health Plus Members
- Special Provisions Related to Medicaid, CHP and HARP Members
- Medicare Advantage Addendum

Health Care Transparency in Cost and Quality Information

Effective Dec. 27, 2020, the Consolidated Appropriations Act, 2021 includes provisions designed to expand transparency in cost and quality information for health care consumers and employer groups.

As a result, our provider network contracts no longer restrict EmblemHealth from:

1. Disclosing provider-specific cost or quality-of-care information or data, through a consumer engagement tool or any other means, to referring providers, employer groups, members, or individuals eligible to become members; and

2. Electronically accessing and sharing, in accordance with applicable privacy regulations, de-identified claims and encounter information or data with a business associate for plan administration and quality improvement purposes.

Additionally, if any Federal Employees Health Benefits (FEHB) member schedules an item or service, the provider and/or facility furnishing such item or service is required to:

1. confirm the individual is enrolled in FEHB (and if so, whether the individual is seeking to have a claim for such item or service submitted for coverage), and

2. provide to EmblemHealth a notification of the good faith estimate of the expected charges for the item or service (including items or services that are reasonably expected to be provided in conjunction with the primary item or service), with the expected billing and diagnostic codes.

If the FEHB member schedules the item or service at least 3 business days in advance, the provider or facility shall provide the above information not later than 1 business day after the date of such scheduling. If the FEHB member schedules the item or service at least 10 business days in advance, the provider or facility shall provide the above information not later than 3 business days after the date of such scheduling.

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