EmblemHealth®

Access, Availability, and After-Hours Coverage Standards

The access-to-care standards in the following tables are monitored by 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

Failure Reasons	Routine and Non-Urgent "Sick" Appointments	After Hours Access
If no provider staff "live voice" reached.	• No answer. • On hold for more than 10 minutes. • Answering service representative/voicemail with no indication to expect a call within a period of time. • Wrong telephone number. • Telephone number is not in service. • Constant busy signal.	• No answer. • No answer at the after-hours number. • Wrong telephone number. • Telephone number is not in service. • Constant busy signal. • 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.) • A voicemail with instruction to leave message for provider but the call-back time was unspecified.
If a "live voice" is reached, but an appointment cannot be made:	• Staff inaccurately states that the provider is: – Not accepting new patients – Not a plan participant – Restricted to specialty care or changed specialty • Staff not scheduling appointments at this time. • Staff requires previous medical records before appointment can be made. • Provider requires a referral. • Provider not at site and no alternative provider available. • Provider will not see patient because the pregnancy is too far along. • Provider must see social worker/case manager before a medical appointment can be made. • Caller told they must complete a health questionnaire/registration form before medical appointment can be made. • Caller instructed to go to Emergency Room regardless of need.	• Provider does not participate in caller's health plan. • Provider incorrectly states that they do not participate in caller's health plan. • Provider does not participate but did not inform the plan. • Provider no longer at site. • Provider is not covered by an answering service. • On hold for more than 10 minutes. • Caller told to call back the next day for an appointment and/or was not given an appointment. No clinical involvement in the discussion. • Hospital/facility staff could not identify the requested provider. • Only answering service responded and could not connect with a clinician. • Telehealth visit/video visit not offered. • Member not referred to appropriate services for the concern.

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Standards	Definition	Scheduled Appointment Time Frame
Emergency Care (Emergent)*	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).	Urgently needed services or emergency — immediately. If a provider or covering provider is not immediately available, the member or representative should call 911.
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.	Urgently needed services or emergency — immediately. **For Medicaid members:** Within **24 hours** of request.
Non-Urgent Sick Visit	Medical care given for an acute onset of symptoms that are not emergent or urgent in nature. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.	Services that are not an emergency or urgently needed, but the enrollee requires medical attention — within seven business days. **For Medicaid members:** Within **48 - 72 hours** of request, 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.	Within **30 business days.** **For Medicaid members:** Within **four weeks** of 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.	Within **30 business days.** **For Medicaid members:** Within **four weeks** of request.
Routine Specialty Care	Specialty care is medical care given by a specialist. Examples include podiatry and neurology.	Within **30 business days.**
Oncology Specialist Visit	Initial oncology visit for medical care when the patient has a positive test result and is requesting an initial visit.	Within **three business days** 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 **two business days** of member request. Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS — within **ten days** of request by an MMC enrollee.
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 **two weeks (14 days)** of member request.

* 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.

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 **three weeks** for first trimester, **two weeks** for second trimester, and **one week** 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 **21 – 56 days** 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 **four weeks** of member request.
Pediatrician Conference	A prenatal visit (during third 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 **ten days** of member request or as clinically indicated.
Follow-Up Visit for Breastfed 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 **48 to 72 hours** 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 **two weeks** 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 **four weeks** of member request.
Any Other Condition		Up to medical judgment of the practitioner.

Availability of Provider Network

In accordance with clinical policy, network is required to meet or exceed current availability standards under the following conditions with separate analyses of appointment availability for behavioral health care practitioners who prescribe medications (e.g., psychiatrists) and for behavioral health care practitioners who do not prescribe (e.g., psychologist) for:

Emergencies – member must be seen immediately:

- **Non-life-threatening emergent** – member must be offered the opportunity to be seen within **six hours** of the request.
- **Urgent** – member must be offered the opportunity to be seen within **48 hours** of the request.
- **Initial visit for routine care** – member must be offered the opportunity to be seen within **10 business days.**
- **Follow-up routine** – member must be offered the opportunity to be seen within **10 business days.**

Network standard of performance is that the network has a 95% or greater availability across all licensure types.

Two primary care providers (PCPs) per county with languages of English, Spanish, and Chinese should be available to members. This cultural linguistic metric is monitored and measured as regulatory requirements, the health plan, and accreditation bodies dictate.

High Volume and High Impact Specialty Care Practitioners (SCPs) Adequacy Availability

- EmblemHealth monitors OB/GYNs for its high-volume SCP and oncologists for its high-impact SCP.
- At least 90% of members must be offered a choice of at least three open-practice, high-impact SCPs within EmblemHealth's distance/travel time standard.
- The ratio of at least one open-practice, high-volume and high-impact SCP per 3,000 members (1:3000; 1:3000 SCP).
- At least 50% of open-panel/practice, high-volume and high-impact SCPs shall be wheelchair accessible (as self-reported or via CAQH application). This is monitored and measured as regulatory requirements dictate. At least 90% of the members must be offered convenient choice of practitioners listed above within the following distance/time standards (by car or public transportation):

Distance Standards for PCP and SCP Adequacy — Availability

Travel time adequacy measures:

- Non-rural areas — 30 miles or 30 minutes.
- Rural areas — 60 miles or 60 minutes.

Standards	Definition and Benchmark
Access to Services	***Ensuring equitable access to Medicare Advantage (MA) Services***. Ensure that services are provided in a culturally-competent manner and promote equitable access to all enrollees, including the following: (i) People with limited English proficiency or reading skills. (ii) People of ethnic, cultural, racial, or religious minorities. (iii) People with disabilities. (iv) People who identify as lesbian, gay, bisexual, or other diverse sexual orientations. (v) People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex. (vi) People living in rural areas and other areas with high levels of deprivation. (vii) People otherwise adversely affected by persistent poverty or inequality. **For Medicaid:** The plan will maintain a network that is geographically accessible to the population to be served. Travel time/distance to primary care sites shall not exceed 30 minutes from the enrollee's residence in metropolitan areas or 30 miles from the enrollee's residence in non-metropolitan areas. Transport time and distance to rural areas to primary care sites may be greater than 30 minutes/30 miles from the enrollee's residence if based on the community standard for accessing care or if by the enrollee choice. Travel to HIV specialist PCP sites shall not exceed 30 minutes. However, in certain counties identified by the AIDS Institute (based on the community standard for accessing HIV specialist care), travel time shall not exceed 30 minutes/30 miles. **For Medicaid members:** Enrollees may, at their discretion, select participating PCPs located farther from their homes, as long as they are able to arrange and pay for transportation to the PCP themselves. In the case of a Restricted Enrollee as described in Appendix Q of this Agreement, the Contractor may allow the Restricted Enrollee to select a Restricted Recipient Program (RRP) PCP farther from their home as long as they are able to arrange and pay for transportation to the RRP PCP themselves. **Medicaid Managed Care Plan recipients are also subject to the Recipient Restriction Program. The Plan is required to conduct reviews of Medicaid recipients and restrict recipients to care provided by, or referred by, a Primary Care Provider if it is found that the recipient has received duplicative, excessive, contraindicated, or conflicting health care services, or committed fraudulent acts with their benefit card.* Travel time/distance for Long-Term Services and Supports LTSS provider types in which an enrollee must travel to the provider to receive services, or to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed 30 minutes/30 miles from the enrollee's residence. Transport time and distance in rural areas for LTSS provider types in which an enrollee must travel to the provider to receive services, or to specialty care, hospitals, mental health, lab and x-ray providers may be greater than 30 minutes/30 miles from the enrollee's residence if based on the community standard for accessing care or if by enrollee choice.
Geographic (GEO) Access Standards for All Physicians	A Medicare Advantage (MA) plan must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type. (i) Each contract provider type must be within maximum time and distance of at least one beneficiary (in the MA Medicare sample census) in order to count toward the minimum number. (ii) The minimum number criteria and the time and distance criteria vary by the county type.

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 them. **Medicaid members** with appointments shall not routinely be made to wait longer than one hour.
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. **For Medicaid members:** Under no circumstances may the practitioner routinely refer calls to an emergency room.

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.	The member or representative should call 911. Urgently needed services or emergency — immediately. **For Medicaid members:** Immediately upon presentation at a service delivery site.
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.	Urgently needed services or emergency — immediately. **For Medicaid members:** Within **24 hours** of request.
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 five days of member request or as clinically indicated, but no later than seven days post discharge. **For Medicaid members:** Within **five days** of request, or as clinically indicated.
Routine Care	An appointment for specific mental health or substance use concerns that are not of an urgent nature, i.e., marital problems, tensions at work, and general anxiety disorder.	Routine and preventive care — within **30 business days.** **For Medicaid members:** Within **one week** of 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 **30 seconds.**
Call Abandonment	The number of calls that went unanswered by a live voice and ultimately voluntarily disconnected in the Mental Health department.	Less than five percent.

NCQA health plan standards:

- Care for a non-life-threatening emergency within **six hours.**
- Urgent care within **48 hours.**
- Initial visit for routine care within **10 business days.**
- Follow-up routine care within **30 days** following an initial therapy appointment and within **90 days** following an initial medication appointment.

Appointment Availability Standards for Medicaid Behavioral Health Providers

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

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 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 an RRP PCP farther 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.

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 one week	Within five business days of request	Within five business days of request
IPRT			Two - Four weeks	Within 24 hours	
Partial Hospitalization				Within five business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within one week of request	Within five business days of request	Within five business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within one week of request	Within five business days of request	Within five business days of request
Crisis Intervention	Within one hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in-home and crisis response services under definition)	Within one week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within one week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within one week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within one week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within five business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within five business days of request	Within five business days of request	Within five business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within one week of request	Within one week of request	
Prevocational Services			Within two weeks of request		Within two weeks of request
Supported Employment			Within two weeks of request		Within two weeks of request
Community Self-Advocacy Training and Support			Within five business days of request		Within five business days of request
Habilitation			Within two weeks of request		

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 two weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within two weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within two 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 Time frame	Who Performs
24 Hours	Initial screening/screening for abuse/neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
Five Days	Initial determination of capacity to consent for HIV risk assessment and testing	X	X	Child Welfare caseworker or designated staff
Five 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 and 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 ages 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 and 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 use assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent and 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

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