2026 Provider Policies

Your guide to working with MVP Health Care®

Updated August 14, 2026
Updated policies this quarter effective October 15, 2026

MVP Provider Policies

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Claims

Claims Submission

Sending Claims Electronically

MVP offers several options for submitting claims electronically using an Electronic Data Interchange (EDI)

- MVP's Payee ID is 14165
- For EDI questions, call MVP's EDI coordinators at **1-877-461-4911** or via email at **ediservices@mvphealthcare.com**

Sending Claims Manually (CMS-1500 or UB-04)

Submit claims for all products and Members to the following address:

MVP Health Care
Attn: Claims Department
PO Box 2207
Schenectady, NY 12301

Claims Adjustments or Appeal Requests

- Call MVP's Customer Care Center for Provider Services at **1-800-684-9286**
- For faster processing, go to **mvphealthcare.com** to submit claim adjustment requests. The status of online claim adjustments is also available through your Provider online account.
- Initial Claim Adjustment forms should be submitted to the following address for all products and Members:

  MVP Health Care
  Attn: Claims Department
  PO Box 2207
  Schenectady, NY 12301

- Second Clinical Review Claims Adjustment forms should be submitted to the following address:

  MVP Health Care
  Attn: Operations Adjustment Team
  PO Box 2207
  Schenectady, NY 12301

- Appeals should be submitted to the following addresses:

MVP ID#	Address
Not Medically Necessary	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305

No Prior Authorization Obtained/Eligibility (excludes medical necessity appeals)	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305
Claims Exceeding Timely Filing Limits/ Contractual Denials Per MVP Policy	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305

Coordination of Benefits (COB)

Call **1-800-556-2477**

Credentialing

Providers who would like to become a participating provider should complete the Provider Credentialing Application Request form found at Provider Credentialing | MVP Health Care, and follow the instructions, including selecting the *Provider Application Request* to complete the application form. Once you have completed the form, include state and county in the subject line and email it to **MVPPR@mvphealthcare.com**.

Customer Care Center for Provider Services

Providers can verify Member eligibility and benefits online at **mvphealthcare.com** or by calling MVP's Customer Care Center for Provider Services at **1-800-684-9286**.

To find the appropriate Customer Care Center phone number for a Member, please refer to the back of their MVP Member ID card.

Durable Medical Equipment (DME)

- The Prior Authorization Request Form for DME/O&P Items and Services (PARF) located at: mvphealthcare.com/providers/forms
- The PARF can be submitted online, faxed to **1-888-452-5947** or emailed to authorizationrequest@mvphealthcare.com.
- Be sure to include all appropriate and pertinent medical documentation (e.g., office notes, lab, and radiology reports) with the completed PARF.
- Phone requests will only be taken for urgent care determinations and hospital discharges. Call **1-800-684-9286**

Hospital Billing Questions

Call MVP's Customer Care Center for Provider Services at **1-800-684-9286**, or contact us via mail at:

MVP Health Care
Hospital Billing Coordinator
PO Box 2207
Schenectady, NY 12301-2207

Pharmacy

- The MVP Formulary is available online at **mvphealthcare.com/providers**, then select *Resources*, then *Pharmacy*, then *MVP Formularies*
- The Medicare Formularies are available online at **mvphealthcare.com/providers/pharmacy**
- For formulary exception and prior authorization requests, a Medication Prior Authorization Request form should be submitted
- All medication request forms can be found online at **mvphealthcare.com**, then *Admissions and Prior Authorizations* and choose the appropriate form
- For non-Medicare Members, fax the form to **1-800-376-6373**
- For all Medicare Members (Preferred Gold, GoldValue, GoldAnywhere, and USA Care), fax the form to **1-800-401-0915**

MVP Provider Partnership Liaison (PPL) and Provider Relations

To find your MVP Provider Partnership Liaison or your Provider Representative, visit **here** and select your representative under *Contact Information for Participating Providers*.

Additionally, you can contact MVP Provider Relations, email **MVPPR@mvphealthcare.com**.

Behavioral Health Provider Relations

To find your Behavioral Health Professional Relations Representative, visit **mvphealthcare.com/providers/contact-us** and select *Professional Relations Listing – Behavioral Health*.

Additionally, you can email Behavioral Health Professional Relations at **ihprovidercontracting@mvphealthcare.com**.

Utilization and Case Management

Members	Please call the number on the back of their ID card. For Case Management, call **1-866-942-7966**
Providers may call or fax their UM requests to MVP	Call MVP's Provider Services at **1-800-684-9286** Faxes may be directed to the following numbers: • Prior Authorization Request Forms or Out-of-Network Requests: **1-800-280-7346** • Acute Inpatient Concurrent Review**: 1-888-207-2889** • SNF or Acute Rehabilitation: **1-866-942-7826** • Commercial, Medicare, ASO, and Medicaid Plans: **1-866-942-7826**

Please reference the Utilization and Case Management section for all other numbers related to Utilization and Case Management.

Services That Require a Referral for MVP Medicaid Managed Care

Restricted recipient Members—referrals are required to all specialties for Members who have a physician restriction. Providers should verify eligibility by calling MVP's Customer Care Center for Provider Services at **1-800-684-9286**.

Appeals Process

Introduction

MVP provides our Members with the highest quality health care and customer service. However, on occasion, misunderstandings and differences of opinion may occur. The MVP Appeal Process provides Members with a dignified and confidential process to address and resolve these concerns and differences. MVP's Subscriber Contract, Certificate of Coverage, or Summary Plan Description will prevail in cases of any dispute or question concerning coverage or rules of eligibility, enrollment, or participation in an MVP health plan. MVP is committed to resolving all appeals and complaints fairly and amicably, and to assure a high level of quality care and service for Members. MVP encourages Members to use the appeal and complaint procedures when necessary. MVP will not retaliate or take any discriminatory action against a Member who files an appeal or complaint.

Appeal

An appeal is a request for MVP to change a decision that has been made. It may concern whether a requested service is a benefit covered by MVP. An External Appeal is the review of MVP's denial based on Not Medically Necessary, Experimental/Investigational or Out of Network determination by an independent third party not related to MVP.

Appeal Reviewers

For all levels of internal appeal, appeals are reviewed by persons who are not subordinate to those who made prior adverse benefit determinations Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who were not involved in the initial determination, at least one of whom will be a clinical peer reviewer. For any Medicaid Behavioral Health appeals, upon request by submitting provider, a peer-to-peer review will be conducted prior to a decision being made and are subject to specific Behavioral Health requirements including:

- A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment
- A physician board certified in addiction treatment must review all inpatient level of care denials for Substance Use Disorder (SUD)

Provider Submitting Appeals on a Member's Behalf

A Provider may appeal a request for a service as the designated representative of an MVP Member. MVP shall only accept appeals submitted by providers on a Member's behalf after the Member or appropriately appointed Member representative has designated the Provider to act on their behalf. Such designation must be in accordance with MVP's policies and procedures. (A Provider filing an appeal on their own behalf for a retrospective UM or claim denial should follow the Provider appeals process.)

Expedited Appeals Provider/Hospital on Member's Behalf

An expedited appeal is used whenever a Member or Member's designee appeals a denial of services that:

- Could seriously jeopardize the Member's life or health or the Member's ability to regain function, as determined by MVP applying the prudent layperson standard
- In the opinion of the Provider/hospital with knowledge of the Member's medical condition would subject the Member to severe pain that cannot adequately be managed without the care or treatment that is the claim's subject
- Involves MVP's review of continued or extended health care services or additional services when the Member is undergoing a course of continued treatment prescribed by the health care Provider
- Involves additional inpatient substance abuse treatment at least 24 hours before the member is discharged
- Mental health or substance abuse services that may be related to a court appearance

Providers/hospitals can initiate an expedited appeal on a Member's behalf prior to the Provider/hospital being appointed the Member's designated representative, if the Provider/hospital does the following:

- Calls the MVP Member Services/Customer Care Center and indicates that he/she would like to submit an expedited Member appeal on the Member's behalf
- Confirms to MVP's Member Services/Customer Care Center that it is his/her reasonable belief that an expedited Member appeal is appropriate in this case
- Advises MVP's Members Services/Customer Care Center that it is his/her reasonable belief that any further delay in submitting an appeal could have a detrimental effect on the Member's health

Expedited Appeals

An expedited External Appeal for Medical Necessity or experimental/investigational services can be made simultaneously with an expedited internal appeal. Members requesting an expedited External Appeal must still pursue the internal appeal option. The Member Appeals staff responsible for the disposition of the appeal investigates the situation thoroughly, including contacting the Member, Provider, MVP Medical Director, or clinical peer, who are available 24/7, for clarification of issues or additional information when necessary.

MVP will make the expedited appeal determination for MVP Medicaid Managed Care (Medicaid), MVP Harmonious Health Care Plan (HARP), and NY State of Health Members, as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the appeal or two business days of receipt of the information necessary to conduct the Appeal whichever is earlier. For IBP members within two (2) business days of receipt of information. A written notice of final adverse determination concerning an expedited Utilization Review appeal will be transmitted to the Member within 24 hours of the decision being rendered. necessary information and no later than 72 hours of the date of the receipt of the Appeal. For Medicaid and HARP Members, this time may be extended for up to 14 days upon the Member's or the Provider's request; or if MVP demonstrates that more information is needed, and the delay is in the best interest of the Member. The Member and/or Provider will be notified of this verbally and in writing.

Any Medical Necessity-related appeal not conducted within the required timeframes shall be deemed a reversal of the determination. (For Medicaid and HARP Members, any administrative appeal requests in which the Member submits an appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from MVP within State-specified timeframes or the appeal resolution or extension notice does not meet noticing requirements, the Member is eligible to file a state Fair Hearing.) The Member is also sent written confirmation of the decision within two working days of rendering the decision.

To submit an expedited appeal on the Member's behalf, the Provider/hospital must contact the MVP Member Services/Customer Care Center at **1-888-687-6277**, Medicaid and CHP at **1-800-852-7826**, or HARP at **1-844-946-8002**, between 8 am and 6 pm Monday through Friday; or fax the appeal to MVP Member Appeals Department at **1-518-386-7600**. For IBP members, contact the MVP Member Services/Customer Care Center at **1-866-954-1872**, from 8:00AM to 8:00PM Monday to Friday EST (and 7 days a week between October 1 and March 31).
Appeals should be filed within 180 days (60 calendar days for Medicaid, CHP and HARP, 45 calendar days for IBP Members) of the Member's receipt of denial notice.

Member Appeals (Excludes Medicare Members)

MVP has one level of internal appeal: The appeal must be initiated within 180 days of the initial denial (60 calendar days for Medicaid CHP, HARP) and 45 calendar days for IBP

A full investigation of each appeal, including any aspects of clinical care involved, is conducted and completed within 30 calendar days of receipt of the appeal or as expeditiously as the Member's condition requires for expedited appeals (NY State of Health appeals are completed within the following timeframes, small group, pre-service/pre-authorization 30 calendar days, individual policy, 30 calendar days, small group, post-service/retrospective 30 calendar days, individual policy, 60 calendar days, Medicaid, CHP and HARP 30 calendar days, IBP 30 calendar days). Any Medical Necessity-related appeal not conducted within the required timeframes shall be deemed a reversal of the determination. For Medicaid, CHP and HARP, the Members are eligible to file a state Fair Hearing.

A written acknowledgement is sent to the Member within 15 calendar days for Medicaid, CHP, HARP, Essential Plan, Post Service HMO, EPO, PPO and Individual NYSOH and IBP. Within two days of rendering the decision, MVP sends the Member written confirmation of the appeal decision, including an explanation of the Member's right to appeal further or to proceed directly to external review, if applicable.

For expedited appeals, MVP will decide and notify the Member and Provider by telephone as expeditiously as the medical condition requires, but no later than 72 hours for Medicaid, CHP. HARP, Exchange, Essential, HMO, EPO, PPO) after the request is received. For Medicaid, CHP, HARP and IBP Members, this time may be extended for up to 14 days upon the Member's or the Provider's request; or if MVP demonstrates that more

information is needed, and the delay is in the best interest of the Member. The Member and/or Provider will be notified of this verbally and in writing.

Expedited appeals not resolved to the satisfaction of the Member and/or Provider who filed the appeal may be re-appealed through the external appeal process.

A Member or his/her representative, or a Provider acting on behalf of a Member, may file an appeal verbally or in writing. (See policies for acceptance of verbal and written appeals filed by a Member representative or Provider acting on behalf of a Member). An appeal may be filed verbally by contacting the Member Services/Customer Care Center at the number on the back of their ID card, Monday through Friday from 8 am to 6 pm. (Refer to Member Services Policy and Procedure: Accepting Verbal Appeals.) If the Member calls after hours, the MVP Answering Service will accept the Member's name and telephone number, and a Customer Care Center Representative will return the call during the next working day. If the Member does not speak English, either a bilingual MVP employee will speak with the Member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages.

Appeals should be filed within 180 days (60 calendar days for Medicaid, CHP and HARP and 45 calendar days for IBP Members) after receipt of the denial notice. An appeal may be filed in writing to the following address:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, New York 12301

Written requests for appeal submitted by a Member will be accepted into the Member appeals process. For written requests for appeal submitted by a designated representative acting on behalf of the Member, the appeals staff will first send a Third-Party Authorization form to the Member to verify that the Member authorizes this representative to act on the Member's behalf. For Medicare expedited appeals, the timeframe begins once the appeal has been received by the Appeals department.

A Medicaid, CHP or HARP Member filing an appeal within 10 days of notice of the Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or termination of previously approved services will receive Aid Continuing. To keep the services the same, the Member must ask for an Appeal within 10 days of the date of the Initial Adverse Determination, or by the effective date of the decision, whichever is later. If the Member does not want Aid Continuing, they must say they do not want to do this.

If the Member loses the appeal, they may have to pay for the services they received while waiting for a decision. If the Member asks for a timely Fair Hearing, the Office of Administrative Hearings will order MVP to keep the Member's services the same, unless the Member says they do not want to do this.

MVP must also provide Aid Continuing if the Office of Administrative Hearings (OAH) orders MVP to do so. For appeals submitted by a Provider acting on the Member's behalf, refer to the Member Appeals section.

Department Policies and Procedures: Providers Submitting Appeal Requests

If a Medicaid or HARP Member files a verbal appeal, the MVP Member Services/Customer Care Center will accept the appeal:

- If additional information is needed to complete the appeal, MVP will also notify the Provider and Member in writing, as soon as possible but within 15 days of receipt of the appeal, of such request for information. If only a portion of the information is received, MVP will request the missing information, in writing, within five business days of receipt of the partial information. If the appeal is expedited, this request for information will be made by telephone, followed by written notification to the Member and Provider.

For Medicaid, CHP and HARP Members, MVP will send the appeal case file with all the information about the appeal request to the Member, Provider and/or representative prior to a decision being made on the appeal. For IBP members, MVP will send the appeal case file within five (5) business days of receiving the request. MVP will provide all Members with reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. If the appeal is expedited, MVP will inform the Member of the limited time to present such evidence. MVP will allow the Member or Member's designee, both before and during the appeal process, to examine the Member's case file, including medical records and any other documents and records considered during the appeal process. MVP will consider the Member, Member's designee, or legal representative of a deceased Member a party to the appeal. A written response is sent to a Member on MVP letterhead within two business days of the appeal determination.

The letter includes:

- The date the appeal was filed, a summary of the appeal
- The Member's coverage type
- The name of the Provider or facility, as applicable
- The date the appeal process was completed
- The disposition of the appeal, in clear terms, with contractual (benefits) and/or clinical (Medical Necessity) rationale if appropriate
- The Member's right to appeal further (to external review if appropriate, including relevant written procedures to do so, and relevant reference to attached standard description of the external appeals process)
- If an adverse determination is rendered

- A list of titles and qualifications of the individuals participating in the review of the appeal including the name and address of the UR agent
- A statement of the reviewer's understanding of the pertinent facts of the appeal
- Reference to the evidence or documentation used as the basis for the decision (such as the Medical Policy Criteria, Subscriber Contract, Member Handbook, Summary Plan Description, Certificate of Coverage, or clinical criteria, including either a copy of the specific rule, guideline, protocol, or criterion, or a statement that such rule, guideline, protocol, or criterion is available upon request, free of charge)
- A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim for benefits by contacting a Member Services/Customer Care Center Representative at the number on the back of their ID card, between 8 am and 6 pm Monday through Friday. For IBP, contact a Community Service Care Coordinator at the number on the back of their ID card, between 8:00AM and 8:00PM Monday through Friday (and 7 days a week between October 1 and March 31). Members may also write to us at:

  MVP Health Care
  Attn: Member Appeals Department
  625 State Street
  Schenectady, New York 12305
- A statement of the Member's right to bring civil action under section 502 (a) of ERISA (excluding Federal Government Members, Medicaid, HARP, CHP, and New York State Members)

For Medicaid, CHP, HARP and IBP Members, this written response will include the right of the Member to contact the New York State Department of Health (including the Department's toll-free number), and a statement that the notice is available in other languages and formats for special needs, and how to access these formats. It will also include a description of the Members' fair hearing rights. New York State allows Members the right to request a review by a State-approved External Appeal agent if MVP has denied coverage based on Medical Necessity or because the service is experimental and/or investigational.

Fair Hearings (MVP Medicaid, Medicaid SSI, CHP, HARP and IBP Only)

A Member may request a fair hearing after completing MVP's internal appeals process. A Member may request a fair hearing and an External Appeal; if both requests are made, the fair hearing decision is the one that will be binding.

A Member may ask for a fair hearing from New York State:

- After receiving an appeal resolution that an adverse benefit determination has been upheld (Final Adverse Determination)

- The Member is deemed to have exhausted MVP's appeal process when notice and timeframe requirements under 42 CFR 438.408 have not been met; (42 CFR 438.408 provides that the Member has no less than 120 days from the date of the appeal resolution to request a state fair hearing)
- The Member asked for a plan appeal and received inadequate notice of the appeal decision
- The Member asked for an expedited appeal and the timeframe for the decision has expired (no notification that the request for the expedited appeal was denied and being handled as a standard appeal)
- The Member asks for an appeal about an adverse benefit determination and MVP refuses to accept or review the appeal
- The appeal process is "deemed exhausted"
- The Member requests an appeal, verbally or in writing, and does not receive an appeal resolution letter or extension letter from MVP within the state specified timeframes
- MVP's appeal resolution letter or extension letter does not meet the noticing requirements in 42 CFR 438.408

The Member can use one of the following ways to request a Fair Hearing:

Tel: **1-800-342-3334**
Fax: **518-473-6735**
Online: **otda.state.ny.us/oah/forms.asp**
Mail: NYS Office of Temporary and Disability Assistance
Fair Hearings
PO Box 22023
Albany, NY 12201-2023

A Member also may make a complaint to the New York State Department of Health at any time by calling **1-800-206-8125**.

For New York Members (this does not apply to MVP's self-insured policies or federal government policies), denials for Medical Necessity and experimental/investigational natures of appeal will include a statement of Final Adverse Determination (FAD). The Member must first request an internal appeal through MVP, or the Member and MVP must have jointly agreed to waive the internal appeal process. The letter agreeing to a waiver must contain all the applicable elements issued in a final adverse determination letter and must be provided to the Member within 24 hours of the agreement to waive MVP's internal appeal process. The Member has four months from the date of MVP's FAD to request an External Appeal.

If the requested health care service has already been provided and the Member appealed, the physician may file an External Appeal application on the Members' behalf, but only if the Member consents to this in writing. The FAD also will include a statement written in

bolded text stating that the four-month timeframe for requesting an External Appeal begins upon receipt of the final adverse determination of the internal appeal.

For Commercial Members, the Member has 120 days from the final adverse determination to request an external appeal.

For Vermont Members, the External Appeal request can be requested after a standard internal appeal, unless the request is for an expedited appeal; please refer to the Expedited Appeals section.

The Member's Right to Appeal a Determination that a Health Care Service Is Not Medically Necessary

If MVP denies benefits on the basis that the health care service is not Medically Necessary, the Member may appeal to an External Appeal Agent if they can satisfy the following three criteria:

1. The service, procedure, procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), or treatment must otherwise be a Covered Service under this Contract;
2. They must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or the Member and MVP must agree in writing to waive any internal appeal; and;
3. The appeal is an expedited appeal in which case the Member can choose to file an internal expedited appeal at the same time as the external expedited appeal.

An "Out-of-Network Denial" means a denial of a request for prior authorization to receive a particular health service from an out-of-network Provider, which is based on the determination that the requested service is not materially different from a service available in-network. (A denial of a referral to an in-network Provider is available to provide the requested service is not an Out-of-Network Denial.) To appeal an Out-of-Network Denial, you must submit the following items with your appeal:

- A written statement from the Member's attending physician certifying that the requested out-of- network service is materially different from that which is available in-network; and
- Two documents citing medical and scientific evidence that the requested out-of-network service is likely to be more clinically beneficial to the Member than the in-network service and that the requested out-of-network service is not likely to increase the adverse risk to the Member substantially

The Member's Right to Appeal a Determination that a Health Care Service Is Experimental or Investigational

If the Member has been denied benefits on the basis that the health care service is an experimental or investigational treatment, they must satisfy the following three criteria:

- The service must otherwise be a Covered Service under this Contract;
- They must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or the Member and MVP must agree in writing to waive any internal appeal; and
- The appeal is an expedited appeal in which case the Member can choose to file an internal expedited appeal at the same time as the external expedited appeal

In addition, the attending physician must certify that the Member has a life-threatening or disabling condition or disease.

- A "life-threatening condition or disease" is one in which, according to the current diagnosis of the attending physician, has a high probability of death
- A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the Member unable to engage in any substantial gainful activities
- In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity

The attending physician must also certify that the Members life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by MVP or one for which there exists a clinical trial (as defined by law). In addition, the attending physician must have recommended one of the following:

- A service, procedure, or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation—the attending physician should contact the State to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which the Members are eligible (only certain clinical trials can be considered)

For the purposes of this Section, the physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the area appropriate to treat the Member's life-threatening or disabling condition or disease.

The external review agent will render a decision within 30 days of receiving the Member's application for a standard appeal, or within three days for an expedited appeal. The agent's decision is final and binding for both the Member and MVP. In cases where the external review agent overturns MVP's decision, MVP will provide written notification to the Member.

The Member's Right to Appeal a Determination to Allow an Out-of-Network Referral

If MVP denies an Out-of-Network Referral (OON referral), these denials are eligible for further appeal through the New York State External Appeal process. The Member or his/her designee can appeal an out-of-network referral denial by submitting a written statement from the Member's attending physician, who must be a licensed, board certified, or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the Member for the health care service sought. The written statement must:

- Specify that the in-network health care Provider(s) recommended by MVP does not have the appropriate training and experience to meet the health care needs of the Member; and
- Identify an out-of-network Provider with the appropriate training and experience to meet the health care needs of the Member, who can provide the requested service

The External Appeal agent will consider the training and experience of the in-network health care Provider, the training and experience of the OON Provider, the clinical standards of the plan, the information provided concerning the Member, the attending physicians' recommendation, the Member's medical record, and any other pertinent information. The External Appeal agent will overturn MVP's denial if they determine that MVP does not have a Provider with the appropriate training and experience to meet the particular health care needs of the Member who is able to provide the requested service, and that the OON Provider has the appropriate training and experience to meet the health care needs of the Member who is able to provide the requested service and is likely to produce a more clinically beneficial outcome.

The change is effective for HMO and EPO policies that require a referral from their Primary Care Physician for denials issued after March 31, 2015.

When the Department of Financial Services receives an External Appeal application for an OON referral denial MVP will be contacted to determine the eligibility of the application. MVP will be required to provide the type of policy providing coverage and the renewal date of the policy. Like other requests for information on an External Appeal, MVP will be required to provide this information within 24 hours for a standard appeal or 1 hour for an expedited appeal.

ASO External Appeals

External Appeals

External appeals of certain adverse benefit determinations are only available to Members of non-grandfathered self-funded plans. Members who have questions about their plan's status may contact their employer's human resources personnel or MVP's Customer Care Center at **1-800-229-5851**.

Standard External Appeals

Under the following circumstances, Members may request a standard External Appeal:

- If they have completed the internal appeal of an adverse benefit determination (for reasons other than eligibility) and the adverse benefit determination was upheld; and/or
- If, at any point during the internal claim or appeal process, the plan fails to adhere to the requirements outlined in this attachment.

Expedited External Appeals

Under the following circumstances, Members may be eligible to file an expedited External Appeal:

- If they receive an adverse benefit determination (claim denial) that: involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, and they have filed a request for an expedited internal appeal
- If a Member receives a final adverse benefit determination (claim denial upheld on internal appeal) and:
    - They have a medical condition for which the timeframe for completion of a standard External Appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, or;
    - If the final adverse benefit determination concerns admission, availability of care, continued stay, or health care item or service for which they have received emergency services but have not been discharged from a facility

How to File an External Appeal

An External Appeal request must be received by MVP within 120 days or four (4) months after the receipt of a notice of a final adverse benefit determination (the denial of the internal appeal).
A Member (or their authorized representative) may file an appeal either verbally or in writing as follows:

- To file an appeal, Members can call MVP's Customer Care Center at **(800)-229-5851,** IBP members at **(866)-954-1872**. They should have their claim denial notice, ID card and any other information they would like to have considered in connection with the appeal with them when they make the call.
- To file a written appeal, Members can write a letter to MVP's Appeal Department stating their position. The letter must be sent to:

    MVP Health Care
    Attn: Member Appeals Department
    PO Box 2207, 625 State Street Schenectady, NY 12301

Whether filing a verbal request for an External Appeal or filing a written request, the External Appeal application form must be submitted. A filing fee of $25 must accompany the application form. There is an annual limit for any Member of $75 per year. (A filing fee needs to have been imposed.) If the external agent overturns MVP's denial the $25 filing fee is returned to the Member. If the external review agent agrees with MVP's denial, then MVP will retain the check which will be credited back to the employer group. For an expedited External Appeal, a filing fee of $25 must be submitted within 30 days. For more information on how to file an appeal, including how to designate an authorized representative, Members can contact MVP's Customer Care Center at **(800)-229-5851**. For IBP members call (866)-954-1872.

The Decision-Makers

Within five business days from the receipt of the standard External Appeal, MVP will complete a preliminary review of the request to determine a Member's eligibility for an External Appeal. Within one business day after completion of the preliminary review, MVP will issue the Member and/or the authorized representative (and the IRO) a written notification of the Member's eligibility for an External Appeal. If the request is complete but not eligible for External Appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the Member will have an opportunity to complete the request. MVP will assign an eligible and complete External Appeal request to an independent review organization (IRO) to conduct the appeal. Please note that the IROs are independent from MVP and MVP does not make External Appeal determinations. MVP will maintain contracts with no fewer than three (3) IROs for assignments, and the assignments will be made in a random and unbiased fashion.

The External Appeal Process

Standard External Appeals

Within five business days after the External Appeal request has been assigned to an IRO, MVP must provide the IRO the documents and any information considered in making the adverse benefit determination. If MVP fails to provide the information in a timely manner, the IRO may terminate the External Appeal and reverse the adverse benefit determination in the Member's favor. The IRO will review all the information and documents received in a timely manner and it will not be bound by any decisions or conclusions reached during the claims and internal appeal processes. The IRO also will, to the extent the information and documents are available, and the IRO considers them appropriate, consider other sources of information including, but not limited to, the Member's medical records, the health care professional's recommendations, the terms of the plan, appropriate practice guidelines and clinical review criteria. The IRO will provide, to Members and the plan, written notice of its decision within 45 days after it receives the request for the External Appeal. Upon receipt of a notice of a final External Appeal decision reversing the adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

Expedited External Appeals

Immediately upon receipt of the request for an expedited External Appeal, MVP will complete a preliminary review of the request to determine the Member's eligibility for an External Appeal. Immediately after completion of the preliminary review, MVP will issue the Member and/or the authorized representative a written notification of the Member's eligibility for an External Appeal. If the request is complete but not eligible for External Appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the Member will have an opportunity to complete the request. Upon the determination that a request is eligible for an expedited external review, MVP will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to the Member and the plan of the final External Appeal decision as expeditiously as possible, but in no event no later than 72 hours after the IRO receives the request for the expedited External Appeal. Upon receipt of a notice of a final External Appeal decision reversing the final adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

For both standard and expedited External Appeals, please note that the determination of the assigned IRO is final and binding on the plan, the Member and MVP.

Right to Legal Action

When an initial claim denial is upheld after the appeals process and a Member has complied in full with the plan's claim and appeal procedures as well as any time limits for taking legal action, they may bring a civil action under Section 502(a) of the federal law commonly known as "ERISA" regarding the denied claim. Any questions relative to this right should be addressed to a Member's own legal advisor.

For Assistance

For further questions about a Member's appeal rights or for assistance, New York Members can contact the Employee Benefits Security Administration at **(866)-444-3272**; Vermont Members can contact Vermont Legal Aid at **(800)-917-7787**.

Member Complaints

A complaint is a written or verbal expression of dissatisfaction with MVP that does not involve a plan decision. If the Member submits a complaint, it will be investigated thoroughly, and the Member will be sent a response within 30 calendar days, 45 calendar days for Medicaid and HARP Members and (15 calendar days for Vermont Members). A full investigation of each complaint is conducted and completed within 30 calendar days of receipt of the complaint. A written acknowledgment is sent to the Member within five calendar days of the complaint receipt (Medicaid, HARP,

and IBP Members, 15 calendar days) and written confirmation of the complaint decision within two business days of rendering the decision. All quality-of-care issues are fully investigated and responded to by MVP's Appeals designated staff within 45 calendar days, (Medicare Members, 30 calendar days; and 15 calendar days for Vermont Members,).

A Member or his/her representative, or a Provider acting on behalf of a Member as the designated representative, may file a complaint verbally or in writing.

- A complaint may be filed verbally by contacting the MVP Member Services/Customer Care Center at the number on the back of their ID card, between 8 am and 6 pm Monday through Friday. For IBP members, contact MVP Member Services/Customer Care Center at the number on the back of their ID card, between 8:00AM and 8:00PM Monday through Friday (and 7 days a week between October 1 and March 31). A complaint may also be filed in writing to:

  MVP Health Care
  Attn: MVP Customer Care Center
  PO Box 2207
  625 State Street Schenectady, NY 12301

For Medicaid, CHP and HARP Members:

- Medicaid, CHP, and HARP Members have 60 calendar days after notice of MVP's determination to file an appeal
- They can do these themselves or ask someone they trust to file the appeal for them. They can call the Customer Care Center at the number listed on the back of their ID card if they need help filing an appeal
- We will not treat them differently or badly because they file an appeal
- The appeal can be made by phone or in writing. If they make an appeal by phone, it must be followed up in writing

Inpatient Hospital Appeal Process

For the reconsideration process, please refer to MVP Case and Utilization Management policy.

Definitions

1. Hospital
To MVP's Reconsideration and Appeal Process, a Hospital shall mean a facility that has an agreement with MVP to provide services to MVP's Members, and is licensed pursuant to Articles 28, 36, 44 or 47 of the New York State Public Health Law or licensed pursuant to Articles 19, 31 or 32 of the Mental Hygiene Law or applicable Vermont or New Hampshire law. If a facility is licensed outside of New York State, then comparable legislation of the state where licensure has been obtained will be reviewed to determine if the facility meets the definition of a Hospital.

2. New York, Vermont, and Fully Insured Products
To MVP's Reconsideration and Appeal Process, the reference to "New York, Vermont, Fully Insured Products" refers to health insurance or HMO products issued by MVP Health Plan, Inc., MVP Health Insurance Company, MVP Health Services Corp., which are subject to Article 49 of the New York State Public Health Law, Article
49 of the New York State Insurance Law, or applicable Vermont Law.

3. Provider
To MVP's Hospital Reconsideration and Appeal Process, Provider shall mean a hospital (as defined above) or other appropriately licensed health care professional.

Services Deemed Not Medically Necessary or Experimental or Investigational

A hospital appeal is a request submitted by a hospital to MVP requesting review of a denial of a properly submitted claim on the basis that such services were not Medically Necessary.

Levels of Hospital Appeals

MVP provides two levels of inpatient hospital appeals post discharge or claim denial (described below). Eligibility requires that the hospitals are appealing on their own behalf (NOT the Member); therefore, the hospitals are not the Member's representative designee for this appeal process. This level of appeal applies to either inpatient or outpatient levels of care only and does not include administrative denials. The hospital and/or the Provider notified of the adverse determination may elect to appeal the determination.

1. Level One Hospital Appeals
The first step in the hospital appeal process is to initiate a Level One Hospital Appeal, which will be reviewed by MVP's Health Services Inpatient Department.

A hospital may request to initiate a Level One Hospital Appeal by writing within 180 days, (or per the specific contracted payment dispute time frame) from the hospital's receipt of MVP's initial denial notice (either the UM denial letter or the EOB, or MVP's Remittance Advice—whichever comes first) to:

MVP Health Care
Attn: Inpatient Provider Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

For New York fully insured products, MVP will render a decision on an appeal of a post-service (retrospective) claim denial within 30 days of MVP's receipt of all necessary information to conduct the appeal and will provide written notice of the decision within two business days upon rendering its decision.

2. Level Two Hospital Appeals
Unless otherwise contracted, if the hospital is not satisfied with the result of the Level One Hospital Appeal, it may commence a Level Two Hospital Appeal, which a third-party arbitrator shall conduct. A hospital may initiate a Level Two Appeal by submitting a written request to the designated third-party arbitrator within 30 days of the hospital's receipt of MVP's Level One Appeals determination notice.

Empire State Medical, Scientific and Educational Foundation, Inc. (ESMSEF) is an accredited agency that provides external medical review services and DRG/coding validation and serves as a third-party arbitrator for Second Level Appeals initiated by a hospital. ESMSEF functions as an independent review organization to review external appeals involving medical necessity downgrades in level(s) of care and/or DRG/coding assignments by a hospital. ESMSEF's review of Level Two Hospital Medical Necessity Appeals are limited to:

- Second Level Appeal with ESMSEF: Downgrade of inpatient to observation
- Downgrades of inpatient to ambulatory surgery
- Downgrades of inpatient or observation to emergency room

The DRA determination is considered binding on both parties. In rare instances, either MVP or the facility through the DRA (ESMSEF), may request a reconsideration review which would require another review fee submission if the facility or MVP believe the original DRA determination did not significantly reflect medical record documentation and criteria.

Under Article 49 Title 1 Section 4906: A facility licensed under Article 28 of the Public Health Law and the MCO may agree to alternative dispute resolution in lieu of an External Appeal under PHL 4906(2). This Level II Hospital Appeal conducted by MVP's designated third-party arbitrator is binding on both parties and serves as the final level of appeal. A hospital requesting a Level II Appeal is prohibited from seeking payment from a Member for services determined not medically necessary by the designated third-party arbitrator.

The party submitting the appeal to a third-party arbitrator is responsible for payment of the processing fee. MVP will reimburse a hospital for the entire processing fee if MVP's denial is reversed in total; and reimburse 50 percent of the processing fee if MVP's denial is reversed in part. In such cases, to obtain reimbursement from MVP for the third-party arbitrator processing fee, the hospital must submit a written request with a copy of the third-party arbitrator decision to MVP at:

MVP Health Care
Attn: Inpatient Provider Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

Facilities not subject to the third-party arbitrator may have External appeal rights with the New York State Department of Financial Services (DFS) (for fully insured New York products). If the facility is subject to this option, they will be sent the External appeal application packet with the letter of final adverse determination. The completed application along with the filing fee of $50 (make checks payable to MVP Health Care) should be sent to the address listed in the packet within 60 days of the date of the letter.

Hold Harmless: Public Health Law was amended to add a new section 4917. A Provider requesting an External Appeal of a concurrent adverse determination, including a Provider requesting the External Appeal as the Member's designee, is prohibited from seeking payment, except applicable co-pays, from a Member for services determined not medically necessary by the External Appeal agent.

Participating Provider Claims Appeals

A Participating Provider claims appeal is a request submitted by the Participating Provider, on their own behalf, to have MVP review a denial of a properly submitted Clean Claim. Participating Provider has only one level of internal appeal. An appeal must be submitted within 180 days of the date on MVP's remittance advice. Appeals can be submitted in writing by letter with supporting documentation.
Participating Provider appeals denied for "not Medically Necessary" should be mailed to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207
625 State Street Schenectady, NY 12301

All other appeals should be mailed to:

MVP Health Care
Operations Adjustment Team
PO Box 2207
Schenectady, NY 12301

Providers may appeal verbally by calling the Customer Care Center for Provider Services at **1-800-684-9286**. They may also call this number for more information about initiating an appeal.

MVP will decide on appeals within 30 days of receipt of all necessary information. MVP will mail a written notice of the determination within two business days of the determination. If the services being appealed are approved, the claim(s) in question will be adjusted.

For New York fully insured products, if you are appealing a post-service claim denial based upon Medical Necessity or because the service was determined to be experimental or investigational in nature, then the written notice will include instructions on how to submit an External Appeal with the State of New York.

MVP staff who were not involved in the initial claim's denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Medicare Member Appeals and Complaints (Grievance)

A "general issue" is a type of expressed dissatisfaction that does not involve attitude, access, or quality of services received. It does not involve an initial determination (e.g., denied claim or referral) and there is no further financial liability from the Member or the Member's representative. MVP will document and investigate all general issues brought to our attention either by phone or mail. All findings and actions taken will be reported to the Member as expeditiously as necessary, but no later than 30 days by either phone or mail.

A "Grievance" is a complaint a Member makes if they have any other type (except for an appeal) of problem with MVP or Network Provider. Appeal determinations are not considered grievances. For example, they would file a grievance regarding things such as:

- The quality of their care;
- Waiting times for appointments or in the waiting room;
- The way their doctors or others behave;
- Being able to reach someone by phone or get the information they need; or
- The cleanliness or condition of the doctor's office.

An "appeal" is a Member request for MVP to reconsider and change a decision made about what services are covered or what will be paid for a service. Specifically, the Member has the right to appeal if:

- MVP refuses to cover or pay for services they think should be covered;
- MVP or one of their plan Providers refuses to give them a service they think should be covered;
- MVP or one of their plan Providers reduces or cuts back on services they have been receiving; or
- The Member thinks MVP is stopping coverage of a service too soon.

Medicare Grievance Process

If the Member has a Grievance regarding attitude, access, or quality of care or service received, MVP encourages them to call the MVP Medicare Customer Care Center, **(800)-665-7924**. MVP will try to resolve their Grievance (not related to Quality of Care or Quality of Service) over the phone. If the Grievance cannot be resolved over the phone, a formal procedure called the "Grievance Procedure" is used to review the Grievance. The Member may also submit a grievance in writing to the Member Service— Grievances Department, 20 S Clinton Avenue, Rochester, NY 14604. The grievance must be filed within 60 calendar days of the incident and include a description of the incident or events that led to the Grievance.
A Member may file his or her own Grievance, or the Member may appoint a representative. To appoint a representative:

- In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, "I [member name] appoint [name of representative] to act as my representative in requesting a grievance from MVP regarding (service/claim)"
- The Member and the representative must sign and date the statement
- The authorization statement must be submitted with the grievance

Medicare Standard Grievances

MVP will acknowledge the Quality of Care and Quality of Service Grievance within 3 days of receipt. MVP will respond to the Member's concern within 30 days from receipt of the grievance, by letter. In some instances, MVP may need more than 30 days to properly address the Member's concern. If more than 30 days is necessary, MVP will notify the Member and explain why additional time is required.

Expedited "Fast" Grievances

A Member may file an expedited grievance if they disagree with MVP's decision not to expedite an appeal, not to expedite a request for approval made by a Provider or if they disagree with MVP's request for more time to complete an appeal or request for more time to approve a service requested by a Provider. MVP will respond to these requests within 24 hours.

Quality Improvement Organization (QIO) Complaint Process

If Members are concerned about the quality of care they receive, including care during a hospital stay, they may file a Grievance through MVP, or a complaint with Livanta BFCC-QIO. Livanta is a Quality Improvement Organization (QIO) for the States of New York and Vermont that is paid to handle this type of complaint from Medicare patients. The QIO review process is designed to allow an external review organization to investigate health care issues. To contact Livanta, Members may call **(866)-815-5440**. TTY users may call **(866)-868-2289**. USA Care Members must contact the QIO within the state in which he/she resides.

Five Possible Steps for Requesting Care or Payment from MVP

If the Member has problems getting care, or payment for care, there are five possible steps they can take. At each step, their request is considered, and a decision is made. If they are unhappy with the decision there may be an additional step they can take.

- In Step one the Member makes their request directly to MVP. It is reviewed and the decision is communicated.
- In Steps two through five, people in organizations that are not connected to MVP make the decisions. To keep the review independent and impartial, those who review the request and make the decision in Steps two through five are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The five possible steps are summarized below:

Step One: Appealing the Initial Decision by MVP

If the Member disagrees with the initial decision one, they may ask MVP to reconsider the decision. This is called an "appeal" or a "request for reconsideration". The Member can ask for a "fast or expedited appeal" if their request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing the appeal, MVP will decide whether to stay with the original decision or change this decision and give the Member some or all of the care or payment they want.

MVP staff who were not involved in the initial claim or service denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Step Two: Review of the Request by an Independent Review Entity (IRE)
If MVP turns down part of the request or the entire request (Step one), MVP is then required to send the request to an independent review entity that has a contract with the federal government and is not part of MVP. This entity will review the request and decide about whether the Member is granted the care or payment they requested.

Step Three: Review by an Administrative Law Judge (ALJ)
If the Member is unhappy with the decision made by the IRE that reviews their case in step two, they may ask an Administrative Law Judge to consider their case and decide. The Administrative Law Judge works for the federal government. To qualify for review by an ALJ, the amount in controversy must meet a minimum amount to be determined by the ALJ. The amount in controversy must be at least $190.00 and this minimum amount is incrementally increased annually by CMS, based on increases in the consumer-pricing index.

Step Four: Review by a Departmental Appeals Board
If the Member or MVP are unhappy with the decision made in step three, either party may be able to ask the Medicare Appeals Council (MAC) to review the case. This Board is part of the federal department that runs the Medicare program.

Step Five: Federal Court
If the Member or MVP are unhappy with the decision made by the Medicare Appeals Council in step four, either party may be able to take the case to a Federal Court. The dollar value of the contested medical care (amount in controversy) must be at least $1,900.00 in calendar year 2025.

Pre-Service and Post-Service Appeals Process

All appeals must be completed as expeditiously as the Member's health requires, but no later than the times indicated. If the Member wants to file a pre-service or post-service appeal, the following steps must be taken:

File the request verbally by contacting MVP's Medicare Customer Care Center. If the Member calls after hours, the MVP Answering Service will accept the Member's

name and telephone number, and a Customer Care Representative will return the call during the next working day. If the Member does not speak English, either a bilingual MVP employee will speak with the Member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages. Members may also submit the request in writing to MVP at the following address: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, NY, 12305. Alternatively, the request may be filed with an office of the Social Security Administration or the Railroad Retirement Board (if the Member is a railroad retiree). Even though the Member may file a request with the Social Security Administration or Railroad Retirement Board office, that office will transfer the request to MVP for processing.

- Mail, fax, or deliver the request in person. Use the address above or fax the appeal to MVP Member Appeals Department at **1-800-398-2560**

The request must be filed within 65 calendar days from receipt of the initial denial notice or explanation of benefit MVP will gather all necessary information, including referral notes, medical records, and all information used in the initial determination and any new information that may be relevant to the appeal. Appeal decisions that do not involve Medical Necessity are made by a reviewer(s) trained and experienced in interpreting contracts, policies, benefits, Member eligibility, and health care regulations. Decisions that involve Medical Necessity will be made by a licensed Provider in the same or similar specialty as the health care Provider who typically manages the medical condition or disease or provides the service or treatment under review. In addition, the appeal decision is made by a reviewer who was not involved in the initial determination.
To protect the Member's privacy and ensure an unbiased review of the appeal, all personally identifiable health and financial information will be removed from the record unless a business associate's agreement is in effect between MVP and the health care Provider reviewing the appeal.

A Member may request free of charge, a copy of all documents relevant to the appeal, including the clinical criteria; internal policy, guidelines, protocol, or rule relied upon to make the appeal decision by contacting a Medicare Customer Care Center Representative at **1-800-665-7924**, Monday – Friday from 8 am – 8 pm. From Oct. 1 – Mar. 31, call seven days a week, 8 am – 8 pm (TTY: 711). Members may also write to us at:

MVP Health Care
Attn: Member Appeals Department
625 State Street
Schenectady, New York 12305

A Member is given the opportunity to submit written comments, documents or other information related to the appeal.

A decision must be provided to the Member within 30 calendar days from receipt of a pre-service appeal and within 60 calendar days of a post-service appeal. However, if the Member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional 14 calendar days to make the decision for a pre- service appeal. No extension is allowed for post-service appeals. The substance of the appeal and

any actions taken are documented in the Member's file. If MVP does not notify the Member of the decision within 30 calendar days or by the end of the extended time for a pre-service appeal, or within 60 calendar days for a post-service appeal, the request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services for review of the case. The Member is notified in writing within three (3) calendar days of the decision. If the decision is unfavorable, the notice will also include information advising them that the case has been forwarded to Maximus Federal Services who will render an appeal decision.

Expedited Appeals Process

An expedited appeal may be initiated verbally or in writing by the Member, the Members appropriately appointed representative or a Provider acting on behalf of the Member. If any party requests an expedited decision, he or she must do the following:

- File a verbal or written request for an expedited (fast) appeal, specifically stating that they want an expedited appeal, fast appeal, or 72-hour appeal, or that they believe that their health could be seriously harmed by waiting 30 days for a standard appeal
- To file a verbal request, the Member or the Members appropriately appointed representative can call MVP's Medicare Customer Care Center at **1-800-665-7924** (TTY: 711)
- A hand delivered request can be received at the following addresses:

  20 S. Clinton Avenue
  Rochester, NY 14604; or
  625 State Street
  Schenectady, NY 12305

Members can also mail their request to:

625 State Street
Schenectady, NY 12305

The 72-hour review time will begin when the request for appeal is received by MVPs Medicare Appeals Department.

- To fax a request, our fax number is **1-800-398-2560**. If the Member is in a hospital or a nursing facility, he or she may request assistance in having the written appeal transmitted to MVP by use of a fax machine.
- The Member must file the request within 60 calendar days of the date of the initial denial
- The Expedited Appeal process applies only to pre-service appeals

If a Member requests a 72-hour expedited (fast) appeal, MVP's Medical Director will decide if an expedited appeal is appropriate. If it is not appropriate, the appeal will be processed

within 30 days. MVP will notify the Member verbally and in writing of the decision not to expedite the appeal within 72 hours, and the Member will also be given expedited grievance rights. If any physician supports the need for a fast appeal, it must be granted. For this process, Medicare defines a physician as any Medical Doctor, Doctor of Osteopathic Medicine, or a Doctor of Podiatry. MVP will make a decision and notify the Member and Participating Provider within 72 hours or sooner if the Member's health condition requires, from receipt of the expedited request. A written confirmation of an overturned decision will be sent to the Member and Participating Provider within the appeal timeframe unless MVP provides verbal notification to the appealing party. If MVP provides verbal notification to the appealing party. then MVP has three (3) calendar days to mail out the appeal decision letter. However, if the Member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional 14 calendar days to make the decision for Part C appeals only. If MVP does not inform the Member or the Provider of the decision within 72 hours (or by the end of the extended time period), their request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services ("Maximus") for review of the case. If the decision is not fully in favor of the Member's request, MVP will automatically forward the appeal to Maximus for an independent review decision. Maximus will notify the Member and MVP of their decision within 72 hours from receipt of the appeal. If necessary, Maximus may require an extension up to 14 additional days.

Inpatient Hospital Appeals

When a Member is hospitalized, they have the right to get all the hospital care covered by MVP that is necessary to diagnose and treat their illness or injury. The day they leave the hospital (discharge date) is based on when their stay in the hospital is no longer medically necessary.

If a Member is inpatient at a hospital the facility on behalf of MVP will provide them with the Notice of Discharge and Medicare Appeal Rights notice, they have the right by law to ask for a review of their discharge date. As explained in the Notice of Discharge and Medicare Appeal Rights, if they act quickly, they can ask an outside agency called the Livanta BFCC-QIO to review whether their discharge is medically appropriate. The Notice of Discharge and Medicare Appeal Rights gives the name and telephone number of Livanta and tells them what they must do.

Livanta is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of MVP or the hospital. The doctors and other health experts in Livanta review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

The Member must be sure that they have made their request to Livanta no later than noon on the first working day after they are given written notice that they are being discharged from the hospital. This deadline is very important.

If they meet this deadline, they are allowed to stay in the hospital past their discharge date without paying for it themselves, while they wait to get the decision from Livanta.

Livanta will make this decision within one full working day after it has received their request and all of the medical information it needs to make a decision.

- If Livanta decides that the Member's discharge date was medically appropriate, the Member will not be responsible for paying the hospital charges until noon of the calendar day after Livanta gives them its decision
- If Livanta agrees with the Member, then MVP will continue to cover their hospital stay for as long as medically necessary

If the Member requests a Livanta appeal, he/she cannot subsequently request an appeal for the same denial through MVP.

Skilled Nursing Home (SNF), Home Health Care, and CORF Appeals

When the Member is a patient in a SNF, home health agency, or Comprehensive Outpatient Rehabilitation Facility (CORF), they have the right to get all SNF, home health or CORF care covered by MVP that is necessary to diagnose and treat their illness or injury. The day MVP ends their SNF, home health agency or CORF coverage is based on when their stay is no longer Medically Necessary.

If MVP decides to end coverage for a Member's SNF, home health agency, or CORF services, they will receive a written notice from their Provider at least two (2) calendar days in advance of MVP ending the coverage. The Member (or someone they authorize) may be asked to sign and date this document to show that they received the notice. Signing the notice does not mean that they agree that coverage should end—it only means that they received the notice.

Review of the Termination of Your Coverage by the QIO

The Member has the right, by law, to ask for an appeal of MVP's termination of their coverage. They must ask the QIO (Livanta or Acentra Health) to review whether MVP terminating their coverage is medically appropriate and this is explained in the notice they get from their Provider.

Getting the Livanta Review

If the Member wants to have the termination of their coverage appealed, they must act quickly to contact the QIO. The written notice they get from their Provider gives the name and telephone number of QIO and tells them what they must do.

- If they get the notice two days before coverage ends, they must be sure to make their request no later than noon of the day after they get the notice from their Provider.
- If they get the notice and they have more than two days before coverage ends, then they must make their request no later than noon the day before the date that their Medicare coverage ends.
- The QIO will make this decision no later than 2 days after the effective date of the termination of coverage.
- If the QIO decides that the decision to terminate coverage was medically appropriate, the Member will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice they got from their Provider.
- If the QIO agrees with the Member, then MVP will continue to cover the SNF, home health, or CORF services for as long as medically necessary.

If the Member does not ask the QIO by noon after the day they are given written notice that MVP will be terminating coverage for their SNF, home health or CORF services, and if they continue to receive services from the SNF, home health agency or CORF after this date, they run the risk of having to pay for the SNF, home health or CORF care received on and after this date. However, the Member can appeal any bills for the SNF, Home Health or CORF care received using the appeals process.

Medicare Appeals

The following information applies to all Medicare Appeals:

Support for an Appeal

The Member is not required to submit additional information to support their appeal. MVP is responsible for gathering all necessary medical information; however, it may be helpful for the Member to include additional information to clarify or support their position. For example, the Member may want to include information such as medical records or physician opinions in support of their appeal. MVP will provide an opportunity for the Member to submit additional information in person or in writing.

Providers are required to abide by CMS guidelines. If a Member requests an Expedited Appeal, MVP will request that the Provider fax (or expedite mailing) all pertinent medical records to the Appeals Department. This will allow MVP to meet the required 72-hour time frame.

Who May File an Appeal

- The Member may file their own appeal.
- The Member may appoint a representative. To appoint a representative:

  - In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, "I [name] appoint [name of representative] to act as my representative in requesting an appeal from MVP regarding (service/claim)."
  - The Member and the representative must sign and date the statement.
  - The authorization statement must be submitted with appeal.
- A non-contract provider may file a post-service appeal only if the provider completes a waiver of liability statement, which says they will not bill the Member regardless of the outcome of the appeal
- A court appointed guardian or an agent under a health care proxy to the extent provided under state law
- If the Member is unable to appoint a representative due to their mental status, the appeal must be signed by a legal representative as determined by state law
- If the Member is deceased, the appeal must be filed by a legal representative as determined by state law
- The Member's treating physician may also file an expedited or pre-service appeal on behalf of the Member without appointment of representation

Part D Appeals Only

MVP will provide a decision to the Member within seven calendar days of receipt of a pre-service, or post-service request and fourteen calendar days for reimbursement requests. If MVP does not notify the Member of the decision within seven calendar days or pre-service or post-service requests or 14 calendar days for reimbursement requests, the request will go to Medicare's External Review Organization. For expedited Part D appeals, MVP will make a decision within 72 hours, or sooner if the Member's health condition requires, from receipt of the expedited request. Written confirmation of the decision will be sent to the Member (appealing party) and Participating Provider within the appeal timeframe unless MVP provides verbal notification to the appealing party. If MVP provides verbal notification to the appealing party. then MVP has three (3) calendar days to mail out the appeal decision letter.

Second level reviews will go to C2C Innovative Solutions Inc. (C2C) for review. MVP does not automatically submit these appeals. For Part D denials, the Member must request a review by C2C; However, MVP will automatically forward a Part D appeal case, if the appeal timeframe is missed.

Summary

Review Date	Revision Summary
August 14, 2026	

Behavioral Health

Behavioral Health Management Overview

MVP's model of care is focused on integrating medical and behavioral health as equal components of a person's overall well-being. MVP's Integrated Health initiative is designed to enable primary care and behavioral health professionals to succeed at integrating patient care, enabling them to support an individual's journey to better health and optimal living.

MVP offers behavioral health care management services, for all lines of business, to manage Members' behavioral health and Substance Use Disorders.

For questions related to Behavioral Health Services contact us at **1-800-684-9286** and listen for the Behavioral Health prompt.

Communication and Coordination of Care with PCPs

MVP strongly encourages behavioral health Participating Providers to communicate with the Member's PCP. This allows both health care Providers to have a complete overview of the Member's health issues and concerns, in addition to coordinating any medications the Member might receive.

MVP recognizes that, after a discussion of the importance of coordination of care, some Members may not allow their behavioral health information to be shared with their PCP. This declination should also be documented in the Member's medical record.

MVP's Mental Health Consultation form for behavioral health Providers should be used to communicate with Member's PCPs. The Mental Health Consultation form can be downloaded by visiting **mvphealthcare.com/providers** and selecting Forms, or by calling your MVP Professional Relations representative.

MVP requires contracted Behavioral Health Providers to review the release of information (ROI) with Members prior to the onset of treatment and that any communication between a Behavioral Health Provider and PCP is documented in the Member's medical record.

Behavioral Health Services Programs

MVP Behavioral Health Advocates

MVP Members may obtain the services of behavioral health Advocates, who are trained to assist MVP Members in accessing their behavioral health benefits, by supplying them detailed, accurate, and current information regarding treatment options in the Member's geographic area of service, Utilization Review determinations and processes, Medical Necessity criteria, and Appeals.

Medicaid Health Homes

MVP's Health Home Program provides care management to all qualified adult and children Medicaid Members. Qualified Medicaid Members will be assigned to Health Homes that will be responsible for coordinating all their care. Health Homes facilitate the development of a Plan of Care that integrates all aspects of a Member's health. For detailed information on Medicaid Health Homes, please see the Health Home Program in the MVP Government Programs Section.

Children's Home and Community Based Services

Children's and Family Treatment and Support Services (CFTSS) and Medicaid Managed Care Children's Home and Community Based Services (CHCBS) provide opportunities for Medicaid Members, and beginning January 1, 2025, for Child Health Plus Members, under the age of 21 that have Behavioral Health needs and/or medically complex conditions to receive Covered Services in their own home or community. For detailed information on CHCBS, please see the CHCBS in the MVP Government Programs Section.

Harm Reduction Services

Harm Reduction Services (HRS) are provided for Medicaid Members addressing overdose prevention and response and preventing transmission of HIV, Hepatitis B and C, and other illnesses in Members with Substance Use Disorders. For detailed information on HRS, please see HRS in the MVP Government Programs Section.

Behavioral Health Utilization Management (UM)

Medical Necessity

MVP's Medical Necessity Criteria for behavioral health consists of Change Healthcare's InterQual® Criteria, guidelines provided by New York State (e.g. Assertive Community Treatment [ACT], Personalized Recovery Oriented Services [PROS], Adult Home and Community Based Services [HCBS], Children's HCBS and Children and Family Treatment and Support Services [CFTSS]). In 2021, MVP created new Medical Necessity Criteria for Applied Behavior Analysis (ABA) services and Transcranial Magnetic Stimulation (TMS).

For NY members, excluding ASO and Medicare Advantage Plans, MVP has developed a supplemental risk assessment to use together with InterQual criteria when establishing medical necessity for mental health Inpatient and/or Residential Treatment Center (RTC) services. This risk assessment takes into consideration several factors impacting the member's environmental stress and support in the recovery environment, treatment and recovery history, and acceptance and engagement in treatment (to include caregivers for children/adolescents).

For all NY Members and lines of business, excluding Medicare and Medicare D-SNP, MVP applies the current version of the New York State Office of Addiction Services and Support ("OASAS") Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) for substance

use treatment provided within New York State. For all other members and lines of business, and for New York members and lines of business when treatment is provided outside of New York State, MVP uses InterQual criteria.

Effective January 1, 2023, for CHP and Medicaid Managed Care Plans, MVP began using the Level of Care for Gambling Disorder Treatment Referral (LOCADTR Gambling Module) for the treatment of problem gambling when provided through one of the following OASAS certified programs:

- OASAS Certified Title 14 NYCRR Part 818 Inpatient Rehabilitation Programs
- OASAS Certified Title 14 NYCRR Part 820 Residential Treatment Programs
- OASAS Certified Title 14 NYCRR Part 822 Outpatient Clinic with a Problem Gambling designation
- OASAS Certified Title 14 NYCRR Part 825 Integrated Outpatient Services with a Problem Gambling designation

For ASO and fully insured plans, MVP provides unlimited benefits, subject to medical necessity, for inpatient and outpatient Behavioral Health services, as well as for residential treatment for Behavioral Health conditions, except for family counseling services, which may be limited to 20 visits per calendar year.

For Medicare plans, MVP provides inpatient and outpatient behavioral health care services, subject to medical necessity. There are some limits to inpatient mental health care based on place of service. There is a 190-day lifetime limit of inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Except for these restrictions, all inpatient and outpatient services are unlimited days. The Medicare portfolio does not provide coverage for residential behavioral health services.

The criteria for Medical Necessity determinations made by MVP regarding behavioral health benefits are available: (i) on a website accessible by MVP Participating Providers; and (ii) upon request, to any current or potential participant, beneficiary, or contracting provider.

Authorization/Notification Requirements

For all lines of business, excluding self-funded plans, MVP requires notification for all Inpatient and Residential Mental Health and Substance Use Treatment admissions. to notify MVP within (2) business days of admission by completing the necessary forms and when indicated, submitting supporting clinical information. Forms may be accessed by visiting **mvphealthcare.com/providers** and selecting *Behavioral Health*.

Authorization requirements for self-funded plans vary and may require prior notification and/or prior authorization for non-urgent/emergent levels of care.

Please contact MVP directly at **1-800-684-9286** to determine authorization requirements and for Plan of Care submissions.

The following ambulatory behavioral health services require an authorization:

- TMS—Transcranial Magnetic Stimulation
- All Home and Community Based Services (HCBS)
- ABA—Applied Behavior Analysis

With the exception of urgent/emergent care, prior authorization is required for all out-of-network services when an MVP Member has no out-of-network benefits.

MVP adheres to New York State legislation:

- **Inpatient Mental Health Treatment at MVP Network facilities licensed by the Office of Mental Health (OMH):** Inpatient mental health treatment at an MVP Network OMH-licensed facility is not subject to preauthorization or concurrent review for the first 30 days of the inpatient admission if the OMH-licensed facility notifies MVP of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 30 days of the inpatient admission, MVP may review the entire stay to determine whether it is Medically Necessary, and MVP will use clinical tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, the Member is only responsible for the in-network cost sharing that would otherwise apply to the inpatient admission.
- **Substance Use Disorder Treatment at Participating OASAS-Certified Facilities:** Inpatient Detoxification, Inpatient Rehabilitation, Stabilization Services in a Residential Setting and Rehabilitative Services in a Residential Setting at a participating OASAS-certified Facility is not subject to preauthorization or concurrent review for the first 30-days of the inpatient admission if the OASAS-certified Facility notifies MVP of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 30-days of the inpatient admission, MVP may review the entire stay to determine whether it is Medically Necessary, and MVP will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, the Member is only responsible for the in-network Cost-Sharing, if applicable, that would otherwise apply to the inpatient admission.

For Home and Community-Based Services (HCBS)

MVP's Behavioral Health clinicians will ensure that the NYS established Medical Necessity criteria for each HCBS, as well as Member's goals and preferences, will be carefully evaluated when making decisions regarding services. MVP will ensure that the Plan of Care is developed based upon all assessment documentation with the assistance of the Member, the service provider(s), and any individual the Member wishes to participate in service planning and delivery of services that are delivered in home and community-based

settings. In addition, the Plan of Care and Member's medical chart will be reviewed to ensure that the Plan of Care identifies strengths, capacities, and preferences of the Member and that resources are available to meet these needs. When services are temporarily unavailable, MVP will work with the Member, the Case Management Agency (CMA), and providers on a back-up plan to ensure that necessary assistance or services are provided.

Notification/Authorization Request Forms

Notification/Authorization Request Forms may be accessed by visiting **mvphealthcare.com/providers/forms**, then select Behavioral Health. All requests for services can be faxed to **1-855-853-4850** or emailed to BHServices@mvphealthcare.com.

Discharge Notification

MVP works collaboratively with in-network and out-of-network providers throughout the entire course of inpatient admissions to ensure quality of care, coordinated care, and discharge planning. Discharge planning is coordinated among multiple entities involved in the Member's care. MVP ensures that the Member has a safe and appropriate link to another level of care and will continue to assist in connecting the Member with appropriate resources and/ or professionals for follow-up care. When Members are discharged, providers should notify MVP of the discharge date along with the discharge plan within 24 hours of discharge. This includes Members leaving against medical advice (AMA).

Behavioral Health Case Management

MVP offers dedicated Case Management programs to Members at a variety of service levels. Drawing on the combined strength of registered nurses, behavioral health clinicians, pharmacists, physicians and community health care providers, the Behavioral Health Case Management Program offers an integrated Member centric approach in helping Members regain optimal health, well-being and/ or improved functional capability in the right setting and in a safe, cost-effective manner. As part of our contractual relationship, representatives of the MVP Care Management team will at times need to contact your practice to obtain health information and/ or contact information regarding our Members. To assure that we provide the best care possible, it is important that Participating Providers furnish MVP with the requested information in a timely manner. Together with Participating Providers, MVP can ensure Members with chronic conditions understand the best course of action to address their needs and recognize the emergency room is often not the best solution. Your cooperation allows us to better educate Members to provide the highest quality of care. Sharing timely data and maintaining open communication will help us both give Members appropriate guidance in navigating the health care continuum.

The MVP Behavioral Health Case Management Program ensures that Members identified with Behavioral Health or Substance Use disorder needs can access and obtain the highest

quality of care possible. The process includes comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring and follow-up. Case Management referrals are accepted through provider referrals. In addition, Members may self-refer to the program. If you have a Member in crisis or for Behavioral Health referrals, contact MVP at **1-800-684-9286**.

HCBS and Care Management

Care management for Members is offered by Health Homes designated by NYS. Upon meeting Health Home eligibility criteria and enrollment into the Health Home, Members interested in Adult BH-HCBS are screened for BH-HCBS eligibility by their Health Home Care Manager or by a State Designated Entity. Once eligibility is established, Members work with their Health Home Care Manager to develop a comprehensive person-centered Plan of Care (POC). This POC is used to identify and document appropriate services and supports to meet each Members unique needs including the array of available BH-HCBS. This document is shared with MVP and includes the scope, type, and duration of services the Member is eligible to receive. BH-HCBS and CORE services are a voluntary program. HARP Care Management may be provided regardless of BH-HCBS and CORE services utilization.

As an alternative to enrolling into a Health Home, Members who are interested in BH-HCBS can choose to be screened for BH-HCBS eligibility by a State Designated Entity (SDE). If eligible for BH-HCBS, the SDE will work with the member to identify recovery goals and the BH HCBS that will help the member achieve their goals; request the Level of Service Determination; offer choice of BH HCBS Providers to the member; make referrals to the appropriate BH HCBS; and develop and maintain the Adult BH HCBS Plan of Care.

Adult Behavioral Health - Home and Community Based Services (BH-HCBS)

Adult Behavioral Health Home and Community Based Services (BH-HCBS) enhance access to Behavioral Health and substance use treatment and recovery services for eligible Members. BH-HCBS provides alternatives to hospital based, inpatient or other institutional care settings. This program is designed to empower Members to take an active role in their health care and through an integrated approach support Members in maintaining success in the community. The array of services includes opportunities for Members to be served in the community setting or within their own homes in many cases.

Core Principles of BH-HCBS include:

- **Person-Centered Care:** Care should be self-directed whenever possible and emphasize shared decision- making approaches that empower Members, provide choice, and minimize stigma
- **Recovery-Oriented**: The system should include a broad range of services that support recovery from mental illness and/or substance use disorders

- **Integrated:** Service providers should attend to both physical and behavioral health needs of Members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met
- **Driven:** Providers and plans should use data to define outcomes, monitor performance, and promote health and well-being
- **Evidence-Based:** Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices
- **Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)
- **Peer-Supported:** Peers will play an integral role in the delivery of services and the promotion of recovery principles
- **Culturally Competent:** Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural diversity
- **Flexible and Mobile:** Services should adapt to the specific and changing needs of everyone, using off-site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each individual's needs. BH HCBS, where indicated, may be provided in home or off-site, including appropriate community settings such as where an individual works, attends school or socializes
- **Inclusive of Social Network:** The individual, and when appropriate, family members and other key members of the individual's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support
- **Coordination and Collaboration:** These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers

BH-HCBS Eligibility

Eligibility for BH-HCBS is assessed annually for all eligible Members using the NYS Eligibility Assessment. To be assessed for BH-HCBS eligibility, Members must either participate with a Health Home or Recovery Coordination Agency (RCA*) who will complete the screening tools and POC development in compliance with conflict free case management requirements. All eligible Members expressing interest in or receiving BH-HCBS are screened for BH-HCBS eligibility annually.

The assessment identifies level of need associated to the following functional areas:

- Employment/Education
- Stress and Trauma
- Cognitive Skills
- Co-morbid Conditions
- Social Relations
- Engagement
- Substance Use
- Risk of Harm
- Instrumental Activities of Daily Living (IADL)

BH-HCBS has two tiers of service eligibility. The NYS Eligibility Assessment is used to determine overall BH-HCBS and Tier eligibility. Members may be found eligible for Tier 1 services, Tier 2 services, or not eligible. Tier 1 services include:

- Employment
- Education

Tier 2 Services includes (in addition to above):

- Habilitation

Once Members qualify for BH-HCBS and Tier eligibility is established, the assessment is used to develop a comprehensive POC which includes all eligible and appropriate BH-HCBS and recovery goals. Members will work with their Care Manager (or RCA) in conjunction with the MVP HARP Case Manager to identify and refer to BH- HCBS providers within the MVP network.

*Recovery Coordination Agencies (RCAs) are State Designated Entities (SDEs) who assist Members who are not enrolled or do not wish to be enrolled in a Health Home in accessing Behavioral Health Home and Community Based Services (BH HCBS). These providers work with MVP to conduct NYS Eligibility Assessments, referrals, and Person-Centered Care Planning for Adult Behavioral Health HCBS.

BH-HCBS Descriptions

Many of the BH-HCBS are designed to be provided in clusters which promote recovery along a spectrum.

Pre-Vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/ or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as integrated community settings.

Pre-vocational services occur over a defined period of time and with specific person-centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to hide individual employment support.

Transitional Employment (TE)

This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective, and a career plan used to guide individual employment support.

Intensive Supported Employment (ISE)

This service assists individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective, and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

Ongoing Supported Employment

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective, and a career plan used to guide individual employment support.

Educational Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university, or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant. Examples of these goals would include, but not be limited to tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e., SUD or mental health) in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from a SUD disorder. Services include things such as: instruction in accessing transportation, shopping, and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the

community and endure recovery, health, welfare, safety, and maximum independence of the participant.

Community Oriented Recovery and Empowerment (CORE) Services

HARP and Dual Access Complete Members have access to recovery-oriented services known as Community Oriented Recovery and Empowerment (CORE) Services. Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services – Peer Supports.

Community Oriented Recovery and Empowerment (CORE) Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

(CORE) Services are available to Members who would benefit from CORE Services in the pursuit of valued recovery goals.

CORE Services will provide opportunities for eligible Members with mental illness and/or substance use disorders to receive services in their own home or community. CORE designated providers will work together with MVP, service Providers, plan Members, families, and government partners to help Members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

This partnership will be based on the following key principles:

- **Person-Centered Care**: Services should reflect a Member's goals and emphasize shared decision-making approaches that empower Members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the person's overall well-being and full community participation.
- **Recovery-Oriented**: Services should be provided based on the principle that all Members have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, employment, and social skills, and be offered in community-based settings that promote hope and encourage each person to establish a Member's path towards recovery.
- **Integrated**: Services should address both physical and behavioral health needs of Members. Whenever possible, the Individual Service Plan should address social determinants of health (SDOH).
- **Data-Driven**: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

- **Evidence-Based**: Services should utilize evidence-based practices where appropriate and provide or enable continuing education and ongoing support activities to promote uptake of these practices.
- **Trauma-Informed**: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all Members with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)
- **Peer-Supported**: Peers will play an integral role in the delivery of services and the promotion of recovery principles. Culturally Competent: Serving Members in a manner that is respectful and responsive to the unique cultural attributes of the people being served. Spiritual beliefs, art/music, fashion, and culinary interests should all be leveraged to support recovery. Additionally, special attention should be given to being responsive to the social, economic, and system-level factors that might be promoting or impeding the Member's recovery goals.
- **Flexible and Mobile**: Services should adapt to the specific and changing needs of each Member, using off- site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each Member's needs. CORE Services, may be provided in homes or off-site, including appropriate community settings such as where a Member works, attends school, or socializes.
- **Inclusive of Social Network**: The Member, and when appropriate, family members and other key members of the Member's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.
- **Coordination and Collaboration**: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the Member, family and other key natural supports and service providers.

A central pillar of the CORE Services demonstration is the "No Wrong Door" referral pathway, which enables Members to easily access the services with as few barriers to admission as possible. Members may learn about CORE Services through any number of sources, including through MVP, Health Home Care Manager (HHCM), inpatient and outpatient clinicians, primary care providers, family and friends, or provider outreach and education efforts. Providers may develop their own referral requirements and intake paperwork or forms. Once a Member expresses an interest in receiving the services, they may work with any qualified Licensed Practitioner of the Healing Arts (LPHA) to establish eligibility and obtain a recommendation for services.

Eligibility and Recommendation by a Licensed Practitioner of the Healing Arts (LPHA)
An MVP Member must have met the New York State (NYS) high-needs behavioral health algorithm-based criteria. In addition, the Member must either be enrolled in MVP's IBP or for HARP Eligible Members, have the Medicaid Recipient Restriction Exception (RRE) code of H9 to be eligible for CORE Services. CORE Services require a recommendation of a Licensed Practitioner of the Healing Arts (LPHA).

Members meeting the NYS high-needs BH criteria are assigned a Medicaid Recipient Restriction Exception H-code within eMedNY. A provider can find out someone's "H-code" status by looking in ePACES or PSYCKES, or by calling MVP.

- H1 indicates an individual is enrolled in a HARP and has met the BH high needs criteria
- H9 indicates an individual has met the NYS BH high-needs criteria. Eligible MAP Members with RRE code of H9 are eligible for CORE Services.

For the purposes of making a recommendation for CORE Services, LPHA qualifications are as follows: Physician; Physician's Assistant; Nurse Practitioner; Registered Professional Nurse; Licensed Psychologist; Licensed Psychoanalyst; Licensed Creative Arts Therapist; Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Clinical Social Worker; and Licensed Master Social Worker under the supervision of a Psychiatrist, Psychologist, or LCSW employed by the agency.

The LPHA recommendation is documented using a standardized template released by New York State. The LPHA Recommendation Form should be kept on file in the Member's CORE Services case record. The LPHA's recommendation must be in writing and a copy of it should be maintained in the Member's CORE case record. The LPHA does not need to be employed by the CORE designated provider; however, if the LPHA is not a Member of the CORE provider's staff, then the recommendation should also include their National Provider Identifier (NPI).

The LPHA recommendation may be obtained as part of the referral process or during the Intake and Evaluation (I&E) process described below. The LPHA recommendation must be obtained prior to completion of the initial Individual Service Plan. The LPHA recommendation is a determination of medical necessity for CORE Services. The recommendation may be made for one or multiple services. There is no standardized assessment process or tool necessary to complete the recommendation; the recommendation is based on clinical discretion. If the Member is found eligible for services, the CORE Services Provider will conduct an intake and engage the

Member in a person-centered planning process to determine frequency, scope, and duration.

Intake and Evaluation Process for CORE Services

Upon acceptance of a referral, the CORE provider will schedule an intake and evaluation (I&E) with the Member, at the Member's convenience.

The intake and evaluation process for CORE is a person-centered process intended to engage the Member in a discussion of the Member's recovery goal(s); the Member's strengths and resources; the Member's barriers and needs; the Member's preferences for service delivery (including days, times, staffing, etc.); and how the CORE service will be used to support attainment of their goal.

Members will engage in services for many different reasons, and present at various stages of change, with many different expectations, aspirations, and perspectives about their recovery journey. They will have different ideas of what successful services and supports would look like for them, including the steps they believe will get them to their goal. The intent of the intake and evaluation period is to listen carefully to what the Member is saying and to skillfully work with the Member to a mutual understanding of the problem the Member has presented, the outcome that is desired and some initial steps to begin developing the roadmap to those outcomes.

The I&E process is conducted by a member of the staff qualified to provide the service. I&E sessions must be documented in the Member's CORE case record; this documentation may appear in intake form and/or progress notes. The documentation should include a description of the discussion and a summary of the Member's goal(s), strengths and resources, barriers, and needs.

The Intake and Evaluation process results in an initial Individual Service Plan (ISP) which should be completed within 30 days of the first session/visit or within 5 sessions, whichever is greater.

Notifying MVP

The provider is responsible for notifying MVP within three (3) business days after the first I&E session with the Member. This notification is completed using the Provider Service Initiation Notification template provided by New York State Office of Mental Health, which can be submitted electronically to MVP.

MVP will notify relevant providers within three (3) business days of notification receipt if the Member is receiving a duplicative service, such as the same CORE Service or an equivalent service from another provider. CORE Service intake and evaluation sessions are not considered duplicative of any other service. Until informing the CORE provider of a service duplication, MVP is responsible for reimbursing CORE Service claims. If the Member is receiving a duplicative service, MVP will initiate a person-centered discussion between the Member, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs.

MVP is responsible for communicating with the Member and providers, in writing, the outcome of the person- centered discussion and the Member's decision regarding which services will continue.

Key Terms and Concepts for CORE Services

Recovery Goal: A statement that expresses the Member's desire for positive change and improvement in their lives, ideally captured in their own words.

Objective: Something the Member will do or accomplish as a step toward achievement of the goal. Objectives should address identified barriers to the goal and should drive the ISP forward.

Scope of Services, or Intervention: The activities and services provided by CORE staff that help the Member achieve objectives and goals.

Person-Centered Planning and the Individual Service Plan (ISP)

Person-centered services start with an ISP that is created using the Member's own language and is consistent with the person's values, culture, beliefs, and goals. Person-centered planning is a collaborative process where the Member participates in the development of the goal and planning for services to the greatest extent possible. It is important to support a Member's personal motivation for seeking services and to ensure the recovery/service planning remains non-judgmental and free from bias. Using a person's own words in identifying what elements of their substance use or mental health barriers they find problematic, and prioritization of their main goals, helps to align the ISP to the person. In this way, the Member is placed "in the driver's seat" of their recovery.

The person-centered planning process focuses on what the Member is saying and their framing of the problems and potential solutions. The Provider is active in guiding, reframing, raising discrepancies, offering compassion and hope by taking what the Member is saying and translating that into a plan of action that recognizes the Member as an individual. Person-centered planning is strengths-based. The CORE provider is expected to engage the Member in person-centered planning both during the I&E process and throughout service delivery. Focused attention should be given to understanding and addressing the impact of the social determinants of mental health and wellness, including housing, income/finances, and impact of discrimination.

Person-centered services include harm reduction options for Members who wish to continue risky behaviors/ substance use but who also want to reduce the risk of transmission of illness secondary to use, avoid overdose; test a sample of substance; learn ways of living healthier; gain support; and reduce social isolation.

CORE Service providers must be prepared to engage the Member using harm reduction techniques and/or refer to outside harm reduction programs that provide these services.

CORE Service Description

Community Psychiatric Support and Treatment (CPST) include goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multicomponent service that consists of therapeutic interventions such

as clinical counseling and therapy, which assist the individual in achieving stability and functional improvement. CPST addresses behavioral health barriers that impact daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation.

CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible of-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.

Psychosocial Rehabilitation (PSR) is designed to assist an individual in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to develop skills to overcome barriers caused by an individual's behavioral health disorder and promote independence and full community participation.

Family Support and Training (FST) offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach. Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, in-laws, or others defined as family by the individual receiving services. Family does not include individuals who are employed to care for the individual receiving services.

Empowerment Services – Peer Support (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources.

Peer Support must include the identified goals or objectives in the individual's ISP, with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.

Children's Behavioral Health Services

Covered Benefits and Services

Members enrolled in the MVP Medicaid Managed Care Plan have access to following Children's Behavioral Health benefits for all Medicaid participants under 21 years of age.

As of January 1, 2025, benefits traditionally available only to Medicaid Managed Care are now also available to MVP Child Health Plus (CHP) Members.

- Assertive Community Treatment (ACT)
- Children's Day Treatment
- Comprehensive Psychiatric Emergency Program including Extended Observation Bed
- Continuing Day Treatment (minimum age is 18)
- Inpatient Psychiatric Services
- Licensed Behavioral Health Practitioner (LBHP) Service
- Licensed Outpatient Clinic Services
- Medically Managed Detoxification (hospital-based)
- Medically Supervised Inpatient Detoxification
- Medically Supervised Outpatient Withdrawal
- OASAS Inpatient Rehabilitation Services
- OASAS Residential Treatment Services
    - Stabilization Services in a Residential Setting
    - Rehabilitation Services in a Residential Setting
    - Reintegration Services in a Residential Setting
- OASAS Residential Rehabilitation Services for Youth (RRSY) was made available for CHP Members as of April 1, 2023. This benefit is already available for Medicaid Members through Medicaid Fee-for-Service (FFS).
- OASAS Outpatient Rehabilitation Programs
- OASAS Outpatient Services
- OMH State Operated Inpatient West
- Partial Hospitalization
- Outpatient Clinic and Opioid Treatment Program (OTP) services
- Personalized Recovery Oriented Services (PROS) (minimum age is 18)
- Residential supports and services (Early Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)
- Children's Crisis Residence
- Medicaid and CHP Members meeting applicable medical necessity criteria may access Children and Family Treatment and Support Services (CFTSS)
    - Other Licensed Practitioner (OLP)
    - Crisis intervention
    - Community Psychiatric Supports and Treatment (CPST)

- Psychosocial Rehabilitation Services
- Family peer Support Services
- Youth Peer Advocacy and Training

Additionally, Medicaid Members meeting CHCBS Eligibility may access Children's home and Community Based Services (CHCBS)

- Respite (Planned / Crisis)
- Community Habilitation
- Caregiver/Family Support and Services change to Caregiver/Family Advocacy and Support Services
- Supported Employment
- Prevocational Services
- Non-Medical Transportation
- Adaptive and Assistive Technology
- Vehicle Modifications
- Environmental Modifications
- Palliative Care Counseling and Support Services
- Palliative Care Pain and Symptom Management
- Palliative Care Expressive Therapy
- Palliative Care Massage Therapy

Palliative care services are specialized medical care services focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with the child/youth's doctors. The services are appropriate at any stage of a chronic condition or life-threatening illness and can be provided in addition to curative2
This is a consolidation of the previous services for "Caregiver Family Support and Services" and "Community Advocacy Training and Supports. treatment.
Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic conditions or life-threatening illnesses.
Palliative Care Expressive Therapy (art, music, and play) helps children/youth better understand and express their reactions through creative and kinesthetic treatment.
Palliative Care Expressive Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to children/youth.

Children and Family Treatment and Support Services

Children and Family Treatment and Support services (CFTSS) are available to all MVP Medicaid Managed Care enrolled children under the age of 21 meeting applicable medical necessity criteria. As of January 1, 2023, CFTSS are additionally available to MVP CHP Members. These services focus on provision of individualized Behavioral Health interventions which promote greater care flexibility and include family and community provider integration. Medical Necessity criteria can be found on the NYS Office of Mental Health (OMH) website. The following is a description of the various CFTSS. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible.

Other Licensed Practitioner

Non-physician licensed behavioral health practitioner (NP-LBHB) who is licensed in the State to prescribe, diagnose, and/or treat individuals with a physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law (i.e., services can be delivered in the community outside the four walls of the agency). NP-LBHPs include individuals licensed and able to practice independently or are under the supervision or directions of a licensed clinical social worker, a licensed psychologist, or a psychiatrist. Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables, and nuances
- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy
- Developing recovery-oriented treatment plans

Crisis Intervention

Crisis intervention services are provided to all children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it.

Community Psychiatric Support and Treatment (CPST)

Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community-based onsite rehabilitative services.

Psychosocial Rehabilitation

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environment barriers associated with a child's/youth's behavioral health needs.

Family Peer Support Services

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provided a structure, strength- based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

Youth Peer Support

Youth Peer Support (YPS) services are formal and informal services and supports provided to youth and families raising an adolescent who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community-centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Children's Home and Community Based Services (CHCBS)

Children's Home and Community-Based Services (CHCBS) is a State operated 1915c Children's Waiver which provides opportunities for Medicaid Member's under 21 that have Behavioral Health needs and/or medically complex conditions to receive services in their own home or community. The array of available services supports children with significant need who are at risk for hospitalization or institutionalization care to support them maintaining within their home and community setting. MVP, Health Home Care Managers, service providers, plan members, and their chosen supporters/caregivers, help Members prevent, manage, and ameliorate chronic health conditions and improve health outcomes. CHCBS will also be available to MVP Child Health Plus Member's under the age of 21 effective January 1, 2025.

MVP's 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

Children's Home and Community Based Services Eligibility Criteria

Children and youth must be under 21 years of age and eligible Medicaid to receive CHCBS. Eligibility is established using the HCBS/LOC Eligibility Determination tool housed within the Uniform Assessment system (UAS) along with the Child and Adolescent Needs and Strengths—NY (CANS-NY) Assessment. Only Health Home Care Manager, Children and Youth Evaluation Services (C-Yes) or the OPWDD Developmental Disabilities Regional Office (DDRO) are given access within the UAS to complete the HCBS/LOC Eligibility Determination. Members may opt to use either the HHCM/C-Yes to complete the assessment and subsequent POC development. As made available through the State operated Children's Waiver, the Member must also be provided a CHCBS Waiver slot, appointed by NYS DOH prior to accessing services.

CHCBS eligibility is comprised of three components:

- Target Criteria
- Risk Factors
- Functional Criteria

These three components are evaluated using the HCBS/LOC Eligibility Determination to establish which CHCBS eligibility group the child or youth is eligible for (if any). There are two CHCBS eligibility Groups. Level of care (LOC): Children that meet institutional placement criteria. There are 4 subgroups within the LOC group:

1. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
2. Children with a Developmental Disability in Foster Care
3. Children who are Medically Fragile
4. Children who are Medically Fragile with a Developmental Disability

There are two subgroups within the LON group:

- Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)

Abuse, Neglect and Maltreatment or Health Home Complex Trauma
The HCBS/LOC Eligibility Determination is completed annually and remains active for a 12-month period with the following exceptions:

- Significant life event
- If there is a significant life event for a child/youth while receiving HCBS, a new HCBS/LOC Eligibility Determination may be needed. A significant life event is something that occurs in child's/youth's life that impacts their functioning, daily living situation or those that care for the child/youth

- The Member is found HCBS/LOC eligible but initially declines CHCBS. A new assessment is needed if the active determination is not utilized within six (6) months of the date of the eligibility outcome

If a child/youth is found HCBS/LOC ineligible and there is a change in circumstances, the child/youth can be reassessed at any time, as there is no wait period between assessments.

Capacity Management

Capacity Management is the process by which New York State manages the combined slots for the 1915c Children's Waiver. Slot capacity is tracked by NYS using target population regionally. Upon completion of the HCBS/LOC Eligibility Determination within the UAS the NYS Capacity Management team will review the Eligibility report by the next business day and provide notification to the HHCM (or C-YES) of slot assignment. The Capacity Management team will also send a Notice of Decision to the Member. Once assigned, the Member will maintain the Waiver slot until discharged from the waiver.

Review Guidelines

Once LOC has been established (or LON once implemented) the HHCM (or C-YES) will work with the Member to develop a person-centered Plan of Care (POC) inclusive of all eligible and appropriate Services. The HHCM will work to refer the Member to all applicable CHCBS providers within the plans network. Once referred CHCBS provider(s) will conduct service specific evaluation(s) and forward additional information to Health Home Care Manager regarding intensity and duration of services which is captured within the POC shared with MVP.

HCBS providers will be required to submit a notification to MVP when a Member has been accepted and a first appointment scheduled. Notification will allow for authorization of specific CHCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. MVP utilization management will ensure the Member's plan of care reflects the Member's individual, assessed, and self-reported needs and is aligned with concurrent review protocols.

MVP will oversee and support the Health Homes and CHCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by NYS-established criteria. The program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for eligible enrollees.

All eligible Members will additionally be provided access to an MVP Care Manager who will serve as the contact with the Health Home, review clinical information, and collaborate on coordination of care, as appropriate.

These review guidelines provide a framework for discussion between HCBS providers and MVP. The review process is a collaboration between all pertinent participants including but not limited to, the Health Home Care Manager, HCBS provider and Member to review

progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the Member's chosen goals. Conversations will focus on the Member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all Members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

Children's Home and Community-Based Services Descriptions

Respite (Planned and Crisis)

Respite provides short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/caregivers. Respite can be planned or delivered in a crisis environment. To the extent that the skilled nursing is provided as a form of respite, this service must be ordered by a physician. This service may be provided in a one-to-one, individual session, or group session. The need for crisis respite may be identified because of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis respite should be included on the plan of care to the extent that it is an element of the crisis plan or risk mitigation strategy.

Caregiver/Family Advocacy and Support Services[3]

Caregiver/Family Advocacy and Support Services enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's POC) with techniques and information not generally available so that they can better respond to the needs of the participant. These services are intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disabilities. These services can enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. The use of this service may appropriately be provided to prevent problems in community settings when the child/youth is experiencing difficulty. The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people, who interact with and support the child/youth in these endeavors. Caregiver/Family Advocacy and Support services improve the child/youth's

ability to gain from the community experience and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or healthcare issues. Caregiver/Family Advocacy and Support Services are divided into Individual and Group services, as well as different levels based on provider qualifications. They can be delivered with or without the child/youth present. The services would be billed with distinct rate codes for:

- Caregiver/Family Advocacy and Support Services – L1 Individual
- Caregiver/Family Advocacy and Support Services – L1 Group of 2
- Caregiver/Family Advocacy and Support Services – L1 Group of 3
- Caregiver/Family Advocacy and Support Services – L2 Individual
- Caregiver/Family Advocacy and Support Services – L2 Group of 2
- Caregiver/Family Advocacy and Support Services – L2 Group of 3

Prevocational Services

Prevocational services are individually designed to prepare a youth aged 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities (developmental, physical, and/or behavioral). In addition, prevocational services assist facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational services are not job-specific, but rather are geared towards facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in a participant's service plan directed to teaching skills rather than explicit employment objectives.

Supportive Employment

Supported employment services are individually designed to prepare individuals with disabilities (developmental, physical, and/or behavioral) age 14 and older to engage in paid work. Supported employment services aid participants with disabilities as they perform in a work setting. Supported employment provides ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in a competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Habilitation (Community)

These services focus on helping children with developmental, medical, and behavioral disabilities who are eligible for HCBS to be successful in the home, community, and school by acquiring both social and environmental skills associated with his/her current developmental stage. This service assumes that the child has never had skills being acquire. Habilitation services assist children who have never acquired a particular skill with the self-help, socialization, and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate. This service may be delivered in an individual or group setting.

Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skill sets.

Palliative Care Counseling and Support Services

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and the family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition medical, physical or developmental condition, or life-threatening illness and can be provided along with curative treatment. There are Palliative Care Services available including:

- Palliative Care Pain and Symptom Management
- Palliative Care Counseling and Support Services
- Palliative Care Massage Therapy
- Palliative Care Expressive Therapy

Adaptative and Assistive Technology

This service provides technological aids and devices identified within the child/youth's Plan of Care (POC) which enable the accomplishment of daily living tasks that are necessary to support the health, welfare, and safety of the child/youth.

Vehicle Modifications

This service provides physical adaptations to the primary vehicle of the enrolled child/youth which, per the child/ youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

Environmental Modifications

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence in the home and without which the child/youth would require and institutional and/or more restrictive living setting.

Most providers of environmental modifications, vehicle modifications, and adaptive and assistive technology, V-Mods, and AT will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

Behavioral Health Prescription Drugs

Please refer to the *MVP Pharmacy Benefits* Section for more information.

Behavioral Health Access Standards

Behavioral health providers must adhere to the appointment availability time frames as set forth below:

Service type	Standard	Urgent	NON-URGENT MH/Sud	BH specialist	FOLLOW-UP TO EMERGENCY OR HOSPITAL Discharge	FOLLOW-UP TO JAIL/PRISON Discharge
MH Outpatient Clinic/ PROS Clinic		Within 24 hours of request	Within 1 week of request		Within 5 days of request	Within 5 days of request
ACT		Within 24 hours of request			Within 5 days Of request	
PROS		Within 24 hours of request		Within 2 Weeks of request	Within 5 days of request	Within 5 days Of request
Continuing Day Treatment				Within 2 Weeks		Within 5 days of request
IPRT				Within 2–4 weeks		
Partial Hospitalization					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
Crisis intervention	Upon presentation	Within 24 hours for			Immediately	

		short term respite				
Community Mental Health Services (These Are 599 Clinic Services Offered In The Community) From Date Of Request	Within 1 week of request	Within 24 hours of request	Within 5 days of request	Within 5 days of request		
Oasas Outpatient Clinic		Within 24 hours of request		Within 1 week of request	Within 5 days of request	Within 5 days of request
Detoxification	Upon presentation					
Sud Inpatient Rehab From Date Of Request	Upon presentation	Within 24 Hours of request				
Opioid Treatment Program					Within 5 days of request	
Residential Addiction Services		Within 24 hours of request		Within 2–4 Weeks of request	Within 5 days of request	
Behavioral Health Home and Community Based Services						
Psychosocial Rehabilitation, CPST Habilitation, And Family Support And Training	n/a	n/a	Within 2 weeks of request		Within 5 days of request	
Educational And Employment Support Services	n/a	n/a	Within 2 weeks of request		n/a	
Peer Supports	n/a	Within 24 hours for symptom management	Within 1 week of request		Within 5 days of request	

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") and Chapter 748 of the Laws of 2006 (a New York State law commonly referred to as "Timothy's Law") require health insurance plans to provide coverage benefits for behavioral health and substance use disorder conditions in a manner that ensures "parity" with physical illnesses.

MVP Provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, equal to the coverage provided for other physical health conditions. Behavioral health conditions include mental health and substance use disorders. Accordingly, there is no number of day or visit restrictions for Members who have a behavioral health benefit

and meet Medical Necessity criteria. Prior approval requirements may be applicable. The utilization review conducted by MVP for each request or claim for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by MVP for each request or claim for similar Medical/Surgical benefits. Any annual or lifetime limits on behavioral health benefits for MVP plans are no stricter than such limits on Medical/Surgical benefits. MVP does not apply any cost-sharing requirements that are applicable only to behavioral health benefits. MVP does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be limited to 20 visits per calendar year. Where an MVP Product covers Medical/Surgical benefits provided by out-of-network Providers, the MVP Product will equally cover Behavioral Health benefits provided by out-of-network Providers.

Where an MVP Product has a deductible, MVP will charge a uniform deductible for all benefits, irrespective of whether Covered Services are rendered for Medical/Surgical or Behavioral Health conditions, with the exception that MVP charges a separate deductible for prescription drugs.

Confidentiality of Behavioral Health and Substance Use Disorder Information

Providers are required to develop policies and procedures to ensure the confidentiality of behavioral health and Substance Use Disorder information. Comprehensive policies must include:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for BH/SUD information protocols to protect persons with behavioral health and/or substance use disorder from discrimination

Cultural Competency

All Participating Providers must ensure that services are provided to Members in a culturally competent manner. For more information on the MVP policy, please review the MVP Provider Responsibilities Section.

Claims

When to Call the Customer Care Center

Our Customer Care Center is reserved for Providers who are having issues retrieving claim status through the IVR, have questions regarding benefits and eligibility, or who need clarification on Provider participation status. Providers may check the status of all claims submitted to MVP by Signing In to their account at **mvphealthcare.com/providers** and gather remittance information through their **Zelis account.** Customer Care Center contact phone numbers are: **1-800-684-9286** and **1-800-999-3920**.

When to Resubmit a Claim

Providers may resubmit a claim directly to MVP electronically if it was not processed on MVP's system. If you are correcting a claim that was already processed, you may resubmit electronically or with a Claims Adjustment Request form, to:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

When resubmitting a claim directly, use the following guide to determine if a claim adjustment form is required:

Claim Adjustment Form IS NOT REQUIRED	For a different or corrected: • Date of service • ID number • Service provider • Date of birth • Procedure or revenue code
Claim Adjustment Form IS REQUIRED (UNLESS sending electronic EDI Request)	For any other change to the information on the 02/12 1500 claim form, UB-04 form, or a Standard EDI Transaction (ANSI 278): • For a different or corrected name • For claims appeals • For claims denied for no EOB from primary carrier and provider submitting Explanation of Benefits (EOB) • For a different or corrected place of service

When a corrected claim is submitted, the entire claim must be resubmitted on one claim. Lines that are not resubmitted will be considered by the system to be incorrectly billed the first time and be removed.

Claim Requirements

Claim information must be entered in the designated field for all claims submitted. MVP uses state-of-the-artoptical imaging and optical character recognition (OCR) for all paper claims. Therefore, print quality and data alignment for paper claims must be of high quality for optimum clarity when scanned into the computer system.

Providers are required to use the most current version of the CMS 02/12 1500 claim available. The *CMS Medicare Billing: Form CMS-1500 and the 837 Professional* booklet is available here. The CMS Medicare Claims Processing Manual—Completing and Processing the Form CMS-1450 Data Set (also known as the UB-04) is located here.

Important NPI Reminder

HIPAA mandates that all health care providers performing standard electronic transactions obtain a National Provider Identifier (NPI). MVP requires NPIs on paper claims. Up to date NPI information, revised EDI Companion Guides, and a link to the CMS website are available at **mvphealthcare.com**.

Providers must report their NPIs to MVP at the time they request to become a Participating Provider. MVP will not credential or register a new Provider without verifying an active NPI status.
When submitting claims for MVP's D-SNP Members, please be sure you are following all applicable CMS and NYS billing guidance for the services being provided.

Clean Claim Processing Timeframes

Clean Claim Definition

A complete and accurate claim or "Clean Claim" is defined as a completed and accurate UB-04 or 02/12 1500 claim form which does not include any erroneous or conflicting information containing all data necessary for processing the claim. It must be submitted no more than 180 days after the date of discharge or 180 days after the date of service rendered.

Clean Claim Processing

If the Provider submits a Clean Claim, including all requisite information to process the claim at the time of submission, MVP will:

- Pay the claim or any undisputed portion of the claim within applicable regulatory timeframes
- Notify the Provider of any adverse determination, in writing, within 30 days after MVP's receipt of the claim. However, if a claim is denied for lack of medical records, requested information must be resubmitted within 180 days from receipt of MVP's notice
- If the Provider receives an adverse determination, the Provider may request reconsideration or appeal the denial on the Member's behalf as described in the Appeals section of this Manual

If the Provider does not submit a Clean Claim, it will be rejected and returned to the Provider.

Hospital Inpatient Claim Itemized Bill Requirement

Providers must submit an itemized bill for all Inpatient hospital claims with billed charges greater than or equal to fifty thousand ($50,000) dollars. Inpatient claims that are reimbursed solely at the inlier DRG methodology will be excluded. MVP will suspend all claims that do not include an itemized bill. MVP will send the provider notice of the pended claim, along with a request for the required itemized bill. Provider must submit

such an itemized bill with MVP's request letter for claim to be processed. Failure to provide an itemized bill may result in a claim denial.

Optum Claim Review Guidelines

MVP adheres to CMS's Provider Resource manual, Chapter 22, section 2202.6 section for all lines of business when reviewing charges for specified claims that are included in the general cost of room and board or associated surgery and are considered non-billable for separate reimbursement.

The general cost of the room where services are being rendered includes routine services and supplies. As such, these items are considered non-billable for separate reimbursement and are not eligible to be included in outlier calculations for additional reimbursement.

Timely Claims Submission Reminder

MVP applies a timely filing limitation of 180 days, or as specified in your contract, from the date(s) of service for the filing of claims. All claims received after the applicable time will be denied. MVP Members cannot be billed for services denied because of timely filing issues.

There are two exceptions to the timely filing limitation:

- Claims that involve Coordination of benefits where MVP is the secondary payer have a timely filing limitation of 180 days, or as specified in your contract, from the date of the primary EOB but no more than two (2) years after the date of service
- Claims for Workers' Compensation or No Fault are not subject to the timely filing limitation of two (2) years after the date of service if MVP receives the claim with appropriate denials/documentation no later than the contracted filing limit of 180 days, or as specified in your contract, from the date of the primary EOB

In addition to filing claims in a timely manner, MVP imposes the timely filing limit on adjustment requests. An adjustment is defined as a request to correct a processing error, whether the claim was denied or modified by MVP erroneously, or the Provider has amended the claim for a billing error or omitted data. Providers may request an adjustment within 180 days, or as specified in your contract, from the date of MVP's denial or incorrect payment. For all timely filing reconsiderations, MVP requires supporting documentation to overturn a denial.
For inquiries of Workers' Compensation, No Fault, or Coordination of Benefits (COB) claims, call MVP's COB Unit at **1-800-556-2477, option; press 2.**

Electronic Claim Submission

Providers that are enabled to submit claims electronically must do so. If you cannot initiate electronic submission of claims with MVP via standard EDI Transactions (ANSI 837) for institutional, professional claims, Providers may create and submit medical and behavioral health claims online to MVP by accessing **mvphealthcare.transshuttle. axiom-**

systems.com. This website is hosted and powered by AXIOM and the services available therein are offered by AXIOM to providers on behalf of MVP. AXIOM may require that users agree to AXIOM's site requirements and certain terms of use before accessing AXIOM's services. If you are unable to submit electronically, mail scannable paper claims.

Optical Scanning Instructions

Providers must submit paper claims on the official CMS 1500 Drop-Red-Ink 02/12 claim forms. Claims that are black-and-white, faxed or photocopied may not scan as cleanly, requiring manual keying. Providers who pre-print their names and address in Field 33 should use a 10- or 12-point font size.

- Use UPPERCASE characters only
- The print should be 10- or 12-point font size. Do not use multiple font sizes on a claim
- This includes re-submissions with corrected information
- Use standard fonts—typewritten (Courier). Do not use unusual fonts such as sans serif, script, italics, etc.
- Claims that are too light cannot be scanned
- Enter all information on the same horizontal line
- Enter all information within the designated field
- Avoid handwriting anything on the claim form
- Avoid folding claims
- A maximum of six line-items are allowed per claim in Field 24
- Do not use special characters such as slashes, dashes, decimal points, dollar signs, or parentheses
- Make sure the claim is aligned correctly and the data is within the box. If information is not contained within the intended field, the claim may be returned.
- Staple any multiple page claims (with or without attachments)

If you are unable to submit electronically, mail scannable paper claims.

EDI Transactions

MVP is prepared to receive standard EDI Transactions (ANSI 837) for institutional, professional claims. Refer to the MVP EDI Companion Guide for additional information. Contact MVP's EDI Services Department toll-free at **1-877-461-4911** to initiate electronic submission of claims with MVP. Please refer to the following documents for additional information related to electronic claim submission:

- Companion Guides on MVP's website for information specific to MVP electronic claim submissions are located at the **Provider Reference Library: EDI**.

The HIPAA Technical Report Type 3 (TR3) guides, which contains complete information for each of the mandated EDI transactions. You can obtain copies of these guides from Washington Publishing Company at wpc-edi.com.

Electronic Replacement and Void Claims Submission

Claims processing system recognizes claim frequency codes on professional electronic claim transactions (ANSI 837P) and institutional electronic claim transactions (ANSI 837I). Using the appropriate code indicates that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

Claim Frequency Code	Description
1	Indicates the claim is an original claim.
7	Indicates the new claim is a replacement or corrected claim, the information present on this bill represents a complete replacement of the previously issued bill.
8	Indicates the claim is a voided/canceled claim.

Direct Electronic Options

MVP offers the following electronic transactions in the approved HIPAA standard format:

- 837P—Professional Claims
- 837I—Institutional Claims
- 837D—Dental Claims
- 835—Electronic Remittance Advice
- 270/271—Electronic Eligibility and Benefits Request and Response
- 276/277—Electronic Claim Status Request and Response
- 278—Electronic Authorization Request

When submitting claims electronically to MVP, the Provider should refer to MVP's HIPAA EDI Companion Guide. For questions about electronic claims submission, contact MVP's EDI Services Department at **1-877-461-4911** or at ediservices@mvphealthcare.com.

Electronic Claim Filing Tips

When filing claims electronically, please review the "Payer Reports" to ensure MVP has accepted the claim. When billing claims electronically through a clearinghouse, the claim is checked by clearinghouse edits to ensure that all required fields are complete, and the format is correct. If the claim passes the clearinghouse edits, it is then forwarded to MVP. MVP also performs edits prior to processing claims.

837 Professional Claim Submission

The CMS Medicare Billing: Form CMS-1500 and the 837 Professional booklet is available here.

Replacement Claims

Replacement claims (sometimes referred to as corrected claims or recall claims) submitted electronically will help MVP process the claim promptly and accurately. A replacement claim is any claim that has a change to the original claim (e.g., changes or corrections to charges, procedure or diagnostic codes, dates of service, Member name). Corrected claims may be submitted immediately. When a replacement claim is being submitted, Providers may submit the correction electronically with a "7" as the frequency code.

Quick Review Grid

Question	Definition	Examples	How to Submit Claims
What is a replacement (or corrected or recall) claim? (Type of bill ending in 7)	A replacement claim is sent when data on the claim was either missed or needed to be corrected.	• Incorrect date of service (DOS) • Incorrect units • Procedure code missing • Diagnosis code change or addition • Revenue code changes • Line being added • Change to injury date • Change to related cause code • Change to place of service • Change to rendering provider with no billing provider change	If claim was previously processed on Facets and was billed via paper, send in CARF. If claim was previously processed on Facets and billed electronically, follow EDI/MVP replacement claim submission guidelines. Claims that require timely filing review or additional documentation need to be submitted via CARF.
What is a voided claim? (Type of bill ending in 8)	When identifying elements change, a void submission is required to eliminate the previously submitted claim.	• Payer information change • Subscriber information change • Billing provider change • Patient information change • Statement covers period • Patient did not want insurance billed • Bill type changes from IP to OP or OP to IP	Whether original claim was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim. Follow EDI/MVP submission guidelines.

Coordination of Benefits—EDI

When MVP is not the Member's primary payer, claims can be submitted via an 837 Transaction set. Please be sure to include the following information from the other payer:

- Total Charge
- Primary Approved Amount
- Patient Responsibility
- Other Payer Information
- Payer Paid Amount
- Non-Covered Charges
- Remaining Patient Liability

See MVP's Secondary Payer and COB rules here: Secondary Payer and COB Rules
Please contact MVP's EDI Services Department for more information at ediservices@mvphealthcare.com. or at **1-877-461-4911**.

Claim Returned to Provider Letters

Providers that receive a "Claim Returned to Provider" letter, which indicates that all required fields have not been populated for a Clean Claim, must respond to the letter, or submit a corrected claim within the Provider's contractual adjustment guidelines. The receipt date for a Corrected Claim or contact date for a call made to MVP, beyond the contractual adjustment timeframe, will be subject to timely filing requirements as outlined in the Providers contract and may be subject to denial.

Non-Liability

Providers may not bill Members for Covered Services, except for the collection of permitted Deductibles, Co-insurance, or Co-payments as specifically provided in the Subscriber Contract and as set forth in the terms and conditions of the contract.

YME/YUV Denials

A claim denied for remark code "YME—Provider Tax ID/Address discrepancy" or "YUV—The tax ID and/or address billed are not on file for the NPI billed" indicate that the demographic information billed on the Provider claim form does not match the demographic information on file with MVP. Providers must update demographic information, address, tax ID information, new billing locations, or additional office locations with MVP by submitting a change request through MVP's *Online Demographic* form, found here.

Facilities needing to make a change to demographic information should complete the PDF version of the *Provider Change of Information* form, found here.

Ambulance Mileage Billing

When submitting a chargeable transport service for payment, the transport distance quantity field in Loop 2300:CR106 of an electronic claim must be greater than 0 miles but less than or equal to 9,999 (miles). Claims submitted with values more than 9,999 miles will be denied, stating "Transport Distance Quantity (CR106) exceeds 9,999."

Interim Bills

Interim bills are required once a Member has been inpatient for 120 days, and then every 120 days thereafter. Once the 120-day threshold is met, the facility must submit an interim bill to MVP within 30 days of the 120th inpatient day. Claims will be adjusted to pay the difference as interim payment for each submission until final discharge.

Clinical Edits

MVP utilizes industry standard claims editing software including Lyric's ClaimsXten® (CXT) to improve overall efficiency and claim payment accuracy. The software analyzes claims data by applying a predetermined set of rules to each claim to ensure it aligns with established standard correct coding methodologies. A few examples of these coding methodologies are:

- Age Conflict: Ensuring that the procedures and diagnoses are appropriate for the patient's age.
- Frequency Limitations: Checking that the frequency of services provided is within the acceptable limits for a given period.
- Mutually Exclusive: Refers to pairs of codes that cannot be billed together because they represent procedures or services that would not reasonably be performed at the same session, on the same patient, or at the same anatomical location.
- Unbundling: Preventing the practice of billing multiple codes for a procedure that should be billed as a single comprehensive code.

These methodologies help maintain the integrity of our claims process and ensure that healthcare providers receive correct reimbursement for their services efficiently. Clinical editing also ensures compliance with essential coding conventions and guidelines from authoritative sources such as the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI), and various specialty societies.

Appealing Any Claim Editing Denial

Providers may dispute a claim edit denial by using a Claims Adjustment Request Form with the clinical and/or coding rationale supporting the Adjustment Request. Any medical records/and/or/operative reports that will substantiate the appropriateness of the appeal must be included. Information about MVP policies and procedures is available online here or from an MVP Professional Relations representative.

Anesthesia

- MVP reimburses in accordance with ASA guidelines
- Anesthesia Participating Provider Groups must submit anesthesia-specific claims with ASA codes, not surgical codes
- Anesthesia Participating Provider Groups must submit claims with the total time minutes in the quantity field. MVP automatically calculates the base units from the ASA code billed, and then adds the time units by using the information in the quantity field
- MVP reimburses based upon 15-minute time units and will calculate the time units automatically based upon the total time minutes billed by group. MVP reviews all claims submitted with P modifiers. The diagnosis must justify billing of these modifiers/codes
- Deleted code 01997 should no longer be used. Per CPT guidelines, use the appropriate evaluation and management (E&M) code
- MVP reimburses code 01996 once per day at three units

Coordination of Benefits (COB) Determination

COB determines the order in which benefits are paid when a Member is covered by another insurance policy or contractual entitlement issued by a payer other than MVP ("Other Payer"). MVP will coordinate its benefits with the Other Payer to prevent overpayment and duplicate payments for the same service. Contact the COB Department at **1-800-556-2477**, **option/ press 2** for all Coordination of Benefits including Auto or Work-related accidents.

If MVP is the Secondary Payer, the rules and procedures of MVP as stated in the Member's Subscriber Contract must be followed before MVP will make payment and MVP shall not pay more than it would have paid if it were the Primary Payer.

When billing MVP as the secondary Payer, all MVP primary billing requirements and codes must be followed for the services provided according to specific coding requirements in the Agreement and MVP Protocols, regardless of what was billed to the Other Payer. MVP

will not act as secondary payer on services not covered under a Member's Subscriber Contract.

MVP as Secondary Payer

If a Member has an accident and is covered for accident-related expenses under any of the following types of coverage, the Other Payer is primary, and MVP may be secondary:

- No-fault auto insurance
- MedPay Insurance
- Group auto insurance
- Traditional fault-type auto insurance that you
- Workers' compensation
- Other property/liability insurance providing medical payment benefits
- Personal injury protection insurance
- Financial responsibility insurance
- Homeowner's insurance
- Uninsured/underinsured motorists' insurance
- Automobile-medical payment insurance
- Medical reimbursement insurance coverage that you did not purchase

Note: The above list varies by state.

Effect of Medicare

Members must enroll in Medicare Part B upon eligibility when Medicare is determined to be the Member's primary plan. If the Member fails to enroll in Part B when eligible and Medicare is primary, MVP will reduce Product benefits by the amount Medicare would have paid for the services or care. The reduction in benefits will occur even if the Member fails to enroll in Medicare, does not pay premiums or charges to Medicare, or receives services at a Hospital or from a Provider that cannot bill Medicare.

Medicare is considered the Secondary Payer if the Member is:

- Medicare-eligible by reason of age and the subscriber is currently employed by an employer group with 20 or more employees
- Medicare-eligible because of end-stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective
- Disabled (by reason other than ESRD) and the subscriber is currently employed by an employer group with 100 or more employees

MVP-Contracted Vendors

MVP contracts with several vendors who may reach out to providers for additional information. These vendors are:

Conduent Payment Integrity Solutions (formerly known as Xerox Recovery Services, Inc.)
P.O. Box 30115
Salt Lake City, UT 84130

Conduent reviews MVP claims and eligibility data for possible other Insurance including Commercial and Medicare, as well as various audits for Hospice, 3-day rule, duplicates, and eligibility. Conduent performs their service as a secondary review after MVP's COB team and Operations processing is complete. Conduent utilizes various methods to analyze the data to determine which Members to investigate for other insurance. While not the only focus of their attention, Medicare makes up much of Conduent's investigations. In addition, MVP is contracted with Conduent to provide the additional services of Credit Balance Audits, under their business associate agreement with CDR.

CDR

307 International Circle, Suite 300
Hunt Valley, MD 21030

CDR is contracted to perform facility credit balance audits.
Optum Insight, Inc. ("Optum")
9390 Bunsen Parkway Louisville, KY 40220

Optum/ Equian receives claims and eligibility data extracts from MVP monthly. They use software that sorts and analyzes data, compiling high probability cases for subrogation investigation. Optum/ Equian pursues Third-Party Liability cases including ~~on~~ Workers' Compensation and No Fault.

Other Party Liability (OPL) Subrogation
415 Chartiers Avenue
Carnegie, PA 15106

Other Party Liability is contracted for subrogation recovery efforts for specific self-funded groups not handled under Optum/ Equian. OPL pursues Third-Party Liability cases including Workers' Compensation and No Fault. OPL receives claims and eligibility data extracts monthly from MVP. They use software that sorts and analyzes the data, compiling high probability cases for investigation.

Zelis Payments
Zelis offers complete transparency and easy access to payment and remittance data from over 550 MVPs across all your TINs in one user-friendly experience, significantly reducing manual work and operational costs to collect related to claim payments, while accelerating provider cash flow.
With Zelis, you will:

- Choose to receive a faster premium payment experience via Virtual Credit Card or ACH+.
- Access consolidated payments and data from over 550+ MVPs in one, secure portal.
- View payments history by claim and export remittance data in various formats (835, CSV, XLS, or PDF).
- Deliver ERA/835s to your clearinghouse or via SFTP reducing the need for manual entry.
- See key revenue and claims insights visualized in intuitive dashboards.
- Benefit from a single point of contact for support on payment delivery and remittance questions across all 550+ MVPs in the Zelis Network.

You can register at **mvp.epayment.center** or call **855-774-4392** to receive claim payment data and remittances electronically.

Recoveries for Overpayments

All applicable state and federal recovery overpayment guidelines are adhered to by MVP, as well as by MVP's Contracted Recovery Vendors.

MVP is regularly audited by external auditing agencies, such as the New York State Department of Financial Services, CMS, and ASO group audits. MVP is required to comply with time limits established by these auditing agencies. Audits may include up to three years of claim data. MVP has no time limit for provider-initiated refunds to MVP. In the event of an overpayment to a Provider, identified by MVP or another applicable auditing agency, MVP may pursue recovery efforts via claim adjustments as permitted by law and in accordance with the following timeframes:

1. Medicare, Medicaid, CHP, HARP, Essential Plan Products

MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a Provider.

2. Self-Insured Products

MVP shall initiate overpayment recovery efforts in accordance with the employer group's contract or up to twenty-four (24) months after the original payment was received by the Provider which includes Medicare primary claims.

3. New York Providers

MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a Provider; provided, however, no such time limit shall apply to overpayment recovery efforts that:

- Involve fraud, waste, or abuse

Are required by, or initiated at the request of, a self-insured plan are required or authorized by a state or federal government program or coverage that is provided by New York State or a New York municipality or its respective employees, retirees, or Members

- Involve recovery of incorrect claims payments made due to a Provider previously receiving payment for services

4. Vermont Providers

MVP shall not initiate overpayment recovery efforts more than twelve (12) months after the original payment was received by a Provider; provided, however, that the retrospective denial of payment shall be allowed beyond the twelve (12) month period if:

- MVP has a reasonable belief that fraud or other intentional misconduct occurred
- Provider was previously paid
- The health services identified in the claims were not in fact delivered by the Provider
- The claim payment is subject of adjustment by an Other Payer

The claim payment is the subject of litigation. If you have any questions relating to the claim(s) adjustments, need documentation, or benefit information, please contact our Provider Services Department at **1-800-684-9286**.
If you're calling to advise us of a refund that has already been submitted, cleared, or would like to plan for payment please contact the Recovery Department on our toll-free line **1-800-556-2477** (option/press #1).

Please be advised that if you are receiving a monthly Recovery overpayment letter with a spreadsheet of adjusted claims, the adjustments have taken place within the contracted adjustment time limits described above. There is no time limit for MVP to complete its collection efforts/recoupment of such outstanding overpayments. MVP participating providers should look at the terms and conditions of their MVP participating provider contracts for additional information.

Services Provided Free of Charge

MVP shall not pay for Covered Services provided to Members free of charge, or when those Covered Services are at no cost to the Provider as they are subsidized through a Government or related program, i.e., vaccinations. Covered Services that are provided free of charge should be billed to MVP with the modifier SL.

New CMS Code and Relative Value Units (RVU) Updates

CMS creates new medical codes and assigns RVUs on a quarterly basis. MVP will begin updating fee schedules with the appropriate assigned RVU to all CMS codes on a quarterly basis. Applicable Provider contracts will still be reimbursed at the agreed upon percentage of Medicare as stated in the applicable Fee Schedule.

Claim Auditing

MVP audits a random sampling of 3–5 percent of all processed claims to ensure processing accuracy.

Special Investigations Unit (SIU)

Special Investigations Unit Insurance laws require MVP to establish and maintain a process to investigate potential occurrences of health care fraud, waste and/or abuse. The Special Investigations Unit's (SIU) mission is to assist MVP in detecting and addressing situations where fraud and/or abuse may have occurred.

SIU uses a formal process for detecting, investigating, and preventing these types of activities. The investigation process includes investigators and nurses with backgrounds in insurance fraud investigations and medical claim reviews. The SIU staff surveys and evaluates claim data—including provider/facility history, specialty profiles, common fraud schemes, waste, and/or abuse, and claim patterns that differ from history or peer norms for a given condition or specialty.

During a review, audit, or investigation it may be determined that a sustained or high level of payment errors exists. In such cases, MVP, in its sole discretion, reserves the right to utilize statistical sampling and an extrapolation methodology to identify the totality of overpayments.

SIU's investigative process also includes the use of high-tech Artificial Intelligence based software, Fraud Scope to detect, track, analyze, and report instances of health care fraud, abuse, or misrepresentation.

It may be necessary for SIU to obtain medical records to complete its investigation as efficiently and accurately as possible. However, if SIU requests information from your practice, it does not necessarily indicate a problem exists. MVP also relies on our participating facilities, providers, and their office staff to help us fight insurance fraud, waste and/or abuse.

Please report any suspicious activity by calling MVP's Special Investigations Unit (SIU) toll-free at 1-877-TELL-MVP (**1-877-825-5687**) or by using the reporting pathway on the MVP internet site Report Health Insurance Fraud | MVP Health Care. All information will be kept confidential.

Required Self-Disclosure Reporting

In accordance with NY Social Services Law Section 363-D, MVP and its Participating Providers and subcontractors are required to report, return, and explain overpayments within sixty (60) days of identification. Additionally, MVP is required to promptly report all recoveries, including those that result from a Provider or subcontractor reporting, returning, and explaining an overpayment. Providers can report any overpayment they incorrectly received by using the reporting pathway on the MVP internet site Reporting Overpayments (www.mvphealthcare.com/contact-us/reporting-overpayments).

Concierge (Retainer-Based) Medical Services

Reimbursement Guideline Disclaimer

MVP maintains policies that reflect requirements applicable to MVP's Provider network and health plans. This policy is intended to serve as a general reference for concierge or retainer-based medical service arrangements and does not address every operational, contractual, or regulatory scenario. Other factors may supplement, modify, or supersede this policy, including but not limited to applicable law, regulatory guidance, Provider agreements, MVP protocols, Member benefit coverage documents, and product-specific requirements.

MVP may deny claims, require corrective action, seek recoupment, or take other action permitted under the Provider agreement and applicable law when a Provider fails to comply with this policy, MVP billing and reimbursement requirements, or applicable Member billing protections.

Purpose

The purpose of this policy is to establish MVP's requirements for Participating Providers that offer concierge, retainer-based, Membership-based, or similar service arrangements to MVP Members. MVP permits such arrangements only when they comply with applicable law, MVP Provider agreement requirements, MVP protocols, and Member access and billing protections.

Scope

This policy applies to Participating Providers in New York that offer or administer concierge, retainer-based, Membership-based, or similar service models involving MVP Members. Unless otherwise stated, this policy applies across MVP lines of business; however, government program requirements may impose additional restrictions.

- Enrollment in a concierge program must be voluntary.
- MVP Members must not be required to enroll in, or pay for, concierge services to:
    - Obtain an appointment
    - Receive covered services
    - Continue as a patient

Definitions

Concierge or Retainer-Based Services means optional services, conveniences, or administrative features for which a patient pays a fee and that are not Covered Services under the Member's benefit plan. Examples may include enhanced administrative support, non-covered access features, or other non-covered conveniences.

- Covered Services means Medically Necessary health care services that are authorized for payment under the applicable Member benefit plan or subscriber contract
- Participating Provider means a Provider that has entered into an agreement with MVP to provide Covered Services to MVP Members

- Government Program Member means a Member enrolled in Medicaid Managed Care, HARP, Child Health Plus, Essential Plan, Medicare Advantage, D-SNP, or another government-sponsored product administered by MVP, as applicable

Policy

MVP permits Participating Providers to offer concierge or retainer-based services to MVP Members only when the arrangement is voluntary, limited to non-covered services, does not restrict access to Covered Services, and does not result in additional charges for services covered or reimbursed by MVP.

- MVP Members must be able to obtain Covered Services from the Provider without enrolling in or paying for a concierge program
- Concierge fees may apply only to optional, non-covered services that are clearly separate from Covered Services
- Providers must comply with all applicable hold harmless provisions, balance billing prohibitions, MVP billing rules, Provider agreement requirements, and state and federal law

Provider Requirements

- **Voluntary participation.** Enrollment in a concierge program must be voluntary. MVP Members must not be required to enroll in, or pay for, concierge services to obtain an appointment, receive Covered Services, or continue as a patient of the Provider.
- **Equal access to Covered Services.** Providers must ensure that MVP Members who do not enroll in a concierge program receive access to Covered Services and medically necessary care that is comparable to the access available to Members who enroll in the concierge program.
- **No additional charges for Covered Services.** Providers may not charge MVP Members concierge, retainer, administrative, access, Membership, or similar fees for Covered Services or services otherwise reimbursed by MVP.

Separation of Covered and Non-Covered Services

Providers offering concierge programs must clearly distinguish between Covered Services billed to MVP and optional non-covered concierge services paid by the Member. Concierge fees must apply only to non-covered services and must not duplicate, replace, condition, delay, or restrict access to Covered Services.

- Providers must maintain documentation showing which services are included in the concierge program and which services remain Covered Services
- Providers must not represent that MVP requires or endorses concierge participation as a condition of receiving care
- Providers must ensure concierge participation does not affect medical necessity determinations, appointment timeliness, continuity of care, or Provider availability for MVP Members

Member Communications and Transparency

Providers must give Members clear written information regarding the concierge program before collecting any concierge or retainer fee. The disclosure must describe the fee, the services included and excluded, and state that enrollment is optional and not required to receive Covered Services from the Provider.

- Member communications must not be misleading, coercive, or inconsistent with MVP Member billing protections
- Members must be informed that they may continue to access Covered Services without enrolling in the concierge program
- Providers must retain copies of concierge program materials, Member disclosures, and related agreements and provide them to MVP upon request

Government Program Members

- For Medicaid Managed Care, HARP, Child Health Plus, Essential Plan, Medicare Advantage, D-SNP, and other government program Members, Providers must comply with all product-specific and program-specific restrictions on Member billing and access to care
- Providers may not charge additional fees beyond those permitted by law and the applicable MVP Provider agreement
- Concierge arrangements must not require payment for access to Covered Services, restrict access, duplicate covered benefits, or otherwise conflict with government program requirements
- Where program requirements are more restrictive than this policy, the more restrictive requirement applies

Provider Notification, Directory, and Reporting Requirements

Providers must notify MVP if they offer or intend to offer concierge, retainer-based, Membership-based, or similar service arrangements to MVP Members. Providers must provide program details upon request and cooperate with MVP to confirm accurate Provider directory information and Member-facing communications.

- Program materials must be made available to MVP upon request
- Providers must promptly notify MVP of any material change to the concierge program that may affect MVP Members
- Providers must cooperate with MVP's review of access, billing, Member complaints, directory accuracy, and compliance concerns related to concierge arrangements

Compliance and Audit

MVP reserves the right to review concierge program materials, Member disclosures, Provider communications, billing records, access data, and other information necessary to evaluate compliance with this policy, MVP protocols, Provider agreement requirements, and applicable law.

- Failure to comply may result in corrective action, Provider education, claims denial, recoupment, referral for further review, or termination from MVP's network, as permitted by the Provider agreement and applicable law.
- may require a Provider to discontinue or modify a concierge arrangement that conflicts with this policy, MVP requirements, or Member protections.

Failure to comply may result in:

- Corrective action
- Recoupment of payments
- Termination from MVP network

Key Provider Obligations

Providers must ensure concierge arrangements do not interfere with MVP Members' access to Covered Services or result in prohibited Member billing.

- No required concierge participation as a condition of receiving Covered Services
- No additional charges for Covered Services or services reimbursed by MVP
- No reduced, delayed, or restricted access for Members who do not enroll in the concierge program
- Clearly written disclosures confirming that concierge enrollment is optional
- Full compliance with MVP Provider agreements, MVP protocols, Member billing protection, and applicable state and federal requirements

Regulatory and Contractual References

This policy is supported by federal and state requirements governing access to covered services, Member billing protections, Provider network obligations, and plan/Provider compliance responsibilities. The following references should be reviewed together with applicable MVP Provider agreements, product-specific benefit documents, and MVP protocols.

- **New York State Department of Health Medicaid Managed Care guidance and model materials**. NYSDOH managed care materials, including Medicaid Managed Care policy documents and model Member handbook language, support Member access expectations, covered service protections, and limitations on improper Member billing for covered services
- **Centers for Medicare & Medicaid Services Medicare Managed Care Manual, Chapter 4 — Benefits and Beneficiary Protections.** CMS guidance supports requirements related to Medicare Advantage covered benefits, beneficiary protections, cost sharing, access to services, and limits on charges beyond permitted Member financial responsibility
- **42 C.F.R. Part 422, including Subpart C — Benefits and Beneficiary Protections.** Federal Medicare Advantage regulations establish requirements related to covered benefits, access to services, Provider networks, disclosure, beneficiary protections, and protections against liability or loss of benefits

- **MVP Provider Agreements and applicable MVP Provider policies, protocols, and billing requirements.** Participating Providers must comply with contractual obligations, hold harmless provisions, Member billing restrictions, claims submission requirements, audit rights, corrective action requirements, and product-specific policies
- **Member benefit documents and product-specific requirements.** Coverage, cost sharing, access standards, and Member billing protections are governed by the applicable Member contract, subscriber certificate, evidence of coverage, handbook, rider, or other controlling benefit document

Revision History

Revision Date	Summary of Change
August 14, 2026	New policy

Credentialing

Credentialing

Review of Practitioner Credentialing and Recredentialing Information

MVP will execute a Participation Services Agreement only upon the successful completion of initial credentialing (including primary-source verification of submitted information) for practitioners applying for participation or continued participation (Recredential) in the MVP Network. Practitioners must be credentialed and contracted before being reimbursed for seeing a Member and being listed in MVP's Participating Provider Directory.

Participation in the MVP Network is at MVP's sole discretion. Credentialing or Recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or based solely on the types of procedures performed or the types of patients the provider sees.

MVP will retain all verification information for Credentialing and Recredentialing purposes, pursuant to state and federal data requirements. Credentialing and Recredentialing applications will only be reviewed upon the receipt of a Complete Credentialing/Recredentialing Application. A Complete Application for Credentialing shall include: a complete and accurate CAQH application that has been attested/re-attested to within the last 90 days, and supporting documentation including, but not limited to, malpractice insurance certificate with limits of at least $1 million per incident and $3 million annual aggregate for New York and Vermont providers, continuity of care arrangements that meet MVP criteria for specialty, explanation of any affirmative responses to disclosure questions including malpractice suits, an explanation of any work gaps of over six months, a sufficient re-entry plan for all gaps in employment over one year, MVP's receipt of all verification from third party sources, including but not limited to an active state license and DEA in the state of practice if applicable, and confirmation of completion or pending completion of appropriate education/training related to the requested specialty, and information sufficiently detailed to render an opinion regarding any affirmative responses to disclosure questions.

Who We Credential and Recredential

Consistent with NCQA guidelines MVP shall credential and recredential Participating Providers every thirty-six (36) months, or three (3) years.

Practitioner Types

MVP contracts with and credentials the following practitioner types:

- Providers (MDs and DOs)- including Neonatologists
- Naturopaths (ND) (Vermont only)
- Podiatrists
- Chiropractors
- Oral Surgeons (providing services under the medical benefit)

- Orthodontists (providing services under medical benefit)

Ancillary and Mid-Level practitioners, including, but not limited to:

- Acupuncturists
- Advanced Practice Registered Nurse (APRN) in Vermont who meets requirements for independent practice.
- Audiologists
- Certified Diabetes Care and Education Specialists
- Certified Midwives (New York)
- Certified Nurse Midwives
- Certified Professional (Lay) Midwives (Vermont)
- Dieticians/ Nutritionists
- Doulas
- Massage Therapists
- NPs in a Provider practice with a PCP specialty who wish to practice as a primary care provider (PCP) who meet requirements for independent practice in primary care areas approved by New York State Public Health Law
- Nurse Practitioners (NP) who meet requirements for independent practice in specialty areas approved by New York State Public Health Law
- Occupational Therapists
- Physical Therapists
- Physical Therapy Assistants
- Physician Assistants (practicing in Primary Care specialties (Internal Medicine, Family Practice, Pediatrics, General Practice, Geriatrics (Medicare plans only), or OB/GYN.
- Speech/Language Pathologists
- Athletic Trainers (VT)
- Dentistry
- Optometrists
- Registered Nurse First Assistants (NY Only-excludes Medicare line of business) working in an outpatient setting.

Behavioral Health practitioners as outlined below:

In New York

- Licensed Alcohol and Drug Counselors (LADC)
- Licensed Applied and Assistant Behavior Analysts (LBA)
- Licensed Clinical Social Workers (LCSW)
- Licensed Creative Arts Therapists (LCAT)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Mental Health Counselors (LMHC)
- Licensed Psychologists (PsyD, PhD, or EdD)
- Licensed Psychoanalysts
- Independent Nurse Practitioners (NP)–provided all other MVP credentialing criteria are satisfied.
- Independent Psychiatric Nurse Practitioners

NYS Behavioral Health Participating Providers in the Medicaid line of business must certify that they will not seek reimbursement from MVP for Conversion Therapy as defined by the Medicaid Model Contract.

In Vermont

- Licensed Clinical Mental Health Counselors (LCMHC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Social Workers (LICSW)
- Master's-Prepared Psychologists (MA, MS, or MACP)
- Licensed Alcohol and Drug Counselors (LADC)
- Licensed Psychologists (PsyD, PhD, or EdD)
- Applied Behavior Analysts (PhD, MA, MS)
- Assistant Behavioral Analysts (BA, BS)
- Independent Advanced Practice Registered Nurse (APRN) – provided all other MVP credentialing criteria are satisfied.
- Independent Psychiatric Advanced Practice Registered Nurses

A note regarding Registered Behavioral Technicians: MVP's Medical Policy for Applied Behavior Analysis (ABA) for autism spectrum disorder draws from tenets established in the Behavioral Analysts Certification Board (BACB)'s Practice Guidelines for Healthcare Funders and Managers.
The ABA Practice Guidelines[1] establish standards that are considered "best practices" for ABA services and advise that Registered Behavior Technicians (RBTs) receive specific, formal training before providing treatment.

[1] See ASD Guidelines - Council of Autism Service Providers

While MVP does not currently credential or register RBTs, Participating Providers are expected to adhere to these best practices.

CAQH Application Process

MVP uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource application for Credentialing and Recredentialing activities for all MVP Participating Providers.

This CAQH Universal Credentialing DataSource is a free online service that allows practitioners to complete initial credentialing and recredentialing applications for multiple health payors. Once the application is complete, practitioners only need to update their information that has changed or expired and attest to the accuracy of the data every 120 days (4 months).

To register with CAQH or learn more about the Universal Credentialing DataSource, visit **proview.caqh.org** and select the **Register Here** link.

Registered Practitioners

MVP is not required to credential all practitioner types per state and federal regulations and/or accreditation standards. However, some providers are subject to MVP's Registration Process. Providers who are registered are not shown in MVP's directory. Certain Mid-Level practitioner types, such as non-independent Nurse Practitioners (NP) or Advanced Practice Registered Nurses (APRNs) (including psychiatric NP/APRN), Certified Midwives (CM, CNM, CPM) who do not wish to be listed in the MVP Provider directories, Physician Assistants (PA) in a non-primary care setting, Certified Registered Nurse Anesthetist (CRNA), and Registered Nurse First Assistant (RNFA) may be registered in lieu of credentialing. Variations may exist regarding Mid-Level Registration, depending on individual state laws and/or IPA bylaws as below.

NYS/VT

The following hospital-based inpatient practitioner types must be Registered:

- Hospitalists* (examples: Internal Medicine, Pediatric, Family Medicine)
- Emergency Department Physicians*
- Pathologists
- Anesthesiologists*
- Intensivists*
- Certified Registered Nurse Anesthetists
- Non-independent Nurse Practitioners (including psychiatric NP)
- Registered Nurse First Assistants

- Physician Assistants who do not meet MVP criteria for Credentialing
- Licensed Master Social Workers (LMSW)

***Exceptions:** Anesthesiologists who want to be designated as Pain Medicine specialist; Intensivists who will provide services outside of the ICU; and Hospitalists who provide outpatient services must be credentialed. Emergency Physicians who also provide services in an urgent care center, or any other outpatient setting, must be Credentialed. Neonatologists must be credentialed. Exceptions may vary based on contractual requirements. The Provider Application Request form may be found in the provider section of the MVP website at MVP Provider Registration Application Request.

For more information, see the *MVP Provider Responsibilities* section.

Locum Tenens

Locum tenens providers are required to be provisionally credentialed if they work less than 60 calendar days and full credentialing is required for locum tenens working 60 calendar days or more. Please refer to Payment Policies for information referring to the locum tenens payment policy.

Virtual Practice Credentialing

Some health care providers can provide medical services solely via Telehealth. Such providers must be fully Credentialed/Recredentialed by MVP as a Virtual Practice. MVP will review each Virtual Practice, including their model of care, and reserves the right to credential virtual practice specialty groups.

Emergency Response Credentialing

During a declared State of Emergency (SOE) or Public Health Emergency (PHE), to ensure adequate access to Members, MVP may expedite the credentialing of health care providers as set forth by State/Federal authorities or NCQA. Such expedited Emergency Response Credentialing may include Provisional Credentialing or providers with temporary licensing due to such SOE/PHE or other such licensing as directed by the State/Federal authorities or NCQA.

Emergency Response providers, those designated by State/Federal authorities or NCQA as a team of practitioners deemed appropriate to provide care to MVP Members in a specific state or locality— shall not be required to be credentialed prior to providing services to MVP Members unless required by State/Federal authorities or NCQA. Emergency Response providers will be advised to follow the established MVP Locum Tenens policy (*see* Locum Tenens).

Excluded and Precluded Individuals if Medicare or Medicaid has sanctioned a Participating Provider, MVP may in its sole discretion suspend or terminate such Participating Provider

from the applicable lines of business. If Medicare or Medicaid has excluded or precluded the Participating Provider, MVP will administratively deny or terminate the Participating Provider from MVP's Medicare/Medicaid Network, as applicable. Participating Provider appeal rights may apply. Providers that are sanctioned by the NYS DOH's Medicaid Program will be excluded from participating in MVP's Medicaid products.

Medicare Opt Out

Medicare Opt Out status will be verified to ensure that a practitioner has not opted out of the Medicare program. If the practitioner has opted out of the Medicare program, they will not be allowed to participate in the MVP Medicare Advantage and Dual Special Needs Program lines of business.

New York State Medicaid Program Enrollment

Participating Providers who bill for services for Medicaid Members must be enrolled in the New York State Medicaid Management Information System (MMIS) with the exception of Licensed Master Social Workers, Certified Registered Nurse Anesthetists, and Registered Dietitians unless they are also Certified Diabetes Educators. Additional information regarding enrollment in the New York State Medicaid Program is available at eMedNY Homepage. Please note that Certified Diabetes Care and Education Specialists must be under the supervision of a Provider in a practice setting to be eligible for enrollment in MMIS. Licensed Creative Arts Therapists are excluded from being able to bill Medicaid and Medicaid Managed Care for services. Licensed Mental Health Counselors and Licensed Marriage and Family Therapists are required to obtain an MMIS to be eligible for MVP Medicaid, CHP, and HARP programs.

Criteria for Admission and Continued Participation

To participate with MVP, the following are required:

1. The appropriate education for the requested specialty, state licensure in the relevant practice area and completion of one of the following residency programs: Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC), as applicable to the profession. Physicians who were trained outside of the U.S. and Canada, or whose training was not accredited by one of the entities, will be subject to additional review. MVP recognizes abdominal transplant fellowships accredited by the American Society of Transplant Surgeons/Transplant Accreditation and Certification Council (TACC).
2. Specialty listings will also be granted based on completion of one of the following recognized fellowship programs: ACGME, AOA, RCFPC, RCPSC, or TACC, as applicable to the profession.

3. Board certification is not required of applicants unless it is a prerequisite for state licensure/certification. However, applicants claiming board certification must be certified in accordance with the definition of their specialty board. MVP recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC) and the Royal College of Physicians and Surgeons (RCPSC) boards for physicians and other appropriate boards for Certified Nurse Midwives, Certified Midwives, Certified Professional (Lay) Midwives, Certified Diabetes Care and Education Specialists, Registered Dietitians/Nutritionists, Podiatrists, Nurse Practitioners, Registered Nurse First Assistants, Oral Surgeons, Physician Assistants, and Behavioral Analysts.
4. A valid license to practice medicine in the state where MVP Members are seen.
5. A valid Drug Enforcement Agency (DEA) Certificate or Controlled Dangerous Substances (CDS) Certificate is required for physicians (MD, DO), Naturopaths (ND) who prescribe controlled substances, Podiatrists (DPM), Oral Surgeons, Nurse Practitioners (NP-NY only), Independent Advanced Practice Registered Nurses (APRN), and Certified Midwife (CM, CNM) applicants for all states in which they treat MVP Members (note: CPM in VT may not prescribe medications). Naturopaths (ND) who do not prescribe medications must submit a description of their scope of practice to be considered as an exception to this requirement.
6. Any Participating Provider whose specialty scope of practice includes prescribing medications must have the ability to write prescriptions, including controlled substances, as applicable to their specialty and scope of practice. Practitioners with prescription limitations may be denied participation in MVP's Network. Participating Providers with a suspended, revoked, or restricted DEA Certificate or who have prescribing restrictions placed on their ability to provide a full scope of care to MVP Members, may be suspended or removed from the Network and will not be considered for Recredentialing until such limitation has been removed.
7. Provide a minimum of five years' work history. The practitioner must clarify employment gaps of six months or longer. Any gaps in work history of greater than one (1) year must be fully documented in writing on the CV, the CAQH application, MVP Re-Entry Plan form, or via email and signed by the applicant. A sufficient Re-Entry Plan must include provisions for chart review, practice observation, mentorship, and for physicians only, thirty (30) hours of Continuing Medical Education (CME) per year of non-practice.
8. A complete history of professional liability claims, including claims that resulted in settlements or judgment paid by, or on behalf of, the practitioner.
    - Proof of current malpractice insurance coverage with minimum coverage amounts of $1 million per incident and $3 million annual aggregate for New York and Vermont, and the absence of excessive malpractice claims for the area and type of practice as determined by the MVP Credentialing Committee.
9. A Completed CAQH application containing a signed attestation statement and release that includes:
    - A history of loss of license and/or felony convictions

- History of loss or limitation of privileges or disciplinary activity
- Reasons for any inability to perform the essential functions of the position, and that could impact on the ability to deliver adequate care to MVP Members, with or without accommodation.
- Certification that physician/practitioner is free of any physical or mental conditions that could impact his/her ability to deliver adequate care to MVP Members
- Certification of a lack of present illegal drug use
- Current malpractice insurance coverage
- The correctness and completeness of the application

10. Reasonable office hours to maintain adequate access to care. PCPs for MVP Medicaid Members must maintain a minimum of 16 hours per week at one location.
11. MDs/DOs, Oral Surgeons, DPMs, NPs, and Certified Midwives (CM, CNM) must maintain clinical privileges in good standing, as appropriate to their specialty, on the medical staff of an MVP participating hospital designated by the practitioners as their primary admitting facility or demonstrate proof of coverage for admissions and/ or inpatient coverage as outlined in MVP criteria.
12. Oral Surgeons must possess a valid and current anesthesia certificate and proof of current Advanced Cardiac Life Support (ACLS) certification.
13. Dentists who provide conscious sedation, deep sedation, or general anesthesia outside of a hospital setting must provide a copy of the appropriate certificate(s) issued by the state for the level of sedation and age of the patients being treated.
14. Comply with MVP medical record, accessibility, and office standards.

If the Participating Provider is in an area where MVP contracts with an Independent Practice Association, then participation with MVP may be contingent upon (1) the contractual relationship between MVP and the IPA; (2) the provider's admission into the IPA; and (3) the specific criteria for admission such IPA.

The criteria as outlined in the section above may change periodically. Contact your Professional Relations representative for the most current criteria.

Notification Time Frames for New Applicants

MVP will comply with the state regulatory notification time frames in processing applications for participation as specified by the state in which the practitioner is located.

New York State

- MVP shall complete review of the health care professional's application to participate in MVP's network and shall, within 60 days of receiving a Completed

Application and all required documentation to participate in the MVP's network, notify the health care professional as to whether:

- Credentialing approval or denial; or
- Additional documentation is required. MVP may require additional time to decide due to the failure of a third party to provide necessary documentation ("incomplete file"). MVP shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the Completed Credentialing/Recredentialing Application.

Note: For applicants that are (1) newly licensed health care professionals or (2) a health care professional who has recently relocated to New York from another state and has not previously practiced in New York, and who are joining a participating group in which all members of the group currently participate with MVP, (3) New York State Providers who are employed by MVP Network licensed general hospital, licensed diagnostic and treatment center or Mental Health Law licensed facility whose other employed Providers are Participating Providers in the MVP Network or, (4) newly trained Medicare practitioners that are contracting with MVP in the Medicare line of business and have completed all appropriate training and education within the last twelve months, the applicant shall be eligible for provisional Credentialing as of the 61st day of the application if:

- The applicant has submitted a Complete Application and any requested supporting documentation; and
- The applicant provided written notification to the MVP Leader, Credentialing, including a statement that in the event the applicant is denied, the applicant or the applicant's group practice:
    - Shall refund any payments made for in-network services provided during the period of provisional Credentialing that exceeds the Member's out-of-network benefits; and
    - Shall not pursue reimbursement from the Member, except to collect the co-payment or co-insurance that otherwise would have been payable had the Member received services from a Participating Provider

Vermont

- MVP shall notify a practitioner applicant concerning an incomplete Credentialing Application no later than 30 business days after MVP receives the Completed File.
- MVP shall notify a practitioner concerning the status of the practitioner's Completed Credentialing Application no later than:
    - 60 days after the MVP receives the Completed File
    - Every 30 days after the notice is provided until the MVP makes a final Credentialing determination concerning the practitioner

Delegated Credentialing

MVP may, in its sole discretion delegate its Credentialing to a third-party delegate to act on its behalf in matters of approval, termination, and appeal. MVP shall remain accountable for the overall Credentialing delegation oversight and retains the right to approve, suspend, or terminate individual Participating Providers.

Directory Listing

Prior to being listed in MVP's Directories and/or marketing or Member materials, the following must be in place:

- An executed Participation Services Agreement with MVP or with an affiliated IPA/PO/PHO
- A completed Credentialing Application reviewed and approved by the MVP Credentialing Committee

Provider applicants who are not ABMS, AOA, RCFPC, or RCPSC board-certified or have not completed an accredited training program recognized by MVP requesting specialty listings must supply additional information in support of such request for a specialty listing.

MVP only lists the ABMS/AOA specialties and the ABMS/AOA sub-certificates of the specialties in Provider specialty listings. MVP also recognizes transplant surgery as a sub-specialty for Providers trained at a TACC-accredited fellowship. MVP may recognize other specialties if mandated to do so by state and/or federal regulations.

Confidentiality of Practitioner Information

MVP complies with all applicable state and federal laws regarding the confidentiality of practitioner data and information. Steps taken to safeguard practitioner information include, but are not limited to, maintenance of files in locked cabinets, password-protected databases, limiting access to appropriate personnel, and confidentiality/ conflict of interest statements signed by MVP personnel and Credentials Committee members annually. MVP has policies and procedures surrounding how Credentialing information is stored, modified, secured and how oversight of these elements is conducted in compliance with NCQA requirements.

General Practitioner Rights

Right of Practitioners to Be Informed of Application Status

Applicants have the right to be informed of the status of their credentialing or recredentialing application. MVP, upon direct verbal or written request from the applicant, will notify the applicant of their application status.

Right of Practitioners to Review Information

Applicants have the right to review the information obtained from any outside primary source that is presented to the Credentials Committee in support of their credentialing and/or recredentialing application. Upon written request, MVP will make its Credentialing and recredentialing criteria available to all applicants. Release of information obtained from a third party will be subject to the consent of the third party. Recommendations, letters of reference, and other peer review protected information are not subject to this disclosure. MVP also acknowledges that information obtained from the National Practitioner Data Bank or other outside entities that is not allowed to be released will not be released to the practitioner.

Right to Correct Erroneous Information Submitted by Another Party

MVP will notify the applicant of any information obtained during the credentialing and/or recredentialing process that varies substantially from the information given to MVP by the practitioner. The applicant will have seven (7) calendar days from notification to clarify and/or correct such discrepancies.

Change in Information

MVP requires applicants and Participating Providers to immediately notify MVP in writing of any change in information relative to their application. This information includes, but is not limited to, demographic changes to their practice, malpractice coverage, new malpractice actions, or updated information on previously pending actions, as well as any adverse actions taken by state or federal agencies, hospitals, or other health plans.

Non-compliance with Recredentialing

Failure to meet Recredentialing criteria or non-compliance with the Recredentialing process will result in termination of participation in MVP's Network. Non-compliance with the Recredentialing process includes, but it's not limited not responding to or returning requests for the Recredentialing application (a CAQH application that has been re-attested to within the past 90 days and to which MVP has been authorized access) and all supplemental information within 14 calendar days from the date of request.

Compliance with MVP Protocols

MVP monitors Participating Provider compliance with MVP Protocols. Non-compliance is identified as failure to follow MVP Protocols including but not limited to, prior authorization, unauthorized out of plan referrals, balance billing of Members, failure to respond to MVP's requests for current information, and general lack of cooperation with MVP staff.

Performance Monitoring

To ensure Participating Providers continue to meet MVP guidelines, MVP tracks performance through three-year (thirty-six month) Recredentialing cycles. Information

related to Participating Provider's performance is collected by the QI and includes site visit scores, QI investigations, Member complaints, and issues related to non-compliance with MVP Protocols, as well as various quality metrics as determined by the QI Department. Data is reported to the Credentials Committee at the time a Participating Provider is Recredentialed, and such data is used by the Committee in its decision-making process. In some cases, the QI Department will perform immediate intervention, including, but not limited to, a request for a Corrective Action Plan or early review by the Credentials Committee. As an example, any two complaints regarding record keeping practices or office conditions will trigger a site assessment, regardless of specialty.

Participating Providers receiving five or more complaints of any type, and from any source, within a three-year period will be subject to review by the Credentials Committee. In addition to the data gathered for the review of Participating Provider, the data collected by the QI Department is presented to the Credential Committee in a semi- annual aggregate report. Further details regarding the quality metrics used in performance monitoring quality can be found in the MVP Quality Improvement section.

Ongoing Monitoring

Ongoing monitoring is the monitoring of Participating Providers between Recredentialing cycles and the assessment of adverse events such as readmissions, unexpected death, accessibility issues, and complications of therapy pertaining to performance. This activity includes, but is not limited to, the monitoring of state license sanctions, Medicare and/or Medicaid sanctions, Medicare opt out reports, Medicare precluded practitioners, adverse events, a determination of fraud, and/or other criminal charges/convictions.

MVP Credentialing Committee—Processes and Procedures

The MVP Credentialing Committee reports to the MVP Quality Improvement Committee. It reviews Credentialing and Recredentialing applications for participation in the Network, and it may consider recommendations from any applicable IPA Credentials/membership committees.

Notification of Credentialing Committee Decision

Credentialing Approval-Upon approval of the Participating Provider MVP shall:

- Notify the applicant of the approval decision, within 30 calendar days of the approval date through a "Welcome Letter";
- Add the Participating Provider's name to the MVP Directory at the next publishing date, as appropriate;
- Provide Participating Provider and office staff orientation to MVP procedures, as appropriate.

Recredentialing Approval. Upon Participating Provider's Recredentialing approval, Participating Provider shall continue to be listed in the Provider Directory, if appropriate.

Credentialing Denial. Upon denial of a new Credentialing applicant MVP shall:

- Notify the applicant and/or any affiliated IPA in writing within 30 calendar days of the denial decision by the MVP Chief Medical Officer or his/her designee;
- If the applicant is licensed and practicing in Vermont, the Provider/practitioner will have appeal rights as outlined in Vermont Rule 10.203(F)(9) and 10.203(I);
- If the Provider applicant applied for participation with a Medicare product, the Provider will be permitted to request a review of the decision by presenting information and views on the decision.

Recredentialing Denial. Upon termination of a Participating Provider, MVP shall:

- Notify the Participating Provider and/or any affiliated IPA in writing of the termination decision by the MVP Chief Medical Officer or his/her designee;
- Advise Participating Provider of any applicable right to a hearing or review.

Termination Process for Participation with MVP

If the MVP Credentials Committee proposes to suspend or terminate a Participating Provider such Participating Provider will be notified in writing of the decision. Such notice will state:

- The nature of the basis for the Committee's decision. For Medicare Advantage Participating Providers, the reason shall include, if relevant, the standards and data used to evaluate the Participating Provider and the numbers and mix of practitioners needed for the MVP Network.
- The Participating Provider's right to request a hearing or review of the decision before a hearing panel appointed by MVP.
- A time limit of 30 calendar days to request a hearing or review and a description of the way a request may be properly made to MVP.

Upon receipt of the notice of proposed termination, the Participating Provider has 30 calendar days to request a hearing before the hearing panel. Failure to request a hearing or review within 30 calendar days shall result in termination of a Participating Provider's participation or contract with MVP. If a hearing is requested during the 30-day notice period, MVP will notify the Participating Provider of the scheduled hearing date. The hearing must be held within 30 calendar days of receipt of the request. The 30-day time limit may be extended by agreement of MVP and the Participating Provider.

If such an extension is agreed to, Participating Provider shall sign a waiver evidencing his or her consent to such extension. The hearing panel shall be composed of at least three persons appointed by MVP, the majority of whom shall be clinical peers in the same discipline and the same or similar specialty as the Participating Provider under review. The hearing panel will render a decision, and a copy of such decision will be memorialized in writing and mailed to the Participating Provider in a timely manner. Decisions will include one of the following: reinstatement, provisional reinstatement with conditions set forth by

MVP, or termination. The effective date of the termination shall be not less than 30 days after Participating Provider's receipt of the hearing panel's decision. In no event shall termination be effective earlier than 60 days from the Participating Provider's receipt of the notice of termination.

Summary Suspension/Termination of Participation

MVP may Summarily Terminate or Summarily Suspend a Participating Provider's participation in the Network immediately for the reasons defined below.

Summary Suspension:

- Cases involving actions or accusations that may represent imminent harm to patient care.
- A charge of fraud by a competent state of federal legal authority.
- Cases where the actions raise the potential for financial or administrative damage to MVP.
- A preliminary disciplinary action or pending investigation by the New York State Office of Professional Medical Conduct, other state licensing board, or other governmental agency that might impair the Participating Provider's ability to practice.
- Physical or behavioral impairment that may impede or limit the Participating Provider's ability to provide appropriate medical care.

Summary Termination:

- Cases involving actual or imminent harm to patient care.
- Cases involving a determination of fraud by a competent state or federal legal authority.
- A determination of fraud by the MVP Special Investigation Unit
- A final disciplinary action that has been take against the Participating Provider by a state licensing board or other governmental agency that impairs the Participating Provider's ability to practice.
- Participating Provider's license in the state where they see MVP Members is expired or showing as not registered.

A Participating Provider does not have the right to appeal a summary suspension/summary termination. Summary Suspension/Summary Termination of a Participating Provider's participation in the Network shall be effective immediately upon notice to the Participating Provider. Participating Provider's contracted for the Medicare Advantage Plan network have the right to appeal a Summary Suspension or Summary Termination.
The requirement to hold the hearing within thirty (30) days of the Participating Provider's request does not apply in the case of a Summary Suspension.

Vermont Participating Providers are entitled to request a review of a decision to reduce, suspend, or terminate privileges.

A Participating Provider's suspension may not exceed thirteen (13) months. When the Participating Provider reaches a twelve (12) month period of suspension, they will be notified of the pending termination upon reaching a thirteen (13) month period of suspension and will be offered the right to appeal the termination.

Reasons MVP May Not Terminate

MVP may not terminate a contract or Participating Provider solely because the Participating Provider has:

- Advocated on behalf of an enrollee;
- Filed a complaint against MVP;
- Appealed any MVP decision;
- Provided information or files a report pursuant to Section 4406-c of the Public Health Law of the State of New York;
- Requested a hearing or review pursuant to Section 4406-d of the Public Health Law of the State of New York;
- Discussed treatment options with Members;
- Reported, in good faith, to state or federal authorities any act or practice by MVP that jeopardizes patient health or welfare.

Reporting Requirements

MVP shall report to state professional disciplinary agencies and/or the federal National Practitioner Data Bank (NPDB) as per applicable state and/or federal laws.

Review Process for Medicare Advantage Providers

Providers denied participation who have applied for participation with a Medicare product are permitted to present information and their views on the decision. The Provider must request the review within 30 days of receipt of the denial notification letter.

Reapplication for Participation

- Practitioners who are denied participation must wait one year before they may reapply.
- Participating Provider whose participation is involuntarily terminated (except for non-compliance with recredentialing) must wait a minimum of three years or as required

by regulatory bodies. If terminated due to a license action, the action must be fully resolved before reapplication will be allowed.

- Participating Provider who voluntarily resign their participation due to an unwillingness to meet criteria or due to contractual issues will be required to wait one year before they will be allowed to reapply.
- Participating Provider who were suspended and/or terminated due to pending criminal charges that were resolved in the Participating Provider's favor (charges that were dismissed/dropped, or the Participating Provider was acquitted of all charges) will not be subject to a waiting period for reapplication.

Practitioner Leave of Absence

Participating Provider shall notify MVP prior to taking a leave of absence (LOA) that will last more than 90 days. The following guidelines apply to Participating Provider taking a LOA longer than 90 days:

- LOA may be contingent upon MVP or IPA approval, if applicable.
- Participating Provider must complete the MVP Leave of Absence form and return it to their Provider Relations Representative at least 30 days prior to the start of their leave except in urgent or emergent circumstances. The Leave of Absence form can be found on the Forms page on mvphealthcare.com under the Provider Forms Library, Provider Demographic Change forms (all regions).
- The covering practitioner must be a Participating Provider.
- The specialty of the covering practitioner must fall within the MVP accepted covering rules.
- The Participating Provider's membership will be voluntarily suspended at the beginning of the leave.
- Participating Provider returning from a LOA of less than 13 months will be reinstated as a Participating Provider if there has been no change to their specialty, spectrum of services provided, physical or mental health, nor any other substantive change in the Participating Provider's ability to provide care to MVP Members.
- Participating Provider must provide proof of current malpractice coverage which meets minimum limits of $1 million per incident and $3 million annual aggregate (or appropriate coverage as determined by MVP Credentialing criteria, state requirement, or contract), prior to reinstatement.
- Participating Provider' LOA may not extend beyond 13 months. Practitioners returning from a LOA of more than 13 months must reapply for participation via the Credentialing process.
- An "indefinite" LOA shall be regarded as an LOA exceeding 13 months.

- When an LOA extends beyond 13 months, the Participating Provider will be notified of pending termination and will be offered appropriate appeal rights as per state and federal regulations.

Facility/Organizational Provider Credentialing Guidelines

To be compliant with NCQA credentialing guidelines and MVP policy, MVP Credentials and Recredentials participating organizational providers every thirty-six months, or three years. MVP Credentials the following organizational Participating Provider:

- Adult Day Care programs
- Ambulatory mental health and alcohol/substance use disorder treatment facilities
- Bariatric surgery centers*
- Clinical laboratories
- Birthing Centers
- Federally Qualified Health Centers (FQHC)
- Free-standing ambulatory surgery centers (ASC)
- Free-standing laboratories
- Free-standing dialysis centers
- Free-standing Midwifery Birth Center (NY Only)
- Free-standing radiology centers
- Free-standing rehabilitation centers (mental rehab and physical rehab only)
- HIV/AIDS Day Care programs
- Home health/infusion agencies/home health agencies providing Personal Care Assistant Services
- Hospice
- Hospitals
- Hyperbaric Medicine Treatment Centers
- Inpatient Mental Health Facilities
- Long-term care facilities
- National Diabetes Prevention Programs
- Portable/Mobile X-ray Suppliers
- Residential alcohol/substance use disorder treatment facilities
- Skilled nursing facilities (SNF)
- Transplant programs*
- Urgent Care Centers (UCC)

- Ventricular Assisted Device Facilities (LVAD)*

  * Indicates Center of Excellence Program

Criteria for Facility/Organizational Provider Participation with MVP

To participate with MVP the Facility/Organization Provider must mee the following requirements:

- **Operating Certificates/Licensure/Certification:** A current and active operating certificate or licensure in the state where MVP Members are serviced is required, where applicable.
- **Participation in Medicare (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act):** If contracted for services to Medicare and/or Medicaid Members, documentation of participation in those programs is required, where applicable.
- **General Liability and Professional Malpractice Insurance:** Proof of general liability and professional malpractice insurance coverage acceptable to MVP is required with minimum coverage amounts of $1 Million Dollars per incident and $3 Million Dollars annual aggregate for most providers (including facilities). Urgent Care Centers coverage amounts are considered acceptable with $1 Million Dollars per incident and $2 Million Dollars annual aggregate per current MVP Credentialing Criteria.
- **Malpractice History:** MVP will obtain written confirmation from the applicant for the past 10 years of malpractice settlements (three years at time of recredentialing). Applicants with any history of malpractice cases are required to fully document, in writing, the case specifics. As per New York State Public Health Law, hospitals are not required to disclose information regarding malpractice claims.
- **Application and Attestation:** A completed MVP application (excluding CAQH application) containing a signed attestation statement is required for initial Credentialing and at Recredentialing.

Accreditation

Organizational providers must provide proof that they have been reviewed and are accredited by one of the following:

Entity	Abbreviation	Facility Type
Accreditation Commission for Health Care	ACHC	ASC/CAH/ESRD (dialysis) Facility/Hospital/Home Health Agency/Home Infusion Therapy (if home care agency accreditation includes private duty nurse module)/Hospice

Designation as a Comprehensive Bariatric Surgery Center by the American College of Surgeons and the American Society for Metabolic and Bariatric Surgeons Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program	MBSAQIP	Bariatric Surgery Centers
Foundation for the Accreditation of Cellular Therapy for bone marrow transplants	FACT	Bone Marrow Transplants
Commission on the Accreditation of Rehabilitation Facilities	CARF	Day Treatment Health Centers (Adult and HIV/AIDS)/Mental Health/Substance Use Disorder Facilities/Rehabilitation Facilities
National Dialysis Accreditation Commission	NDAC	ESRD (dialysis) treatment centers
Accreditation Association of Ambulatory Health Care	AAAHC	Free Standing Ambulatory Surgery Centers/Mental Health/Substance Use Disorder Facilities
QuadA (American Association for Accreditation of Ambulatory Surgery Facilities)	QuadA (AAAASF)	Free Standing Ambulatory Surgery Centers/Rural Health Clinics/Outpatient Rehabilitation
RadSite		Free Standing Radiology Centers
American College of Radiologists	ACR	Free Standing Radiology Centers, Mobile Radiology Units
Intersocietal Accreditation Commission	IAC	Free Standing Radiology Centers, Mobile Radiology Units
Community Health Accreditation Program	CHAP	Home Health Care and Hospice/Mental Health/Substance User Disorder Facilities
Center for Improvement in Healthcare Quality	CIHQ	Hospital
Healthcare Facilities Accreditation Program	HFAP	Hospitals/FQHCs/SBHC/Mental Health/Substance Use Disorder Facilities
The Joint Commission	TJC	Hospitals/SNFs/Home Health/FQHCs/SBHCs, ASCs, Urgent Care Centers, Ventricular Assisted Devices
Det Norske Veritas Health Care Inc.	DNV	Hospitals/SNFs/Mental Health/Substance Use Disorder Facilities

Undersea and Hyperbaric Medical Society	UHMS	Hyperbaric Treatment Facilities
Clinical Laboratory Certification Amendment certification	CLIA	Laboratories
Council on Accreditation	COA	Private and public mental health and community based social service agencies
The Compliance Team	TCT	Rural Health Clinics
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Urgent Care Association of America	UCAOA	Urgent Care Centers

Non-accredited organizational providers will be considered for participation based on Network need as defined by MVP. Non-accredited organizational providers must supply MVP with a copy of their CMS or state review, Credentialing Process, Quality Improvement (QI) Plan, and meet any additional requirements. The organizational provider must demonstrate satisfactory completion of an on-site quality assessment using MVP-developed assessment criteria.

Site Visit

The organizational provider must meet MVP's facility site standards. The facility reviews focus on patient safety, access and availability, confidentiality, emergency services, Credentialing processes, and quality-improvement processes. The corresponding medical record review is tailored to address the specific needs of each of these facility types. For a copy of the criteria for any of these facilities, contact the Provider Data Services team at **credentialing@mvphealthcare.com**.

A CMS or state review may be substituted for an MVP-conducted site review. If MVP is using a state review in lieu of an MVP-conducted site visit, MVP must verify that the review was completed within the time limits and meets MVP's site visit standards. In this instance, organizational provider applicants must provide a copy of the CMS or state review report performed within the previous 36 months and a copy of the organization's QI Plan and Credentialing Process. MVP is not required to conduct a site visit if the state or CMS has not conducted a site review of critical access hospitals and the hospital is in a rural area, as defined by the U.S. Census Bureau.

Access Standards

The facility must meet MVP Access Standards for appointment availability, as applicable. (See QI policies and procedures on Access Standards).

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to New York State Medicaid Recipients

Home health agencies that provide Personal Care Assistant services are required to attest that the agency has policies, procedures, programs, and protocols to demonstrate compliance with NYS Medicaid Standards for the following:

- The level of personal care services provided and title of those providing services.
- The criteria for selection of persons providing personal care services.
- Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402).
- That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions.
- The agency assigns appropriate staff to provide personal care services to a Member according to MVP's authorization for the level, amount, frequency, and duration of services to be provided.
- There is administrative and nursing supervision of all persons providing personal care services.
- The agency's administrative supervision assures that personal care services are provided according to the MVP's authorization for the level, amount, frequency, and duration of services to be provided.
- The administrative supervision includes the following activities:
    - Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency, and duration.
    - Notifying MVP when the agency providing services accepts or rejects a Member.
    - When accepted, the arrangements made for providing personal care services, and when rejected, the reason for such rejection.
- The agency promptly notifies the MVP when the agency is unable to maintain case coverage.
- The agency provides nursing supervision to assure Member's needs are being met.

Exemptions for NYS-Approved Children's Managed Care Transition Program and Health Home Program

Effective October 1, 2019, when contracting with organizations or facilities approved by the New York State Department of Health for services provided to medically fragile children and Health Home program recipients, MVP shall not perform separate Credentialing of Behavioral Health or other health care practitioners employed by organization or designated as an approved provider by the Department of Health.

Exemptions for NYS-Licensed 29-I Voluntary Foster Care Agencies

Effective July 1, 2021, when credentialing a licensed 29-I Health Facility, MVP shall accept DOH designation, licensure, or operating certificates in place of, and not in addition to,

any credentialing process for individual employees, subcontractors, or agents of such providers.

- 29-I Health Facilities licensed to provide primary care may elect to credential as a PCP with MVP
- The individual designated as the 29-I Health Facility PCP must meet the credentialing standards and requirements of MVP. Credentialing solely as a 29-I Health Facility is not sufficient for an individual to be credentialed as a PCP.
- MVP shall collect and accept integrity related information programs (Fraud, Waste, and Abuse) as part of the licensing and certification process.
- MVP requires that such providers shall not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare and Medicaid programs.

Exemptions to Credentialing Process for HARP HCBS Designated Providers and OMH and OASAS Certified Organizations and Facilities

- When credentialing HARP, HCBC designated providers and NYS licensed Office of Mental Health (OMH) -certified, and NYS Office of Addiction Services and Supports (OASAS)-certified organizations, MVP shall accept OMH and OASAS licenses, operations, and certifications in place of, and not in addition to, any Credentialing process for individual employees, subcontractors, or agents of such organizations.
- MVP shall collect and accept program integrity-related information (Fraud, Waste and Abuse) as part of the licensing and certification process.
- MVP requires that such providers shall not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government or otherwise excluded from participation in the Medicare or Medicaid program. Refer to the Provider Responsibilities section of this document for additional information.
- A New York State mental health facility that participates in the Medicaid lines of business must certify that it will not seek reimbursement from MVP for Conversion Therapy provided to any Member.
- MVP reports to the State of New York OMH and OASAS at least quarterly regarding provider performance deficiencies and corrective actions related to performance issues. In addition, MVP reports any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

MVP Credentialing Committee

The MVP Credentials Committee, which reports to the MVP QI Committee, reviews the credentials of organizational providers for participation in the MVP Network.

Change in Information

MVP requires organizational Credentialing and Recredentialing providers to immediately notify MVP in writing of any change in information relative to their application or any other information that is being verified as part of Credentialing or Recredentialing.

Non-compliance with Recredentialing

Failure to meet Recredentialing or non-compliance with Recredentialing may result in termination of participation. Non-compliance is defined as not responding to or returning requests for the recredentialing application and all supporting documentation.

Compliance with MVP Protocols

MVP monitors Participating Provider compliance with company policies and procedures. Non-compliance is identified as failure to follow MVP Protocols for prior authorization of services, unauthorized out of plan referrals, balance billing of Members, failure to respond to MVP's requests for current information, and general lack of cooperation with MVP.

Notification of Credentialing Committee Decision

Following a complete review of the organizational provider's credentials application, the MVP Credentialing Committee will approve or deny the organizational provider.

- Upon approval of a new organizational provider applicant, MVP will notify the applicant of the approval decision and assign a provider number.
- Upon denial of a new organizational provider applicant, MVP will notify the applicant in writing of the decision.
- Upon termination of a Participating Provider, MVP will notify the Participating Provider in writing of the decision.

Denial or termination of organizational providers will not be subject to appeal.

Summary

Review Date	Revision Summary
August 14, 2026	Removed licensed genetic counselor from the list of provider types that we credential, as this was for NH only and NH is no longer in our service area; Removed hyperlink for ABA Practice Guidelines as it is no longer valid. Added footnote for reference to publication ; Under Registered Practitioners section, added a sentence to clarify that registered providers are not shown in the directory and clarify the capacity in which PAs are currently registered ; NYS Medicaid Program eMedNY link updated; Added PAs to board certifications that we accept;

	Added language to reflect that limitations on DEA may result in denial rather than certainly result in denial (based on cred policy update) ; Corrected a misspelling for CLIA in the Accreditation section.
August 1, 2025	Added new hyperlink in Notification/Prior Authorization Requests to reference where all MVP policies are housed.

Inpatient and Outpatient Services

Overview

MVP and its Participating Facility Providers use industry-standard billing formats, which allow for efficient claims processing and expedited adjudication of cleanly submitted claims. Facility Providers should refer to the rate sheet documents contained in their most current MVP agreement for the methodologies specific to that Facility Provider's reimbursement.

Inpatient Hospital Services

The following represent the most inpatient stay categories for which payment rates may be distinguished:

- Medical/surgical
- ICU/CCU
- Obstetrical delivery
- Obstetrical-related care; non-delivery
- Newborn
- Neonatal intensive care
- Licensed, hospital-based skilled nursing facility
- Tertiary care exclusions
- Skilled nursing level
- Physical rehab
- Sub-acute level
- Psychiatric and Chemical dependency exempt units

Note: Payment rates are "all inclusive," meaning that all services provided during the inpatient stay, including all pre-admission testing, will be paid at one rate. Except as defined in the agreement, MVP does not reimburse hospitals separately for any service provided during the inpatient stay. The hospital may elect to include the Provider component in the inpatient per diem or case rates. The effective date of a hospital's rates is indicated on its rate sheet. Newborn reimbursement includes payment for the New York State-required newborn hearing screening.

Per diem services that overlap contract periods will be paid based on the rate effective on the applicable date of service. Diagnosis Related Group (DRG) and case rates will be paid based on the Member's admission date. MVP considers the Member's inpatient hospital admission date to be the date and time the Provider writes the order to admit the Member to an inpatient level of care. MVP, in conjunction with facilities that have rate agreements, has reimbursement methodologies in place to process and pay different levels of inpatient care, as appropriate, within a hospital stay.

DRG Reimbursement Payment Methodology

DRG reimbursement is a payment methodology that reimburses select hospitals a lump sum payment for the entire admission to the facility. Facility pre-admission testing or outpatient services that are provided three or more days immediately preceding and including the date of admission are included in the inpatient payment. MVP utilizes the NYS Department of Health All Payer Revised DRG reimbursement rules and methodologies in addition to Medicare Severity (MS) DRG methodology reimbursement for MVP Medicare as outlined in the hospital's rate sheet documents. If Members require hospital services during the covered admission which are not available at the hospital, the hospital will be responsible for all costs of covered services provided at other facilities, including transportation to those facilities unless the Member is discharged from the hospital prior to treatment. A hospital must notify MVP of all Member admissions within 24 hours of each admission or the first business day after each admission if the admission takes place on a weekend or MVP-recognized holiday (see Concurrent Review in Utilization Management for more details).

Outpatient Hospital Services

Examples of outpatient service types for which payment rates may be distinguished include:

- Ambulatory surgery/major
- Ambulatory surgery/minor
- Laparoscopic surgery
- Scope procedures
- Angioplasty
- Cardiac catheterization
- Observation stays
- Emergency room
- Electrophysiology studies
- Sleep studies
- Physical, occupational, and speech therapy
- Non-capitated lab services
- Non-capitated radiology services
- MRI/MRA
- PET and PET/CT
- Lithotripsy
- Hyperbaric chamber
- Wound care
- Other special case rates
- Other referred ambulatory services

- Other referred ambulatory services without CPT or HCPCS procedure code

"Per Visit" Outpatient Service Format

All surgeries, scope procedures, cardiac catheterization, lithotripsy, emergency room, observation bed, PT/OT/ ST, sleep study services, and other services are subject to a "per visit" payment methodology. This methodology assumes that the payment rates are all-inclusive, which means all services provided during the outpatient visit are included in one case rate, including preadmission testing. Except as defined in the Agreement, MVP will not reimburse hospitals separately for any service provided during the outpatient visit. The hospital may elect to include the Provider component in the "per visit" rates.

Hospital-Based Ambulatory Surgery

Hospital-based ambulatory surgery services are determined by the principal CPT procedure codes. CPT and HCPCS codes designated as ambulatory surgery are updated annually. The payment rates for hospital-based ambulatory surgical procedures are all-inclusive and include all facility services directly related to the procedure within 24 hours of the surgery.

Reimbursement for hospital-based ambulatory surgical procedures is defined by the Provider contract. If the patient is admitted following the surgery, the hospital's ambulatory surgery services are inclusive to the payment terms of the inpatient service category.

Observation Status

Please refer to MVP Payment Policies, Observation Services for Facilities and Providers.

Emergency Room

Emergency room (ER) services are defined by the applicable revenue codes 0450-0459 (excluding 0456). One of MVP's ER methodologies is a four-level program based upon diagnosis severity of an ER visit. The principal diagnosis submitted on the UB04, or Standard EDI Transaction (ANSI 837) will determine the ER level and thus the payment rate. The MVP ER classification system is updated annually to add new codes and remove deleted codes. If a patient is approved for an inpatient admission, ambulatory surgery, or observation of the ER, services are inclusive to the payment terms of those service categories.

Multiple Surgery Protocol—Vermont only

Refer to *MVP Payment Policies* for information.

Other Referred Ambulatory Procedures

The laboratory, radiology, and other referred ambulatory procedures are defined as referred care not part of a "per visit" service type. MVP will only reimburse these procedures if they are not covered as part of an existing capitation agreement or other

contract. It is important that hospitals follow the guidelines for billing and claims submission relative to the contract that is in place for these services. Under a fee schedule agreement, if a laboratory, radiology, or other referred ambulatory procedure is not covered as part of an existing contract, these procedures are to be reimbursed on a fee-max-based system. The fee-max-based system is based upon the resource-based relative value scale (RBRVS) for Provider payment format. The RBRVS uses the federal system that assigns a relative value unit to CPT or HCPCS procedure codes multiplied by a negotiated "conversion factor" dollar amount.

The RBRVS RVUs that MVP uses as well as the Clinical Lab Fee Schedule are available at National Provider Fee Schedule Relative Value File from Medicare at cms.gov. If Medicare has not published an RVU for a given code, MVP will pay these codes at all other referred ambulatory rates without CPT/HCPCS code at reasonable charges. Please refer to your rate agreement for further details. Under a fee-max-based system, the amount allowed shall not exceed billed charges.

On or about January 1 of each year, MVP will update the MVP Fee Schedule to be consistent with the regionally or nationally adjusted Medicare Fee Schedule, most recently updated during the immediately preceding calendar year. Such updates shall not be retroactive.

Free-Standing Ambulatory Surgical Centers

Services provided at free-standing ambulatory surgical centers are determined by the principal CPT procedure code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes designated as ambulatory surgery are updated annually.

Reimbursement for free-standing ambulatory surgical center procedures is defined by the Provider contract. Unless specifically contracted, reimbursement for professional services and anesthesia are not included.

Urgent Care Centers

Services provided at urgent care centers are determined by the place of service code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes are updated annually.

Reimbursement for urgent care center procedures is defined by the Provider Agreement.

OMH-licensed or OASAS-certified Ambulatory Behavioral Health Services

Notwithstanding anything to the contrary in a Participating Provider's provider services agreement, Participating Providers shall be reimbursed in accordance with the applicable ambulatory patient group ("APG") rate-setting methodology or other government rates established and published by the New York State Office of Mental Health (OMH) or New York State Office of Alcoholism and Substance Abuse Services (OASAS) as required for

certain services, including OMH-licensed or OASAS certified ambulatory behavioral health services and outpatient mental health services at Article 28 hospital-based and free-standing clinics, Article 31 and Article 32 outpatient clinics, and rehabilitation and Opioid Treatment Programs, regardless of billed charges and/or any other rates identified in the Participating Provider's fee schedules. Therefore, any requirement, whether it be in the Participating Provider's provider services agreement or fee schedules, that the Participating Provider be paid the lesser of billed charges or the rates set forth in the Provider services agreement or fee schedules, is not applicable to claims for those certain services which are required to be reimbursed using the APG methodology or other required government rates.

Laboratory Data

Overview

Laboratory data is essential to MVP's HEDIS, risk and clinical operations and analytics. A secure file transfer process will be established to allow for seamless transfer of laboratory data to MVP.

Required Data Requirements

Table 1 contains the requirements for the data elements that must be sent to MVP.

Table 1: Required Data Requirements

Area	Definitions	Comments
Content/File Data Format	List of Data elements E.g., Date of Service, Member ID, LOINC, etc.	See Table 2 below
Naming Convention	Vendor name and date	
File Frequency Requirement	How often/what date file is sent to MVP	Monthly
Transmission Schedule	Date and time the file sent	Suggest 20th of the month at 9 am
Transmission Requirements	Protocol by which the data will be sent	SFTP
Encryption	Encryption to be used	PGP Encryption
Aggregation/Compression	Type of compression to be used	Zip
General File Characteristics	Encoding of the file	All upper case, ASCII Tilde (~) delimited, cr/lf line terminations
Sensitivity	Does this file contain PHI; PII; STI/Substance Abuse data, or other information requiring special handling?	

Required Data Elements

Table 2 indicates the fields that must be submitted in laboratory data feeds transmitted to MVP. MVP wants to receive all laboratory tests conducted on their Members in their monthly submissions.

Table 2: Required Data Elements

Field	Description	File Format
Member ID	11-digit unique identifier	String (11)
Name	(Last Name, First Name MI)	String (<255)
Date of Birth	Date of birth formatted as 'MM/DD/YYYY'	String (10)
Lab ID	Site of Service location	String (<255)

Field	Description	File Format
Ordering Provider	If known, formatted as Last Name, First Name, MI, Credential: e.g., Smith, John, A, MD	String (<255)
DOS	Date of service formatted as 'MM/DD/YYYY'	String (10)
CPT/HCPCS Procedure Code	CPT or HCPCS Procedure Code	String (10)
LOINC	LOINC	String (20)
Result	Test results	String (<255)
Principal Diagnosis Code	If available	String (<255)
Lab Test Panel Code	Two sample values: 52142E, 15981X	String (20)
Lab Test Panel Name	Two sample values: "HETEROPHILE, MONO SCREEN", "CELIAC DISEASE COMP PANEL"	String (<255)
Lab Test Code	Two sample values: 4011, 5620	String (<255)
Lab Test Description	Two sample values: "HETEROPHILE, MONO SCREEN", "TISSUE TRANSGLUTAM AB IGA"	String (<255)
Reference Range Description	Two sample values: Negative, <5	String (20)
Reference Range Low Value	Two sample values: 0000011000000, 0000003800000	String (<255)
Reference Range High Value	Two sample values: 0000011000000, 0000003800000	String (<255)

Revision Summary

Review Date	Summary
August 1, 2025	• Added "Psychiatric and Chemical dependency exempt units" under Inpatient Hospital Services as another common example • Added new hyperlink in Notification/Prior Authorization Requests to reference where all MVP policies are housed.

the MVP internet site Reporting Overpayments (www.mvphealthcare.com/contact-us/reporting-overpayments).

MVP Medicare Advantage Plan

Medicare Advantage Plan Overview

The MVP Medicare Advantage plans are specifically designed for Medicare-eligible individuals. These plans take the place of Original Medicare. To enroll, prospective Members must have Medicare Parts A and B and meet the residency qualification(s) specific to the product. Medicare Advantage plans provide more benefits in addition to the hospital and Provider services that are covered benefits under Original Medicare. MVP Medicare Advantage plans may offer "extra" benefits such as coverage for dental, eyewear, hearing aids, over-the-counter items, medical transportation, fitness memberships, and more! Additionally, MVP Medicare Advantage plans can come with or without Part D prescription coverage.

MVP Medicare Preferred Gold with Part D (HMO-POS), MVP Medicare Preferred Gold without Part D (HMO-POS), and MVP Medicare Secure Plus (HMO-POS) are the types of HMO-POS plans offered by MVP. MVP HMO-POS plans feature a large network of health care Providers and facilities across New York. No specialist referrals are required, and the plans provide a point-of-service benefit that covers Members for some non-urgently needed care with non-participating Providers. MVP Preferred Gold (HMO-POS) can also be provided to Members through an employer group.

MVP Medicare WellSelect with Part D (PPO), and MVP Medicare Complete Wellness with Part D (PPO) are the types of PPO plans offered by MVP. MVP PPO plans offer all the benefits of the HMO-POS plans, with the flexibility to see any Provider that participates in the Original Medicare program for non-urgently needed care.

The MVP DualAccess (HMO D-SNP) plans are designed for individuals that are eligible for both Medicare and Medicaid. When a healthcare benefit or service is offered under both the Medicare and Medicaid plan benefits, the healthcare benefit or service is covered in full. The MVP DualAccess plan includes coverage for medical services and prescription drugs. Additionally, it provides extras such as dental, eyewear, over-the-counter medicine and health- related purchases, and transportation An additional Supplemental Benefit for the Chronically Ill (SSBCI) is available to select members who meet the eligibility criteria, which provides a monthly allowance for healthy food and produce purchases, and utility payments. .

MVP DualAccess Complete (IBP –Integrated Benefit Plan) is a Medicare Advantage plan specifically designed for individuals that have Medicare coverage through MVP D-SNP and MVP Mainstream Medicaid or MVP HARP plan. Members do not require long-term support services (LTSS) for more than 120 days in a calendar year. This plan operates as one plan for all integrated services and Members have a $0 cost share. This plan option includes Part D prescription drug coverage. Additionally, it provides extras such as dental, eyewear, over-the-counter medicine and health- related purchases, and transportation An additional Supplemental Benefit for the Chronically Ill (SSBCI) is available to select members who meet the eligibility criteria, which provides a monthly allowance for healthy food and produce purchases, and utility payments.

MVP USA Care (PPO) is offered by employer groups. It can be offered with and without prescription drug coverage. This plan is a unique PPO in that the network is any Provider that participates in the Original Medicare program. MVP RxCare is a stand-alone Part D prescription drug plan offered by employer groups. MVP RxCare Members have access to more than 66,000 pharmacies in the MVP national network.

Contact Information

See the Contacting MVP Health Care section for contact information.

Claims Submission

Submit all MVP Medicare Advantage plan claims, correspondence and appeals to:

MVP Health Care
Medicare Advantage Plans
PO Box 2207
Schenectady, NY 12301

Claims may also be submitted electronically to MVP.

NOTE: Per CMS requirements, "Original Medicare (not MVP plans) pays the clinical trial doctors and other Providers for the covered services you get that are related to the clinical trial." Based on this requirement, any claims that are part of a clinical trial should be sent directly to Original Medicare and not to MVP Health Care.

Identifying MVP Medicare Advantage Providers in the Provider Directory

Providers appearing in red in this resource manual participate in MVP Medicare Advantage plans. Providers should refer HMO-POS plan Members to only those Providers for non-routine services. PPO Members may be referred to non-participating Providers, though their cost share may be higher. USA Care Members may see any Provider in the country who accepts Medicare. MVP DualAccess Members should see a Provider that participates with in MVP Medicare Advantage plans and Medicaid. Visit **mvphealthcare.com** for the most current listings.

Medicare Sales and Marketing

MVP Medicare Advisors can answer questions and help eligible individuals understand plan options and enroll in a plan that meets their care needs. MVP Medicare Advisors are experienced, licensed professionals that strictly adhere to CMS Communications and Marketing Guidelines. Potential enrollees can connect with an MVP Medicare Advisor

at **1-800-324-3899** (TTY 711).

Prompt Payment and Claims Submission

Claims will be processed in accordance with each Provider's contract. Refer to this manual's Claims section for additional details.

Beneficiary Financial Protection

MVP Medicare Advantage Members are protected for the duration of the contract period for which premium payments have been made. For Members who are hospitalized on the date MVP Medicare Advantage contract with CMS terminates, they will be covered through discharge.

Plan-Directed Care

When a Participating Provider furnishes non-covered services or refers a Medicare Advantage Member to a non-contracted Provider for services the Member believes are covered, Federal law prohibits holding the Member financially liable for the service. In these circumstances, the service may be referred to as "Plan Directed Care."

A Member will generally be deemed to believe the service is covered unless the Member received an adverse organization determination from MVP. Therefore, MVP requires the following:

- Participating Providers should not refer to out-of-network Providers without prior authorization from MVP (See Utilization Management, Prior Authorization section)
- If a Participating Provider knows or believes an item or service the out-of-network Provider will furnish is not covered, the Member or Provider must request a pre-service or organization determination from MVP. As noted below, an ABN may not be used. In the case of a Member who routinely receives the same non-covered service, one organization determination (denied authorization) received at the beginning of the course of service may be used, as long as it is clear that the Member understands that the services will never be covered

Pursuant to law, if a Participating Provider fails to follow these authorization requirements, MVP may decline to pay the claim, in which case the Provider will be held financially responsible for services received by the Member.

For more information on Plan-Directed Care, Balance Billing, and other topics, refer to Chapter 4 of the Medicare Managed Care Manual.

Please note: An MVP-participating Medicare advantage Provider must never use an Advance Beneficiary Notice (ABN) with a Medicare advantage enrollee.

Services of Non-Contracting Providers and Suppliers

MVP must make timely and reasonable payment to or on behalf of the MVP Medicare Advantage plan Member for services obtained from Provider or supplier who does not contract with the Medicare Advantage organization. Such services include, but are not limited to, emergency and urgently needed care and renal dialysis services for Members outside the service area for less than six months.

Balance Billing

Participating Providers cannot balance bill MVP's Medicare Members when furnishing covered services. Balance billing is the practice of billing the patient for the difference between what MVP Health Care pays for covered services and the "retail" price you charge uninsured patients for these services.

Balance Billing Rules Under Medicare

The Medicare Managed Care Manual, Chapter 4, Section 170, states in part: Medicare Advantage Members are responsible for paying only the plan-allowed cost-sharing (co-payments or co-insurance) for covered services.

- MVP Health Care as the Medicare Advantage Organization (MAO), not the Medicare Member, is obligated to pay limited balance billing amounts to non-par Providers; see below
- If a Member inadvertently pays a bill which is MVP's responsibility, we must refund the amount to the enrollee

Limited Balance-Billing Payments to Non-Participating Providers— Medicare Contracts Only

Please see below for definitions of Provider types:

Contracted Providers and non-contracting, Original Medicare Participating Providers Balance billing is not allowed

- Non-contracting, non-(Medicare)-Participating Providers Bill the MAO [MVP Health Care] the difference between the Member's co-payment or co-insurance and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a Provider. Non-contracting, non-participating DME suppliers Bill the MAO (MVP Health Care) the difference between the Member's cost-sharing (co-payment or co-insurance) and your charges**

Please note that this applies only to Members with out-of-network DME coverage**

- According to the Medicare Managed Care Manual, Chapter 6, and Section 100, Special Rules for Services Furnished by Non-Contract Providers:
    - Non-contract Providers [including non-contract facilities] must accept as payment in full payment amounts applicable in Original Medicare (Provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare)
    - Non-contract Providers may not balance bill Medicare Advantage plan enrollees for other than their plan cost-sharing amounts

Balance Billing Prohibited for Qualified Medicare Beneficiaries (QMBs)

MVP must make timely and reasonable payment to or on behalf of the MVP Medicare Advantage plan Member for services obtained from Provider or supplier who does not contract with the Medicare Advantage organization. Such services include, but are not limited to, emergency and urgently needed care and renal dialysis services for Members outside the service area for less than six months.

Federal law bars Medicare Providers from billing a QMB beneficiary (also known as "dual-eligible") under any circumstances. QMBs are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100 percent of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office. Medicaid is responsible for deductibles; co-insurance and co-payment amounts for Medicare Part A and B covered services. Further, all original Medicare and Medicare Advantage (MA) Providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost sharing.

Medicare Providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare Providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1) (A), and 1848(g)(3)(A) of the Act.)

Access to Care

MVP ensures that its Provider network is adequate to provide access to covered services.

MVP will arrange for specialty care outside of the plan Provider network when network Providers are unavailable or inadequate to meet a Member's medical needs.

Health Assessment

MVP will assess new and existing Medicare Advantage plan Members for complex or serious medical conditions. Determination is based on a score indicating a complex or serious medical condition by using a tested and accepted health-risk assessment tool, claims data, or other available information.

- For new Members, MVP must complete the assessment within 90 days of the Member's enrollment date
- The health care Provider who has primary responsibility for the patient's well-being will complete and implement a treatment plan consistent with CMS guidelines
- Health care Providers and MVP will provide Member communication regarding the importance of follow-up and self-care consistent with the patient's medical status

Provision of Care

MVP Participating Providers should note that decisions made by MVP concerning covered and non-covered services shall in no way affect the health care Providers' responsibility to provide services in a manner consistent with professionally recognized standards of care.

Appeal Procedures

MVP and its Providers must follow the Medicare appeals/expedited appeals procedures for Medicare Advantage enrollees, including gathering and forwarding information on appeals to MVP and/or MAXIMUS, as necessary. As of February 1, 2021, Medicare Part D second level appeals must be sent to C2C Innovations Inc. Following are the variations for the Provider appeal process:

- All appeal types will have one level of dispute. The Provider cannot go on to a second level with the NYS DFS or the VT DFR for an external appeal of a CMS product. The decision of the health plan will be final and binding for the Provider appeal process
- Only the Provider will receive an acknowledgment letter(s). No copies of outcome letters will be sent to the Member.
- The Provider can appeal as the Member's appointed authorized representative or on behalf of the Member. The Member may appoint a representative:
    - In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as the Member's representative. (Ex: I [name] appoint [representative's name] to act as my representative in requesting an appeal from (policy type) regarding service description/claim
    - The Member and the representative must sign and date the statement
    - The authorization statement must be submitted with the appeal. If the Provider is the Member's appointed authorized representative, then the appeal will follow the Member appeal path allowing the case to go to

MAXIMUS also, if applicable. As of February 1, 2021, Medicare Part D appeals will go to C2C Innovations Inc.

- The Provider can appeal as the Member's appointed authorized representative or on behalf of the Member for Part D

Medicare Part D

Some of MVP's Medicare Advantage products will be offered with the Medicare Part D benefit. See the Pharmacy Benefits section for additional information on MVP's Medicare Part D benefits and MVP's Part D formulary.

Medication Therapy Management

MVP Medicare Advantage plan Members with a Medicare Part D benefit may be eligible to participate in MVP's Medication Therapy Management program (MTM). This program is designed to improve patient safety and adherence to medication therapy for individuals who meet CMS enrollment requirements. For more details, visit mvphealthcare.com and select Members, then Medicare.

How to Refer a Member to a MVP's Case Management Program

For all MVP Medicare Members, apart from DSNP Members: referrals can be made by calling MVP Case Management at **1-866-942-7966**. Voice messages can also be made on this secure line.

An MVP Case Manager will reach out to the Member by phone and will assist in coordinating the most appropriate program and/or services for the Member.
Additionally, all MVP DSNP Members receive care management. The DSNP Care Management program consists of frequent, targeted, and documented communication among the team who interact with each Member. Each DSNP Member has a care team that works collaboratively with the Members, caregivers, and Providers. In the event, an urgent care management need arises for a DSNP Member, Providers can call **1-800-684-9286** or send an email to careteam@mvphealthcare.com.

Program Compliance

MVP requires Providers to cooperate in and abide by all of MVP's programs, protocols, rules, and regulations, including MVP's Quality Improvement (QI) Program, Medical Management Program, credentialing process, peer- review processes, Member grievance processes, and Utilization Management Program.

Medicare Advantage regulations require MVP to make quality improvement a priority and engage in activities and efforts that demonstrate consistency in improving MVP's performance.

Providers are also required to maintain compliance by MVP with applicable health laws and regulatory requirements from external regulators such as the New York State Department of Health (NYSDOH), New York State Department of Financial Services (NYSDFS), Vermont Department of Financial Regulations (DFR), Centers for Medicare and Medicaid Services (CMS) and the National Commission for Quality Assurance (NCQA).

Laws and Regulations

All MVP Medicare Advantage Providers are paid by MVP from federal funds and must comply with all laws applicable to recipients of federal funds, including, without limitation:

*Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to:

- Applicable provisions of Federal criminal law
- The False Claims Act (31 U. S.C. 3729 et seq.)
- The Anti-Kickback statute (§1128B(b) of the Act)

* Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR Parts 160, 162, and 164.

Disclosure of Information

MVP will collect and submit information to CMS that will help administer and evaluate MVP Medicare Advantage contracting entities, and the Medicare Advantage program. MVP will collect and provide information to CMS and to Medicare beneficiaries that will help them exercise choice in obtaining Medicare services.

Auditing

To ensure compliance, the Department of Health and Human Services, the Government Accounting Offices, or their designees have the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation, other MVP Medicare Advantage records, contractors, subcontractors, or related entities for 10 years from the date of service.

Accountability

MVP and its contracting entities are accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and Medicare laws. MVP retains ultimate responsibility to ensure regulations and laws are satisfied.

Documentation, Process, and Quality Standards Requirements

Auditing

The Department of Health and Human Services, the Government Accounting Offices, or their designees have the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, and other records of MVP Medicare products, MVP's contractors, subcontractors, or related entities for 10 years or periods exceeding six years or completion of an audit, whichever is later to ensure compliance.

Marketing

MVP has a Medicare marketing staff available to answer questions and assist Medicare Beneficiaries with enrollment. Our marketing staff utilizes Medicare-approved materials and they have been specially trained in Medicare marketing rules.

Access to Care

MVP ensures that the Provider network is adequate to provide access to covered services.

Cultural and Health-Related Considerations

Providers shall ensure that services are provided in a culturally competent manner to all enrollees, including services for those Members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities or conditions.

Non-Discrimination

Regulations prohibit MVP and its contracted health care Providers from discrimination in the delivery of health care services consistent with the benefits covered in our contracts based on a person's race, color, ethnicity, national origin, religion, age, mental or physical, disability, health status, claims experience, medical history, genetic information, evidence of insurability, sex (including sexual orientation and gender identity), or geographic location within the service area.

Participating Providers are required to have practice policies and procedures that demonstrate that they accept for treatment any Member in need of the health care services they provide.

Beneficiary Financial Protection

Enrollees are protected for the duration of the contract period for which the Centers for Medicare and Medicaid Services (CMS) payments have been made and, for enrollees who are

hospitalized on the date MVP's contract with CMS terminates or in the event of insolvency, through discharge.

Disclosure of Information

MVP will collect and submit to CMS information that will help to administer and evaluate MVP, MVP contracting entities, and the Medicare Advantage program. MVP will collect and provide information to CMS and to Medicare beneficiaries that will assist them in exercising choice in obtaining Medicare services. Examples include satisfaction survey results, disenrollment statistics, disenrollment survey results, health outcomes survey results, statistics regarding beneficiary appeals and their disposition, Provider payment mechanisms, and various other regulatory reports or data.

Provider Termination

Although CMS requires that a Provider or MVP give at least a 60-day notice for termination without cause, the actual amount of days is identified in your contract. If a Provider voluntarily terminates his or her contract, we will make a good-faith effort to notify all affected Members of the termination of the Provider contract within 30 days of receiving notice about the termination. MVP will notify a Provider in writing of reasons for denial, suspension, or termination of his or her contract. (See administrative policy, entitled Suspension and Termination of Practitioners.)

Accurate Encounter Data

Providers must make every effort to code patient encounters accurately and to the highest level of specificity for each encounter. Encounter data is submitted to CMS and is used for multiple purposes such as statistics for HEDIS reporting.

Excluded Individuals

MVP and its contracted entities are prohibited from employing or contracting with an individual who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act for the provision of any of the following: health care, utilization review, medical social work, or administrative services.

Program Compliance

CMS requires that Providers cooperate with an independent quality review and improvement organization's activities. Medicare Advantage regulations require plans to implement improvement activities each year. Also, Providers must comply with MVP's medical policies, Quality Improvement program, and medical management program. All standards and guidelines are created in consultation with network Providers.

Accountability

MVP and its contracting entities are individually accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and Medicare laws. As the managed care organization, however, MVP understands and acknowledges that CMS will hold MVP responsible for the compliance of its contracted providers and other entities.

Requirements of Other Laws and Regulations

All Providers are ultimately paid from Federal funds and must comply with Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Americans with Disabilities Act; and other laws applicable to recipients of Federal funds; and all other applicable laws and rules.

Review Summary

Review Date	Summary
November 1, 2025	• Updated plan names to reflect 2026 plan offerings. • Removed references to UVM Health Advantage. • Updated MVP DualAccess plan language to reflect 2026 benefit offerings.

MVP Network Vendors

MVP Network Vendors

Cigna HealthCare

Under the MVP national alliance with Cigna HealthCare, Cigna Members may access MVP's Upstate New York Participating Provider Network to receive medical care. Likewise, MVP EPO and PPO Members with national coverage have access to Cigna's national network to receive medical care.

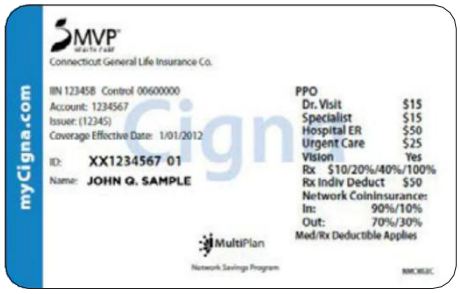
MVP Members with New York HMO and POS plans use Cigna as their national network for covered urgent/emergency care, as well as elective out-of-area care when prior-authorized. However, Cigna Members must continue to use the Cigna HealthCare provider network for the following services:

- Behavioral Health
- Dental Care
- Pharmacy
- Routine and Non-routine Vision Services

MVP Members with New York HMO and POS plans do not have access to the Cigna HealthCare provider network for Behavioral Health and must access MVP's network.

ID Card Sample

Cigna Members seeking health care services should present this or a similar Cigna ID card to their providers at every visit.



Cigna Contact Information

Call Cigna to confirm eligibility, obtain benefit coverage information or prior authorization requirements, or for any claim submission/coverage questions: **1-800-CIGNA24 (244-6224)**

Visit **cignaforhcp.com** for online tools that can help answer questions and provide other information for any health care professionals treating Cigna Members. An online demo shows providers how to register and use the site's other tools.

Where to Submit Claims

NPI numbers must be included on all claims submitted to Cigna to help ensure timely processing. Submit paper claims to the address on the back of the Member's ID card. For information on EDI claim submission, you may either visit **cignaforhcp.com** or call **1-800-CIGNA24 (244-6224)**. Cigna will pay Participating Providers for Covered Services

rendered to Cigna Members provided all prior authorization and claim requirements are met. Participating Providers' MVP reimbursement schedule will be used to process claim payment for these services. When payment is received, Participating Providers cannot bill the Cigna Member for any amounts above and beyond the Member's cost share as identified on Cigna's remittance advice.

Cigna's Other Alliances and Cigna Payer Solutions℠

Cigna maintains alliances with other health plans, including Tufts Health Plan, HealthPartners, and Health Alliance Plan. Additionally, Cigna administers benefits for several Third-Party Administrators through its Cigna Payer Solutions℠ subsidiary.

Members of these plans will have the Cigna logo on their Member ID card and will typically have the MVP logo on their card as well. These Members should be treated no differently than MVP and Cigna Members.

If a Member of one of these health plans presents for services with an MVP Participating Provider, they should contact that health plan directly by calling the toll-free number on the back of the Member's ID card to verify benefits and eligibility and submit claims directly to that health plan either electronically or on paper to the claim address found on the back of the ID card.

Evernorth Behavioral Health

As of January 1, 2023, MVP partnered with Evernorth, a wholly owned subsidiary of Cigna, for their national Behavioral Health network. Evernorth will be used for Commercial and ASO products; government plans do not utilize the Evernorth network. Providers or facilities that are contracted with Evernorth and have a primary specialty of Behavioral Health, Mental Health, or Substance Use Disorder are considered In-Network with MVP. Claims processing and utilization/case management services will be done by MVP.

First Health

First Health serves as MVP's primary out-of-network 'wrap' network. This network is utilized if the Provider or Facility is in MVP's Service Area but is not contracted with MVP, or if the Provider or facility is not contracted with Cigna. Additionally, First Health provides a Behavioral Health network to MVP. First Health is used for Commercial and ASO products; government plans do not utilize the First Health network. Providers or facilities that are contracted with First Health and which have a primary specialty of Behavioral Health, Mental Health, or Substance Use Disorder are considered In-Network with MVP. Outside of the specialties listed above, MVP does not direct Members to First Health-contracted Providers, thus the Provider search function on the MVP website does not specifically identify these Providers.

Contact Information

Providers that are contracted with First Health should contact MVP to confirm Member eligibility, obtain benefit coverage information or Prior Authorization requirements, or for any claim submission/coverage questions.

Claims Submission

Providers that are contracted with First Health should submit claims to MVP either electronically or on paper to the claim address found on the back of the Member ID card. Additional information on claims submission can be found at **mvphealthcare.com**.

Upon submission to MVP, out-of-network claims will be routed to First Health. If the submitting Provider is found to be contracted with First Health, the claim will be priced and sent back to MVP for payment. First Health-contracted Providers will receive payment from MVP and may not bill the MVP Member for any amounts above and beyond the Member's cost share as identified on MVP's remittance advice.

Other Network Vendors

MVP partners with EyeMed to offer routine vision benefits to select members. If a member presents an EyeMed ID card, their routine vision claims will be submitted to EyeMed. All medical vision services will continue to be managed by MVP.

EyeMed Insight

Overview

MVP partners with EyeMed Vision Care® (EyeMed) to manage routine vision care for Members in several MVP plans. MVP selected EyeMed because they can provide more robust benefits for our Members' routine vision care than what is currently available to them.

Will current MVP Provider contracts be discontinued as of January 1, 2022?

MVP is not discontinuing any contracts with Participating Providers. However, to offer care to Members with MVP routine benefits administered by EyeMed, you will also need to contract with EyeMed. However, the network of MVP Participating eye care Providers will still be used for medical and diagnostic services for Members in all MVP plans.

How would an MVP Participating Provider contract with EyeMed?

If you do not currently participate in the EyeMed Insight network and would like to join, please contact Lynne Kraemer at **lkraemer@eyemed.com** or visit here. You can also call **1-800-521-3605**.

What if I currently participate in the EyeMed Network?

If you currently participate in the EyeMed Insight network, then there is nothing you need to do.

How will Providers identify if a Member utilizes the EyeMed Network?

Providers will be able to determine which network Members utilize based on their vision ID card. MVP Members that have the EyeMed product will have an EyeMed ID card.

Where do I submit a claim?

The EyeMed ID card will have the claims address, or Providers can sign up for the EyeMed Provider portal.

Note: The Provider needs to be credentialed with EyeMed to use the portal. Visit **EyeMed.com** select Providers and select Submit Claims.

Review Summary

Review Date	Summary
November 1, 2025	• No Changes

MVP Plan Type Information

Overview

MVP will administer these products in accordance to their respective MVP Certificates and/or Contracts of Coverage, including the MVP medical management requirements and the MVP claims adjudication processes.

Most network Providers and facilities will receive services and claims payment from the Schenectady office. On the following pages, you will find brief overviews of the plans offered by MVP. For additional benefit details, please log into your Provider account.

Essential Plan

In New York, the Essential Plan (Basic Health Program) is an Insurance Affordability Program that offers qualified individuals and families a choice of plans through the New York State of Health Marketplace. To be eligible, individuals must be ages 19-64, reside in New York State, and not be eligible for Medicaid or Child Health Plus. Health Maintenance Organizations (HMO) are the models for this plan and Members must use participating MVP Providers, hospitals, and other Providers for all covered services. Essential Plans include a $ $225 reimbursement for qualified wellness items and activities. These plans also include coverage for Virtual Care, Vision, and Dental benefits.

MVP VT and VT Plus

The MVP VT and VT Plus plans, which are available through Vermont Health Connect, were built based on an HMO model, where Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services. Upon enrollment, Members are encouraged to select a Primary Care Provider (PCP) who is responsible for providing or coordinating and overseeing the Member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP. These plans include Virtual Care coverage. These plans feature a wide variety of deductibles, co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

All MVP VT Plus plans include $600 Well-Being Reimbursement and a $500 allowance for Acupuncture.

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP VT and VT Plus plans have access to the Cigna Healthcare national Provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP Providers, hospitals, and other Providers for all covered services.

MVP VT HDHP and VT Plus HDHP

The VT HDHP plans are high-deductible HMO plans available through Vermont Health Connect and qualified according to federal regulations. These plans can be offered alongside an optional Health Savings Account (HSA). The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines. They are available at three metal levels (Bronze, Silver, and Gold). These HDHP plans also cover preventive care services in full. As an HMO product, these HDHPs suggest a PCP selection; however, referrals are not necessary for specialty care.

All VT Plus Plans include $600 Well-Being Reimbursement and a $500 allowance for Acupuncture.

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP VT HDHP and VT Plus HDHP plans have access to the Cigna Healthcare national Provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP Providers, hospitals, and other Providers for all covered services.

MVP NY Premier and NY Premier Plus

The MVP NY Premier plans, which are available for individuals directly from MVP and on the New York State of Health Marketplace, were built based on an HMO model, where Members must use participating MVP Providers, hospitals, and other Providers for all covered services. Upon enrollment, Members are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. If specialty care is required, these plans do not require the PCP to submit a referral to MVP. These plans feature a wide variety of deductibles, co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

MVP NY Premier and NY Premier Plus plans include the $600 Well-Being Reimbursement and Virtual Care benefits that are covered in full. These plans can also be offered alongside our optional Pediatric Dental and Vision plans.

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP NY Premier Plus plans also include:

- Up to $1,000 in out-of-service-area covered benefits per Member, up to the age of 26, per plan year (outside MVP's network of Providers), subject to pre-authorization (except for emergency care). Services received out-of-area are subject to the applicable in-network Member cost-share

- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery
- Acupuncture benefit

MVP NY Premier Plus HDHP

The MVP NY Premier Plus HDHP plans are High-Deductible HMO plans. They are available for Individuals directly from MVP and on the New York State of Health Marketplace and are qualified according to federal regulations. These plans can be offered alongside an optional HSA. The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines and are available at three metal levels (Bronze, Silver, and Gold). These HDHP plans also cover preventive care services not subject to the deductible; these services are covered in full. As an HMO product, these HDHPs suggest a PCP selection; however, referrals are not necessary for specialty care.

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP NY Premier Plus HDHP plans also include:

- Up to $1,000 in out-of-service-area covered benefits per Member, up to the age of 26, per plan year (outside MVP's network of Providers), subject to pre-authorization (except for emergency care). Services received out-of-area are subject to the applicable in-network Member cost-share
- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery
- Acupuncture benefit
- $600 Well-Being Reimbursement

MVP NY Premier Plus HDHP plans can also be offered alongside our optional Pediatric Dental and Vision plans.

MVP EPO, and MVP HMO (NY)

These plans are available to Small Groups directly from MVP and are available as either an Exclusive Provider Organization/Plan (EPO) or Health Maintenance Organization (HMO). Members who receive covered services from non-participating providers will pay 100 percent of the actual costs. MVP EPO plans do not require PCP selection. MVP HMO plans are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. These plans have Preferred Provider

Facilities for Advanced Imaging, Laboratory procedures, Diagnostic Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery. The plans include integrated ACA-required Pediatric Dental and Vision benefits. These plans also include the $600 Well-Being Reimbursement and an Acupuncture benefit.

These plans have no out-of-network benefits. Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services as well as the Cigna Healthcare national Provider network outside the MVP network area for in-network benefits.

These plans feature a wide variety of deductibles (some of which are high), co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

MVP EPO HDHP, and MVP HMO HDHP (NY)

MVP EPO HDHP and MVP HMO HDHP are High-Deductible plans that are available to Small Groups directly from MVP and are qualified according to federal regulations. These plans can be offered alongside an optional HSA. The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines and are available at three metal levels (Bronze, Silver, and Gold). The EPO HDHP plan does not require PCP selection or referrals for specialty care. The HMO HDHP plans are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. These Small Group plans have Preferred Provider Facilities for Advanced Imaging, Laboratory procedures, Diagnostic Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery. Also, these plans include integrated ACA required Pediatric Dental and Vision benefits.

MVP EPO and HMO HDHP plans include the $600 in Well-Being Reimbursement.

MVP Healthy NY

MVP offers a comparable "Off-Exchange" Commercial HMO Gold metal level plan directly to Small Groups that was Marketplace certified beginning January 2020. Eligible Small Groups can purchase this plan from MVP and still receive a Small Business Health Care Tax Credit.

Sole proprietors can choose from several plans both "on" and "off" of the exchange.

MVP Secure NY and VT

MVP Secure NY and VT plans are catastrophic policies that are available on the New York State of Health Marketplace and Vermont Health Connect. They were built based on an

HMO model. Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services. Upon enrollment, Members are required to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP. These plans feature three PCP visits and preventive care services covered in full; all other covered benefits are subject to deductible and/or applicable cost-share (co-pay/co-insurance).

These plans have no out-of-network benefits. Members who receive covered services from non-participating Providers will pay 100% of the actual costs.

MVP Secure VT plans have access to the Cigna Healthcare national Provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP Providers, hospitals, and other Providers for all covered services.

MVP HMO

This is MVP's traditional Large Group plan. Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services. Upon enrollment, Members are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP.

All plans include:

- Meal delivery
- Free virtual care

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

For Vermont only, plans include a $500 Acupuncture allowance and an annual vision exam. These plans pair well with an MVP Vision plan, HRA or FSA plan.

MVP HMO HDHP (VT)

MVP offers an HMO HDHP plan to Vermont Large Groups. Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services. Upon enrollment, Members are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the Member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP.

All plans include:

- $500 Acupuncture allowance
- An annual vision exam

- Meal delivery
- Free virtual care after plan deductible is met

These plans have no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

These plans pair well with an MVP Vision plan, HSA or HRA plan.

MVP POS (NY and VT)

Available in New York and Vermont . The MVP POS adds an" out-of-network" benefit to the traditional MVP HMO plan. "Out-of-network" means the Member can receive covered services from a non-participating provider. Out-of-network benefits are subject to deductible and co-insurance payments by the Member instead of co-payments (as in the HMO). For "in-system" coverage, Members are required to use participating MVP Providers, hospitals, and other Providers for all covered services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP.

MVP EPO—Large Group

Available in New York only. The MVP EPO plan does not require PCP selection or referrals for specialty care. Members have access to the entire MVP network, as well as to the Cigna Healthcare national Provider network outside the MVP network area for in-network benefits. This plan type features a wide variety of deductibles (ranging from low to high), co-payments, and/or co-insurance.

MVP EPO plans include:

- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic
- Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery
- MVP Well-Being Reimbursement
- Access to the Cigna Healthcare National Network
- Meal delivery
- Free virtual care

This plan has no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP EPO HDHP—Large Group

Available in New York only.

The MVP EPO HDHP plans are qualified according to federal regulations to be offered alongside an HSA. The MVP EPO HDHP plans are designed with co-insurance and/or co-pays after deductibles and annual out-of-pocket maximums that apply to all benefits, including integrated prescription drugs. These HDHP plans also cover certain preventative care services in full, in front of the deductible. The plans also provide optional coverage for certain medical services to help better manage certain chronic conditions. As an EPO product, these HDHP EPOs do not require PCP selection or referrals for specialty care. Members have access to the entire MVP network, as well as to the Cigna Healthcare national Provider network outside the MVP network area for in-network benefits.

MVP EPO HDHP plans include:

- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic
- Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery
- MVP Well-Being Reimbursement
- Access to the Cigna Healthcare National Network
- Meal delivery
- Free virtual care after the plan deductible is met

This plan has no out-of-network benefits. Members who receive covered services from non-participating providers will pay 100% of the actual costs.

MVP PPO—Large Group

Available in New York only.

The MVP PPO plan is an insurance plan offering Members in-network and out-of-network benefits. In-network Providers (Preferred Providers) are participating MVP Providers, hospitals, and other health care Providers and include the Cigna Healthcare national network. Members do not select a PCP nor obtain referrals for specialty care. Members can self-refer to a preferred or non-preferred provider for covered services. Members who receive covered services from non-preferred providers will pay higher out-of-pocket costs. Some services may be limited with non-preferred providers or covered through Preferred Providers only.

The MVP PPO includes

- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery

- MVP Well-Being Reimbursement
- Access to the Cigna Healthcare national network
- Meal delivery
- Free virtual care

MVP PPO HDHP—Large Group

Available in New York only.

The MVP PPO HDHP plans are qualified plans, meeting annual federal regulations to be offered alongside an HSA. The MVP PPO HDHP plans are designed with co-insurance and/or co-pays after deductible and annual out-of-pocket maximums that apply to all benefits, including integrated prescription drugs. The HDHP plans cover certain preventive care services in full, in front of the deductible. These plans also provide optional coverage for certain medical services to help better manage certain chronic conditions. The MVP PPO HDHP plans offer in-network and out-of-network benefits. In-network Providers are participating MVP Providers, hospitals, and other health care Providers and the Cigna Healthcare national network. Members do not select a PCP, nor must they obtain referrals for specialty care. Members can self-refer to a participating or non-participating provider for covered services. Members who receive covered services from non-participating providers will pay higher out-of-pocket costs. Some services may be limited with non-participating providers or covered through participating Providers only.

MVP PPO HDHP plans include:

- Preferred Provider Facilities benefits for Advanced Imaging, Laboratory procedures, Diagnostic
- Radiology services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery
- MVP Well-Being Reimbursement
- Access to the Cigna Healthcare national network
- Meal delivery
- Free virtual care after the plan deductible is met

MVP Select Care

Available in New York and Vermont.

MVP Select Care is the MVP company that provides fee-based administrative services to companies that self-insure their employee health benefits. Employers have the flexibility of choosing and customizing the standard plan types including PPO, EPO, HDHPs, and

Indemnity plans. Members may be responsible for co-payments, deductibles, and co-insurance based on the plan type chosen.

Riders

Riders are available for the Commercial group plans described above to enhance or alter the standard core plan benefits. Some common riders include:

- Changing visit/day limits on benefits such as Physical Therapy, Skilled Nursing, Home Health Care, and Hospice
- Prescription drug coverage options
- Adding benefits such as Acupuncture, Hearing Aids, and Foot Orthotics
- Cost-share changes for benefits such as Diabetic Supplies, Hearing Aids, and DME, changes for in-patient/out-patient hospital surgery/emergency room services

MVP Vision Plans

As of January 1, 2023, MVP Commercial vision plans (through EyeMed) are available in both New York and Vermont. The plans are available for both individuals as well as businesses. There are three plans offered:

- MVP Vision 1
- MVP Vision 2
- MVP Vision 3

Each vision plan offers its unique set of benefits, with MVP Vision 1 including the most robust set of benefits (e.g., highest reimbursement allowances).

Benefits across the three plans include one routine eye exam every year, frame allowances (both contact and regular) ranging from $130 to $170, and a wide variety of lens options (single, bifocal, trifocal, UV coating, solid or gradient tint, etc.).

All three plans offer in-network benefits, with varying degrees of out-of-network benefits. However, some options are not covered out-of-network, such as UV coating, solid or gradient tint, standard AR coating, and other add-ons and services for lenses.

Diversified Services

MVP offers various medical spending accounts that are designed to assist Members in paying for qualified health and lifestyle expenses. The below accounts can be offered alongside the various health benefit plans.

Health Savings Accounts (HSA)

HSAs are personal, interest-bearing savings accounts that can be used to cover out-of-pocket medical, dental, and vision costs as qualified by the IRS. Funds rollover from year to year and they are completely portable. Allowable contributions are tax-deductible and can be contributed through employer payroll (both on the behalf of the employee or the employer). The funds grow tax-free and are not subject to tax when withdrawn for qualified health related expenses. Individuals can contribute to an HSA if selecting a qualified high deductible health plan (QHDHP).

Once funds in the HSA reach a certain threshold, the individual may choose to invest a portion of the HSA dollars in a variety of stocks, bonds, and mutual funds. All contributed funds vest immediately, and unused funds rollover annually. HSA assets are portable with the employee.

Health Reimbursement Arrangements (HRA)

HRAs are employer-owned and funded accounts that reimburse employees for qualified out-of-pocket medical expenses. The arrangement can be set up in many ways, at the employer's discretion. Unlike HSAs, unused funds in an HRA do not rollover to the next plan year and are non-portable. If an employee is terminated or separates from the employer, unused HRA funds would revert to the employer and the account is terminated. HRAs are compatible with any plan type and are thus versatile tax-advantaged accounts.

Flexible Spending Accounts (FSA)

Similar in a lot of ways to the HRA, the FSA is owned by the employer. One key difference between an HRA and an FSA is that the employee can contribute to their FSA dollars—pre-tax—out of their payroll. The employer is also allowed to make contributions for their employees. Here is the list of FSA accounts an employer can offer to their employees:

- Medical: All IRS-qualified medical expenses
- Limited Purpose: Qualified dental and vision expenses
- Dependent Care: Child or adult day care expenses
- Parking and Transit: Work-related parking and transit expenses

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides an employee, and their family members, the right to continue group health benefits for a limited duration under certain circumstances, such as voluntary or involuntary separation from employment, reduction in hours, transition between jobs, and other qualifying life events. To be eligible for COBRA insurance, an individual must have been previously employed and covered under the employer's group health plan.

When appropriate, MVP will mail election notices, coordination of coverage documents, and other required information to individuals to assist them in obtaining COBRA benefits.

MVP Medicare Preferred Gold with Part D(HMO-POS), and MVP Medicare Secure Plus (HMO-POS)

MVP Medicare Preferred Gold with Part D (HMO-POS), and MVP Medicare Secure Plus (HMO-POS) are Medicare Advantage HMO-POS plans specifically designed for Medicare-eligible individuals. Members are required to select a PCP. These plan options are offered with Part D prescription drug coverage. These Members have a limit on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. When a Member reaches the maximum out-of-pocket payment amount, they will not have to pay any out-of-pocket costs for the remainder of the calendar year for covered Part A and Part B services. Prescription Part D Drugs, Routine Eyewear, Preventive Dental, and Hearing Aids do not apply to the out-of-pocket maximum.

MVP Medicare Preferred Gold Without Part D (HMO-POS)

MVP Medicare Preferred Gold without Part D (HMO-POS) is a Medicare Advantage HMO-POS plan specifically designed for Medicare-eligible individuals. Members are required to select a PCP. This plan option does not include Part D prescription drug coverage. These Members have a limit on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. When a Member reaches the maximum out-of-pocket payment amount, they will not have to pay any out-of-pocket costs for the remainder of the calendar year for covered Part A and Part B services. Prescription Part D Drugs, Routine Eyewear, Preventive Dental, and Hearing Aids do not apply to the out-of-pocket maximum.

MVP Medicare WellSelect (PPO)and MVP Complete Wellness(PPO)

MVP Medicare WellSelect with Part D (PPO) and MVP Complete Wellness(PPO) with Part D, are Medicare Advantage PPO plans specifically designed for Medicare-eligible individuals. Members are not required to select a PCP. Members have unlimited coverage for out-of-network services. These plan options are offered with Part D prescription drug coverage. These Members have a limit on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. When a Member reaches the maximum out-of-pocket payment amount, they will not have to pay any out-of-pocket costs for the remainder of the calendar year for covered Part A and Part B services. Prescription Part D Drugs, Routine Eyewear, Preventive Dental, and Hearing Aids do not apply to the out-of-pocket maximum.

MVP DualAccess (D-SNP)

Dual – Eligible Special Needs Plans (D-SNP) are a type of Medicare Advantage Plan for individuals enrolled in Medicare and Medicaid (dually eligible individuals). Like other Medicare Advantage Plans, D-SNPs typically require use of an in-network provider. To participate in the DualAccess network, Providers must be contracted for both Medicare and Medicaid line of businesses. Additionally, 100% of MVP's DSNP Members receive care management. The DSNP Care Management program consists of frequent, targeted, and documented communication among the team who interact with each member. Each DSNP Member has a care team that works collaboratively with the Members, caregivers, providers.

MVP DualAccess (HMO D-SNP) MVP DualAccess (HMO D-SNP) plans are designed for individuals that are eligible for both Medicare and Medicaid. When a healthcare benefit or service is offered under both the Medicare and Medicaid plan benefits, the healthcare benefit or service is covered in full. The MVP DualAccess plan includes coverage for medical services and prescription drugs. Additionally, it provides extras such as dental, eyewear, over-the-counter medicine and health- related purchases, and transportation An additional Supplemental Benefit for the Chronically Ill (SSBCI) is available to select members who meet the eligibility criteria, which provides a monthly allowance for healthy food and produce purchases, and utility payments.

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MVP DualAccess Complete (IBP –Integrated Benefit Plan) MVP DualAccess Complete (IBP –Integrated Benefit Plan) is a Medicare Advantage plan specifically designed for individuals that have Medicare coverage through MVP D-SNP and MVP Mainstream Medicaid or MVP HARP plan. Members do not require long-term support services (LTSS) for more than 120 days in a calendar year. This plan operates as one plan for all integrated services and Members have a $0 cost share. This plan option includes Part D prescription drug coverage. Additionally, it provides extras such as dental, eyewear, over-the-counter medicine and health- related purchases, and transportation An additional Supplemental Benefit for the Chronically Ill (SSBCI) is available to select members who meet the eligibility criteria, which provides a monthly allowance for healthy food and produce purchases, and utility payments

MVP RxCare PDP

The MVP RxCare PDP is a stand-alone prescription drug plan (PDP) for employer group Members with Medicare Part A and Part B. PDP Members enrolled in MVP RxCare may or may not have Commercial medical coverage through their employer group. This plan covers Medicare Part D drugs only. Any medications or supplies that are considered Part B must be billed to Original Medicare. PDP Members with a Commercial medical product through MVP will have limited coverage for Diabetic Testing and Insulin Pump Supplies, as mandated by the state.

MVP Medicaid Managed Care

MVP's Medicaid Managed Care (MMC) Product is offered through New York State for Medicaid-eligible Members residing in counties within MVP's Medicaid licensed service area. Members are required to select a PCP upon enrollment. Members must use MVP Providers who have contracted to provide services to Government Program (Medicaid HARP and Child Health Plus) enrollees unless MVP gives prior authorization for the service. MVP Providers not contracted for Government Programs must obtain prior authorization before treating an MVP MMC Member. This Product has benefit coverage established by the New York State Medicaid Managed Care program. There are no deductibles or co-insurance associated with this Product.

MVP Child Health Plus

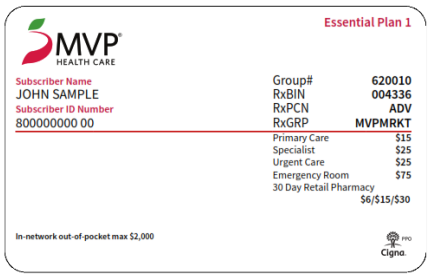
Child Health Plus (CHP) is a Product for children under 19 years of age who do not have insurance, are Medicaid-ineligible, and reside in counties within MVP's licensed Child Health Plus service area. Members are required to select a PCP upon enrollment. Members must use MVP Network Providers who have contracted to provide services to Government Program (Medicaid, HARP, and Child Health Plus) Members unless MVP gives prior authorization for the service. MVP Providers not contracted for government programs must obtain prior authorization before treating an MVP CHP Member. This Product has no co-payments, deductibles, or co-insurance. There are some visit limits for select benefits.

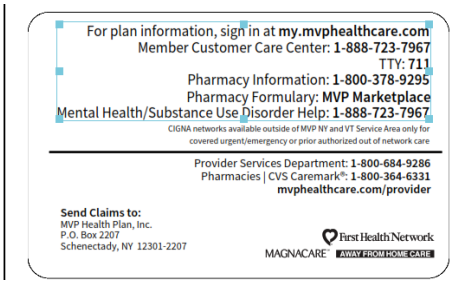
MVP Harmonious Health Care Plan

The MVP Harmonious Health Care Plan, a Health and Recovery Plan (HARP), is available to existing MMC Members aged 21 and over who are identified by New York State as suffering from serious mental illness and/or substance use disorders, and who may benefit from additional treatment and community-based support. The MVP Harmonious Health Care Plan includes traditional MMC benefit coverage in addition to comprehensive Behavioral Health Home and Community Based Services (BH-HCBS) for additional, specialized, and integrated physical and behavioral health support and treatment. These services require prior authorization by MVP following an assessment of the Member as well as the submission and review of a Member's plan of care that detail the provision of BH-HCBS and goals of the Member.

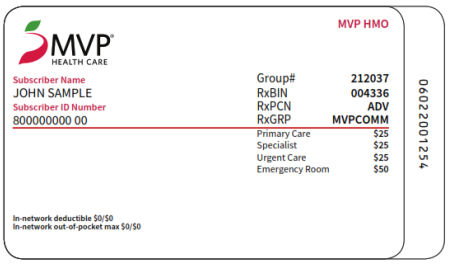
Plan Type ID Cards

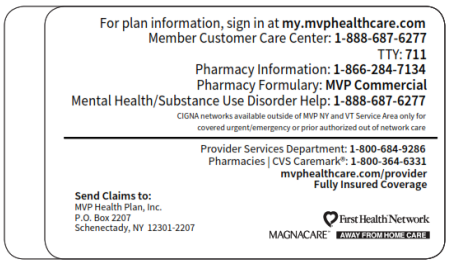
Essential Plan





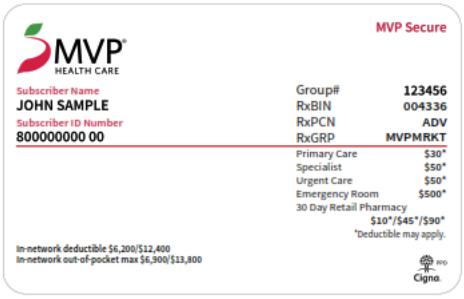
HMO





Administrative Services Only (ASO)

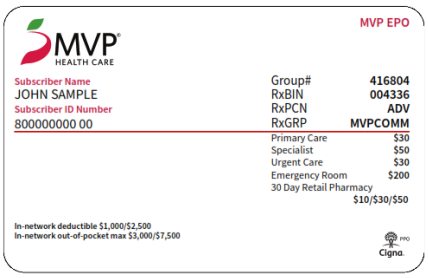
MVP Secure HMO



- Primary Care Provider coordinated care
- No referral required
- No out-of-network benefits

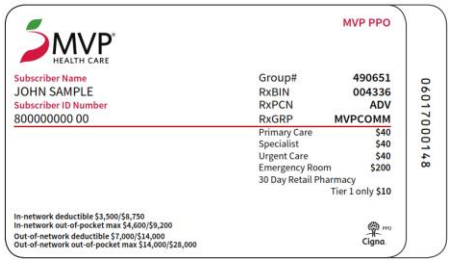
Individual versus Small Group Identification

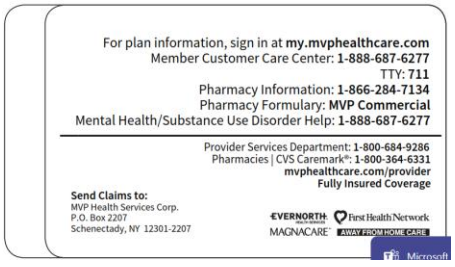
MVP EPO (Large Group)



- Exclusive Provider Organization (EPO) plan
- No referral required
- No out-of-network benefits
- No Primary Care Provider require

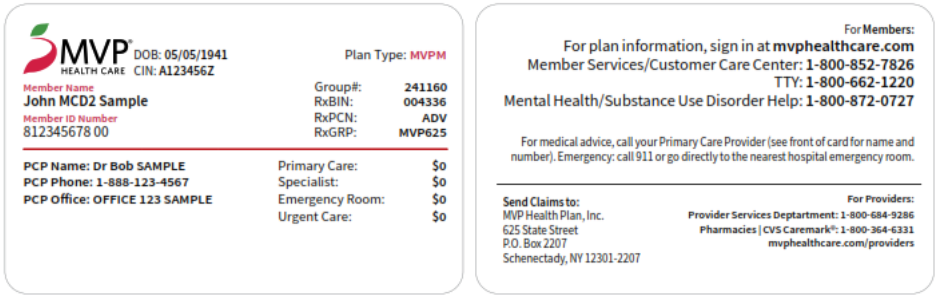
MVP PPO (Large Group)





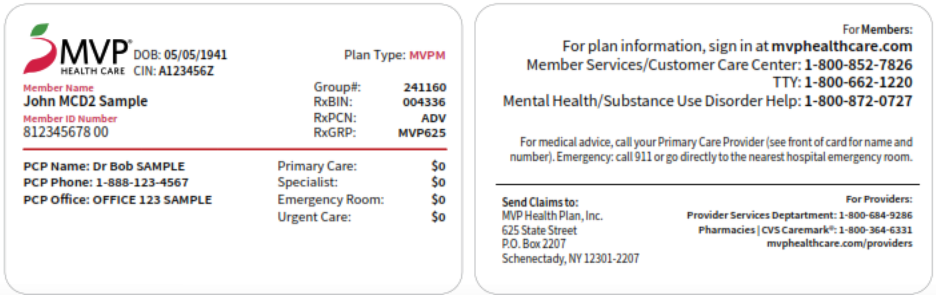
- Preferred Provider Organization (PPO) plan
- No Primary Care Provider or referral required
- Out-of-network benefits available at greater cost
- Access to the Cigna Healthcare PPO national Provider network

MVP Medicaid Managed Care



- Primary Care Provider required
- Pre-authorization required
- Minimal co-payments may apply for pharmacy and medical supplies
- Care must be rendered by a participating MVP Government Programs Provider
- Out-patient imaging pre-authorization required through MVP
- Dental Care through Healthplex

Medicaid Managed Care SSI

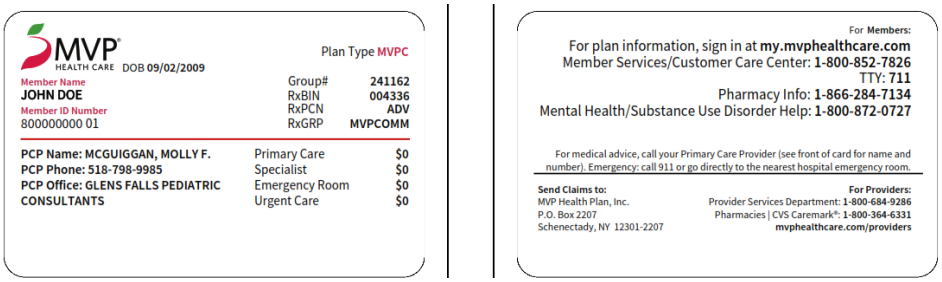


- Primary Care Provider required
- Pre-authorization required
- Minimal co-payments may apply for pharmacy and medical supplies
- Care must be rendered by a participating Government Programs Provider
- Dental Care through Healthplex
- Out-patient imaging pre-authorization required through MVP

Medicaid Restricted Member

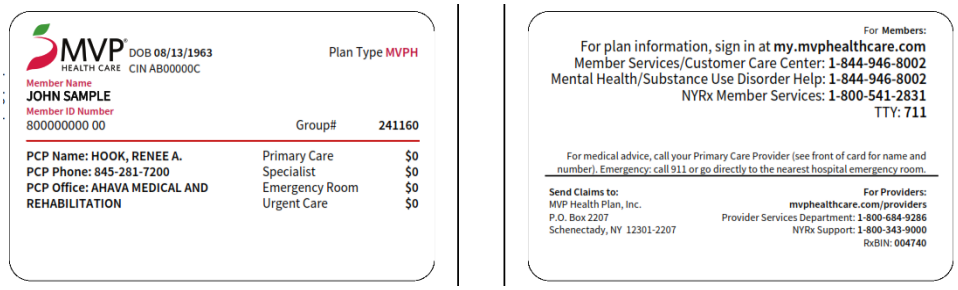
If the card says "Restricted" in red print, then the Member is part of the NYS DOH Restricted Recipient Program. Please call MVP's Provider Services Department for additional information if you see this on an ID card. Restricted recipients require a referral from their PCP to see a specialist.

MVP Child Health Plus (CHP)



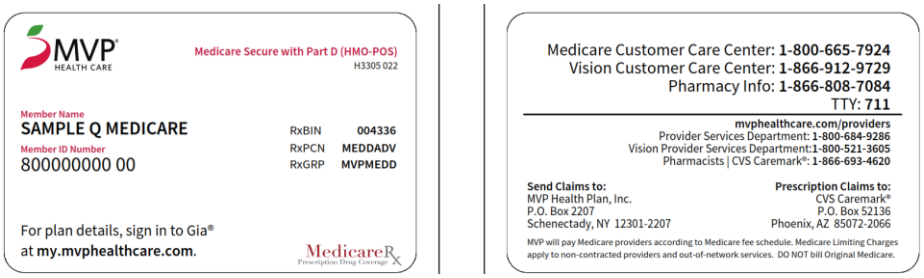
- Primary Care Provider required
- Pre-authorization required
- No co-payments
- Care must be rendered by a participating Government Programs Provider
- Dental Care through Healthplex
- MVP Commercial Formulary applies
- Out-patient imaging pre-authorization required through MVP

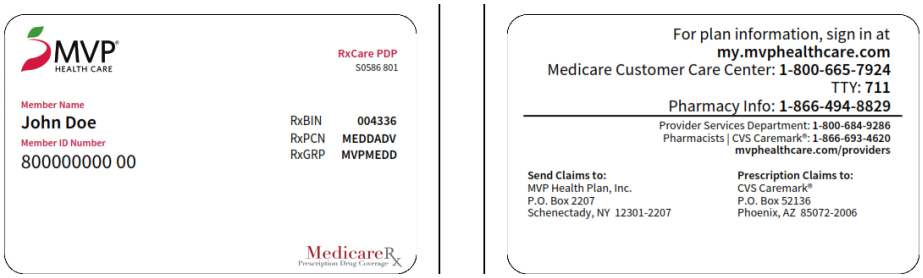
MVP Harmonious Health Care Plan (HARP)



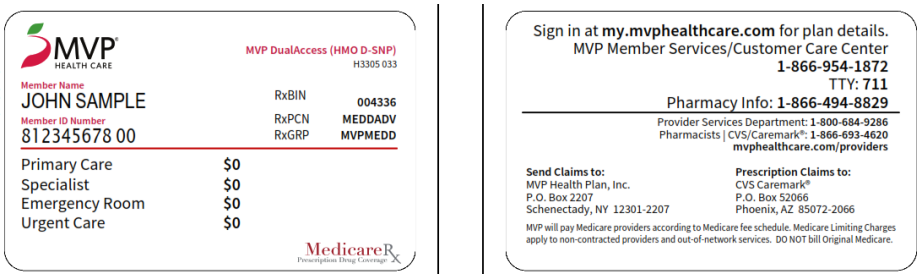
- Managed Care Medicaid Program for Members identified by NYS with behavioral health needs
- Primary Care Provider required
- Pre-authorization required
- Care must be rendered by a participating MVP Government Programs Provider
- Out-patient imaging pre-authorization required through MVP
- Dental Care through Healthplex
- Home and Community-Based benefits are available after assessment and prior authorization

Medicare Products





MVP DualAccess (HMO D-SNP)



Review Summary

Review Date	Summary

November 1, 2025	• The TOC and the document were updated with the removal of the following plans:
	  • Student Health
	  • MVP Medicare Secure(HMO-POS)
	  • MVP Medicare Well Select Plus (PPO)
	  • MVP Patriot Plan (PPO)
	  • All UVM Plans
	
	Updated the descriptions around the DSNP Plans to account for the VBID changes
	
	Removed the UVM and Student Health Plan ID Cards,

MVP's New York State Government Programs

MVP's New York State Government Programs (Medicaid, Health Recovery Plan and Child Health Plus)

MVP's New York State Government Program Plan types offer more health plan choices for individuals and families. MVP's high quality, affordable health plan options include:

Medicaid Managed Care is a health insurance program for low-income children and adults. Eligibility is based on income and family size, as well as citizenship and immigration status. Medicaid is also available to people of any age who are blind or disabled. There are no monthly premiums for Medicaid.

Child Health Plus is a health plan for kids that don't qualify for Medicaid. Almost all children, under age 19, qualify for health coverage with Child Health Plus regardless of family income or immigration status. Depending on income, a small monthly premium may be all that is needed to enroll a child.

Essential Plan is a program for low-income individuals in New York who do not qualify for Medicaid or the Child Health Plus plan. To qualify, an individual must be below 200% of the Federal Poverty Level (FPL). There are various essential plans based on income level.

MVP Harmonious Health Care Plan is a Medicaid Managed Care product called a Health and Recovery Plan (HARP) that combines physical health, mental health, and substance use services in an integrated way, helping Members navigate social care needs such as housing, living independently, getting an education, finding a job, managing stress, and more. Eligibility for HARP services is determined by New York State.

Dual Special Needs Program (D-SNP) is a specialized coordination-only type of Medicare Advantage benefit plan that offers intensive care coordination for individuals with special needs. This plan serves individuals who are dually eligible for Medicare and Medicaid. More information is available in the Medicare Provider Resource Manual.

Member Rights and Responsibilities

Members have rights pursuant to Federal and State law and the applicable program contract. These rights are summarized below. Additionally, Member rights and responsibilities are outlined in the MVP Health Care Member Handbook provided to all Members upon enrollment.

An MVP Member has the right to:

- Receive information about MVP Health Care, our services, our providers, and Member rights and responsibilities
- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation

An MVP Member has the responsibility to:

- Work with providers to guard and improve health Use the MVP complaint system to settle any complaints, or contact the New York State Department of Health or the local Department of Social Services
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

MVP's New York State Government Programs Plan Types

The following plan types are printed on the Member's MVP ID card:

- MVP Medicaid Managed Care (MVPM)
- MVP Medicaid Managed Care SSI (MVPMS)
- MVP Child Health Plus (MVPC)
- MVP Harmonious Health Care Plan Health and Recovery Program (MVPH)

Member-Initiated PCP Changes

A Member may change his/her PCP by contacting the Customer Care Center. Upon selecting a new PCP, the Member will be issued a new MVP ID card. These changes will also appear on **mvphealthcare.com**. Providers are encouraged to verify Members' enrollment at every visit.

PCP-Initiated Changes

If a PCP believes that he/she can no longer manage the Member's care, the Provider should submit a letter to their local Professional Relations Department documenting the reasons necessitating the change. Reasons for a PCP to request a change might include:

- Consistent physical or verbal abusiveness to a provider and/or the providers' staff
- Fraudulent activity
- Repeated non-compliance with treatment plan or keeping appointments
- Repeated non-compliance with MVP administrative guidelines

Providers should include documentation of events and any follow-up taken by the provider and the providers' staff. Additionally, the documentation should show:

- The Provider has ruled out any underlying medical conditions that may be impacting the Member's behavior
- Any special considerations the office may be able to address regarding any disabilities the Member might have

- Any cultural issues that might impact the Provider's ability to work effectively with the Member
- Any additional training delivered or necessitated for staff to be able to work more effectively with the Member

Self-Referral and Free Access

MVP Medicaid Managed Care (MVPM) Members may self-refer for the following services:

- Unlimited Mental Health and substance use assessment services from Participating Provider and BH-HCBS applicable to HARP Members (exceptions: ACT, inpatient psychiatric hospitalization, and partial hospitalization.)
- Routine vision screening with a Participating Provider every two years
- Diagnosis and treatment of tuberculosis by public health agency facilities
- Family planning and reproductive health services from any MVP Participating Provider or any Medicaid provider

Homeless Healthcare Services Policy Overview

Beginning February 1, 2025, MVP was required to reimburse Participating Providers for primary care services delivered to homeless Medicaid Members, regardless of whether the Provider is the Member's assigned PCP. However, the Provider must be credentialed as an MVP Participating Provider and enrolled in the NYS Medicaid program and associated with a physical office location. Services may include care provided in diverse settings such as shelters, drop-in centers, food pantries, mobile units, and unsheltered environments. Providers may only deliver services within the scope of their professional license. Core homelessness services are outlined by the state's Homeless Healthcare Services overview.

Providers must document Medicaid enrollment, Member homelessness status, and the location of service delivery using appropriate Z-codes and place-of-service (POS) codes as outlined by NYS. The provider must document the Medicaid Member's homeless status at the time of encounter by recording the appropriate Z-code in the Member's diagnosis list:

- **Z.59.01 – Sheltered Homelessness:** Use for individuals who are living in a shelter, such as a motel, temporary or transitional living situation, or scattered site housing
- **Z.59.02 – Unsheltered Homelessness:** Use for individuals residing in places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, streets

Providers are encouraged to establish protocols for confirming Medicaid eligibility and housing status.

Restricted Recipient Program

Restricted Recipients are Members identified by OMIG and assigned to specific pharmacies or Providers in the MVP Network. Usually, these Members are "restricted" due to evidence of abuse or fraudulent behavior.

The following procedures should be followed when treating MVP MMC Members.

- Verify eligibility by visiting mvphealthcare.com, using the MVP Member ID (not CIN) presented on the ID card. The word "Restricted" may be present on the Member's ID card. MVP's website will inform you if the Member is restricted and instruct you to call the Customer Care Center for Providers for additional information on the restriction to ensure coverage and confirm referral requirements
- MVP shall not pay for any services rendered to a Restricted Member by a Provider that has not been assigned unless MVP has issued a referral to you as requested by the designated provider
- Participating Providers Assigned to care for Restricted Members may submit specialist referrals using MVP's online referral system or by faxing a referral request
- Specialty referrals and changes to restricted pharmacy are required for all Restricted Recipient Members with a Provider restriction
- Restricted Members are notified of such restriction in writing and must go to their assigned health care provider for treatment

Members in a restricted status have been told which Provider they can go to. They are notified in writing, and the Provider they are assigned to is told as well.

Public Health

Tuberculosis (TB) Screening, Diagnosis and Treatment

PCPs are expected to perform tuberculin screening of adults in high-risk groups. This includes persons who have signs or symptoms of clinically active TB. TB screening guidelines can be found within the age-specific MVP Preventive Care Guidelines.

Required Reporting to Local Department of Health

MVP requires Providers to report to the local County Department of Health (CDOH), as required by state health codes. MVP also expects the PCP and other providers to cooperate with the CDOH to identify case contacts and arrange for or provide services and follow- up care. MVP encourages all Providers to consult with their respective CDOH on TB treatment and preventive therapy. Providers should call their local county department of social services for the appropriate contact number.

Reporting Cases to MVP

MVP requires Providers to report active TB cases to the MVP supervisor of case management to ensure that: (1) case management is initiated; and (2) Appropriate referrals are made to providers within the MVP network, when required (See Utilization Management for MVP's referral policy).

Preventive Therapy and Treatment for Active TB

In the absence of HIV or other complications, the PCP or specialist managing the case should provide preventive treatment to Members who have a positive skin test, following the Centers for Disease Control (CDC) guidelines or other accepted treatment protocols. MVP encourages PCPs to refer active cases, including drug-resistant cases, to hospital-based programs or specialized TB clinics.

HIV-Positive TB Patients

MVP encourages the Provider to refer HIV-positive individuals with TB to providers in designated AIDS centers who have TB treatment expertise. An individual with a dual diagnosis of TB and mental illness may require a referral to a specialized clinic or program.

Members Who Are Non-Compliant with Drug Therapy

If there is a need for Directly Observed Therapy (DOT), the case will be referred by the PCP to the city or county DOH for assessment. Providers are required to report positive TB cases to their local public health agency. Refer to the list of Important Numbers at the end of this section for phone numbers to report TB and other communicable diseases.

Sterilization and Hysterectomy

Sterilization and hysterectomy procedures for MVP's NYS Government Programs Members require an administrative Prior Authorization for all procedures, not a medical necessity review. For sterilization procedures performed on male and female Members, the New York State Sterilization Consent Form (DSS-3134) must be attached to the Prior Authorization request form. For hysterectomies, New York State Hysterectomy Information Form (DSS-3113) must be attached to the prior authorization request form. Prior authorization requests with the required consent form must be faxed to MVP's Provider Services Department at fax number **585-327-5759**.

Informed Consent for Sterilization and Hysterectomy

Participating Providers and certified nurse-midwives must comply with documentation, process, and quality standard requirements including informed consent procedures for hysterectomy and sterilization as specified in 42 CFR, Part 441, sub-part F, and 18 NYCRR §505.13. Participating Providers are required to keep on file copies of the sterilization consent form and/or acknowledgement of the Hysterectomy Information Form for MVP MMC Members who receive these services. Members must also sign the MVP Prior

Authorization Request Form that is required to process claim payment for covered services. is required to process claim payment for covered services.

The Member must:

- Be at least 21 years old
- Be informed of the risks and benefits of sterilization
- Sign the mandated sterilization consent form (LDSS-3134) not less than 30 days or more than 180 days prior to performance of the procedure
- Sign the MVP MMC Prior Authorization Request Form for Sterilization/Hysterectomy

Sterilization

Documentation, Process, and Quality Standards Requirements
Medicaid Management Information System (MMIS) in conjunction with the above noted Federal and State citations for Medicaid Members seeking a sterilization procedure includes the following requirements to be completed by the servicing provider:

- Informed Consent—The person who obtains consent for the sterilization procedure must offer to answer any questions the Member may have concerning the procedure, provide a copy of the New York State Sterilization Consent Form (DSS-3134), and provide verbally all the following information or advice to the Member to be sterilized:
    - Advise that the Member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right for future care or treatment and without loss or withdrawal of any federally funded program benefits to which the Member might be otherwise entitled. Give a description of available alternative methods of family-planning and birth control
    - Advise that the sterilization procedure is irreversible
    - A thorough explanation of the specific sterilization procedure to be performed
    - A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used
    - A full description of the benefits or advantages that may be expected because of the sterilization
    - Advise that the sterilization will not be performed for a least 30 days except in the circumstances specified below under "Waiver of 30-day Waiting Period"

In addition to provision of this information at the initial concealing session, the Provider who performs the sterilization must discuss the above with the Member shortly before the procedure, usually during the preoperative examination.

1. **Waiting Period**—The Member to be sterilized must have voluntarily given informed consent not less than 30 days or more than 180 days prior to sterilization.
2. **Waiver of 30-Day Waiting Period**—The only exception to the 30-day waiting period is in cases of premature delivery when the sterilization was scheduled for the expected delivery date of emergency abdominal surgery. In both cases, informed consent must have been given at least 30 days before the intended date of sterilization. Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, if 72 hours have passed between the original signing of the informed consent and the sterilization procedure.
3. **Minimum Age**—The Member to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.
4. **Mental Competence**—The Member must not be a mentally incompetent individual. To this restriction, "mentally incompetent individual" refers to an individual who has been declared mentally incompetent by a Federal, State, or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
5. **Institutionalized Individual**—The Member to be sterilized must not be an institutionalized individual. For the purposes of this restriction, "institutionalized individual" refers to an individual who is (1) involuntarily confined or detained, under a civil or criminal stature, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
6. **Restrictions on Circumstances in Which Consent is Obtained**—Informed consent may not be obtained while the Member to-be-sterilized is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the Member's state of awareness.
7. **Foreign Languages**—An interpreter must be provided if the Member to-be-sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.
8. **Handicapped Persons**—Suitable arrangements must be made to ensure that the sterilization consent information is effectively communicated to deaf, blind, or otherwise handicapped individuals.
9. **Presence of Witness**—The presence of a witness is optional when informed consent is obtained.

One copy of the completed New York State Sterilization Consent Form (DSS-3134) or Acknowledgment of Receipt of Hysterectomy Information Form (DSS-3113) must be given to the Member, and one copy of the completed form must be kept in the Member's medical record.

Hysterectomy

Federal regulations prohibit reimbursement for hysterectomies which are performed solely for the purpose of rendering the Member permanently incapable of reproducing; or if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing. Approved procedures will be reimbursed by MVP only if the Member (and her representative, if any) has been informed verbally and in writing prior to surgery that a hysterectomy will render her permanently incapable of reproduction. In addition, the Member (or her representative, if any) must sign a written acknowledgment of receipt of that information. The requirements for the Member's written acknowledgment can be waived if:

- The person was sterile prior to the hysterectomy.
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible. This must be documented by the surgeon who performs the surgery.
- Acknowledgment of receipt of Hysterectomy Information Form (DSS-3113). This form documents the receipt of hysterectomy information by the Member or the surgeon's certification of reasons for waiver of the acknowledgment. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

Copies of the New York State Sterilization Consent form or the Acknowledgement of Receipt of Hysterectomy Information form (DSS-3113) can be obtained online at: **health.ny.gov/health_care/medicaid/publications/ldssforms.**

Lead Screening

Providers must comply with lead screening follow-up as specified in 10NYCRR, Sub-par 67.1. MVP will reimburse for "point-of-care" blood lead testing of children under age 6 years and those who are pregnant when performed by practitioners operating Provider Office Laboratories (POLs) that hold appropriate CLIA certification, and clinics that operate Limited-Service Laboratories (LSLs) registered by Wadsworth Center for blood lead analysis. These changes also require properly certified Providers with in-office labs and clinics that operate limited services laboratories to report blood lead test results to the NYS Department of Health (NYSDOH) and the Local Public Health Agency (LPHA).

Child/Teen Health Program

MVP participates in the high-priority New York State Child/Teen Health Program (C/THP) for Medicaid-eligible children under age 21 years, which promotes the provision of early and periodic screening services (Well Care Exams), with diagnosis and treatment of any physical, mental, or dental health problems identified during the conduct of well care, to be consistent with nationally recognized standards.

MVP follows the recommendations of the American Academy of Pediatrics (AAP) for preventive care for children and adolescents and promotes the guidelines including the AAP periodicity schedule with plan providers who care for MVP children and adolescents. MVP assesses provider adherence to guideline recommendations through HEDIS- NYS QARR reporting.

MVP also takes steps to identify Members who do not access preventive care services, including Well Care Exams, immunizations, and blood lead testing. MVP helps with appointment setting and transportation coordination and works to address any barriers that exist to ensure Medically Necessary and preventive care is delivered.

MVP includes pediatric preventive care guidelines in its Provider Quality Improvement Manual. The manual is available at **mvphealthcare.com**.

Immunizations for Medicaid Managed Care and Child Health Plus Members

MVP is taking steps to identify Members who do not access certain preventive care services, including immunizations. A list of these Members will be generated monthly and sent to the appropriate PCP. To ensure children receive the necessary services, PCPs may be asked to cross reference the information MVP provides with their own records and, if necessary, contact the Member and encourage a preventive care visit.

The New York State Vaccines for Children (NYS VFC) immunization program provides free vaccines to Providers who are program participants. Children under 18 who are Members of the Medicaid Managed Care and Child Health Plus coverage programs receive vaccines through the NYS VFC program. Providers may call **1-800-KID-SHOTS** (**1-800-543-7468**) for more information and to register with this program.

Rehabilitative Service Coverage

Including the evaluation, MVP will cover Physical Therapy for Speech Therapy and Occupational Therapy services without limits.

Prevention of Sexually Transmitted Diseases

Providers are responsible for the screening, treatment, and education of Members regarding the risks of sexually transmitted diseases. Providers are also responsible for reporting cases of sexually transmitted diseases to local public health agencies and cooperating with contact investigations in accordance with all existing state and local regulations.

Breast Cancer Surgery Facilities

See the MVP Utilization Management policy section.

New York State Medicaid Perinatal Care Standards

The New York State Medicaid Perinatal Care Standards apply to Medicaid Managed Care (MMC) Plans including HARP and are applicable to all Medicaid perinatal care providers who provide prenatal/antepartum care, intrapartum care, and/or postpartum care. Participating Providers and Facilities must adhere to all requirements, practice and care standards as may be updated from time to time by New York State through the *Department of Health. Obstetric Providers must establish and educate patients regarding arrangements for availability of after-hours, on-call and emergency consultation.

*Please refer to the most current New York State Medicaid Perinatal Care Standards available at **Medicaid Perinatal Care Standards.**

Provider Practice Guiding Principles

All pregnancy-related clinical care and services must be delivered in a high-quality, person-centered, cohesive, and comprehensive manner across all Provider types. To accomplish this goal, all Providers who deliver care to pregnant/postpartum persons must adopt, where applicable, a clinical practice philosophy that:

1. Is consistent with current standards of care, evidence-based practice, and practice guideline recommendations of professional clinical organizations including, but not limited to, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Family Providers, the Centers for Disease Control and Prevention (CDC), and the U.S. Preventive Services Task Force (USPSTF)
2. Applies a health equity framework to eliminate racial and ethnic inequities, implicit bias, and racism. Engages with stakeholders, including but not limited to pregnant/postpartum persons, families, and community partners, to improve racial and ethnic equity, trust, and quality of care.
3. Demonstrates cultural humility with and sensitivity to all pregnant/postpartum persons, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds, sexual orientations, gender identities, and faith communities. Interpretation services must be offered to pregnant/postpartum persons whose primary language is not English, in-person when practical, or via video chat or telephone if an in-person translator is not immediately available.
4. Is patient-centered and focused on meeting the unique needs of the pregnant/postpartum person based on their biopsychosocial circumstances and pregnancy

risk level. Provides respectful maternity care, defined as a universal human right that encompasses the principles of ethics and respect for the pregnant/postpartum person's feelings, dignity, choices, and preferences.

5. Promotes timely access to needed services, including timely referral to appropriate levels of prenatal care (basic, specialty, and subspecialty).
6. Promotes comprehensive early and ongoing biopsychosocial risk assessment to prevent, promptly recognize, and treat conditions associated with maternal and neonatal morbidity and mortality.
7. Utilizes an integrated care model, with emphasis on continuity of care and prompt communication with all Members of the pregnant/postpartum person's care team, including the principal maternal Provider, specialist practitioners, mental health Providers, substance use disorder Providers, nutritionists, social workers, and community organizations, as needed.
8. Has systems and protocols in place for tracking, notifying, and engaging pregnant/postpartum persons who need follow-up services or visits, including those who need follow-up visits for abnormal test results.
9. Conducts quality improvement activities including, but not limited to, the evaluation of the quality, safety, and appropriateness of care provided, and participates in quality improvement activities. Process and outcome data must be tracked, analyzed, and used for improving quality and patient safety.

Principal Maternal Care Provider Training and Credentials

Every pregnant/postpartum person must have a principal maternal care Provider. The principal maternal care Provider functions as the pregnant/postpartum person's main maternal care Provider and is responsible for leading and coordinating the pregnant/postpartum person's obstetric care throughout the course of the pregnancy and postpartum period (the 12 weeks immediately following delivery). Maternal care services can be provided by Providers who have any of the following credentials:

1. NYS licensed Provider (MD/DO) practicing in accordance with Article 131 of the New York State Education Law, and who is Board Certified or Board Eligible in Family Medicine or Obstetrics & Gynecology or has completed an accredited residency program in Family Medicine or Obstetrics/Gynecology.
2. NYS licensed Midwives practicing within their training level and scope of practice, and in accordance with Article 140 of the New York State Education Law.
3. NYS licensed Nurse Practitioner (NP) practicing within their training level and scope of practice, and in accordance with Article 139 of the New York State Education Law.

Doula services are available to all Medicaid Members who are pregnant, birthing, or postpartum. Beginning April 1, 2025, doulas will be covered under MVP Medicaid. The

doula must be contracted with MVP. There are no referrals needed to work with a doula, there is standing order for all New Yorkers who are pregnant, birthing, or postpartum.

Access to Care

Pregnant/postpartum Medicaid persons must be offered prenatal care in a timely manner that is aligned with the requirements of the NYS Medicaid Managed Care Model Contract. Providers must, at a minimum, follow these standards but are strongly encouraged to see the pregnant/postpartum person as soon as possible.

Initial prenatal care visit:

- **First Trimester:** visit must occur within 3 weeks of the request for care
- **Second Trimester:** visit must occur within 2 weeks of the request
- **Third Trimester:** visit must occur within 1 week of the request
- **Initial Family Planning visit** must occur within 2 weeks of the request
- **Emergency care must always be available at an Emergency Room**

For specialist referrals and urgent matters during pregnancy:

- Urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 72 hours
- Non-urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 2 to 4 weeks of when the request was made
- For non-emergent, but urgent matters, pregnant persons must be seen within 24-hours of request

Maternal care practices must provide or arrange for the provision of 24-hour/7 day/week coverage as follows:

- After hours and weekend/holiday number to call that leads to a person or option for leaving a message that can be returned by a health care professional within one hour
- The access-to-care standards mentioned above only depict the minimum required time frames by which pregnant persons must be seen if they request a visit. However, pregnant persons may require more frequent visits and follow-ups, and may need to be seen much sooner, depending on their unique medical-psychosocial condition and needs. Providers must consider each pregnant person's unique medical profile, health needs, and severity of the issue at hand when scheduling the pregnant person's visits. Providers must always strive to see pregnant persons as

soon as possible and as frequently as possible, depending on their medical, obstetric, and/or psychosocial needs

- For routine, periodic, non-acute prenatal care visits, maternal care Providers must follow ACOG/prenatal care visit timing and frequency recommendations

Presumptive Eligibility/Medicaid Coverage

Maternal care Providers must assist or refer pregnant Members for assistance with application for Medicaid and managed care plans.

Medicaid enrolled licensed Article 28 providers of prenatal care must perform Presumptive Eligibility determinations and assist pregnant Members in completing the Medicaid application and submitting the completed Medicaid application (DOH-4220) to the appropriate local Department of Social Services for a full Medicaid eligibility determination. The Presumptive Eligibility determination is performed during a visit to the Provider.

All prenatal care service Providers must provide prenatal care services to pregnant individuals determined to be presumptively eligible for medical assistance, but who are not yet enrolled in Medicaid.

Comprehensive Prenatal Care Risk Assessment

Principal maternal care Providers must conduct a comprehensive prenatal care risk assessment at the first prenatal care visit. The purpose of the comprehensive prenatal care risk assessment is to identify all relevant past and current maternal-fetal biopsychosocial risk factors as early in the pregnancy as possible, so that the identified risk factors can be promptly addressed before they cause any harm to the pregnancy. The comprehensive risk assessment must include all the components in the ACOG Antepartum Record and Postpartum Form and must also include the assessment of all the relevant past and current maternal-fetal medical, dental, mental health, substance use, nutritional, and psychosocial risk factors indicated in the tables below. The USPSTF recommends screening adults ages 18 and older for unhealthy drug use in the form of questions. Screening refers to asking questions about unhealthy drug use, not testing biological specimens. Screening tools are not meant to diagnose drug dependence, abuse, addiction, or drug use disorders. Persons with positive screening results may, therefore, need to be offered or referred for diagnostic assessment.

The comprehensive prenatal care risk assessment must be:

- Conducted at the first prenatal visit
- Reviewed at each visit
- Repeated formally early in the third trimester
- Used to form the basis for the development of the care plan

- Documented clearly in the medical record

Pregnancy Risk Factors			
Age <16 yr. or >35 yr. Preterm birth <37 weeks Hypertension/Preeclampsia Placenta abruption	Preterm labor Multiple gestation Cervical incompetence Stillborn/Fetal death	Fetal abnormality C-section Birthweight >4500 g (10 lbs.) Sexually Transmitted Infections, including HIV	Abdominal surgery Low birthweight <2500g (5.5 lbs.) Gestational Diabetes Placenta previa
Medical and Dental Risk Factors			
Anemia Asthma Autoimmune Disorder Cardiac Disease	Dental problem Diabetes Mellitus Deep Vein Thrombosis/ Pulmonary Embolism HIV/AIDS	Hypertension Kidney Disease Seizures Thyroid Disorder	Eating Disorder Underweight Overweight/obese
Mental Health, Substance Use, Nutritional, and Psychosocial Risk Factors			
Alcohol use Children in foster care Communication/ Language barriers Drug use (parents, partner; past, present) Environmental/ Work hazards	Financial/Employment strain Food insecurity Housing instability Inconsistent or limited prenatal visits Intellectual or developmental disability	Intimate partner/Family violence Lack of childcare Limited/No partner/family support Low health literacy Nutritional deficit/Special Supplemental Nutrition Program for Women Infants and Children (WIC) referral needed	Physical abuse Physical disability Psychiatric disease, e.g., depression/anxiety Risk of self-harm Sexual abuse

If the comprehensive prenatal care risk assessment identifies a maternal-fetal risk factor at any point in the pregnancy, the maternal care Provider must address the identified risk factor as soon as possible using the appropriate means, whether by providing treatment, counseling, education, or referral to the appropriate specialists or community resources for evaluation and management of the identified risk factor. Such specialists and community resources may include, but are not limited to, the following:

• Asthma Educator • Childcare Resources • Community Health Worker • Community Case Manager • Dental Care	• Diabetes Educator • Domestic/Intimate Partner • Violence Services • Health Home • Health Plan Case Manager • High-Risk OB	• Home Visit Provider • Mental Health Provider • Nutrition/Lactation • Counseling • Office Case Manager • Peer Family Navigator	• Remote Patient Monitoring • Substance Use Provider • Supplemental Nutrition • Assistance Program (SNAP) • Tobacco Dependence • Treatment • WIC

Care Plan and Care of Coordination

Principal maternal care providers must develop a care plan jointly with each pregnant/post-partum person which addresses the problems identified because of the initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant/post-partum person, their family and the appropriate Members of the health care team.

Care must be coordinated by the principal maternal care Provider to:

- Ensure that relevant information is exchanged between the principal maternal care Provider and other Providers, human service and community-based service Provider, health plan case managers and sites of care including the anticipated delivery site.
- Ensure ongoing communication between the Provider and the pregnant/postpartum person's health plan to facilitate plan's timely awareness of the person's pregnancy, health insurance application
- Ensure that the pregnant/postpartum person and their family or other designated representative, with their consent, have continued access to information resources and are encouraged to participate in the decisions involving the care and services being provided.
- Encourage and assist the pregnant/postpartum person in obtaining necessary medical, dental, nutritional, psychosocial, drug and substance use services appropriate to their identified needs.
- Provide the pregnant/postpartum person with an opportunity to receive prenatal and postpartum home visitation when medical and/or psychosocial benefits may be derived from the visits
- Provide or refer the pregnant woman to needed services as identified in the risk assessment
- Obtain special tests and services that may be recommended or required by the Commissioner of Health, when necessary to protect maternal and/or fetal health. The following tests are required by law and/or regulation, and the Provider must follow current standards of care, evidence-based practice, and practice guideline recommendations for tests and services:
    i. New York State Public Health Law 2500-e requires that every pregnant woman be tested for the presence of hepatitis B surface antigen (HBsAg) and that the test results and the date be documented in the prenatal record. It also requires that infants of women who are hepatitis B surface antigen positive or whose test results are unknown receive treatment at birth with hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).
    ii. New York State Public Health Law 2112 prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient.

iii. NYS Public Health Law and Regulations (NYCRR Subpart 67-1.5) requires that prenatal care Providers provide all pregnant women with anticipatory guidance on preventing lead poisoning, information on the major sources of lead, and the means to prevent exposure while pregnant. At the initial prenatal visit, each pregnant woman shall be assessed for exposure to lead. If considered to be at risk, the pregnant person should have a blood lead test and be counseled on how to eliminate lead exposure. Providers are also required to provide anticipatory guidance on the prevention of childhood lead poisoning during prenatal and postpartum visits.

iv. NYS Public Health Law, Article 23 Section §2308; New York Code of Rules and Regulations, Title 10, §69-2.2 requires that pregnant women be screened for syphilis at their first prenatal visit and again at delivery. It is highly recommended that syphilis screening be repeated at 28 weeks and no later than 32 weeks of pregnancy to avoid congenital syphilis, and to pair this with the strongly recommended third trimester HIV testing.

The principal maternal care Provider shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:

1. A system for sharing prenatal medical records, including HIV test results
2. Pre-booking of pregnant person for delivery by 36 weeks gestation for low-risk pregnancies and by 24 weeks gestation for high-risk pregnancies
3. Scope of services
4. Sharing of delivery/birth outcome information

Community Health Worker Services

All Community Health Worker (CHW) services must be recommended by a licensed practitioner and may only be billed by the supervising NYS Medicaid-enrolled entity. In addition to pregnant and postpartum individuals, the following Members are also eligible to receive CHW services:

- Children under 21 years old
- Adults with chronic conditions
- Justice-involved individuals
- Those with unmet health-related social needs
- Individuals experiencing community violence.

Initial and Comprehensive Postpartum Visits

All postpartum persons are to have an initial assessment by their principal maternal care Provider within the first 3 weeks postpartum either in-person or via Telehealth to address acute postpartum issues. Ongoing follow-up care must be individualized and provided as needed. Postpartum persons with a complicated gestational history or delivery by cesarean section must have an initial visit scheduled as early as possible or within 7 days of delivery.

The comprehensive postpartum visit must occur in-person between 4 weeks and no later than 12 weeks after birth. The timing must be individualized and person-centered. The purpose of the comprehensive postpartum visit is to conduct a full assessment of all relevant maternal and child physical, behavioral, and psychosocial well-being factors, as per ACOG/AAP postpartum recommendations, and to facilitate timely intervention for warning signs associated with postpartum morbidity and mortality. For example, the comprehensive visit must include, but not be limited to, the following:

The visit shall include but not be limited to the following:

1. Identify whether any medical, dental, psychosocial (including depression), nutritional (including BF/ CF), tobacco/smoking cessation needs, and alcohol and drug treatment need of the postpartum person or infant are being met;
2. Provide anticipatory guidance on the prevention of childhood lead poisoning;
3. Refer the postpartum person or other infant caregiver to resources and providers available for meeting identified needs, including chronic disease management, and aid in meeting such needs where appropriate;
4. Assess family planning/contraceptive needs and provide advice and services or referral when indicated;
5. Provide guidance regarding well-person care, including appropriate inter-conception recommendations such as preconception daily intake of folic acid (400 mcg) as per CDC and ACOG guidelines, and encourage a preconception visit prior to subsequent pregnancies;
6. Refer the infant to preventive and special care services appropriate to their needs;
7. Advise the postpartum person/caregiver of the availability of Medicaid eligibility for infants;
8. Advise or refer the postpartum person for assistance with an application for ongoing medical care assistance for themselves, in accordance with their financial status, health assistance program eligibility, and the policies and procedures established by the Commissioner of Health and the State of New York;
9. Provide communication and collaboration with non-principal maternity care providers to ensure care coordination and seamless transitions of care; and
10. Provide counseling and support to overweight/obese postpartum persons to have a healthy body weight.

Home Visits

The Medicaid reimbursable visit is a skilled nursing home visit provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). Other home visit providers may include, but are not limited to, Nurse-Family Partnership Programs, local health departments, and community health worker programs, which may or may not be covered as a Medicaid benefit.

Prenatal Home Visits

Prenatal home visits must be provided to pregnant persons if ordered by the principal maternal care Provider and if they are medically necessary for managing the pregnant person's prenatal course or prenatal issue at hand. Criteria for medical necessity are as follows:

1. High medical risk pregnancy as defined by the ACOG and the AAP Guidelines for Perinatal Health (Early Pregnancy Risk Identification for Consultation); or
2. Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy; or
3. Pregnant person otherwise unengaged in prenatal care (no consistent visits); or
4. Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance use, unsafe housing, nutritional risk, unstable mental health, and inadequate resources or parenting skills.

The number and frequency of the home visits must be guided by what is medically necessary to manage the pregnant person's prenatal course or prenatal issue at hand, based on the pregnant person's unique medical, obstetrical and/or psychosocial profile.

The prenatal home visit must include:

1. An assessment of the pregnant person's obstetrical status and any pregnancy-related problems;
2. An assessment of the pregnant person's medical status and needs; and
3. An assessment of the pregnant person's psychosocial and environmental risk factors (such as unsafe environment and inadequate resources, including shelter, food/nutrition, and social supports).

The prenatal home visit assessment and its findings must be sent to the pregnant person's principal maternal care provider for next steps as needed to manage any issues that are identified in the prenatal home visit assessment (such as referral to specialists and other community resources for evaluation and management).

Postpartum Home Visits

All postpartum persons are eligible for one initial postpartum home visit after they give birth. Additional postpartum home visits could be covered depending on the postpartum person's unique medical, obstetrical, and/ or psychosocial profile.

The postpartum home visit summary and its findings must be sent to the postpartum person's principal maternal care provider and their health plan case manager for next steps as needed to manage any issues that are identified in the postpartum home visit (such as referral to specialists and other community resources for evaluation and management).

Initial Postpartum Home Visit

The purpose of the initial postpartum visit is to address acute postpartum issues, as per ACOG/AAP postpartum recommendation.

All principal maternal care providers and/or birthing hospitals must offer and arrange for the initial postpartum home visit with all postpartum persons. All birthing hospitals must have a system in place to arrange and schedule the postpartum person's first/initial postpartum home visit prior to discharge.

If a postpartum person agrees to receive the initial postpartum home visit, then the birthing hospital is responsible for arranging and scheduling the initial postpartum home visit for the postpartum person, and the postpartum home visit should take place 36 to 72 hours after the postpartum person's discharge.

The postpartum home visit must include:

1. An assessment of the health of the parent and newborn;
2. An assessment of the labor and delivery care history;
3. An assessment of any current pregnancy-related problems;
4. An assessment of the postpartum person's psychosocial and environmental risk factors (such as unsafe environment, and inadequate resources, including shelter, food/nutrition, and social supports);
5. Nutrition education;
6. Infant feeding, including breastfeeding (BF)/chestfeeding (CF) education;
7. Family planning counseling to ensure optimal birth spacing;
8. Parenting guidance; and
9. Guidance regarding the identification and treatment of early warning signs that occur up to one year after pregnancy.

Additional Postpartum Home Visits

Additional postpartum home visits could be covered if the postpartum person's situation meets one of the four medical necessity criteria listed below:

1. History of a high medical risk pregnancy as defined by ACOG and AAP Guidelines for Perinatal Health
2. (Early Pregnancy Risk Identification for Consultation); or
3. Need for home monitoring or assessment by a nurse for a medical condition complicating postpartum care; or
4. Postpartum person otherwise unengaged in postpartum care; or
5. Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance use, unsafe housing, and nutritional risk

Breastfeeding/Chestfeeding

In accordance with ACOG and USPSTF recommendations, health care providers are to educate and counsel pregnant and postpartum persons about infant feeding decisions and breastfeeding/chestfeeding at all prenatal visits, the maternity stay, and postpartum. Exclusive human milk feeding is recommended for the first 6 months of life and, with the addition of complementary foods, through the second half of the first year of life and as long as desired thereafter. Providers are to educate pregnant and postpartum persons about the known nutritional advantages and health benefits of human milk/ BF/CF for both the birthing person and the infant. Given that racial biases and practices contribute to BF/CF disparities, providers are to implement policies and practices in their offices and hospitals to provide culturally sensitive, equitable BF/CF education, lactation counseling, and maternity care.

All health care providers who care for pregnant and postpartum persons or newborns are to be knowledgeable about BF/CF and competent to provide lactation guidance, education, assessment, and referrals to the full range of lactation providers, including International Board-Certified Lactation Consultants (IBCLCs), to support a person's efforts to breastfeed/chestfeed. Pregnant and postpartum persons must also be referred to community BF/CF support groups and WIC for prenatal, postpartum, infant and child nutrition, and BF/CF education and support. For parents who are separated from their infant or returning to work or school, additional lactation support and counseling may be needed to ensure BF/CF success. BF/CF or feeding expressed milk is not recommended for HIV-positive persons and may be medically contraindicated in other situations.

Pregnant and postpartum persons are to be educated about New York State and federal laws that protect BF/CF in public places and maternity care facilities, provide the rights to express milk in the workplace, the availability, indications and use of breast pumps, and safe storage of human milk.

New York Laws:

1. NY Paid Family Leave Law provides eligible employees with up to 12 weeks of job protected, paid time off to bond with a new child, care for a family Member with a serious health condition, or to assist loved ones when a family Member is deployed abroad on active military service. This time can be taken all at once, or in increments of full days. Employees receive 67% of their weekly wage, up to a cap of 67% of the Statewide Average Weekly Wage. Full-time employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment and part-time employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive. Employees with irregular schedules should look at their average schedule to determine if they work, on average, fewer than 20 hours per week.
2. NY State Labor Law § 206-c Right of nursing mothers to express breast milk. An employer shall provide reasonable unpaid break time or permit an employee to use paid break time or mealtime each day to allow an employee to express breast milk for her nursing child for up to three years following childbirth. The employer shall make reasonable efforts to provide a room or other location, near the work area, where an employee can express milk in privacy. No employer shall discriminate in any way against an employee who chooses to express breast milk in the workplace.

- NY Civil Rights Law § 79-e Right to breastfeed. Notwithstanding any other provision of law, a mother may breast feed her baby in any location, public or private, where the mother is otherwise authorized to be, irrespective of whether the nipple of the mother's breast is covered during or incidental to the breast feeding.

3. NY Penal Law § 245.01 Exposure of a person. An individual breastfeeding an infant is not subject to penal law that punishes exposure of a private or intimate part of their body.
4. NY Correction Law § 611 allows a mother of a nursing child to be accompanied by her child if she is committed to a correctional facility at the time she is breastfeeding. This law also permits a child born to a committed mother to return with the mother to the correctional facility. The child may remain with the mother until one year of age if the woman is physically capable of caring for the child.
5. NY Public Buildings Law § 144 requires that a covered public building shall contain a lactation room that is made available for use by a Member of the public to breastfeed or express breast milk.
6. NY Judiciary Law § 517 amends the Judiciary Law, provides an exemption from jury duty for breastfeeding women, allows that such breastfeeding mother's jury duty shall be postponed up to a certain period after the date on which such service otherwise to commence.
7. NY Social Services Law § 365-a includes pasteurized donor human milk, which may include fortifiers as medically indicated for in person use, under standard coverage for medical assistance for qualifying infants.

Federal Laws:

1. Title VII of the Civil Rights Act, 42 U.S.C. §2000e-2, 42 U.S.C. § 2000e(k), 29 C.F.R. § 1604.10, prohibits sex discrimination in employment based on pregnancy, childbirth, and related medical conditions, such as breastfeeding and lactation. Employees must be given the same type of accommodations as others with temporary medical conditions for all employment-related purposes.
2. Title IX of the Education Amendments of 1972, 20 U.S.C. §1681 et seq, 34 C.F.R. § 106.40(b) (1), prohibits sex discrimination in educational institutions that receive federal funds and discrimination against students based on parental status, pregnancy, childbirth, recovery from childbirth, and related conditions. It requires that pregnant students and those recovering from childbirth-related conditions be given the same accommodations and support services given to other students with similar temporary medical needs.
3. Section 7 of the Fair Labor Standards Act, 29 U.S.C. § 207(r), requires all employers to provide a private, non-bathroom space and reasonable unpaid break time to express breastmilk for up to 1 year. Employers with less than 50 employees who can demonstrate undue hardship are exempt from this law.
4. Friendly Airports for Mothers (FAM) and FAM Improvement Act requires all airports to provide a clean, non-bathroom space in each terminal for the expression of breastmilk and a baby changing table in one man's and one woman's restroom in each passenger terminal building.

Safety Net/TANF Documentation

Upon Member consent, providers are required to supply medical documentation of health, mental health, and chemical dependence assessments as follows:

- Within 10 days of request from a Member or former Member currently receiving or applying for public assistance, the PCP or specialist provider must provide medical documentation concerning the Member or former Member's health or mental health status to the local department of social services (LDSS) or the LDSS's designee
- Within 10 days of request of a Member or former Member who has already undergone or is scheduled to undergo an initial LDSS-required mental and /or physical exam, the Member's PCP shall provide a health, mental health, or chemical-dependence assessment exam or other services as appropriate to identify or quantify a Member's level of incapacitation

Claim Encounters

Providers are required to submit all claim encounters for Medicaid Managed Care (Medicaid, SSI, HARP) and Child Health Plus products following the claim submission guidelines outlined in the MVP Claims section policy.

Special Networks

DentaQuest

Starting June 1, 2025, DentaQuest will administer all dental services for the Medicaid, HARP, EP, DSNP, and CHP, Lines of business. This includes a full range of preventive, prophylactic, diagnostic, and other routine dental care, services, and supplies as well as limited orthodontia services for children enrolled in MVP Medicaid Managed Care and MVP Child Health Plus. If a DentaQuest dental provider identifies a medical issue, they will refer the Member back to their PCP for coordination of the appropriate medical care or referrals.

Pharmacy Services

Refer to **eMedNY.org**.

Fair Labor Standards Act

Licensed Home Care Services Agencies (LHCSA), Certified Home Health Agencies (CHHA) and Fiscal Intermediaries (FI) are required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA) per section 35.11 of the Medicaid Model Contract. Providers must develop protocols to demonstrate compliance with requirements of the FLSA. Such protocols include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate of reimbursement.

Critical Incidents

Critical Incidents are a subset of Serious Reportable Events (SRE-applicable to MVP Members receiving Long Term Services and Supports (LTSS)) including:

- Private Duty Nursing
- Skilled Nursing
- Home Health Services
- Personal Care Services
- Consumer Directed Personal Assistance Services
- Adult Day Health Care
- AIDS Adult Day Health Care
- Institutional services including long term placement in Residential Health Care Facilities

An MVP Participating Provider must report Critical Incidents within 24 hours of their knowledge of the event to the MVP Customer Care Center for Provider Services at **1-800-684-9286.**

The following categories of events constitute a Critical Incident as defined by New York Department of Health Medicaid Model contract Section10.38 and as described by MVP Policy

- **Wrongful Death**—Any cessation of life due to other than natural causes, including deaths determined to be due to abuse, neglect, or exploitation
- **Use of Restraints**—Restraint is defined as the act of limiting or controlling a person's actions or behavior through the use of any device which prevents the free movement of any limb; any device or medication which immobilizes a person; any device which is ordered by a Provider for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a Provider which renders the participant unable to satisfactorily participate in services, community inclusion time or other activities
- **Medication errors that resulted in injury**—Any situation in which a participant experiences marked adverse reactions which threaten his/her health and welfare due to refusing to take prescribed medication; taking medication in an incorrect dosage, form, or route of administration; taking medication on an incorrect schedule; taking medication which was not prescribed; or, the failure on the part of the staff of a provider of waiver services to properly follow the plan for assisting the participant in self-medication
- **Instances of abuse of Members**—The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The abuse may be physical, psychological, or sexual
- **Instances of neglect of Members**—Failure to provide a Member with goods and services that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes inconsistent or inappropriate services, treatment or care which does not meet their needs, or failure to provide an appropriate and/or safe environment
- **Instances of exploitation of Members**—The illegal or improper use of an individual's funds, property, or assets. Includes taking advantage of a Member for personal gain using manipulation, intimidation, threats, or coercion
- **Crimes committed against Member**—An illegal act that is punishable by law that is committed against an enrollee
- **Crimes committed by Member**—An illegal act that is punishable by law that is committed by a Member
- **Other incident resulting in hospitalization**—Any incident that results in an unplanned admission to the hospital. Does NOT include a planned overnight for a procedure
- **Other incident resulting in medical treatment other than hospitalization**—Any incident that requires medical intervention(s) provided as a direct result of an accident/injury or non-accident to the participant, regardless of whether hospitalization is required or not. DOES include the use of an Emergency Room

Deficit Reduction Act (DRA) of 2005

The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities that receive Medicaid funds in excess of $5 million annually to establish written policies informing and educating their contractors about federal and state anti-fraud statutes. As a Medicaid Managed Care contractor, MVP is subject to this DRA requirement. In addition, Participating Providers in MVP's Medicaid Managed Care program are contractors and as such are required to adopt MVP's policy for Detecting and Preventing Fraud, Waste and Abuse. This policy provides information regarding several important anti-fraud statutes, such as the False Claims Act, and MVP's policies and procedures for compliance with these laws. This policy is available by visiting **mvphealthcare.com**, select *Providers*, then *Resources*, then *Reference Library home*, then open the *MVP Policies* accordion, then select *Detecting and Preventing Fraud, Waste and Abuse*.

Non-Emergent Transportation (NY)

Non-emergent transportation for MMC and HARP Members is coordinated by the NYS transportation vendor, Medical Answering Services (MAS).

Providers may also order transportation services via the Medical Answering Services website at **medanswering.com**; phone or fax. Location specific phone number and contact details can be found on the MAS website.

Benefit Coverage

Transportation expenses are covered for MMC Members when essential to obtain Medically Necessary Covered services and are pre-authorized.

Travel Exclusions and Limitations

- Travel for non-authorized care
- Travel to a PCP that the Member has selected that is outside the 30-minute, 30-mile travel standard, unless no provider is available within travel standard

Hemophilia Blood Clotting Factor Program

MVP covers blood clotting factor drugs and treatment rendered by Participating Providers for MMC and CHP Members. Services and supplies must be obtained by practitioners in the MVP Network.

Prior Authorization is not required for MMC Members. However, the prescribing Participating Provider must complete a Clotting Factor Individual Service Plan (ISP) form as a Member starts blood clotting factor treatment or becomes covered by MVP while in treatment. This requirement allows MVP to collect information from the prescriber and the vendor supplying the drug and develop a person-centered service plan that is designed to meet all the Member's potential treatment needs. A new ISP for the Member should be

sent to MVP every 180 days. Quarterly updates from the supplier of the drug are also required. Participating Providers should consult MVP's Benefit Interpretation Manual regarding coverage criteria.

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National Diabetes Prevention Program (NDPP)

The NDPP is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of in-person group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach. MVP will cover 22 NDPP in-person group training sessions over the course of 12 months.

Health Home Program

A Health Home is a care management service model whereby all a Member's caregivers communicate with one another, so all needs are addressed comprehensively, and physical and behavioral health services are integrated. MVP's Health Home Program provides Care Management services to qualified adult and children Members using an integrative model to support the Member's recovery. The Health Home Program is designed to minimize gaps in care, maximize early intervention and improve health outcomes.

New York State's Health Home Eligibility Criteria: Determining Eligibility for Health Home Services

Step One
Step One is to determine Medicaid eligibility. Medicaid reimbursement for Health Home services can only be provided for individuals who are enrolled in Medicaid that is also compatible with Health Home services (refer to Guide to Coverage Codes and Health Home Services. The Health Home Care Management Agency (CMA)/Health Home Care Manager (HHCM) must confirm Medicaid eligibility required for enrollment. It is also important to note that a client's Medicaid eligibility may change frequently. The care manager should continually verify Medicaid eligibility and work with eligible Members to assist them in enrolling or renewing Members for Medicaid benefits as required. It is important to note that Medicaid coverage may be granted retroactively.

Step Two
Step Two is to determine if the Member is eligible for Health Home services. To be eligible for Health Home services, an individual must have two chronic conditions or one single qualifying condition. Having one chronic condition (other than the single qualifying conditions below) and being at risk of developing another condition does not qualify an individual as Health Home eligible in New York State.

Medicaid Members eligible to be enrolled in a Health Home must have:

Two or more chronic conditions OR

One single qualifying chronic condition:
HIV/AIDS or
Serious Mental Illness (SMI) (Adults) or
Sickle Cell Disease (both Adults and Children) or
Serious Emotional Disturbance (SED) or Complex Trauma (Children)

One single qualifying chronic condition:

- HIV/AIDS or
- Serious Mental Illness (SMI) (Adults) or
- Sickle Cell Disease (both Adults and Children) or
- Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Substance use disorders (SUDS) are considered chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition (as described below) to qualify.

Diagnostic eligibility criteria verifying the individual's current condition(s) must be confirmed and maintained in the record. Information may be accepted from any one of these sources: Plan referrals, medical records, or assessments, written verification by the individual's Provider or treating healthcare provider, the Regional Health Information Organization (RHIO), or the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).

MCOs and medical providers may provide the Health Home Care Management Agency (CMA) or Health Home with a Clinical Discretion of Diagnostic Requirements, to allow the CMA/HH to service the Member without documentation and verification of qualifying conditions.

Qualifying chronic conditions are any of those included in the "Major" categories of the 3MTM Clinical Risk Groups (CRGs) as described in the list below.

Major Category: Alcohol and Substance Use Disorder

- Alcohol and Liver Disease
- Chronic Alcohol Abuse
- Cocaine Abuse
- Drug Abuse—Cannabis/NOS/NEC
- Substance Abuse
- Opioid Abuse
- Other Significant Drug Abuse

Major Category: Mental Health

- Bi-Polar Disorder

- Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- Dementing Disease
- Depressive and Other Psychoses
- Eating Disorder

Major Personality Disorders

- Psychiatric Disease (Except Schizophrenia)
- Major Category: Cardiovascular Disease
- Advanced Coronary Artery Disease
- Cerebrovascular Disease
- Congestive Heart Failure
- Hypertension
- Peripheral Vascular Disease

Major Category: Developmental Disability

- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Neurological Impairment
- Familial Dysautonomia
- Prader-Willi Syndrome
- Autism Spectrum Disorder
- Major Category: Metabolic Disease
- Chronic Renal Failure
- Diabetes

Major Category: Respiratory Disease

- Asthma
- Chronic Obstructive Pulmonary Disease

Major Category: Other

Step Three

Step three is to determine appropriateness for Health Home services. Individuals who are Medicaid eligible and have active Medicaid and meet diagnostic eligibility criteria are not necessarily appropriate for Health Home care management. An individual can have two chronic conditions and be managing their own care effectively. An individual must be assessed and found to have significant behavioral, medical, or social risk factors that require the intensive level of Care Management services provided by the Health Home

Program. Appropriateness for Health Home services must be determined for MAPP HHTS Referral Portal referrals, as well as community or bottom-up referrals. An assessment must be performed for all individuals to evaluate whether the person has significant risk factors.

Additionally, currently enrolled Medicaid Members should be evaluated to determine whether they remain appropriate for the Health Home Program. Can the Member manage their condition(s) using existing services and family/natural support without evidence of risk that supported their HH enrollment? Can the Member be disenrolled or transitioned to a lower level of care management?

Determinants of medical, behavioral, and/or social risk can include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Lack of or inadequate social/family/housing support, or serious disruptions in family relationships
- Lack of or inadequate connectivity with healthcare system
- Non-adherence to treatments or medication(s) or difficulty managing medications
- Recent release from incarceration, detention, psychiatric hospitalization, or placement
- Deficits in activities of daily living, learning or cognition issues
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

NOTE: When evaluating appropriateness for the enrollment of the adult population, there are varying factors that must be considered. HHs, CMAs, and MCPs must follow NYS DOH guidance provided in the Eligibility Requirements: Identifying Potential Members for Health Home Services—Appropriateness Criteria, which supplements this policy by providing examples of determinants of risk identified in the above list.

If you have any questions, please contact MVP's Health Home Program at HealthHome@mvphealthcare.com.

MVP Behavioral Health Case Management

MVP offers behavioral health care management services to manage Members' behavioral health care needs (both mental health and substance use disorders.) This service is available to:

- All Medicaid Managed Care, Child Health Plus, and Medicare Members
- Children and Adults

Additional information can be found in the Behavioral Health section of the Provider Policies.

Health and Recovery Plan (MVP Harmonious Health Care Plan)

A Health and Recovery Plan (HARP) is a special needs product that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. MVP's HARP product is called the MVP Harmonious Health Care Plan. This product is designed to promote person-centered, collaborative care which focuses on recovery.

The MVP Harmonious Health Care Plan will:

- Manage the Members Medicaid Services
- Manage an enhanced benefit package of Adult Behavioral Health Home and Community-Based Services
- (BHHCBS) and Community Oriented Recovery and Empowerment (CORE) Services
- Provide enhanced care management for Members to help them coordinate all their physical health, behavioral health and non-Medicaid support needs

More information on this line of business including eligibility and benefits can be found in the Behavioral Health section of the MVP Provider Policies.

Adult Behavioral Health Home and Community Based Services (BH-HCBS)

Adult Behavioral Health Home and Community Based Services (BH-HCBS) enhance access to Behavioral Health and substance use treatment and recovery services for eligible Medicaid and Integrated Benefits Plan (IBP) Members. BH-HCBS provides alternatives to hospital based, inpatient or other institutional care settings. This program is designed to empower Members to take an active role in their health care and through an integrated approach support Members in maintaining success in the community. The array of services includes opportunities for Members to be served in the community setting or within their own homes in many cases.

More information about BH-HCBS can be found in the Behavioral Health section of the MVP Provider Policies.

Community Oriented Recovery and Empowerment (CORE) Services

Community Oriented Recovery and Empowerment (CORE) Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

(CORE) Services Demonstration includes HARP and IBP Members and HARP-eligible HIV/SNP Members who would benefit from CORE Services in the pursuit of valued recovery goals.

CORE Services will provide opportunities for eligible adult Medicaid and IBP beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. CORE designated providers will work together with MVP, service Providers, plan Members, families, and government partners to help Members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

More information about CORE services may be found in the Behavioral Health section of the Provider Policies.

Children's Behavioral Health Services

Members enrolled in the MVP Medicaid Managed Care Plan have access to following Children's Behavioral Health benefits for all Medicaid participants under 21 years of age. This includes an array of Children's Home and Community Based services and State Plan services known as Children and Family Treatment Supports and Services (CFTSS.) Effective 1/1/2023, CFTSS services are also available to CHP Members.

Children and Family Treatment and Support Services

Children and Family Treatment and Support services (CFTSS) are available to all MVP Medicaid Managed Care enrolled children under the age of 21 meeting applicable medical necessity criteria. These services focus on provision of individualized Behavioral Health interventions which promote greater care flexibility and include family and community provider integration. Medical Necessity criteria can be found on the NYS Office of Mental Health (OMH) website. The following is a description of the various CFTSS. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible. Effective January 1, 2023, CFTSS services are also available to CHP Members.

Children's Home and Community Based Services (CHCBS)

Children's Home and Community-Based Services (CHCBS) is a State operated 1915c Children's Waiver which provides opportunities for Medicaid Member's under 21 that have Behavioral Health needs and/or medically complex conditions to receive services in their own home or community. The array of available services supports children with significant need who are at risk for hospitalization or institutionalization care to support them maintaining within their home and community setting. MVP, Health Home Care Managers (*Children Youth Evaluation Services (CYES), service providers, plan Members, and their chosen supporters/caregivers, help Members prevent, manage, and ameliorate chronic health conditions and improve health outcomes.

More information on these benefits and eligibility can be found in the Behavioral Health section of the Provider Policies.

Beginning on January 1, 2025, MVP's CHP benefit package includes Home and Community Based Services (HCBS) for eligible children who meet HCBS eligibility but do not qualify for Medicaid. Covered services include respite, community habilitation, assistive technology, environmental and vehicle modifications, palliative care, caregiver/family support, pre-vocational and supported employment services, and non-medical transportation. Eligibility is determined by contracted Health Homes, and services must be provided by designated children's HCBS providers contracted with MVP. Claims for HCBS should be submitted directly to MVP under CHP billing guidelines.

Voluntary Foster Care in Medicaid Managed Care

Beginning July 1, 2021, children placed in voluntary foster care have transitioned into Medicaid Managed Care. Voluntary Foster Care Agencies (VFCAs) who obtain Article 29-I licensure and provide mandatory Core Limited Health-Related Services to foster care children while they are in active placement. VFCAs may also provide Other Limited-Health Related Services (as outlined in the agency's licensures) to children in active foster care placement and up to one- year post discharge.

Core Limited Health-Related Services (residual per diem):

- Skill building
- Nursing supports and medication management
- Medicaid treatment planning and discharge planning
- Clinical consultation and supervision
- Managed Care Liaison/administration

Other Limited Health-Related Services may include:

- Screening, diagnosis, and treatment related to physical/developmental/behavioral health
- Children and Family Treatment and Support Services (when designated a children's provider)
- Children's Home and Community Based Services (when designated a children's provider)

Effective January 1, 2023, 29I Health Facility (VFCA) services are also available to CHP Members.

Provider Training

MVP provides resources for provider training regarding Behavioral Health services and special populations including Foster Care, HARP, CHCBS and CFTSS. The training is

available at mvphealthcare.com/providers/ education. All Participating Providers in MVPs Medicaid Managed Care program are required to complete Voluntary Foster Care training. The training outlines information including the following:

- Overview of Foster Care population and Article 29-I Voluntary Foster Care Agencies and services
- Determining a child's eligibility for the CHCBS program (e.g., Targeting Criteria, Risk Factors, Functional Limitations)
- How to work with MVP on developing and reviewing a Plan of Care (POC) for these Members
- How to determine if an MVP Member is enrolled in this program as they will not have a different line of business, only additional benefits
- How to determine the additional benefits for these Members
- Utilization and Case Management Requirements regarding required specialized services
- Any special billing and coding requirements, data interface, documentation requirements, Provider profiling programs

Benefit Overview for NYS Essential Plan

Essential Plans (EPs) are offered through MVP Health Care for low-income individuals in New York who meet the income and citizenship requirements. There are no monthly premiums for EPs, but co-pays vary based on play type. Plans specifically designed for American Indians and Alaska Natives (AIAN) are exempt from cost sharing. Unlike Medicaid, Essential Plan Members are eligible for wellness benefits. Standard benefits include:

- Dental care that is preventive and routine is generally fully covered
- Emergency care is covered with co-pays
- Mental health and substance abuse disorder services are covered with co-pays
- Preventive care is generally full covered
- Primary care visits are covered with co-pays
- Professional and Outpatient care is covered
- Prescription Drugs are covered and co-pays will vary depending on the plan and tier of the drug
- Specialist office visits are covered with co-pays
- Vision exams and lenses/frames/contract lenses are generally fully covered

Benefit Overview for NYS Government Programs

The table below outlines the benefits covered by each MVP Government program plan. An "X" in a box indicates that service is covered.

Service	Medicaid	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Adult Day Health Care	X Covered with Prior Authorization	X Covered with Prior Authorization	X Covered with Prior Authorization	Not Covered
AIDS Adult Day Care	X Covered with Prior Authorization	X Covered with Prior Authorization	X Covered with Prior Authorization	Not Covered
Audiology Services: Hearing Aids and Follow-Up Visits	X	X	X	One hearing exam/ calendar year and any medically necessary follow- up
Chiropractic Services	X Covered with Prior Authorization for Members under the age of 21	XCovered with Prior Authorization for Members under the age of 21	Not Covered	Not Covered
Custodial Nursing Home Care	X—Covered with approval from the County LDSS	X—Covered with approval from the County LDSS	Not Covered	Not Covered
Dental*	X*	X*	X*	X*
Doctor Visits	X	X	X	X
Doula (Pregnancy and Postpartum Doulas Only)	X	X	X	Not Covered
Durable Medical Equipment (DME)	X	X	X	X
Emergency Room Services	X	X	X	X
Emergency Transport	X Covered under FFS Medicaid	X Covered under FFS Medicaid	X Covered under FFS Medicaid	X
Family Planning and Reproductive Care	X	X	X	X
Foot Care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care
Harm Reduction Services	X	X	X	
Home Delivered Meals	Covered only for	Covered only for	Covered only for	

	Members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
Hospice	X	X	X	X
Immunizations	X Immunizations for children under age 18 are covered by the NYS VFC program	X Immunizations for children under age 18 are covered by the NYS VFC program	X	X Immunizations for children under age 18 are covered by the NYS VFC program
Infertility Services	X	X	X	Not covered
EPSDT Services Through the Child/Teen Health Program and Adolescent Preventive Services	X	X		X
Inpatient Hospital Services	X	X	X	X
Inpatient Mental Health	X*	X*	X*	X*
Laboratory Services	X	X	X	X
Low Vision and Medical Eye Care	X	X	X	X
Medically Managed Inpatient Detoxification	X*	X*	X*	X*
Mobile Crisis Intervention Services	X	X	X	Not covered
Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP		Not covered
Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP,	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP		Not Covered

National Diabetes Prevention	X Annual limits apply	X Annual limits apply	X Annual limits apply	Not covered
Occupational Therapy	X	X	X	X
Orthodontia	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization
OTC Drugs	Covered under NYRx	Covered under NYRx	Covered under NYRx	Not covered except with prescription. Must be for therapeutic and preventive purposes.
Outpatient Mental Health	X*	X*	X*	X*
Outpatient Substance Abuse Services	X*	X*	X*	X*
Personal Care—Level 1	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Personal Care—Level 2	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Consumer Directed Personal Assistance	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Physical Therapy	X	X	X	X
Prenatal Care	X	X	X	X
Prescription Drugs Use Pharmacy information at https://www.emedny.org/Provider Manuals/Pharmacy for more information				Use MVP Commercial formulary
Preventive Health Services	X	X	X	X
Private Duty Nursing	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Prosthetics and Orthotics	X	X	X	Covered as medically necessary w/ exception of wigs, dental prostheses and orthotics prescribed for sports
Radiology Services	X	X	X	X

Other Preventive Services	X	X	X	X
Renal Dialysis	X	X	X	X
Routine Eye Care and Glasses	X	X	X	X
Routine Transportation	Covered by fee-for service Medicaid, contact Medical Answering Services	Covered by fee-for service Medicaid, contact Medical Answering Services	Covered by fee-for service Medicaid, contact Medical Answering Services	Not covered
Home Health Care	X	X	X	Up to 40 visits/ year as medically necessary
Smoking Cessation Counseling	X	X	X	Not covered
Specialist Care	X	X	X	X
Speech Therapy	X	X	X	X
Substance Use Disorder Services Mandated by LDSS	X*	X*	X*	
Substance Use Disorder (SUD) Inpatient Rehabilitation and Treatment Services	X	X	X	X
SUD Residential Addiction Treatment Services	X*	X*	X*	
SUD Outpatient (Includes Outpatient Clinic; Outpatient Rehabilitation; and Opioid Treatment)	X*	X*	X*	X*
SUD Medically Supervised Outpatient Withdrawal	X*	X*	X*	X*
Buprenorphine Prescribers	X	X	X	X
Crisis Intervention Services	X*	X*	X*	X*
Children's Crisis Residence	X	X	Not covered	X****
Adult Crisis Residence	X*	X*	X*	Not covered
CORE Psychosocial Rehabilitation (PSR)	Not covered	Not covered	X*	Not covered
Children's HCBS Psychiatric Support and Treatment (PSR)	X*	X*	Not covered	X****
CORE Community Psychiatric Support and Treatment (CPST)	X* Not covered	X* Not covered	X*	Not covered

Children's Community Psychiatric Support and Treatment (CPST)	X*	X*	Not covered	X*
Adult HCBS Habilitation Services	Not covered	Not covered	X*	Not covered
Children's HCBS Community Habilitation Services	X*	X*	Not covered	X*
Children's HCBS Day Habilitation Services	X*	X*	Not covered	X*
CORE Family Support and Training	Not covered	Not covered	X*	Not covered
Children's HCBS Caregiver/Family Supports and Services	X*	X*	Not covered	X*
Children's Family Peer Supports and Services (FPSS)	X*	X*	Not covered	X*
Children's HCBS Community Self Advocacy Training and Supports	X*	X*	Not covered	X*
Adult HCBS Short-Term Crisis Respite	Not covered	Not covered	X*	Not covered
Children's HCBS Crisis Respite	X*	X*	Not covered	X*
Adult HCBS Intensive Crisis Respite	Not covered	Not covered	X*	Not covered
Children's HCBS Planned Respite	X*	X*	Not covered	X*
Adult HCBS Education Support Services	Not covered	Not covered	X*	Not covered
CORE Peer Supports/Empowerment Services	Not covered	Not covered	X*	Not covered
Children's Youth Peer Support and Training (YPST)	X*	X*	Not covered	X*
Adult HCBS Pre-Vocational Services	Not covered	Not covered	X*	Not covered
Children's HCBS Pre-Vocational Services	X*	X*	Not covered	X*
Adult HCBS Transitional Employment	Not covered	Not covered	X*	Not covered
Adult HCBS Intensive Supported Employment (ISE)	Not covered	Not covered	X*	Not covered
Adult HCBS Ongoing Supported Employment	Not covered	Not covered	X*	Not covered

Children's HCBS Supported Employment	X*	X*	Not covered	X*
Care Coordination for the HARP Program	Not covered	Not covered	X*	Not covered
Children's Other Licensed Practitioner (OLP)	X*	X*	Not covered	Not covered****
Children's HCBS Palliative Care	X* Prior authorization is required	X* Prior authorization is required	Not covered	X*
Children's HCBS Assistive and Adaptive Equipment	Covered by fee-for service Medicaid	Covered by fee-for service Medicaid	Not covered	X*
Children's HCBS Vehicle Modifications	Covered by fee-for service Medicaid	Covered by fee-for service Medicaid	Not covered	X*
Children's HCBS Environmental Modifications	Covered by fee-for service Medicaid	Covered by fee-for service Medicaid	Not covered	X*
Children's HCBS Non-Medical Transportation	X* Covered by fee-for service Medicaid	X* Covered by fee-for service Medicaid	Not covered	X*
Assistive Technology	Covered by fee-for service Medicaid	Covered by fee-for service Medicaid	Not covered	Not covered
Environmental Modifications	Covered by fee-for service Medicaid	Covered by fee-for service Medicaid	Not covered	Not covered
Article 29-I VFCA Core Limited Health-Related Services	X	X	Not covered	X
Article 29-I VFCA Other Limited Health-Related Services	X	X	Not covered	X
Assertive Community Treatment Services (ACT), Young Adult ACT, and Youth ACT	X*	X*	X*	X

*Refers to special network information

Important Phone Numbers

MVP Government Programs	
MVP After Hours	1-888-MVP-MBRS (687-6277)
MVP Customer Care Center	1-800-852-7826
MVP Harmonious Health Care Customer Care Center	1-844-946-8002
Provider Claims	1-800-684-9286

MVP Medical and Behavioral Health Case Management	1-800-666-1762
MVP Behavioral Health Services	1-800-666-1762
CVS Caremark	1-866-832-8077
DentaQuest(Dental Benefits Administrator)	888-308-2509
Albany County	
Albany County Department of Social Services (DSS)	518-447-7492
Transportation for MMC Members Medical Answering Services	1-855-360-3549
Columbia County	
Columbia Department of Social Services (DSS)	518-828-9411
Transportation for MMC Members, Medical Answering Services	1-855-360-3546
Dutchess County	
Dutchess County Department of Social Services (DSS)	845-486-3000
Transportation for MMC Members, Medical Answering Services	1-866-244-8995
Genesee County	
Genesee Department of Social Services (DSS)	585-344-2580
Transportation for MMC Members, Medical Answering Services	1-855-733-9404
Child Lead Poisoning Prevention Program	585-344-2580, ext. 5000
Greene County	
Greene Department of Social Services (DSS)	518-719-3700
Transportation for MMC Members, Medical Answering Services	1-855-360-3545
Jefferson County	
Jefferson County Department of Social Services	315-782-9030
Transportation for MMC Members, Medical Answering Services	1-866-558-0757
Lewis County	
Lewis County Department of Social Services (DSS)	315-376-5400
Transportation for MMC Members, Medical Answering Services	1-800-430-6681
Livingston County	
Livingston Department of Social Services (DSS)	585-243-7300
Transportation for MMC Members, Medical Answering Services	1-888-226-2219
Child Lead Poisoning Prevention Program	585-243-7299
Monroe County	
Monroe Department of Human Services	585-753-6440
Transportation for MMC Members, Medical Answering Services	1-866-932-7740
Child Lead Poisoning Prevention Program	585-753-5087
Department of Health Tuberculosis Control Program	585-753-5161
Oneida County	
Oneida County Department of Social Services (DSS)	315-798-5700
Transportation for MMC Members, Medical Answering Services	1-855-852-3288
Ontario County	
Ontario County Department of Social Services (DSS)	585-396-4599
Transportation for MMC Members, Medical Answering Services	1-855-733-9402
Child Lead Poisoning Prevention Program	585-396-4854
Orange County	
Orange County Department of Social Services (DSS)	845-291-4000
Transportation for MMC Members, Medical Answering Services	1-855-360-3543

Putnam County	
Putnam County Department of Social Services (DSS)	845-808-1500
Transportation for MMC Members, Medical Answering Services	1-855-360-3547
Rensselaer County	
Rensselaer County Department of Social Services (DSS)	518-266-7991
Transportation for MMC Members, Medical Answering Services	1-855-852-3293
Rockland County	
Rockland County Department of Social Services (DSS)	845-364-2000
Transportation for MMC Members, Medical Answering Services	1-855-360-3542
Saratoga County	
Saratoga County Department of Social Services	518-884-4148
Transportation for MMC Members Medical Answering Services	1-855-852-3292
Schenectady County	
Schenectady County Department of Social Services	518-388-4470
Transportation for MMC Members Medical Answering Services	1-855-852-3291
Sullivan County	
Sullivan County Department of Social Services (DSS)	845-292-0100
Transportation for MMC Members, Medical Answering Services	1-866-573-2148
Ulster County	
Ulster County Department of Social Services (DSS)	845-334-5000
Transportation for MMC Members, Medical Answering Services	1-866-287-0983
Washington County	
Washington County Department of Social Services (DSS)	518-746-2300
Transportation for MMC Members, Medical Answering Services	1-855-360-3544
Warren County	
Warren County Department of Social Services	518-761-6321
Transportation for MMC Members, Medical Answering Services	1-855-360-3541
Westchester County	
Westchester County Department of Social Services (DSS)	1-800- 549-7650
Transportation for MMC Members, Medical Answering Services	1-866-883-7865
New York State	
HIV Confidentiality Hotline	1-800-962-5065
NY State Department of Health AIDS Institute	1-518-402-6814
NYS Domestic Violence Hotline	1-800-942-6906
NYS Domestic Violence Hotline (Spanish)	1-800-942-6906
WIC Hotline	1-800-522-5006
NYS Smokers Quit Line	1-866-697-8487
New York State Vaccines for Children Program	1-800-543-7468

Revision Summary

Review Date	Summary
August 14, 2026	• Page 1 Please remove School Based Health Centers • Pg 4 Changed to 200% • Pg 6 Please Remove School-Based Health Care Centers section Changes Made: • Information on dental benefits was updated to include new dental vendor, DentaQuest • Added doula access to the benefit grid. • Updated transition date of School-Based Health Center per DOH notice of delay for Medicaid Managed Care plans • Corrected minor grammatical edits Changes Made: • EP 200-250 was eliminated and language was updated as appropriate. • SCBHC language was removed.

Pharmacy Benefits

Pharmacy Benefits Manager

CVS Caremark is MVP's pharmacy benefit manager (PBM) for all retail and mail order prescriptions. This applies to all MVP products that offer prescription drug coverage. The CVS Mail Order Pharmacy, part of the CVS Caremark family of pharmacies, is the mail order pharmacy vendor MVP uses to fill prescriptions for maintenance medications for MVP products that have a mail order benefit.

Prescription Drug Benefits

MVP offers multiple different prescription drug benefit options. The CVS Caremark claims system is configured to adjudicate these different benefits as well as program-mandated prescription drug coverage. Most drug plans have prior authorization, Step Therapy, or quantity limit requirements on select medications. Refer to the MVP formularies at **mvphealthcare.com/providers** for a complete list of drugs that are subject to pharmacy management programs.

Pharmacy and Therapeutics (P&T) Committee

The MVP P&T Committee is composed of Providers from multiple specialties and primary care, practicing pharmacists, and MVP staff. The committee uses utilization, pharmacoeconomic, and clinical information to develop drug inclusion/exclusion criteria. Each new drug* requires prior authorization for at least six months. For the Medicare Part D formulary, new drugs may be excluded until the next benefit year. The P&T Committee evaluates the value of adding or excluding a new drug to the formulary based upon whether the new drug offers significant clinical and therapeutic advantages over current formulary drugs. The committee also designates in which coverage tier a specific drug is placed and reviews all policies and drug classes at least annually.

*A "new drug" is defined as a new molecular entity or biosimilar; a new route of administration; a new dosage form, formulation, or delivery system; a combination of currently approved drugs; a drug with potential safety and/or efficacy issues; and a drug that has the potential for inappropriate utilization.

Formularies

The formulary is a guide to use when prescribing medications for Members. The drugs listed on the formulary are intended to provide sufficient therapeutic options for most situations. The formulary is available in several formats:

- The most current printed version is available at **mvphealthcare.com**
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. Updates also can be found at **mvphealthcare.com/fastfax**

Commercial Prescription Drug Formulary

The MVP Commercial formulary applies to Members with employer-sponsored large group and children covered under the Child Health Plus plan (CHP). The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs
- Tier 2 includes covered brand name drugs chosen for their overall value
- Tier 3 includes all other covered prescription drugs and all new drugs that are under review. Tier 3 is non-formulary for CHP and requires prior authorization for coverage

Self-Funded Prescription Drug Formulary

The MVP Self-Funded formulary applies to Members with self-funded (ASO) prescription drug coverage. The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs
- Tier 2 includes covered brand name drugs chosen for their overall value
- Tier 3 includes all other covered prescription drugs and all new drugs that are under review.

MVP Marketplace Prescription Drug Formulary

The MVP Marketplace formulary applies to Members with employer-sponsored small group or individual-purchased through MVP or the state Marketplace, or Essential Health Plan prescription drug coverage.

The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs
- Tier 2 includes covered non-preferred generics and brand name drugs chosen for their overall value
- Tier 3 includes all other covered prescription drugs and all new drugs that are under review

Members in select Essential Health Plan pharmacy benefits may have coverage of some over-the-counter (OTC) medications.

Formulary Indicators

These indicators are common across multiple formularies. Each formulary may also contain additional indicators. Please refer to the descriptions noted within the formulary for additional information.

- **Step Therapy (ST):** Certain drugs requiring prior authorization have a Step Therapy edit in place to systematically allow a claim to process if certain criteria are met. These edits are supported by MVP benefit interpretations that are available in the MVP's Provider Portal. Prior authorization is required if Step Therapy edits are not met. Step Therapy clinical reviews will use recognized evidenced-based and peer-reviewed clinical review criteria that is appropriate for the medical condition
- **Prior authorization (PA):** Requests for drugs requiring a prior authorization must be submitted through the Pharmacy Department using the MVP Prior Authorization Request For Medical and Pharmacy Benefit Medications form. This may be submitted through (1) our electronic PA tool, NovoLogix, accessible through MVP's Provider Portal, (2) through Surescripts or CoverMyMeds, or (3) by faxing it to **1-800-376-6373** for Commercial, Marketplace, and Medicaid members. Benefit interpretations containing applicable prior authorization criteria are available from MVP and are available in the MVP Provider Portal
- **Quantity Limit (QL):** Certain drugs have quantity limitations or durations. Benefit interpretations containing the applicable prior authorization criteria are available from MVP
- **Specialty Medications (SP):** Certain drugs must be obtained from the MVP specialty pharmacy vendor or contracted specialty pharmacy
- **Medical Copay (MC)**: Some MVP plans may offer a different co-pay or coinsurance for medical benefit medications. This may be different than your regular tier co-pay. Please refer to your MVP Prescription Drug Rider for the specific co-pay or co-insurance amount associated with this category of medications.
- **Diabetic Co-Pay (DC):** Some MVP plans may offer a different co-pay or coinsurance for medications used to treat diabetes. This may be different than your regular tier co-pay. Please refer to your MVP Prescription Drug Rider for the specific co-pay or co-insurance amount associated with this category of medications.
- **Limited Distribution (LD):** Some specialty medications are only available from certain pharmacies. They usually treat rare or complex medical conditions. You would not be able to pick it up from your regular pharmacy.
- **Not Available for Mail Order (NM):** For plans that offer a mail order benefit, certain medications are not available through the mail order pharmacy benefit. In general, maintenance drugs are available through the mail order benefit. A maintenance drug is defined as "any drug taken regularly to treat or prevent a chronic health condition such as, but not limited to, high blood pressure, diabetes, or asthma." Drugs that are not suitable for mail delivery, such as medications that are indicated for short term use, or medications requiring frequent provider evaluation and/or dose adjustments may not be eligible for mail order.
- **Over-The-Counter Medications (OTC):** Certain medications listed in the Formulary are available over the counter. For these to be covered by insurance, a prescription is required.

  AGE: Some medications have age restrictions to ensure they are used in appropriate age groups. If you are outside of the age restriction but require the use

of a drug with an age edit, your provider can submit a request for coverage and tell us why you need this drug.

The above indicators are common across multiple formularies. Each formulary may also contain additional indicators. Please refer to the descriptions noted within the formulary for additional information.

MVP Medicare Part D Prescription Drug Formulary

There are three MVP Medicare Part D formularies which apply to all Members with Part D prescription drug coverage. There is a formulary for Medicare Advantage plans with coverage through a former employer, a formulary for Individual Medicare Advantage Plans (plans purchased directly by the Member), and a formulary for DSNP members. The Part D formularies are a guide to use when prescribing medications for Members. The drugs listed in the formularies are intended to provide sufficient therapeutic options for most situations.

The Medicare Advantage through an employer and the Medicare Advantage Individual Part D formularies are divided into five (5) tiers:

- Tier 1 includes select generic drugs used to treat chronic conditions such as diabetes, high blood pressurel, high cholesterol, and osteoporosis/bone health
- Tier 2 includes most other generic drugs on our Formulary
- Tier 3 includes preferred brand drugs that have the lowest cost sharing for brand name drugs. Certain generic drugs may appear in Tier 3 due to potential safety concerns or the high cost of the drug.
- Tier 4 includes non-preferred brand name and non-preferred generic drugs. In addition, Part D drugs excluded from the formulary must go through an exception process for MVP to cover them. If they are approved, they will be covered in Tier 4
- Tier 5 (Specialty tier) includes high cost specialty generic and brand-name drugs that cost $950 or more for a one-month supply. Most drugs in this tier are restricted to a one-month supply at retail, and are excluded from the mail order program and tier exception process.

The DSNP Formulary is divided into six (6) tiers:

- Tier 1 – Preferred Generic Drugs – Includes select generic drugs used to treat chronic conditions in the lowest cost-sharing tier.
- Tier 2 – Generic Drugs – Includes most other generic drugs on our Formulary.
- Tier 3 – Preferred Brand Drugs – Includes preferred brand-name drugs that have the lowest cost-sharing for brand-name drugs. Certain generic drugs may appear on Tier 3 due to potential safety concerns or the high cost of the drug.
- Tier 4 – Non-Preferred Drugs – Includes all other brand-name and generic drugs on our Formulary.
- Tier 5 – Specialty Drugs – Includes high-cost specialty generic and brand-name drugs. This is the highest cost-sharing tier.
- Tier 6 – Select Care Drugs – Includes select care $0 generic drugs for treating conditions such as diabetes, high blood pressure, and high cholesterol.

The Medicare Part D formularies exclude most new drugs and most drugs with a generic equivalent (as determined by the FDA). These drugs may be obtained through the Formulary Exception Procedure (see below). Medicare regulations also require that certain drug classes not be covered: DESI drugs, unapproved drugs (approved via NDA/ANDA/BLA), drugs used to treat sexual dysfunction (including erectile dysfunction), and drugs used to promote weight gain or loss. Brand name drugs manufactured by companies that did not sign the Medicare Coverage Gap agreement are not eligible to participate in the Medicare Part D program. Some enhanced Part D riders may include coverage of Medicare Part D excluded drugs, including drugs for weight loss or weight gain, or erectile dysfunction medications. Prior authorization criteria and quantity limits for these medications follow the Commercial pharmacy policies.

Members and Providers may view MVP's Medicare Part D Pharmacy Management programs on **mvphealthcare.com**. Requests for Prior Authorization and Formulary Exceptions should be submitted using the MVP Prior Authorization Request for Medical and Pharmacy Benefit Medications form or the Medicare Part D Coverage Determination form. These should be submitted along with the Provider supporting statements, through (1) our electronic PA tool, NovoLogix, accessible through MVP's Provider Portal, (2) through Surescripts or CoverMyMeds, or (3) by faxing it to **1-800-401-0915.**

Formulary (Medicare Part D) Indicators

- Prior Authorization (PA): MVP requires prior authorization for certain drugs
- Quantity Limits (QL): For certain drugs, MVP limits the amount of the drug that we will cover
    - For example, MVP covers one tablet per day for Linzess®. This limit may be applied to a standard one-month or three-month supply
- Step Therapy (ST): In some cases, MVP requires certain drugs to treat a medical condition to be tried before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, MVP may not cover Drug B unless Drug A is tried first. If Drug A does not work, MVP will then cover Drug B
- Part B versus Part D drug coverage (B/D): Some drugs could be covered under the Part B or Part D benefit, depending on the specific Member situation. This means that a request must be submitted to MVP to determine, based on Medicare guidelines, if the drug will be covered as Part B or Part D
- Not available at mail-order (NM): Certain drugs are not available through the mail order pharmacy

Medicare Medical Injectables and Vaccines

Most injectable medications, including all vaccines (**except Part D vaccines for Medicare Members), administered in a provider's office must be obtained by the provider and billed to MVP on the appropriate billing code (i.e., J-code), unless otherwise specified. Office-

administered injectable medications should not be purchased at the retail pharmacy by the Member and transported back to the office; these medications are not covered under the Member's prescription drug benefit when obtained at a retail pharmacy. Provider-administered injectables may be covered under the Member's Medicare Part B benefit and applicable co-insurance. Review the Medicare Part D formulary at **mvphealthcare.com**, which includes injectable medications that may be covered under the Medicare Part D benefit. Most home infusion medications are covered under the Medicare Part D benefit and billed to the PBM.

For Medicare Members: All commercially available vaccines will be covered under the Part D pharmacy benefit only (unless excluded as a Part B benefit, such as pneumococcal and influenza vaccines). This also includes the administration fees associated with the vaccinations. All Part D vaccines and vaccine administration fees must be billed through CVS Caremark. Since Provider offices may not be able to bill CVS Caremark directly, Medicare Members with a Part D rider may need to pay the provider for the vaccine and administration fee and then submit a reimbursement claim directly to CVS Caremark. Members will be reimbursed the full amount unless the vaccine administration is not recognized under the IRA, provisions then it will be reimbursed at the negotiated rate minus their applicable co-payment for these vaccines. Reimbursement forms are available at **mvphealthcare.com.

Providers now have an online option for processing Medicare Part D vaccine claims electronically. TransactRx Part D Vaccine Manager, a product of Dispensing Solutions Inc., provides Providers with real-time claims processing for in-office administered vaccines. This new online resource helps to reduce the current challenges in providing Medicare Part D vaccines and vaccine administration reimbursement to our Members. Enrollment in TransactRx is available at no cost to providers. Simply complete the one-time online enrollment process at **mytransactrx.com/ws_enroll**.

For questions related to enrollment or claims processing, contact Vaccine Manager Support at **1-866-522-3386**.

When to Contact MVP's Pharmacy Department

The following are examples of when to contact MVP's Pharmacy Department under either urgent or routine circumstances:

- Medications requiring prior authorization (including medical drugs listed on the formulary)
- Medications that are not on the formulary, on MVP's excluded drug list, or when requesting coverage of a non-formulary drug when the Member has a two-tier prescription drug benefit
- Medications subject to Step Therapy when criteria are not systematically met
- Medications that are subject to quantity limitations or durations

- Member with an existing authorization and changes to a different MVP benefit will require a new authorization (Commercial to Medicare, Commercial to ASO, Medicare to DSNP, etc.)

For Members with a two-tier prescription drug benefit (MVP Child Health Plus), a prior authorization for non-formulary agents will be considered in accordance with criteria listed in the Formulary Exception Policy and noted below. The form must be completed, and the request approved before the Member can fill the prescription at the pharmacy. Medicare Members requesting a formulary exception request for non-formulary drugs or drugs with a quantity limit will follow the Medicare Formulary Exception process.

Incomplete information on the request may result in a decision delay or denials. The MVP Prior Authorization Request For Medical and Pharmacy Benefit Medications form must be completed and can be submitted through (1) our electronic PA tool, NovoLogix, accessible through MVP's Provider Portal, (2) through Surescripts or CoverMyMeds, or (3) by faxing it to 1-800-401-0915 (Medicare) or 1-800-376-6373(other lines of business). Forms must include the signature of the prescriber or an attestation from the prescriber attesting that the information on the submitted form is complete, accurate, and available for review if requested. All urgent requests must be marked "Urgent" at the top of the form. The turn-around time for urgent requests is typically one business day from MVP's receipt of the request and three business days for non-urgent requests. See Coverage Determination for Medicare Members below for the applicable Medicare Part D timeframes.

For NYS Commercial, NYS Marketplace, a Step Therapy protocol determination will be made within 24 hours (urgent) or 72 hours (standard) of the receipt of a supporting rationale and documentation. Marketplace and Large Group requests for non-formulary drugs: a determination will be made within 24 hours (urgent) or 72 hours (standard) of the receipt of a supporting rationale and documentation.

Only the prescriber responsible for the treatment and evaluation of the Member, an authorized agent, Member, or Member's authorized representative may initiate a prior authorization or coverage determination. An authorized agent is an employee of the prescribing provider and has access to the Member's medical records (e.g., nurse, medical assistant, etc.). An authorized representative is someone who has been designated by the Member to represent them for a specific health care decision via a Power of Attorney (POA) or Authorization of Representation (AOR) form. Pharmacists, pharmacies, third-party vendors, or other patient advocacy personnel are not eligible to initiate a prior authorization or coverage determination. Requests from these providers will not be accepted or acknowledged as received. Prescribers excluded by CMS, OIG, OMIG, or other regulatory entities will be deemed "excluded" and prescriptions will be rejected by the PBM.

No payment will be made for prescriptions filled or services rendered prior to the approval of a prior authorization request. For information on lost/stolen/damaged/forgotten medications and vacation overrides, please refer to the Pharmacy Programs Management Policy.

Pharmacy Forms

Access all pharmacy-related prior authorization forms by visiting **mvphealthcare.com/providers/Forms**. Forms should be submitted through (1) our

electronic PA tool, NovoLogix, accessible through MVP's Provider Portal, (2) through Surescripts or **CoverMyMed**s, or (3) by faxing it to the fax number listed on the top of each form.

Formulary Exception Process

There may be occasions when a non-formulary medication is medically necessary. In such cases, the appropriate medication may be obtained through the MVP Formulary Exception Process as follows:

- The provider completes the Prior Authorization Request Form for Medication before the Member fills the prescription at the pharmacy
- The provider follows the instructions on the form to submit the completed form and all necessary clinical documentation to support the medical necessity for the exception on the form. A letter containing the decision to approve/deny the request is sent to the provider and the Member, preceded by a phone call. Although circumstances may vary, reasons for approving an exception may include documentation of the following:
    - Allergic/adverse reaction to all formulary agents
    - Therapeutic failure of all clinically appropriate formulary agents
    - Patient therapy stability issues where a formulary agent is contraindicated or a change in therapy is inadvisable
    - Patient-specific contraindication or reason formulary agents are inappropriate
    - Policy and/or benefit interpretation
    - Member contract and/or prescription drug rider
- "Sample" use alone does not satisfy criteria

Step Therapy Program (NY Commercial, NY Exchange, VT Commercial, VT Exchange)

Prior authorization requests for drugs requiring Step Therapy will use recognized evidenced-based and peer-reviewed clinical criteria that is appropriate for the medical condition of the Member. Refer to the MVP Step Therapy policy for additional information.

New York

A step therapy protocol override request will be granted when it includes supporting rationale and documentation from a requesting health care professional. Step therapy protocol override requests are reviewed within the following parameters:

- Trial and failure on up to two (2) prescription drugs to treat the member's medical condition or disease.

- Medications required within a step therapy protocol will be FDA approved or supported by current evidence-based guidelines for the member's medical condition.
- The step therapy protocol will not apply if a therapeutic equivalent to the requested Prescription Drug is not available.
- The step therapy protocol will not apply if the requested Prescription Drug has been covered by the member's plan within the last 365 days.
- The step-therapy protocol will not apply for more than thirty days, or the duration of treatment supported by current evidence-based treatment guidelines for the member's medical condition
- For members new to the plan who completed step therapy protocol with a previous health plan within the last 365 days, the step-therapy protocol will not apply for the requested Prescription Drug.
  Documentation demonstrating previous step therapy use must be submitted.
- If a step therapy override is granted and the Plan implements a formulary or utilization management change that impacts the step therapy protocol, no changes to the previously approved authorization will be allowed until the override authorization expires unless there is a specifically identified and current evidence based safety concerns and a therapeutic alternative Prescription Drug exists

Vermont

Per Vermont H.766, a step therapy protocol override prior authorization request will be granted when it includes supporting rationale and documentation from a requesting health care professional, demonstrating that:

- The member is stable on a prescription drug
- Failure, including discontinuation due to lack of efficacy or effectiveness, diminished effect, or an adverse event, on the same medication on more than one occasion for members who are continuously enrolled in a plan will not be required.
- The Member has already tried the prescription drugs on the step therapy protocol, or other medications in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The medication required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm.
- The medication required under the step-therapy protocol is expected to be ineffective based on the member's known clinical history, condition, and prescription drug regimen.
- The step-therapy protocol or a prescription drug required under the protocol is not in the Member's best interests because it will: (I) pose a barrier to adherence; (II) likely worsen a comorbid condition; or (III) likely decrease the Member's ability to achieve or maintain reasonable functional ability.

Coverage Determination Procedure for Medicare Members

Coverage determination requests are requests required for:

- Drugs that require prior authorization

- Drugs subject to Step Therapy
- Part D drugs that are non-formulary
- Quantity limits that are in excess of the formulary allowed amount
- Tier exceptions (requests to cover a drug at a lower tier co-pay than what is listed on the formulary)

Coverage determination requests may be submitted on one of the MVP Prior Authorization Request For Medical and Pharmacy Benefit Medications form, which can be submitted through (1) our electronic PA tool, NovoLogix, accessible through MVP's Provider Portal, (2) through Surescripts or **CoverMyMeds**, or (3) by faxing it to **1-800-401-0915.** Requests can also be submitted via the online Medicare Coverage Determination form.

Coverage determination requests for drugs that require prior authorization or Step Therapy will be reviewed and a decision made within 72 hours of the receipt of the request unless the request is marked "URGENT," in which case the request will be reviewed, and a decision made within 24 hours.

Coverage determination requests to cover a non-formulary Part D drug, a quantity that exceeds the allowed amount, or a request to cover a drug at a lower-tier co-pay must be accompanied by a supporting statement from the prescriber. Requests submitted without the supporting statement will be placed in a "pending" status for a decision until the information is received, but no longer than 14 days from the receipt of the request. Supporting statements may include:

- Rationale why all other drugs included on the formulary have not been or would not be as effective; or would cause adverse effects compared to the non-formulary (higher tier) drug, formulary excluded drug, or drug requiring step therapy
- The number of doses available has not been effective, would likely not be effective, or would adversely affect the drug's effectiveness

Approved formulary exceptionsand medications on a specialty tier are all excluded from tier exceptions.

Mail Order Pharmacy

MVP Members (excluding MVP Child Health Plus, some MVP Marketplace and some MVP Select Care [ASO] Members) may use the mail service option when filling prescriptions. Mail service includes home delivery of medications. In most cases, there are Member co-payment savings by ordering a 90-day supply. When prescribing a drug that is eligible for the mail order program for the initial order, the MVP Member may ask the provider to send two electronic prescriptions. One is for up to 30 days to be filled at a local pharmacy. The other can last up to 90 days, with refills for up to one year, and can be filled through the CVS Caremark Mail Service Pharmacy

MVP recommends that an order be placed two to three weeks before medications are needed to save on rush delivery charges and avoid possible problems if the shipment is delayed. Not all prescription drugs are eligible to be filled through the Mail Order Pharmacy. Please refer to the MVP formularies to determine if the drug is eligible to be filled through the Mail Order Pharmacy.

Brand/Generic Difference Program

When a health care provider writes a prescription for a brand name drug and indicates "dispense as written" and there is a Food and Drug Administration (FDA) approved generic equivalent, the Member will be responsible for paying the generic co-pay plus the difference between the cost of the brand and generic drug. This Brand/Generic Difference program helps encourage the use of generic drugs over brand name drugs. This does not apply to all MVP prescription benefits. Please refer Member to their prescription rider to determine if a co-pay penalty applies.

Note: Co-payment reduction for medical necessity for Commercial and Marketplace Members may be submitted for medications subject to the brand/generic penalty only. Criteria must meet that listed in the MVP Copayment Adjustments for Medical Necessity policy. Requests should be submitted on the Medication Prior Authorization Form and specifically marked "Co-payment Adjustment."

Specialty Pharmacy

Select oral and injectable medications, as indicated on the formulary, require Provider and/or Member acquisition through a contracted specialty vendor. Providers must send prescriptions for these medications to a contracted specialty vendor (except certain ASO clients and Medicare Part D Members). Use of an out-of-network pharmacy or home infusion vendor or one that is not contracted as a specialty pharmacy in MVP's specialty pharmacy network requires a separate medical necessity review and may be subject to out-of-network cost sharing.

Compounded Prescriptions

For all lines of business except Medicare Part D, compounded prescriptions more than $100 require prior authorization from MVP. Compound medications containing bulk powders and non-covered medications are not covered. Compounded medications must be obtained at an MVP participating pharmacy. Refer to the MVP Compounded (Extemporaneous) Medications Policy for additional information.

Onco360

For those unique situations where a Provider is administering an oncology drug in the office setting and is not able to obtain the medication through their supplier, MVP has contracted with Onco360 to provide a select list of oncology medications. More information on Onco360 and the medications they can deliver can be obtained from your Professional Relations representative.

Benefit Coverage (Commercial and Marketplace Unless Otherwise Noted)

Most contracts and prescription drug riders allow for coverage of legend (prescription required), FDA-approved medications (FDA approved via NDA/ANDA/BLA) that are reasonably self-administered. The PBM system is configured to process these medications at the pharmacy point-of-service and for the claim to take the appropriate co-pay, co-insurance, deductible etc. Some contracts and/or riders prohibit coverage for certain drug classes (i.e., cosmetic agents, drugs used to treat erectile dysfunction). The PBM system is also configured to deny coverage for these drugs as appropriate.

- **OTC Equivalent Program Legend**
  Drug products that have an OTC equivalent are not a covered pharmacy benefit unless medically necessary. Examples of drugs that are subject to this program include but are not limited to: ammonium lactate topical, benzoyl peroxide, diphenhydramine, meclizine, butenafine topical, ketotifen fumarate, fluticasone nasal spray, and polyethylene glycol 3350
- **Provider Administered Medications**
- Generally, it is the Provider's responsibility to "buy-and-bill" medications that are administered in the office or another similar place-of-service unless otherwise specified. Requests for select medications to be administered in a location other than a contracted provider office or home infusion will be directed to a preferred alternative site of care. Infusions for these medications are excluded from payment when administered in a non-preferred site of care (i.e. outpatient hospital setting). The Site of Care program requirements may be administered as part of the existing prior authorization program. The CVS Caremark system is not configured to allow Provider-administered medications to process at a pharmacy. This includes chemotherapy drugs and vaccines (except for Medicare Part D vaccines, see Medicare Part D section). In rare circumstances when a Provider is unable to obtain a drug, he/she should contact MVP for a case-by-case determination and applicable override. MVP reserves the right to determine whether a medication is usually

Provider-administered and reimbursable under the medical benefit. Provider-administered medications that are mandated to specialty pharmacies as indicated on the applicable MVP Formulary should be billed to the contracted specialty vendor.

A. Generally, when a Provider gives a patient an oral medication, these drugs are excluded from coverage since the form of the drug is self-administered. Similarly, if a Provider gives a patient an injection that is usually self-injected this drug is excluded from coverage, unless administered to the patient in an emergency.

- **Diabetes Drugs and Supplies**

  These drugs (including oral and injectable hypoglycemics and insulin) and supplies (including test strips, lancets, and insulin pump supplies) are generally covered under the Commercial Member's medical plan per applicable state mandates. The PBM system is configured to process these drugs and supplies and therefore claims should be billed online to CVS Caremark. The applicable diabetes co-payment(s) will apply. Preferred diabetes insulins, meters, and test strips may apply. Refer to the applicable formulary for a list of preferred products.

- **Preferred Home Infusion Vendors**

  Medications may be required to be obtained through a preferred home infusion vendor. Access and medical exception requests for use of an alternative vendor must be submitted to the Plan for medical necessity review.

- **Drugs used in coordination with a medical procedure (including Medicaid)**

  Drugs used in coordination with a medical procedure will be deemed to be inclusive of the procedure billing unless the sole purpose of the procedure is the administration of the drug

- **Oral or self-administered drugs part of a Medicare transitional add-on payment arrangement**

  Oral or self-administered drugs which are included in a Medicare transitional add-on payment arrangement (e.g., ESRD PPS) are subject to Member's Part B co-insurance/co-pay (commensurate with the co-payment associated with dialysis services) and the Member's selection of the site of service for the provision of these drugs. Drugs which are covered under a Medicare consolidated billing arrangement cannot be billed to the Member or the plan separately.

- **Emergency supply of a medication**

  Members may be eligible for a 72-hour emergency supply of a medication when an emergency medical or behavioral health condition exists, and access to an emergency seven-day supply of a medication for the management of opioid withdrawal and/or stabilization.

Pharmacy Network

An extensive network, including thousands of pharmacies throughout the United States, is available to most Members. Pharmacies must be enrolled as a Medicaid provider to

provide service to MVP CHP Members. Covered drugs filled at a participating pharmacy are subject to the Member's applicable co-pay(s) as defined by their pharmacy benefit. For information on Plan-participating pharmacies, refer to **mvphealthcare.com/members/prescription-benefits**.

Opiate Management Programs

Prescribers should review prescription claims in the state Prescription Monitoring Program (e.g., iSTOP) prior to prescribing opiate prescriptions. Use of an opiate prescription for greater than three months requires a current provider-patient treatment agreement and documented pain management treatment plan. Cancer patients not in remission, or patients receiving hospice, end-of-life care, or being treated as part of a palliative care service are exempt from this requirement.

Summary

Review Date	Summary
August 1, 2025	Formulary Drug Section: Removed Excluded Drug from Medicare Part D Prescription Drug Formulary Section: Added information on how to submit a PA Self-funded Prescription Drug Section: Removed CHP from Tier 3 bullet point.
February 1, 2026	Added to the Step Therapy Section (VT Commercial and VT Exchange)

Provider Responsibilities

Provider Responsibilities

*MVP's Provider Policies and Payment Policies will be revised as the operational policies change.

Participating Provider Responsibilities Overview

This Section is an overview of MVP Participating Provider roles and responsibilities for which all Participating Providers are accountable. We have created this MVP Provider Policies and Payment Policies with direction and guidance around the basic operational processes for Participating Providers to ensure a positive Provider experience. Please note that Participating Provider Groups and facilities are responsible for providing access to these Policies to their in-network Participating Providers. Please refer to your Provider Services Agreement or Facility Services Agreement (individually and collectively referred to herein as the "Provider Agreement") or contact a Provider Relations representative if you have any questions or need further information.

Participating Provider Training

All Participating Providers are required to provide appropriate training for their employees and applicable subcontractors within ninety (90) days of hire and annually thereafter. Such training shall cover compliance programs that may include but are not limited to Fraud, Waste and Abuse (FWA) training, Potential Quality Issues (PQI), and the HIPAA Provider Review requirements. Participating Providers must agree to permit DOH, DFS, or any other regulatory agency as required, to conduct on-site evaluations periodically in accordance with current state and federal laws and regulations and to comply with the agency's recommendations, if any. Additional trainings may be required depending on Product participation (e.g., Cultural and Linguistic Competency, Dual Access Plans, Foster Care, HARP, HCBS and CHCBS training for Government Programs). Participating Providers must give DFS, HHS, the U.S. Government Accountability Office (U.S. GAO), any Peer Review Organization (PRO) or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, or inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of MVP for the time-period required by applicable law following the termination of the Provider Agreement or the completion of an audit, whichever is later.

Participating Provider Insurance Requirements

Throughout the term of the Provider Agreement, Participating Providers must maintain a malpractice, general and professional liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted conducting business in the State of New York (or State of Vermont, as applicable) and acceptable to MVP. In the event Participating Providers procure a "claims made" policy as distinguished from an occurrence policy, such providers must procure and maintain prior to termination of such insurance, continuing "tail" coverage or any other insurance for a period of not less than five (5) years following such termination. Participating Providers must immediately notify MVP of any material changes in insurance coverage or self- insurance arrangements and must provide a certificate of insurance coverage to MVP upon MVP's request. Copies of insurance policies and/or evidence of self-insurance must be provided to MVP upon request.

Compliance with the Federal "No Surprises Act" (NSA)

MVP employees, business partners, and contracted Providers must comply with the Consolidated Appropriations Act, 2021, which includes a federal law commonly referred to as the "No Surprises Act." Among other provisions, this Act established federal prohibitions against "surprise bills" to Members and requires increased transparency of medical service pricing. Most requirements of the Act became effective on January 1, 2022.

The Act further establishes an independent dispute resolution process to resolve payment disputes between health plans and providers. All MVP resources and materials are developed and maintained in compliance with this Act, as well as other applicable state and federal laws.

Compliance with the Americans with Disabilities Act (ADA) Act of 1990 (rev. 2008)

MVP employees, business partners, and contracted Providers must comply with ADA requirements, as amended, and including but not limited to compliance with Section 504 of the Rehabilitation Act of 1973 that prohibits discrimination in connection with service availability, accessibility, delivery, and other administrative actions on the basis of disability. Members with disabilities must be provided with an equal opportunity to receive health program benefits and services. Amongst other responsibilities, MVP and Participating Providers must ensure that electronic and information technology be accessible to Members with disabilities and special needs. Web pages, portals and other electronic forms of communication need be compliant with these standards. Any documents provided on Member-based portals must also be compliant with Section 504 standards allowing the use of assistive reading programs.

Language Assistance for Limited English Proficiency (LEP)

MVP assesses the linguistic needs of its Members to ensure Members have access to translation and interpretation services for medical services, customer service, and health plan administrative documentation, as needed and in accordance with Title VI of the Civil Rights Act of 1964 and NYS law and regulations. MVP ensures Members receive access to translated or alternative format documents and communication as necessary, including for Members who are visually and hearing impaired.

Confidentiality and Protected Health Information (PHI)

MVP and Participating Providers are considered "Covered Entities" under the HIPAA Privacy Rule and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI. MVP and Participating Providers are required by federal and state laws to protect a Member's PHI and are also required to immediately report any breach in confidentiality. MVP maintains physical, administrative, and technical security measures to safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

MVP Provider Directory

Health care providers who have satisfied MVP's Credentialing requirements and have executed a Provider Services Agreement with MVP or a Provider Organization (i.e., IPA, PHO, PO) will be listed in MVP's Provider Directory. MVP's Provider Directory may be searched for in-network Participating Primary Care Providers, Specialists, lab facilities and additional facility types, and it is important to have up-to-date and accurate provider information in the directory, including but not limited to participation status and demographic information.

The Primary Care Physician's Roles and Responsibilities

The primary roles and responsibilities of Primary Care Physician (PCP) are to coordinate all the Member's health care needs recommended for their age as outlined by the Participating Provider's Provider Services Agreement and the MVP Quality Improvement (QI) Department. Participating Providers agree not to differentiate or discriminate in the treatment of the Member based on race, sex, age, religion, place of residence, handicap, health status, or payment source.

A PCP may be selected from the following types of Participating Providers:

- Credentialed Nurse Practitioner (see Credentialing specific requirements)
- Family Practitioner
- General Practitioner
- Geriatrician (for Medicare Members only)
- Internist
- Obstetrician/Gynecologist
- Pediatrician
- Specialist under the conditions set forth in this section

Health care providers who have satisfied MVP's credentialing process and have a Provider Services Agreement with MVP or a Provider Organization (i.e., IPA, PHO, PO) will be listed in MVP's Participating Provider directory.

Common PCP services include:

- Initial examinations, including screenings, history, and lab/diagnostic procedures
- Patient and parent counseling (as applicable to minors)
- Immunizations

Additionally, the PCP:

- Maintains the medical records for each patient
- Determines the appropriate treatment plan
- Authorizes referrals to MVP participating specialists (see Utilization and Case Management for details), when necessary
- PCP is required to screen for Behavioral Health for all Medicaid, CHP and HARP Members and meet or exceed the Health Access Standards (see below for more details)

Hourly Requirements of PCPs for Government Programs (Medicaid, HARP, CHP)

- To be considered a PCP for Government Program Members, a Participating Provider must practice at least 16 hours per week at that site.

Member Ratio Requirements for Government Programs (Medicaid, HARP, and CHP)

- MVP reports the ratio of Medicaid Managed Care and Child Health Plus Members to certain Providers on a quarterly basis. Any Credentialed PCP r exceeding the enrollment ratio of 1,500 Members-to-Provider, 2,400 for a Credentialed Physician practicing in combination with a registered Physician Assistant or a Certified Nurse Practitioner will have their panels closed to new Members until their numbers fall below the accepted ratios. PCPs must provide Government Program Members with access to care via face-to-face or on-call coverage 24/7. PCPs may not routinely refer Members to emergency rooms for after-hours care. PCPs using an answering machine for after-hours coverage must direct Members how to access a live person.

Member Selection of a PCP

The following MVP Products require Members to select a participating PCP to provide primary care services to Members and who is responsible for maintaining continuity of care provided to Members:

- Child Health Plus
- Dual Special Needs Program (DSNP)
- Health and Recovery Plans (HARP)
- Medicaid Managed Care
- Medicare Advantage HMO
- MVP HMO Including all Exchange Products
- MVP POS
- MVP Select Care (ASO) HMO
- MVP Select Care (ASO) POS

PCP Member Roster

Once a Member selects a PCP, the Member's name will appear on the PCP Member Roster. PCP Member Rosters can be accessed anytime by logging onto your Provider account at www.MVPHealthcare.com, select View PCP Member Roster.

Specialist or Specialty Care Center as a PCP

Certain MVP Products allow for a Specialist or a Specialty Care Center to be designated as a Member's PCP. MVP defines Specialty Care Center as centers accredited or designated as such by a state or federal agency or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition.

- NY HMO, Medicaid, CHP and HARP Only. For current and newly enrolled Members with a life- threatening, disabling, or degenerative disease or condition that requires prolonged specialized medical care, the specialist or a Specialty Care Center may be considered as a PCP. If a Member is using a Behavioral Health Clinic that also provides primary care services, the Member may select his or her lead Participating Provider to be a PCP.
- The specialist or Specialty Care Center assumes the responsibility to coordinate all primary care services and to authorize referrals for specialty care (see Utilization Management for details), lab work, hospitalizations, and all other health care needs.
- For Medicaid only, a School Based Health Center (SBHC) may be designated as a Member's PCP. In some instances, the SBHC may become the child/adolescent's PCP at the request of the parent or guardian.

Member Changing PCP

Members can change their PCP at any time. Medicaid Managed Care, HARP, and CHP ID Cards list the
Member's PCP. A new Member ID card will be issued upon a new or change in PCP selection.

PCP Auto Assignments

Government Programs Members may select a PCP upon enrollment. If a Member has not selected a PCP within twenty-four (24) hours of enrollment a PCP will be assigned based on the following criteria:

- Member's geographic location
- Specific health considerations
- Language and age, if appropriate

A Member will also be auto assigned a new PCP within fifteen (15) business days of notification from a PCP who will no longer participate with MVP.

PCP Referrals to Specialists

For MVP Products requiring a referral, MVP will provide payment for the Covered Services of a specialist only if the Member's PCP makes an appropriate in-network referral after determining the Member's course of treatment.

The specialist will then submit a report to the Member's PCP. The PCP has the primary responsibility to oversee and coordinate all the care needed by the MVP Member. Please see Utilization Management for MVP's referral policy.

PCP-Initiated Changes

If a PCP believes that they can no longer manage the Member's care, the PCP should submit a letter to their local MVP Professional Relations Representative that documents the reasons necessitating the change. Acceptable reasons for a PCP to request a change might include:

- Consistent physical or verbal abusiveness by a Member or their designee to the PCP and/or the PCP's staff
- Fraudulent activity by a Member or their designee
- Repeated non-compliance by a Member with treatment plan or keeping appointments
- Repeated non-compliance by a Member with MVP administrative guidelines
- The PCP should document such events, and any appropriate follow-up by the PCP or staff. Additionally, the documentation should show:
- The PCP has ruled out any underlying medical conditions that may be impacting and/or resulting in the Member's behavior
- Special considerations the office may be able to address regarding any disabilities of the Member
- Any cultural or linguistic issues that might impact the PCP's ability to work effectively with the Member
- Any additional training delivered or necessitated for staff to be able to work more effectively with the Member

Specialists Roles and Responsibilities

As part of MVP's standard of care, specialists should provide regular feedback to the PCP during a Member's course of treatment.

Emergency room physicians should provide feedback to the Member's PCP regarding any treatment rendered during an emergency room visit and any need for follow-up care. Specialists should verify that an authorization is on file before performing any non-emergent procedures that require authorization.

Specialist or Specialty Care Center as a PCP

MVP defines Specialty Care Center as centers accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life- threatening disease or condition or degenerative and disabling disease or condition.

- NY HMO, Medicaid, CHP, and HARP Only. Current MVP Members and newly enrolled Members with a life-threatening, disabling, or degenerative disease or condition that requires prolonged specialized medical care, the specialist or a Specialty Care enter may be considered a PCP. If a Member is using a Behavioral Health Clinic that also provides primary care services, the Member may select his or her lead Participating Provider to be a PCP
- The specialist or Specialty Care Center assumes the responsibility to coordinate all primary care services and to authorize referrals for specialty care (see the MVP Case and Utilization Management section for details), lab work, hospitalizations, and all other health care needs

Health Access Standards

MVP requires the following Health Access Standards as required by Product, law, and regulation:

Type of Service	**MVP Commercial**	**New York State: Medicaid Managed Care, Child Health Plus, and HARP****	**CMS: Medicare Advantage Product**	**Vermont Rule 9-03B**
Emergent Medical (Read further for definitions of "emergency")	Immediate access	Immediate access	Immediate access	Immediate access
Urgent Medical (Read further for definitions of "urgent")	Within 24 hours	Within 24 hours	~~I~~mmediate Access	Within 24 hours

Primary Care within 48–72 hours

Non-Urgent "Sick" Visit		Within 48-72 hours		
Routine Symptomatic: Non-Urgent,	Within two weeks	Within two weeks	Within one weeks	Within two weeks

Non-Emergent				with prompt F/U, including referrals as needed
Routine Asymptomatic: Non-Urgent and Preventive Care Appointments (NYSDOH) Routine and Preventive (CMS)		Within four weeks	Within 30 days	
Preventive Care, Wellness Visits Including Routine Physicals (CM, VT) Adult (>21) Baseline and Routine Physical (NYSDOH)	Within 90 days	Within four weeks		Within 90 days
Initial Assessment		Within 12 weeks of enrollment		Within 90 days of enrollment (good faith effort by plan)
Well-Children		Within four weeks		
Initial PCP OV for Newborns		Within two weeks of discharge from hospital		
Wait in PCP Office (Max)	30 minutes	one hour	30 minutes	
After-Hours Care	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage

Other Medical Care

Initial Prenatal Visit: First Trimester		Within three weeks		
Second Trimester		Within two weeks		
Third Trimester		Within one week		

Type of Service—NYS DOH Guidance Commercial	**MVP Commercial**	**New York State DOH: Medicaid Managed Care, Child Health Plus, and HARP****	**CMS: Medicare Advantage Product**	**Vermont Rule 9-03B**
Initial Family Planning		Within two weeks of request		
Specialist Referrals		Within four–six weeks (non-urgent) of request		
Routine Lab, X-ray, and				Within 30 days
General Optometry				
In-Plan Mental Health or Substance Abuse Visits (Following an Emergency or Hospital Discharge)	Within 7 calendar days of discharge	Within five days of enrollee request, or as clinically indicated		

In-Plan Non-Urgent Mental Health or Substance Abuse Visit	Within 10 business days	Within one week of enrollee request		
Visits to Perform Assessment of Health, Mental Health, Substance Abuse for Recommendation Regarding Ability to Work as Requested by Local DSS		Within 10 days of DSS request		

* The NYS DOH considers it a violation of the Medicaid Contract Standard Clauses to require Medicaid enrollees to provide a medical record or health questionnaire as a condition of scheduling an appointment.

** After-hours availability, if the telephone in provider's office is answered in an automated manner (e.g., an answering machine), Members must be directed to call a second telephone number which is answered by a live person.

Type of Service	**MVP Commercial**	**NYS Government Programs (Managed Medicaid, CHP, HARP)**	**Medicare Advantage Plans**	**Vermont Rule 9-03B**
Behavioral Health: Emergency: Life-Threatening/Non-Life Threatening	Immediate Access	Immediate access	Immediate access	
Urgent BH	Within 24 hours	Within 24 hours	Immediate access	Within 24 hours
Routine BH	Within 10 business days	Within 10 business days	Within 30 business days	
Routine Follow up		30 days		
Licensed to Prescribe BH Providers		20 days		
Non-License to Prescribe BH Providers MH or SUD Follow up		1 week		

Medicare and Dual-Access Plans Variation to Access Standards

MVP must comply with all CMS requirements and ensure that all Covered Services including additional or supplemental services contracted on behalf of the Medicare Member are accessible. At a minimum, all PCPs, specialists, and Ancillary Providers must meet the following standards to ensure accessibility to Members:

- Office waiting room time cannot exceed 30 minutes
- Participating Provider should be accessible 24 hours a day, 7 days a week, and 365 days a year
    - Such assess must include an after-hours phone number published in a phone directory, on office business cards, or on insurance cards which connect the Member to an answering service, a hospital switchboard, an emergency department, or a paging system
    - An office announcement directing Members to leave a message is unacceptable

Medicaid Managed Care, HARP and Child Health Plus Variation to Access Standards

Access and availability studies are routinely conducted by both the New York State DOH and MVP to ensure that the access and availability standards as described above are met for all Medicaid, HARP and CHP Managed Care plans. Representatives from the local Department of Social Services or DOH or their designee may contact a provider's office and attempt to schedule appointments for various types of services. It is important that all staff members are knowledgeable of both MVP requirements and the regulatory standards described above. If DOH contacts a provider's office in this manner, the staff person who answers the telephone will be informed by the state representative at the conclusion of their conversation that their interaction was a simulated test on these standards. The DOH may also conduct randomized tests to ensure that PCPs are available 24 hours a day by attempting to contact providers after business hours to verify that an appropriate live voice "on-call" telephone system is in place. An after-hours voicemail message advising patients to call 911 in an emergency is not acceptable. In addition, as part of MVP's participation in the New York State Medicaid Managed Care program, MVP is required to conduct an annual survey on appointment availability and 24-hour access to our Government Programs network.

Children's Home and Community Based Services (CHCBS) Variation to Access Standards

Effective October 1, 2019, children who have received a 1915(c) waiver will be moved into Medicaid Managed Care programs. Eligible children with a 1915(c)-waiver moved into MVP's Medicaid Plan will receive all current Medicaid along with CHCBS.

Medical Health Access standards listed above must be adhered to for CHCBS. In addition to the Medical Health Access Standards, Members receiving CHCBS will be provided with comprehensive and preventive health care services to ensure they receive appropriate preventive, dental, mental health, developmental and special services.
MVP contracts with Providers that have expertise in caring for medically fragile children, including children with co-occurring developmental disabilities in the event MVP does not have Participating Providers for such Covered Services, the referring provider must submit a prior authorization for an out-of-network provider. Refer to the MVP Utilization and Case Management policy for the process on how to obtain a prior authorization to an out-of-network provider. The following access standards must be met by all providers.

Foster Care Initial Health Services Variation to Access Standards

The following services must be performed by the appropriate provider outlined below in the designated timeframes of a child being placed in foster care. This is limited to Medicaid and CHP Members.

Initial Health Services Time Frames

Activity	Time Frame	Who Performs
Initial Screening/Screening for Abuse/Neglect	Within 24 hours of request	Health Practitioner (preferred) or Child Welfare Caseworker/health staff
Initial Determination of Capacity to Consent for HIV Risk Assessment and Testing	Within 5 days of request	Child Welfare Caseworker or designated staff
Initial HIV Risk Assessment for Child Without Capacity to Consent	Within 5 days of request	Child Welfare Caseworker or designated staff
Request Consent for Release of Medical Records and Treatment	Within 10 days of request	Child Welfare Caseworker or designated staff
Initial Medical Assessment	Within 30 days of request	Health Practitioner
Initial Dental Assessment	Within 30 days of request	Health Practitioner
Initial Mental Health Assessment	Within 30 days of request	Mental Health Practitioner
Family Planning Education and Counseling and Follow up Health Care for Youth Age 12 and Older (or Younger as Appropriate)	Within 30 days of request	Health Practitioner
HIV Risk Assessment for Child with Possible Capacity to Consent	Within 30 days of request	Child Welfare Caseworker or designated staff
Arrange HIV Testing for Child with no Possibility of Capacity to Consent and Assessed to Be at Risk of HIV Infection	30 days	Child Welfare Caseworker or designated staff
Initial Developmental Assessment	45 days	Health Practitioner
Initial Substance Abuse Treatment	45 days	Health Practitioner
Follow-up Health Evaluation	60 days	Health Practitioner
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	60 days	Child Welfare Caseworker or health staff
Arrange HIV Testing for Child With Capacity to Consent Who Has Agreed in Writing to Consent to Testing	60 days	Child Welfare Caseworker or health staff

Coverage Arrangements

Participating PCPs must ensure that there is 24/7 coverage for Members. PCPs may use a back-up call service, provided that a physician is always available to back up the call service. PCPs agree that, in the case of an absence, they will arrange for patient care to be delivered by another provider and ensure the covering provider participates with MVP. If arrangements are made with a non-participating physician*, it is the responsibility of the participating physician to ensure that the non-participating physician will:

- Accept MVP's fee as full payment for services delivered to MVP Member patients
- Accept the MVP peer-review procedures
- Seek payment only from MVP for Covered Services provided to Members and at no time bill or otherwise seek compensation for Covered Services from MVP Members, except for the applicable co-payments
- Comply with MVP utilization management and quality improvement procedures

Note: Providers who are not contracted for Government Program lines of business are considered non-participating for Government Program plan types (Medicaid Managed Care, HARP and Child Health Plus).

When submitting the insurance claim to MVP, the covering provider should indicate "covering for Dr. 'X'" in box 19 of the CMS-1500 claim form.

Provider Directory Policy

MVP is committed to ensuring our Members have access to the care they need. To do this MVP requires all credentialed Providers to be listed in MVP's online and paper directories.

Policy Exceptions

Physicians who are registered with MVP or have a specialty in which a Member does not require a follow-up appointment are excluded from this policy, such specialties include:

- Anesthesiologists (except those credentialed as Pain Management Specialists)
- Critical Care Specialists
- Emergency Medicine Providers
- Hospitalist (hospital only based providers with the specialties of Internal Medicine, Family Practice, and Pediatrics)
- Diagnostic Radiologists (except for Interventional Radiologists), radiology facilities are published.
- Individual Behavioral Health Providers practicing in an OMH/OASAS certified/licensed facility or program are not listed in the directory; however, the facilities are published
- Neonatologists
- Pathologists
- Primary Care Physicians practicing in an Urgent Care setting with the following specialties, Emergency Medicine, Family Practice, General Practice, Internal Medicine or Pediatrics
- Primary Care Physicians who are covering at a location one time a week or less, or those that do not meet the 16-hour PCP requirement for a location
- Providers who only practice in a Skilled Nursing Facility

Mid-Level Providers who are registered with MVP, including:

- Certified Nurse Midwives (CNM) that do not meet MVP credentialing requirements
- Licensed Master Social Worker (LMSW)
- Nurse Practitioner (NP) or Advanced Practice Registered Nurse (APRN) that do not meet MVP credentialing requirements
- Physician Assistant (PA)
- Registered Nurse First Assistant (RNFA)

Changes in Demographic Information or Termination of Participation

Termination or Non-Renewal

Participating Providers must provide MVP of advance written notice of their leaving MVP's network. Termination and Non-Renewal notice requirements are governed by the Participating Provider's Service Agreement and may be provided directly to MVP or through a provider organization (i.e., IPA, PHO, PO). Providers should refer to their Service Agreements for applicable notice requirements and obligations during and post-termination or non-renewal. If a Participating Provider voluntarily terminates or non-renews their service agreement, MVP will make a good faith effort to notify all affected Members of the change in participation status within fifteen (15) days of receiving such notice. Participating Providers leaving the MVP network for Government Programs (Medicaid, CHP, and HARP) must notify Members of the change in status and the impact of such change on the Member.

Transition of Care

When a Member is under the care of a Participating Provider who leaves MVP's network, the Member may be eligible for Continuation of Care with the provider for ninety (90) days from the effective date of the termination of the provider's participation in the MVP network, as long as the provider a) has not been terminated due to quality issues; b) is willing to accept the MVP fee schedule as payment in full, c) remains in MVP's service area(s); d) is able to provide appropriate care; and e) and agrees to follow MVP Policies and Procedures.

Continuation of Treatment: NY HMO Company Only

At the time of enrollment, new MVP Members may be undergoing treatment with a non-participating provider. MVP will provide benefits for Covered Services and will not deny coverage of an ongoing course of care for sixty (60) days from the date of enrollment or until accepted by a new provider (whichever is sooner), if the new Member is undergoing treatment for:

- A life-threatening disease or condition

- A disabling or degenerative disease or condition

MVP also will provide benefits for covered services if the new Member has entered the second or third trimester of pregnancy at the effective date of enrollment. Care will be covered through the completion of postpartum care related to the delivery of the newborn. MVP will provide benefits only if the non-participating provider:

- Accepts MVP's established rates as payment in full
- Adheres to MVP's QI requirements
- Adheres to MVP's Policies and Procedures
- Provides MVP with medical information related to care

Continuation of Care will not be offered if the Provider's departure is due to:

- A determination of fraud
- Final disciplinary action by a state licensing board or other governmental agency that impairs the Provider's or a significant number of Participating Providers' ability to practice
- Suspected or confirmed criminal or exclusionary activity of an employee, staff, member or subcontractor, or MVP's own suspicion or determination of such by Provider or Provider's employees, staff or subcontracts that result in exclusion from participating in the Medicare or Medicaid Programs
- A determination of cases involving imminent harm to patient care

Transitional Care

Transitional care applies to all Members whose Provider leaves MVP's network and is receiving an active course of treatment for an acute episode of chronic illness or acute medical condition, or for a life-threatening, disabling, or degenerative disease or condition.
If an MVP Member is pregnant at the time of the provider's departure, Transition of Care will be allowed until the completion of postpartum care related to the delivery of the newborn. Upon notification of the termination of a Member's Provider, the Professional Relations representative will forward a letter to the Provider outlining the transition of care requirements. If the practitioner agrees to the following stipulations, the signed transition of care letter is returned to the Professional Relations Representative for implementation. The Provider must agree to:

- Continue to treat the Member for an appropriate period based on the written transition plan goals
- Accept MVP's established rates as payment in full and not charge the Member for amounts beyond
- Adhere to MVP's QI requirements
- Provide medical information related to care
- Adhere to MVP Policies and Procedures

Transition of Care for Enrolled Children or Youth Placed in Foster Care

MVP promotes continuity of care for enrolled children or youth placed in foster care. MVP ensures access to services post discharge from a 29-I Health Facility designated under New York State Public Health Law Article 29-I Health Facility ("29-I Health Facility) under the following conditions:

Children or youth who are discharged from a 29-I Health Facility (facilities licensed by DOH and OCFS who provide Core Limited Health Related Services (CLHRS) and Other Limited Health Related Services (OLHRS) to children enrolled in foster care) may continue to receive OLHRS from any 29-I Health Facility up to one-year post discharge. These services may continue beyond the one-year post discharge date, if any of the following apply:

A. The child/youth is under 21 years old and in receipt of services through the 29-I Health Facility for an Episode of Care and has not yet safely transitioned to an appropriate provider for continued necessary services.

B. The child/youth is under 21 years old and has been in receipt of Children and Facility Treatment and Support Services (CFTSS) or Children's Home and Community Based Services (HCBS) through the 29-I Health Facility and has not yet safely transitioned to another designated provider for continued necessary CFTSS or HCBS in accordance with their plan of care.

C. If the Member is 21 years or older, the 29-I Health Facilities may continue to provide OLHRS when the following applies:

- The Member has been placed in the care of the 29-I Health Facility and has been in receipt of OLHRS prior to their 21st birthday and has not yet safely transitioned to another placement or living arrangement
- The Member and/or their authorized representative is compliant with a safe discharge plan
- The 29-I Health Facility continues to work collaboratively with MVP to explore options for the Member's safe discharge, including compliance with court ordered services, if applicable

In accordance with the Medicaid transition guidelines, the Medicaid residual per diem is not reimbursable after the individual's 21st birthday. Adults over the age of 21 are not eligible for CFTSS or Children's HCBS.
An "Episode of Care" is defined as a course of treatment that began prior to discharge by the same facility to the child/youth for the treatment of the same or related health and/or behavioral health condition and may continue within one year after the date of the child/youth's discharge from the 29-I Health Facility.

New York State Confidentiality Law and HIV

The following information is excerpted from the New York State DOH AIDS Institute website available at hivguidelines.org.

New York State Public Health Law (Article 21) requires that:

- Information about AIDS and HIV is kept confidential
- Anyone receiving a voluntary HIV test must first sign a consent form
- Strict limits be placed on disclosure of HIV-related information
- When disclosure of HIV-related information is authorized by a Member or a Member's legally appointed guardian or health proxy signing an HIV release form, the person or facility receiving the HIV-related information must keep it confidential
- Only applies to people and facilities providing health or social services, or who obtain the information pursuant to a special HIV release

Article 21 also requires that physicians and laboratories report the following results to New York State DOH:

- AIDS
- Positive HIV tests
- Viral load tests
- Diagnoses of HIV-related illnesses
- Tests showing t-cell counts under 500

Only tests completed at certified anonymous test sites are exempted from reporting.

Demographic Changes

Participating Providers must notify MVP of any demographic changes; failure to do so may result in claim denials. Providers should use the Online Demographic Form for such updates. Go to mvphealthcare.com/demographics.
Complete the appropriate fields and submit the form. A reference number will be generated for your records; use the reference number when checking on the status of a change.
NYS "Out-of-Network Surprise Bill" requires providers to annually review and update MVP regarding their hospital affiliations and languages spoken. Providers may make the change(s) on their CAQH application and attest the information is correct per CAQH standards. MVP will review all changes made to the CAQH application and contact the Provider with any questions.

Quarterly Demographic Review

CMS requires MVP to perform a quarterly review of demographic information of MVP's online directory. MVP requires all Participating Providers to review demographic information and ensure that it is accurate and up to date. Participating Providers must notify MVP of any demographic changes and update their CAQH profiles as applicable. To review and verify Provider information on a quarterly basis:

Step 1 Visit **mvphealthcare.com** and select Members, and then *Find a Doctor*, and then search by *Find a Doctor*.

Step 2 On the Provider search tool, click on Guest and choose one of the products the Provider(s) in your practice participates in. Search for the Participating Provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new Members
- Street address or missing addresses
- Phone number
- Other changes that affect availability to Members (e.g., handicapped accessible, specialty changes)

Step 3 If demographic information is incorrect, please access the Online Provider Change of Information form and submit the correct information to MVP. This form can be found here. Delegated Providers, please contact your delegate administrator to update your demographic information.

Step 4 If the update applies to multiple Participating Providers in the group, choose contracted group on the form and attach a roster of all Participating Providers the change applies to, including the Participating Provider's name and NPI

Step 5 Once the form is complete, click *Submit*. A reference number will be generated; please keep this for your records and use when checking on the status of your change.

Step 6 Log in to CAQH and make any demographic updates to your CAQH profile so it matches the information you are submitting to MVP and re-attest your CAQH.

Advance Directives

An Advance Directive(s) allows Members to make provisions for future health care decisions in the event; they are unable to make such decisions themselves. Participating Providers are required by law to provide information to Members about Advance Directives. MVP requires Participating Providers to adhere to all applicable laws and regulations and requires that information shared with Members and their treatment options be easily understood by the Member. Participating Providers may not require Members to sign or waive an Advance Directive as a condition of care. Participating Providers must comply with all applicable law and regulations when an Advance Directive is given to a Participating Provider by the Member. Such requirements include but may not be limited to:

- The Participating Provider must include the Advance Directive in the Member's medical record
- The Participating Provider must comply with the health care decisions made by an agent under the Advance Directive to the same extent as the provider would comply with the Member's decisions

- The Participating Provider must inform the health care agent and transfer responsibility for the Member to another Participating Provider if the Member's health care decisions are contrary to the Participating Provider's religious beliefs or moral convictions
- MVP Medicare Advantage Members aged 18 years and older will require documentation in the medical record chart with a notation of the Advance Directive

MVP will monitor compliance of this requirement through the quality assurance medical record review.

Emergency Care

Participating Providers shall provide Members with immediate access to care, which is the standard for emergency conditions. An "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: (i) 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, or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Practitioners Treating Self or Family Members

The American Medical Association (AMA) has stringent guidelines regarding practitioner self-treatment or treatment of immediate family members. The AMA Code of Medical Ethics Opinion 8.19 addresses this issue in detail. MVP endorses the AMA's position regarding practitioner self-treatment and treatment of immediate family members and will not reimburse such care.

Cultural and Linguistic Competency

All Participating Providers must ensure that services are provided to all Members in a culturally competent manner. Cultural and Linguistic Competency in healthcare is the ability of Providers to understand social, ethnic, religious, and linguistic characteristics of a population and use this understanding to improve the quality of care that Providers deliver. MVP is committed to ensuring that our Members are treated with dignity and respect and that their cultural and linguistic needs are adequately considered when interacting with Participating Providers.

The socio-cultural differences between Members and healthcare professionals influence many aspects of the medical encounter that can impact patient satisfaction, adherence to medical advice, and health outcomes. For example, Members generally respond better when care instructions are delivered in their language of preference. Moreover, knowledge of, and sensitivity to, cultural issues can impact the way Members communicate their medical needs, and how healthcare professionals can enhance diagnosis and treatment.

Cultural education for Providers not only does it accomplish the goal of culturally sensitive care but can also help address ethnic disparities in healthcare access and delivery.

Regulations prohibit MVP and Participating Providers from discrimination based on certain protected classes, including but not limited to ethnicity, religion, and health status.

Cultural and Linguistic Competency training is required for Participating Providers serving New York State Government Programs Members and the same or equivalent thereof is strongly encouraged for all other Providers. Participating Providers may access E-learning offered by the Center for Practice Innovation and Think Cultural Health, offered through the United States Health and Human Services website. Training materials and resources are provided free of charge and equip Providers with the necessary competencies to improve the quality of treatment for MVP's diverse Member population.

MVP is required to obtain attestation from Participating Providers annually indicating the required training has been completed.

High-Tech Imaging Services Provided in an Office or Free-Standing Radiology Center

MVP requires that all MRI/MRA, CT/CTA, and PET machines have accreditation from RadSite, the American College of Radiology (ACR) or from the Intersocietal Accreditation Commission (IAC). Providers' offices that are approved to perform these high-tech imaging services are required to submit proof of ACR or IAC accreditation to MVP. Providers' offices that are not accredited and/or do not submit proof of ACR or IAC accreditation to MVP are not authorized to perform these services to Members in their offices and will not be reimbursed for such services.

Until further notice, MVP currently has a moratorium on the addition of such high-tech radiology equipment and will not add to its network unless a demonstrated access need is identified (at MVP's sole discretion).

Telehealth Services

Telehealth services apply to MVP's Medicaid, Health and Recovery Plans (HARP), Essential Health Plans, Commercial, Child Health Plus, and Medicare Advantage and DSNP Products. MVP provides reimbursement for Telehealth furnished by a Telehealth Provider to Members. Please refer to MVP's Payment Policies for detailed information regarding requirements and reimbursement regarding Telehealth, Virtual Check In and Audio Only (VT) the Virtual Care Payment Policy for reimbursement information. Additionally, please refer to the Credentialing Policy for criteria to practice as a Telehealth provider.

Confidentiality

All services delivered via Telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR Parts 160 and 164 (HIPAA Security Rules); 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Additionally:

- HIPAA requires that a written "business associate agreement" (BAA), or contract that provides for privacy and security of protected health information (PHI) be in place between the Telehealth provider and the supporting Telehealth vendor.
- Privacy must be maintained during all patient-Provider interactions
- All existing confidentiality requirements that apply to medical records (including, but not limited to:
    - 45 CFR Part 160 and 164; 42 CFR Part 2; PHL Article 27-F, and MHL Section 33.13) shall apply to services delivered by Telehealth, including the actual transmission of service, any recordings made during the Telehealth encounter, and any other electronic records

Patient Rights and Consents

The provider shall provide the Member with basic information about the services that he/she will be receiving via Telehealth and the Member shall provide his/her consent to participate in services utilizing this technology. Telehealth sessions/services shall not be recorded without the Member's consent. Culturally competent translation and/or interpretation services must be provided when the Member and distant provider do not speak the same language. If the Member is receiving ongoing treatment via Telehealth, the Member must be informed of the following patient rights policies at the initial encounter.

Documentation in the medical record must reflect that the Member receiving Telehealth services are informed of their rights as outlined below:

- Have the right to refuse to participate in services delivered via Telehealth and must be made aware of alternatives and potential drawbacks of participating in a Telehealth visit versus a face-to-face visit
- Are informed and made aware of the role of the provider at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care
- Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed
- Have the right to have appropriately trained staff immediately available to them while receiving the
- Telehealth service to attend to emergencies or other needs

- Have the right to be informed of all parties who will be present at each end of the Telehealth transmission; and
- Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit

MVP Physician, Mid-Level, and Ancillary Provider Registration or Contracting Requirements

Certain physicians, mid-levels, and Ancillary Providers are not required by MVP to be fully Credentialed but instead may be subject to MVP's registration process. Registration requires MVP to confirm that the proper licensure, education, insurance requirements, and required regulatory sanction checks are met and is contingent upon the provider being fully credentialed by their employer (collectively "Provider Registration"). Provider Registration is available to the following providers:

- Nurse Practitioners (NP) If below 3600 hours of practice in specialty NPs will need a collaborating provider
- Physician's Assistants (PA)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwives (CNM)
- Advanced Practice Registered Nurses (APRN)—Vermont only
- Anesthesia Assistants—Vermont only
- Opticians
- Registered Nurse First Assistants (RNFA)
- Licensed Masters Social Workers (LMSW)
- Physicians in the following specialties:
    - Family Practice, Internal Medicine, and Pediatrics in the Inpatient Hospital Setting Only
    - Anesthesiology
    - Critical Care
    - Emergency Medicine
    - Pathology

Upon Provider Registration, MVP shall set the date of participation date and inform the Registered Provider of their participation status ("Par Date"). MVP does not allow retro-activation of Registered Providers. Participation status is at MVP's discretion, and such determination is based on the successful Provider Registration and an executed Provider Agreement with MVP (as applicable). A Registered Provider will not be reimbursed for services provided to MVP Members prior to their Par Date. Providers in the specialties

outlined below must notify MVP as soon as they are aware that they will be providing services to MVP Members. Applications with future effective dates will be accepted, and the provider will be set up with the future effective date upon their successful Provider Registration. Provider Registration may take up to 60 days from the date the executed MVP Provider Agreement (as applicable) and complete registration application are received.

Internal Medicine, Family Practice and Pediatrics. Physicians with a specialty of Internal Medicine, Family Practice, and Pediatrics that are solely practicing in the hospital as a hospitalist in an MVP participating Hospital (or facility) must be bound by the hospital's Provider Agreement with MVP and complete Provider Registration. Physicians with practicing in the specialty of Internal Medicine, Family Practice and/or Pediatrics outside the hospital setting must be fully Credentialed.

Emergency Medicine, Hospital Based Anesthesiology, Critical Care, and Pathology. Physicians with a specialty of Emergency Medicine, Hospital Based Anesthesiology, Critical Care, and/or Pathology must be contracted with MVP and complete Provider Registration. Anesthesiologists and Pathologists that have practices outside the hospital setting must be fully Credentialed.

Mid-Levels and Ancillary Providers. Mid-level and Ancillary Providers providing Covered Services in a Participating Provider's practice are subject to Provider Registration. Mid-level and Ancillary Providers are eligible for Provider Registration if they have (1) collaborating physicians where appropriate (defined as Physician services include making medical diagnoses, prescribing medications and other treatments, and ordering diagnostic tests. Collaboration is defined
by each state, and usually means providing direction and oversight and being available for consultation by telephone or other means) who is a Participating Provider in the same specialty; or (2) in a substantially similar specialty (defined as Provider of patient care provides assessment, treatment, and clinical management which is substantially similar in function or capability) in an integrated clinical practice (defined as a patient- centered approach in which behavioral health and medical providers work together to provide care. Often, this takes the form of two models of care: 1) primary care practices integrating behavioral health providers and 2) behavioral health clinics integrating primary care providers) and are bound by the terms of an MVP Provider Agreement. If an Ancillary Provider is a hospital employee billing under the hospitals Tax ID and practices in the in-patient and/or out-patient-hospital setting, Provider Registration is not required. Mid-level and Ancillary Providers subject to this registration requirement include all office-based physician extenders, including, but not limited to:

- Nurse Practitioners (NP) and Certified Nurse Midwives (CNM)
- NPs and CNMs in the state of New York, practicing independently must be Credentialed and individually contracted with MVP
- CNMs employed by a hospital are subject to the hospital based Mid-Level rules detailed below
- NPs and CNMs who do not meet individual Credentialing requirements may not be individually contracted and are subject to Provider Registration.

- MVP may approve the services of a non-participating CNM in compliance with the NY State mandate, when such the CNM has satisfied MVP's current liability insurance requirements and has a written agreement with a collaborating physician.
- Physician Assistants (PA)

Certified Registered Nurse Anesthetist (CRNA)

- A CRNA a may use an MVP participating surgeon in practice (an Anesthesiologist) as their collaborating physician in accordance with NYS rules.

Advanced Practice Register Nurses (APRN)--Vermont Only

- APRNs practicing in Vermont may use a doctorate level APRN who is credentialed and participating with MVP as their collaborating practitioner, if required
- APRNs practicing independently in Vermont must meet Vermont clinical practice hour requirements for independent practice and be Credentialed and individually contracted with MVP
- Anesthesia Assistants (AA)Vermont Only: Opticians
- Opticians do not require a collaborating provider
- Opticians do not require DEA certification
- Registered Nurse First Assistants: Working exclusively in an MVP Participating Facility and are credentialed and privileged by the hospital
- Medicare does not recognize and reimburse separately for RNFAs. These providers may not participate with MVP Medicare products

Mid-Level and Ancillary Providers in an Integrated Health Practice The following provider types are required to be registered with MVP when practicing in an Integrated Clinical Practice:

- **Nurse Practitioner (NP)** Nurse Practitioners in Integrated Clinical Practice who will be practicing psychiatry must have a collaborating provider that is credentialed and participating provider with MVP and has the same or substantially similar specialty. In this situation, a Primary Care Physician may be considered at MVP's sole discretion, a substantially similar specialty for a collaborating provider. The collaborating provider can be under the same TIN or outside the TIN; however, an NP cannot practice independently unless they meet the credentialing requirements.
- **Advanced Practice Registered Nurse (APRN) VT Only APRNs** in an Integrated Clinical Practice who will be practicing psychiatry must have a collaborating provider that is credentialed and participating with MVP and has the same or substantially similar specialty. In this situation a Primary Care Physician at MVP's sole discretion may be considered a substantially similar specialty for a collaborating provider. Providers may also have a Doctoral Level APRN under the same specialty act as a collaborating provider if they are credentialed by MVP.
    - APRNs practicing independently in Vermont must be Credentialed and individually contracted with MVP

- **Licensed Masters Social Worker (LMSW)** Providers who are LMSWs do not meet MVP's requirements for credentialing and must be registered. LMSW providers must have a supervising provider that is credentialed and participating with MVP and have one of the following specialties: Psychiatry Psychology, or Licensed Clinical Social Workers. Ancillary Providers not listed herein should refer to the MVP Credentialing Section for Credentialing requirements. Mid-levels who are unsure if a contract is required with MVP should contact MVPPR@mvphealthcare.com to determine if they require a contract.

Exceptions to Provider Registration Requirements

MVP shall accept state issued OMH-licensed, OMH-operated and OASAS-certified providers, and accept OMH and OASAS licenses, operation, and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. MVP will not separately Credential or Register individual staff members in their capacity as employees but is still required to collect and accept program integrity-related information from such providers as required by the Medicaid Model Contract and will require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government or otherwise excluded from participation in the Medicare or Medicaid program (collectively, MVP State Registration Process"). These providers can be submitted on MVP's required roster format and should be reviewed and updated quarterly. These rosters should be submitted to MVP via email to BHproviderroster@mvphealthcare.com.

Billing and Payment Rules

Mid-Levels in Private Practice with Collaborating Physician
MVP will make payments for Covered Services rendered by registered Mid-Level Providers to the physician's billing address under that group's tax ID. No claims will be paid to the registered Mid-Level practitioner directly.

Covered Services rendered by MVP registered Mid-Level and Ancillary Providers must be billed using their individual type 1 NPI number and the groups Tax ID number. Mid-Levels may not bill using their collaborating physicians' NPI number.

Mid-Levels must bill with the specialty taxonomy associated with their collaborating physician.

Mid-Level and Ancillary Providers who have opted out of Fee-for-Service (FFS) Medicare May Not Render Services to MVP Medicare Gold Patients. This rule applies to all Mid-Level and Ancillary Providers who have opted out of Medicare FFS, regardless of whether the MVP participating physician with whom they practice has opted in to FFS Medicare and is a participating provider with the MVP Medicare Gold products.

Hospital-Based Mid-Levels
Mid-level providers listed above who are hospital employees and whose services are billed under a hospital Tax ID, and whose services are provided within the inpatient (POS 21) or outpatient (POS 22 and 23) setting, require Provider Registration to receive payment if

contractually applicable. Mid-Level hospital employees (billing under the hospital Tax ID) providing Covered Services must have a supervising physician participating with MVP.

Registered Nurse First Assistants (RNFA) who work exclusively in the hospital and are credentialed and privileged by the hospital require Provider Registration. MVP will not reimburse RNFAs for Covered services provided to an MVP Medicare Member. RNFAs that are not working exclusively in the hospital, please see MVP's credentialing requirements.

If you have any questions regarding Mid-Levels employed by the hospital and their registration requirements, please contact your Professional Relations Representative.

Opticians
Opticians must be contracted and complete Mid-Level/Ancillary Provider Registration. All opticians must have a valid New York State License (or Vermont, as applicable) to practice, and a copy of such license must be included with the Provider Registration. Opticians must receive registration approval before they see MVP Members. Opticians who will be billing independently for services do require an NPI for billing purposes. The Mid-Level/ Ancillary Provider Registration form can be found on **mvphealthcare.com**.

Clinical Nutritionists and Dietitians
Clinical Nutritionists and Dietitians must be Credentialed and contracted with MVP, as outlined in the Credentialing section. These providers are not required to have a collaborating physician and can bill with their own TIN number. To request participation, complete the Provider Credentialing Application Request form found here (click on Join MVP Contracting is at the discretion of MVP. Clinical Nutritionists and Dietitians who are employed by a hospital are subject to the Hospital Based Mid-Level rules detailed in this Section and require Provider Registration. If you have any questions regarding contracting or Provider Registration requirements, please contact your Professional Relations Representative.

New York State Medicaid Enrollment Requirement

Services for Members eligible to receive Managed Care Medicaid, HARP and Child Health Plus to enroll in the New York State Medicaid Program. Providers must have an active Medicaid Management Information System (MMIS) number effective July 1, 2018, or have applied for a MMIS number in order to be registered participating providers in MVP's Medicaid, HARP and Child Health Plus programs. Providers who do not obtain an MMIS Number will not be reimbursed for Covered Services provided to such Members. If a Participating Provider is terminated from, not accepted to, or fails to submit a designated enrollment application to the New York State Medicaid Program and obtain an MMIS number, the Provider shall be terminated from all Government Programs Plans. Please visit emedny.org to obtain an MMIS number.

Note: Contracting, Credentialing, and Provider Registration requirements may vary by state and product and are at the discretion of MVP. Providers should review their MVP Provider Services Agreement to determine if they have a contractual variation that will supersede this policy. Please

refer to MVP Provider Toolkit for additional details on the contracting, Credentialing, and Provider Registration process at **mvphealthcare/providers** and select *Join MVP*.

Provider Complaints

MVP is committed to ensuring that Participating Providers have a positive experience with the MVP. Providers may formally voice concerns on any issue that has not been resolved in a timely matter. Providers can voice a complaint by contacting the Customer Care Center for Provider Services or their Professional Relations Representative. Providers also may submit a complaint in writing to:

MVP Health Care
Provider Complaints
625 State Street
Schenectady, NY 12305

All Providers who formally voice a concern will receive a letter acknowledging that the complaint was received and will receive a resolution within thirty (30) business days of MVP's receipt of the complaint.

Non-Participating Provider Joining a Participating Group

New providers joining a participating group should contact MVP to begin the credentialing process. New providers are considered non-participating until they have been fully reviewed and approved by MVP's Credentialing or have completed the MVP registration process.

Provider Communication

MVP will notify Participating Providers of all policy and procedure changes in a timely manner in accordance with the Provider Agreement. MVP may notify Participating Providers of temporary emergency regulation changes as needed via standard mail, a Provider FastFax, or email.

Collecting Patient Responsibility

A Member's Co-payment is due at the time of service. Providers may collect Member's Co-insurance and Deductible only if the amount due is known to the Provider and the Member. The Provider should wait to collect Co-insurance and Deductible amounts until the Provider receives the remittance from MVP indicating the Member's Responsibility. Providers can check the Member's Deductible accumulator in the Member eligibility section of MVP's Provider Portal to determine if they will be responsible for the Deductible or if the Deductible has been met.
Providers can determine a Member's cost share by accessing the benefits display tool on the MVP Provider Portal. The MVP Provider Portal will indicate if the Member is responsible for Co-payment, Co-insurance, or Deductible.

Participating Providers may only collect Members Co-pay, Co-insurance, or Deductible. Providers are contractually prohibited from billing Member surcharges if cost share is not collected at the time of visit. In no circumstances should Providers collect a co-pay, co-insurance or deductible from a Medicaid or Dual Access Member, even if there is Member responsibility noted on the remit. The only exception to this rule is if a Dual Access Member exceeds the amount of their comprehensive dental allowance or their eyewear allowance. In these instances, the provider is allowed to bill for charges that exceed the allowance.

Additional Provider Requirements for New York Medicaid

Pursuant to Federal and State laws, the NYS DOH Standards Clauses and the Medicaid Model Contract, the following submissions and attestations are required for Medicaid Participating Providers.

Ownership and Disclosure Requirements

Facility Ownership and Disclosure Form
As required by federal law and the Medicaid Model Contract, all Medicaid Participating Provider facilities must complete and submit to MVP the NYS DOH Ownership and Disclosure Certification Form (Facility O&D Form) within five days of contracting with MVP.

The Facility O&D Form must be updated any time there is a change in direct or indirect ownership or controlling interest of five percent (5%) or more and/or a change in any directors, officers, agents, or managing employees of the facility within thirty-five (35) days of such change.

Participating Provider Owner/Manager Disclosure Certification Form
Pursuant to applicable federal and state law, and the NYS SOD Standard Clauses all Medicaid Participating Providers must complete and submit to MVP NYS DOH Owner/Manager Disclosure Certification Form within five (5) days of contract execution.

Participating Provider Attestation of Cultural and Linguistic Competency
As required by OMH, OASAS, DOH, and the MMC, Participating Providers must demonstrate cultural competence and certify, on an annual basis, the completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Medicaid Members.

The Participating Provider Owner/Manager Disclosure Certification form can be found here and select *Miscellaneous Forms*.

Disclosure of Criminal Activity Requirements

Medicaid Participating Providers must complete the Disclosure of Criminal Activity form found at **mvphealthcare.com** within five days of contracting with MVP and updated any

time there is a change regarding health care related criminal convictions of persons affiliated with the provider within five (5) days of becoming aware of a criminal conviction.

MVP shall report this criminal activity information to NYS DOH within twenty (20) days of being notified by a Medicaid Participating Provider of a criminal conviction. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found to be noncompliant with this requirement.

Exclusion Database Monitoring Requirements

All Medicaid Participating Providers must have procedures in place to identify and determine the exclusion status of employees and staff associated with a Medicaid Participating Provider through checks of the following exclusionary databases and must routinely monitor exclusion status of such employees and staff:

MVP requires all Medicaid participating providers to monitor all employees and staff associated with the Medicaid participating provider against the following exclusionary databases on a monthly basis:

- U.S. Office of Inspector General's List of Excluded Individuals and Entities (OIG-LEIE): exclusions.oig.hhs.gov
- U.S. General Service Administration's System for Award Management (GSA-SAM) (formerly known as the Excluded Parties List System (EPLS)): sam.gov

New York State Office of the Medicaid Inspector General List of Restricted and Excluded Provider (OMIG Exclusion List): omig.ny.gov/search-exclusions.

- U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists (including the Specially Designated Nationals (SDN) List as well as the Non-SDN Palestinian Legislative Council List (NS-PLC List), the Part 561 List, the Non-SDN Iran Sanctions Act List (NS-ISA List), the Foreign Sanctions Evaders List (FSE List), the Sectoral Sanctions Identifications List (SSI List), and the List of Persons Identified as Blocked Solely Pursuant to Executive Order 13599 (13599 List)): treasury.gov/resource-center/sanctions/SDN-List/Pages/fuzzy_logic.aspx

MVP requires that all Medicaid participating providers complete an Attestation Regarding Monitoring of Exclusionary Databases annually. The Exclusionary Database Attestation can be found at **mvphealthcare.com** (find *Professional Relations Disclosure Forms*). Participating Providers must notify MVP any time an employee(s) or staff associated with the Participating Provider shows up on the exclusionary databases or as soon as the Participating Provider becomes aware of the change in the exclusion status. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found to be noncompliant with this requirement.

MVP requires all Medicaid participating providers to monitor all employees and staff associated with the Medicaid participating provider against the following exclusionary databases on an annual basis:

- U.S. Centers for Medicare and Medicaid Services National Plan and Provider Enumeration System (NPPES): npiregistry.cms.hhs.gov/
- U.S. Social Security Administration Death Master File (Death Master)

Note that the website addresses provided above are accurate at the time of publication but are subject to change from time to time by the respective controlling regulatory agencies.

MVP Product Participation

MVP Participating Providers are required to discuss with their patients the Medicaid Managed Care (MMC), Family Health Plus (FHPlus) and Child Health Plus (CHP) products offered by MVP and other MCOs with whom the Participating Providers may have contracts:

- Participating Providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts
- Participating Providers who wish to communicate with their patients about managed care options must advise patients taking into consideration only the MCO that best meets the health needs of the patients. Such advice, whether presented verbal based and not merely a promotion of one plan over another
- Participating Providers may display MVPs Outreach materials provided the appropriate material is conspicuously posted for all other MCOs with whom the Participating Providers have a contract
- Upon termination of a Provider Agreement with MVP, a Provider that has contracts with other MCOs that offer MMC, FHPlus and CHP products may notify the patients of the change in status and the impact of such change on the patient

Summary

Review Date	Revision Summary
August 14, 2026	

Quality Improvement

MVP's Quality Improvement Program

The MVP Quality Improvement (QI) Program has been established to develop, implement, evaluate, and report on the various interventions and programs designed to improve clinical quality, to maximize safe clinical practices and to enhance the MVP Member's experience.

The QI Program's objective is to utilize a structured process to monitor and improve the quality, appropriateness of care, and services provided to Members at the right place and at the right time. Please see the complete QI Program Description here.

Each MVP operational area has defined performance metrics with accountability to the Quality Improvement Committee (QIC) and Board of Directors (BOD).

The QI Committee (QIC) and MVP's Board of Directors (BOD) oversee the QI Program. The QIC is chaired by MVP's Chief Medical Officer and includes community providers from various specialties who represent the different Participating Providers and Participating Provider Groups in MVP's Network. Participating Providers interested in participating in QIC are invited to contact the MVP Director, Accreditation and QI Regulatory Compliance at **1-518-991-3498**.

The QI Program is evaluated annually, and the report is sent to QIC and the BOD for approval. For a copy of the Executive Summary of the QI Annual report, please call the Accreditation and Quality Regulatory Compliance Department at 1-518-991-3498.

Members and Participating Providers may participate in the development, implementation, and evaluation of the QI Program. MVP invites Participating Providers to comment on its QI process via the website or by calling Customer Care.

MVP's Quality Reporting Structure

MVP has established quality committee reporting structure, in compliance with New York State (NYS) Department of Health (DOH) requirements for Government Programs including Medicaid Health and Recovery Plan (HARP), Medicaid and Child Health Plus (CHP) regulations. Committees specific to Behavioral Health (BH) include Quality Management (QM) and Utilization Management (UM), BH subcommittees and BH Member advisory groups, specific to behavioral health for children and adults, to ensure that MVP's policies, procedures, and interventions are effective and relevant.

Please see the MVP Quality Improvement Program Description at here for details regarding each committee and subcommittee.

MVP's Quality and Utilization Management Subcommittees

Behavioral Health Quality Management (BH QM) Subcommittee

Separate BH QM adult and children's subcommittees are held consecutively.

The subcommittees are co-chaired by:

- Quality Management Behavioral Health Liaison
- Sr. Director, Behavioral Health and Utilization Management Operations
- BH QM Subcommittee membership includes internal MVP BH staff including but not limited to:
    - MVP Medical Director, Behavioral Health
    - Medical Director, HARP BH Adult Services
    - Medical Director, Medicaid Product Performance Management

Responsibilities include:

- Report meeting summary of the Behavioral Health Member Advisory Committees.
- Separately tracks, trends, and reports Behavioral Health (BH) complaints, grievances, appeals, and denials for Members with BH diagnoses who are Mainstream Medicaid, HARP, Child Health Plus (CHP) and D-SNP Members
- BH prior authorization/denial and notices of action
- Subcommittee will present and discuss how the Quality Assurance program addresses specific monitoring requirements related to the populations, benefits and services covered
- Follow up after discharge:
    - Follow-up After Hospitalization for Mental Illness (FUH), Follow-up after High-Intensity Care for SUD (FUI); Follow-Up After Emergency Department Visit for Mental Illness (FUM); Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Adverse incident reporting
- Describe the HARP plan for capturing and reporting Behavioral Health Home and Community Based Services (HCBS) and support monitoring of compliance with HCBS requirements
- Statewide reporting of HARP enrolled Members without HCBS assessments
- Will track and report on compliance with:

  - BH quality assurance performance measure/reporting of HCBS assurances/sub-assurances and recovery measures including employment, housing, criminal justice status, etc.
  - Protocols for expedited and standard appeals regarding plan of care denials for HCBS
  - Reporting on all performance improvement plans and updates on special populations
- Will conduct an annual consumer perception survey (supplementary to Consumer Assessment of Health Plan Survey (CAHPS)

Behavioral Health Utilization Management (BH UM) Subcommittees (HARP/Mainstream Medicaid/D-SNP Non-Integrated and D-SNP IBP)

- Separate adult and Children's BH UM subcommittees are held consecutively.
- Assesses the clinical and service needs of Mainstream Medicaid, HARP, CHP and D-SNP Members with BH diagnoses
- Develops, implements, evaluates, and reports on the various interventions/programs that will optimize clinical quality, maximize safe evidence-based clinical practices, and enhance services to Mainstream Medicaid/HARP/D-SNP Members with BH diagnoses
- Ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis for the Mainstream Medicaid, HARP, CHP, and D-SNP Members with BH diagnoses. Each population is documented separately on the agendas and meeting minutes in accordance with New York State requirements.

Is chaired by:

- Medical Director, Behavioral Health
- Membership of BH UM subcommittees include MVP internal Medical Directors, Leaders in all Government Programs including BH UM and CM, Children's services and Government liaison
- Consortia participants and other Member-serving agencies as appropriate

Membership also includes:

- MVP Directors in Customer Engagement and Customer Experience, Utilization Management, Pharmacy Management, Quality Performance and Operations, BH Clinical Operations, Quality Regulatory Compliance

Responsibilities Include:

The Mainstream Medicaid/HARP BH UM subcommittees shall be responsible for reviewing/analyzing data, variances and outcomes and developing and/or approving interventions. Ensures interventions have measurable outcomes and are included in meeting minutes. The subcommittees are also responsible for reporting:

- Under- and over-utilization of BH services and cost data

    - Avoidable hospital admissions and readmission rates, trends, and the average length of stay for all mental health, substance use disorder (SUD), residential levels of care, and medical inpatient facilities
- Inpatient utilization:
    - Outpatient Utilization including Outpatient Specialty BH Services (reporting on unique Members, units, units/1000, and cost)
- Inpatient civil commitments:
- Outpatient Civil Commitments including Assisted Outpatient Treatment (AOT)
- Emergency Department utilization and crisis services:
    - Use of Crisis Diversion Services
- Pharmacy utilization including physical health, psychotropic, and addiction medications
- Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services:
    - Rates of initiation and engagement of individuals with FEP in services
- Behavioral HCBS utilization:
    - Health Home engagement rates for the HARP population
- D-SNP UM including:
    - Total quarterly membership numbers
    - Number of admissions per quarter
- All physical health measures required by the Managed Care Organization (MCO) Model Contract
- Discussion/Analysis related to behavioral health and HCBS services for Medicaid enrolled children
- Children's physical health services: Report on service utilization and outcomes for children including medically fragile children
- Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization

Behavioral Health Advisory Committees

Separate adult and children's Behavioral Health Advisory subcommittees are held consecutively.

Behavioral Health Advisory Committees are tri-chaired by:

- Sr. Director, Behavioral Health and Utilization Management Operations
- An External chairperson
- Quality Management Behavioral Health Liaison

- Membership of Behavioral Health Advisory Committees include:
    - MVP BH staff
    - MVP contracted BH Providers
    - Peer specialists
    - Members and/or Member's Caregivers

    - Local government unit (LGU) Representatives
- MVP Directors, Customer Engagement and Experience, Utilization Management, Pharmacy Management, Quality Performance and Initiatives, and Quality Regulatory Compliance
    - Other MVP staff as determined by MVP
- Meet at least quarterly
- Reports regularly to the MVP Clinical Quality Committee (CQC) via the Behavioral Health QM Subcommittee

Responsibilities Include:

- Provide a forum for Members that includes among its Members, MVP BH staff, BH Providers, Peer Specialists, Members, LGU representatives, and other key stakeholders to discuss the physical and BH needs of MVP's QMP and HARP Members:
    - This includes, but is not limited to, challenges, barriers, resources, and unmet needs of this population
    - Solicit ideas and feedback to improve overall Member and Provider experience
- Identify proposed resolutions of issues related to the management of the HARP population and BH benefits

Hourly Requirements of PCPs for Government Programs

A Primary Care Practitioner (PCP)for Government Program Members must practice at least sixteen (16) hours a week at that site to be eligible to provide primary care services to Government Program Members including Medicaid, HARP, or CHP.

Participating Provider Performance Information

MVP provides performance information to Participating Providers and PCPs to assist in delivering high quality, cost- effective care. MVP collects performance information from annual Consumer Assessment of Healthcare Providers and Systems (CAPHS) surveys, Healthcare Effectiveness Data and Information Set (HEDIS) data and submitted claim data. For more information concerning Participating Provider performance reporting, please see the complete 2025 QI Program description here.

MVP Health Care Medical Record Standards and Guidelines

Well-documented electronic or paper medical records improve communication and promote coordination and continuity of care. In addition, detailed medical records encourage efficient and effective treatment. For these reasons, MVP established standards for record keeping in medical offices that follow the recommendations of the National Committee for Quality Assurance (NCQA). The standards are as follows:

- Participating Providers must maintain medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review
- Participating Providers must have an organized medical record keeping system.
    - Medical records must be stored in a secure location that is inaccessible to the public
    - Records are organized with a filing system or search capability to ensure easy retrieval. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care
- Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the Participating Provider, and all diagnostic and therapeutic services for which the Participating Provider referred the Member, such as, home health care notes, specialty physician notes, hospital discharge reports, and physical therapy reports.
- **Confidentiality-**Participating Providers shall comply with current state and federal confidentiality requirements, including Health Insurance Portability and Accountability (HIPAA) requirements and are expected to have implemented policies and procedures that guard against unauthorized or inadvertent disclosure of Protected Health Information (PHI)
- **Retention of Medical Records-**Participating Providers must retain medical records in accordance with contractual obligations and current applicable federal and state laws and regulations
- **Non-discrimination in Health Care Delivery-** In accordance with CMS and NCQA requirements, MVP, expects Participating Providers to have a documented non-discrimination policy and procedure on file "to ensure that Members are not discriminated against in the delivery of health care services based on, race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment"

Specific standards are as follows:

- Each page in the record contains the patient's name or Patient Identification Number (PIN).
- Personal biographical data includes the patient's address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, electronic signature, or initials.
- All entries are dated
- The record is legible to someone other than the author

- *Significant illnesses and medical conditions are indicated on the problem list. (The problem list should include all chronic, serious, or disabling conditions, and active, acute, medical, or psychosocial problems)
- *Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record. (For example, "NKA" or "NKDA") (See number 33 for Medication List requirements)
- *Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, procedures, surgeries, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, procedures, surgeries, and childhood illnesses
- For patients 12 years and older, there is appropriate notation concerning the use of tobacco or exposure to secondhand smoke, alcohol, and substances (for patients seen three or more times, query substance abuse history)
- The history, and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints
- Laboratory and other studies are ordered, as appropriate
- *Working diagnoses are consistent with findings
- *Treatment plans are consistent with diagnoses
- Encounter forms or notes include follow-up care, calls, or visits, when indicated. The specific time of return is noted in weeks, months, or as needed
- Unresolved problems from previous office visits are addressed in subsequent visits
- There is review for under, or over-utilization of consultants
- If a consultation is requested, there is a note from the consultant in the record
- Consultation, laboratory, and imaging reports are filed in the chart and are initialized by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement). If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans
- *There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
- An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults
- There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines
- No-shows or missed appointments must be documented with follow-up efforts to reschedule appointments

- Screening-Preventive care, Health Risk assessment and Social Determinants of Health (SDOH) are documented as evidence that preventive screening and services are offered in accordance with MVP's practice guidelines
- Depression screening may be assessed on a comprehensive physical examination, review of systems, patient health questionnaire, or a formal screening tool (ex. PHQ-9, PHQ-2, or Beck Depression Inventory)
- Advance Care Planning for ages ≥65-Notation of an advance care planning discussion and date or copy of an executed Advance Directive form. Current Advance Directive forms should be maintained in a prominent part of the Member's medical record.
- Annual medication review for ages ≥65-Conducted by a Participating Provider and the date performed
- Functional status assessment for ages ≥65-Components include vision, hearing, mobility, continence, nutrition, bathing, use of telephone, meal preparation, and managing finances. Functional status assessments may be found on a specific tool
- Fall risk assessment for ages ≥65-Components include age, fall history, gait, balance, mobility, muscle weakness, osteoporosis risk, impairments related to vision, cognitive or neurological deficits, continence, environmental hazards, number, and type of medication
- Pain screening for ages ≥65-Includes character, severity, location, and factors that improve or worsen pain. Pain assessments may be found on a specific tool such as a pain scale, visual pain scale, or diagram
    - When indicated by diagnosis, plans of action should include the consultation of Specialists
- Treatment plans should reflect consideration of recorded diagnoses and reported signs/symptoms
- Medication list-Documents all medications including dosage changes and including date changes were made. All medications (prescribed and over the counter), herbal therapies, vitamins and supplements must be noted. Dates of initial and refill prescriptions must be included
- NCQA Guidelines for Medical Record Documentation (Numbers 1 through 21)
- NCQA considers 6 of the 21 as core components to medical record documentation. Core components are indicated above with an asterisk (*)
- Numbers 22–32 are CMS and MVP recommendations for Medical Record Documentation

Access to Medical Records

In accordance with your Provider Agreement, medical records must be provided to MVP when requested. The medical records must be received within 10 business days of the request. If a medical record vendor is used, the Participating Provider is responsible to assure that the vendor provides the medical records within ten (10) business days at no cost to MVP or as otherwise explicitly required by the terms of your contract. MVP will

work with Participating Provider Groups as the best option to obtain records which can include the following:

- Participating Provider offices can provide remote access to MVP staff who will obtain records electronically
- MVP can perform an onsite review of the charts
- Records can be sent to MVP using secure electronic fax or email
- Records can be uploaded via MVP's Provider Portal

Clinical Practice Guidelines

MVP encourages Participating Providers to use acute and chronic care management clinical practice guidelines and preventive care guidelines to assist in the management of specific conditions. MVP endorses recommendations for preventive care and acute and chronic care management clinical practice guidelines based on nationally recognized sources.
All MVP's clinical practice and preventive care guidelines are kept in the Provider Quality Improvement Manual (PQIM). A paper copy of the manual is available by calling the MVP Customer Care Center for Providers. The manual is available online at mvphealthcare.com. MVP updates its clinical guidelines at least every two years unless required annually or as sources are updated. Participating Providers are encouraged to check the PQIM periodically for updates and changes. Guideline updates are also published in MVP's Healthy Practices newsletter.

MVP's guidelines are not intended to replace the Participating Provider's clinical judgment in the management of any condition or disease. They are educational guidelines to assist in the delivery of good medical care. Treatment decisions are left to the discretion of the Participating Provider.

MVP Health Care Dual Special Needs Plans (D-SNP)

The aim of MVP's D-SNP is to provide benefits and integrated interdisciplinary care coordination to improve the health of New Yorkers who meet all eligibility requirements and reside in the Capital District: Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady counties; and Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties: and Monroe County in the West region.

MVP believes that by addressing each Member's needs in a holistic manner, managing effective community care coordination and case management will assist in reducing and/or preventing the need for avoidable hospital admissions and ED visits, and will enhance engagement in improved health outcomes for:

- Individuals with new and existing chronic diseases such as diabetes, chronic heart failure, asthma, cardiovascular disorders, depression, etc.
- Individuals with behavioral and substance use disorders
- Individuals with limited history of preventive and well care service

MVP's Model of Care (MOC) for D-SNP includes member telephonic, in-person, and in-home communications (as appropriate), including interpretation services, and is supported by an integrated interdisciplinary staff which focuses on the facilitation of psycho-social, medical, pharmacy, and behavioral health services. MVP is continuously identifying and expanding its use of digital communication including e-mail, SMS messaging, etc.
MVP partnered with Belong Health to launch a joint venture that created the first D-SNP available in the Capital Region of NYS, which launched January 1, 2022. MVP offers D-SNP to individuals who are dually eligible for Medicare and Medicaid. This allows Members to maximize their benefits in a more coordinated structure, including physical, behavioral, and social health needs.

MVP DualAccess Complete (IBP –Integrated Benefit Plan)

IBP is a Medicare Advantage plan specifically designed for individuals that have Medicare coverage through MVP D-SNP and state government services through MVP Mainstream Medicaid or MVP HARP plan. Members must not require long-term support services (LTSS) for more than 120 days.
This plan has zero cost share on all integrated medical services. This plan option includes Part D prescription drug coverage. Additionally, it provides extras such as some coverage for dental, eyewear, over-the-counter medication and health-related purchases, transportation, post-discharge meal delivery, joint replacement recovery care kits, and a grocery allowance.

MVP Health Care New York State Child/Teen Health Program

The Child/Teen Health Program (CTHP) focuses on delivering early and periodic screening services, known as well care examinations, to Medicaid-eligible children under twenty-one (21) years of age. The program emphasizes the importance of establishing a continuous relationship between each child and a primary health care provider, facilitating early identification and treatment of health issues to enhance health outcomes and minimize the risk of disease, disability, and hospitalization.
The care standards and periodicity schedule outlined by the New York State Department of Health align with the recommendations from the Committee on Standards of Child Health and the American Academy of Pediatrics. This periodicity schedule serves as a foundational guideline for conducting well-care examinations, while also allowing for medically necessary screenings to be performed as needed between scheduled examinations.
The Children and Youth with Special Health Care Needs (CYSHCN) Program aims to enhance the care system for children and youth with special health care needs, supporting them from birth to twenty-one (21) years of age along with their families. The program focuses on ensuring that these families receive optimal health care for their children. Children enrolled in the CYSHCN Program typically have illnesses or conditions that require additional health care and support services. These may include serious or chronic physical conditions, intellectual or developmental disabilities, and behavioral or emotional challenges.
MVP is dedicated to promoting healthcare guidelines by collaborating with MVP Providers to ensure that Members achieve optimal quality outcomes. The organization evaluates Provider compliance with these guidelines through the Healthcare Effectiveness Data and

Information Set—NYS Quality Assurance Reporting Requirements (HEDIS-NYSQARR) reporting system.
To enhance access to preventive care services, MVP identifies Members who may not utilize essential services such as well care visits, immunizations, and blood lead testing. The organization proactively engages with Members and their caregivers through telephonic outreach, as well as mailed and electronic reminders about recommended preventive care. Additionally, MVP assists with appointment scheduling and transportation coordination, addressing any barriers to ensure that both preventive and medically-necessary care are accessible.

MVP Health Care New York State Children's Transformation Program

The New York State Children's Medicaid Redesign fundamentally restructured and transformed the health care delivery system for individuals under 21 with behavioral health (BH) needs and/or medically complex conditions. The MVP Medicaid and Child Health Plus (CHP) BH and Children's programs include, in an advisory capacity, Members, family members, youth and family peer support specialists, and child-serving Providers. The QM/UM Program activities, including the Children's Transformation Program, will be managed and advanced by the BH QM and BH UM subcommittees. The activities will be tabulated and tracked in a work plan annually. The Quality Improvement Committee (QIC) will assess progress toward annual goals and evaluate the program's effectiveness. The QIC will recommend revisions, as appropriate, to further advance improved integration and coordination of BH and PH clinical care and services to mainstream Medicaid Members. Outcomes will be summarized annually and presented to the Board of Directors via the QIC.

Member Rights and Responsibilities

MVP Members have specific health care rights and responsibilities. You can review the Commercial Member Rights and Responsibilities, Medicare Members Rights and Responsibilities, and Medicaid Member Rights and Responsibilities by visiting **mvphealthcare.com** and selecting *Member Rights and Responsibilities* at the bottom of the page.

Confidentiality Privacy Policies

MVP's Network of Participating Providers rendering care and services to MVP Members share responsibility for protecting PHI (Personal Health Information). In compliance with HIPAA privacy and security rules, MVP has established policies describing how and by whom MVP Members' PHI is handled. Please see the Notice of Privacy Practices and Compliance at **mvphealthcare.com** and select Privacy Practices & Compliance at the bottom of the page.

Continuity of Care

Communication is an essential component for quality medical care. Written or verbal communication between PCPs, Specialists, and other Participating Providers helps provide effective follow-up care and improves patient safety.
MVP collects and analyzes data to identify opportunities to improve the continuity of care Members receive from Participating Providers. MVP evaluates the differences between Participating Providers that have achieved Patient Centered Medical Home (PCMH) certification and/or the usage of an electronic medical record and those that have not taken these steps, to see if these efforts had an impact on Member utilization of emergency rooms for non-emergent and non-urgent care.

Improving the All-Cause Hospital Readmission Rate

MVP works continuously to reduce readmissions through various projects across the service area. One example is MVP's Transition Care Program in our Care Management Department. This program provides support to Members who are at risk for hospital readmission. The MVP Transition Care team will outreach Members post- hospitalization or skilled nursing stay, to assist in overcoming any barriers to care.
MVP continues to have embedded case managers in select hospital locations.

Provider Analytics

MVP invests in and provides the tools and resources to be successful such as establishing bi-directional exchange of claims and clinical data to support high value health analytics, delivering analytical insights, and deploying provider engagement resources to assist providers in meeting quality, improved documentation, care coordination, and financial performance goals and driving improved outcomes during execution.

To promote bi-directional exchange of clinical information, MVP offers a range of options for providers to share data based on their capabilities. MVP's preferred option is working with and incentivizing MVP partners to contribute data to their local health information exchange (HIE); however, we also encourage and promote providers to grant electronic health record (EHR) access for self-service chart acquisition for Quality and Risk Adjustment work in some of MVP's alternative payment models (APM) and will work with providers directly to acquire supplemental data as needed.

Providers in APM's currently receive a standard reporting package that includes data on quality, cost and utilization designed to support providers who participate in a value-based program to identify provider performance opportunities and assist with population health management initiatives.

Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts to optimize pay-for-performance (P4P) payouts, may include:

- Key performance indicators
- Cost and utilization of data

- Emergency room cost, utilization, and trending data
- Pharmacy comparisons of brand vs. generic
- Value-Based Contracting performance summaries

HIV-Related Information

New York State Public Health Law (Section 2782—Confidentiality and Disclosure of HIV-related information) requires that all health care providers develop and implement policies and procedures as follows:

- Initial and annual in-service education of staff and contractors on HIV-related information and maintenance of a list of those who received training
- Identification of staff by job title and their specific functions who are allowed access to HIV-related information and limits of access
- A requirement that only full-time or part-time employees, contractors, and medical, nursing or health- related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall have access to confidential HIV-related information while performing the authorized functions listed under paragraph
- Protocol for secure storage of HIV-related information (including electronic storage)
- Procedures for handling requests from other parties for HIV-related information
- Protocols to protect people with, or suspected of having, HIV infection from discrimination by employees/agents/contractors
- Review of the policies and procedures on at least an annual basis

Reference: HIV/AIDS TESTING, REPORTING AND CONFIDENTIALITY OF HIV-RELATED INFORMATION (Statutory Authority Public Health Law, section 2786 and Article 21, Title III (section2139) Part 63.[8]9 Health care provider and health facility policy and procedures.

Behavioral Health and Substance Use Information

New York State and Federal law require health care providers to develop policies and procedures to ensure confidentiality of Behavioral Health and Substance Use Disorder related information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors on Behavioral Health and Substance Use Disorder information
- Identification of staff allowed access to Behavioral Health and Substance Use Disorder information and limits of access
- Procedure to limit access to Behavioral Health and Substance Use Disorder information to trained staff (including contractors)

- Protocol for secure storage of Behavioral Health and Substance Use Disorder information (including electronic storage)
- Procedures for handling requests for Behavioral Health and Substance Use Disorder information and protocols to protect Members with Behavioral Health and Substance Use Disorder from discrimination

Revision Summary

Dates Revised	Revision Items
August 14, 2026	**Access to Medical Records**: MVP email, fax and file transfer information updated **Children's Transformation Program**: Content re-written for more clear understanding-no process changes **BH Structure and Committees:** grammatical updates only **Continuity of Care:** Removed Patient Center Medical Home (PCMH) internal evaluation process **NYS Child Health/Teen Program:** added content to fully reflect current expectations for provider accountability. Added content to meet federally mandated Medicaid EPSDT requirements

Utilization and Case Management

Utilization and Case Management (UM) Activities

UM activities include:

- Prospective review/Prior authorizations
- Concurrent review
- Care Advantage
- Discharge planning
- Retrospective review
- Case management
- Care management

Prospective review takes place before a service is provided. Concurrent reviews take place while treatment is in progress. Retrospective review is performed after treatment has been completed.

Medical Determinations and Utilization and Case Management Criteria

MVP utilizes nationally recognized and Medicare guidelines as well as MVP published criteria (including the MVP Formulary) to conduct prospective, concurrent, and retrospective reviews for medical necessity. The InterQual® Criteria software program, MVP's Benefit Interpretation Manual (BIM) and Medicare Guidelines are used as guidelines to determine medical necessity. The guidelines and criteria are reviewed annually and approved by the Medical Management Committee (MMC) and Quality Improvement Committee (QIC), which consists of Providers from all MVP service regions. Copies of criteria and guidelines are available to MVP Members and Providers upon request.

Site of Service Guidelines are derived from CMS and InterQual. These guidelines are utilized to determine whether the procedure should be provided in an inpatient setting, outpatient setting or within a Provider's office. The Site of Service guidelines are reviewed annually by the MMC and approved by the QIC. Copies of guidelines are available to MVP Providers upon request.

For the Managed Medicaid medically fragile children and foster care children, MVP utilizes the NYS Medicaid guidance into the prior authorization, concurrent or retrospective review.

Specifically, MVP incorporates the following into the policies:

OMH Clinical Standards of Care	NYS Bureau of Inspection and Certification MHOTRS Standards of Care Anchor Element 12/8/23
OASAS Clinical Guidance	Services | Office of Addiction Services and Supports

OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013	health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
OCFS Working Together: Health Services for Children/Youth in Foster Care Manual	https://ocfs.ny.gov/main/sppd/health-services/manual.php
OHIP Principles for Medically Fragile Children	

All dental care should be obtained through DentaQuest as of June 1, 2025.

MVP delegates responsibility for prospective and concurrent UM to Cigna to select self-funded plan and fully insured Members who reside or travel outside of the MVP service area, excluding HMO, Medicare, and Medicaid Members when the care is provided by a Cigna Provider. Cigna uses nationally accepted clinical protocols as guidelines to make UM determinations. Cigna Providers outside of the MVP service area may contact Cigna directly. To contact a Cigna representative, call **1-800-882-4462**.

Participating Providers may request a copy of the specific criteria used to make a UM determination by calling the Customer Care Center at **1-800-684-9286**. The criteria will be mailed or faxed to the Provider's office with a proprietary disclaimer notice. Members may request a copy of the specific criteria used to make a UM determination by contacting the Customer Care Center telephone number on the back of the MVP Member ID card.

MVP uses the Pharmacy Program Administration and various MVP Pharmaceutical Policies to review the medical appropriateness for pharmaceutical therapies.

At least annually, MVP requests a review of the Utilization Management clinical guidelines and criteria by in-plan Participating Providers and the MVP Medical Management Committee to assure that the criteria used during prospective, concurrent, and retrospective reviews are appropriate for all patients in the community.

Participating Providers are notified of new or revised policies via FastFax notification, provider newsletter, Healthy Practices, or other similar electronic means including MVP's online portal. The new or revised policies are published on MVP's website, **mvphealthcare.com.**

For Medicaid Managed Care and HARP Members, MVP may apply NYS Medicaid Guidelines (including but not limited to EMedNY and/or State Coverage Question responses found on the State Health Commerce Site) to assist with coverage determinations.

Medical Necessity determinations for Medicare Advantage Members are rendered using guidance from the Medicare Coverage Database for any pertinent Local Coverage Determination (LCD) or National Coverage Determination (NCD) Policies in addition to MVP's medical policies. The Medicare Coverage Database is available online at cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Medical and Pharmaceutical Policies

MVP uses medically based determinations to determine whether a requested service is Medically Necessary. This is an online repository for all MVP medical, behavioral health, substance use, and pharmacy policies. These medical and pharmaceutical policies provide medical criteria to be used in determining Medical Necessity for Covered Services. The criteria are based upon a review of currently available peer-reviewed medical literature, regulatory status of the technology, evidence-based guidelines, and positions of leading national health professional organizations. Practicing Providers with expertise relevant to each policy are consulted and relied upon. We welcome feedback and supporting studies from participating practitioners. A Member's Product (health benefit plan) may contain exclusions or other benefit limits applicable to the policy. Some benefit plans exclude coverage for services or supplies that MVP considers Medically Necessary.

Participating Providers are responsible for checking Medical Policy updates Section for policy updates each time they access the Medical and Pharmaceutical policies before going into the individual policies. Refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Providers should review the grid at the end of each policy for specific prior authorization requirements for the specific Member's contract.

Participating Providers may access MVP's Medical and Pharmaceutical Policies online by following these instructions:
To view all MVP Medical and Pharmaceutical policy update summaries, visit **mvphealthcare.com/Providers** and *Sign into* your Provider Online Account, then select *Resources*, then *Medical Policies*.
If you have questions or suggestions, use the email link listed on the introduction page. In addition, Providers may offer feedback about the policies to MVP via email. MVP will consider that feedback in future policy development.

Financial Incentives Relating to Utilization and Case Management

It is MVP's policy to facilitate the delivery of appropriate health care to its members and to monitor the impact of the MVP UM program to ensure appropriate use of services. MVP's Utilization management decisions are based only on appropriateness of care and the benefit provisions of the Member's Subscribers Contracts:

- MVP does not provide financial incentives to employees, Providers, or delegates who make Utilization decisions
- Management decisions that would encourage barriers to care and services;
- MVP does not reward Providers or staff, including medical directors and UM staff, for issuing denials of requested care

- MVP does not offer financial incentives, such as annual salary reviews and/or incentive payments, to encourage inappropriate utilization

Adverse Determinations (Prospective, Concurrent, Retrospective)

When MVP denies a service through the UM processes, this is called an adverse determination. Adverse determinations for prospective, concurrent, and retrospective reviews are rendered by the medical director based upon the medical information available and completed within regulatory mandated timeframes.
After an adverse determination is made by the medical director, for concurrent, non-urgent and urgent requests, the clinical reviewer performing prospective and concurrent reviews contacts the requesting Provider or facility by telephone to discuss the adverse determination and to inquire if there is additional medical information available. An opportunity to speak with the medical director is offered: Peer-to-Peer review. If there is no new information forthcoming, the clinical reviewer explains the Appeal process. The requesting Provider is notified in writing of the adverse determination and rights (ability to request an appeal of the decision and, if applicable, speak with the medical director who made the decision). Written notification and verbal notification of an adverse determination is provided to the Member (or designee) and the requesting Provider in accordance with regulatory timeframes.

Informal reconsideration with Peer-to-Peer Review (P2P)

Peer to Peer Reviews:

Providers are offered the opportunity for a peer-to-peer review with an MVP medical director. This is available within fourteen (14) calendar days of the initial determination. In cases involving a concurrent inpatient stay, while the member remains hospitalized for all lines of business, or within fourteen (14) calendar days of discharge for all lines of business excluding Medicare Advantage products. MVP medical directors are available for peer-to-peer review during regular business hours Monday through Friday 8:30am – 5pm. Once a peer-to-peer review is requested, MVP medical directors will make two (2) attempts to contact the requesting or attending provider on two (2) consecutive business days. Any supporting documentation discussed during the peer-to-peer review must be submitted to MVP within two (2) business days for consideration.

Informal Reconsiderations without P2P:

Requests for informal reconsideration, modification or additional review of a utilization management determination must be submitted within fourteen (14) calendar days of the initial determination. In cases involving inpatient stays, while the member remains hospitalized for all lines of business, or within fourteen (14) calendar days of discharge for all lines of business excluding Medicare. Review and determination will be completed as expeditiously as possible, but no later than three (3) business days after the receipt of all required clinical information.

After fourteen (14) calendar days have elapsed, the original determination is considered final. Any further review, whether with a peer-to-peer review or informal reconsideration, will no longer be available for processing through those channels and will be treated as a formal appeal.

Informal reconsiderations and peer-to-peer reviews do not take the place of a formal appeal. Nor does it affect the appeal timeframe. Once an appeal has been initiated, the provider forfeits the opportunity to initiate an informal reconsideration with or without peer-to-peer review.

When new medical information is submitted, and services have not been rendered, the case is re-opened in Utilization and Case Management for Transplants (this is not applicable for Medicare—preservice urgent and non-urgent reviews; see variation under Reconsiderations section below). The new information is reviewed by the Medical Director who documents the rationale to uphold or reverse the denial. The requesting Provider and Member are notified of the determination in writing in accordance with regulatory timeframes.

Verbal and Written Communications on Utilization Review Determinations (Prospective, Concurrent, Retrospective)

MVP notifies Members and Providers, in accordance with applicable regulations, verbally and/or in writing. Verbal notice is provided on prospective (before service) and concurrent (during service) determinations. For inpatient stays, verbal notice is provided to the facility to communicate the determination to the Member. Prospectively, MVP will make two (2) attempts to reach the Member and Provider for verbal notices.
Written notice of an Adverse Determination is provided to the Member and the requesting Provider. For urgent acute hospital services, MVP notifies the hospital UM/Case Manager, who verbally communicates the adverse determination and provides the Member's written notification. The Member and the requesting Provider's written notification of an adverse determination includes the rationale for the decision; instructions for initiating an appeal; the name of the criteria used in making the determination; and notice of the availability of the Clinical Criteria used in making the determination (see Medicaid Managed Care Variation below). The Member and/or requesting Provider may appeal in writing and/or by telephone with the Customer Care Center.

Expedited and standard appeals will be conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

For either non-urgent or urgent Adverse Determinations, the clinical reviewer makes two (2) telephone notification attempts to the Provider's office and Member. For urgent acute hospital services, MVP notifies the hospital UM/Case Manager, who verbally communicates the Adverse Determination and provides the Member's written notification. The Member and the requesting Provider's written notification of an adverse determination includes the rationale for the decision, instructions for initiating an appeal, the name of the Clinical Guidelines or criteria used in making the determination and notice of the availability of

the Clinical Guidelines or criteria used in making the determination. The Member and/or requesting Provider may appeal in writing and/or by telephone with the Customer Care Center.

For NYS Medicaid Managed Care Program

The ordering Provider has the right to have a peer-to-peer review with the MVP Medical Director. In general, denials, grievances, and appeals must be peer-to-peer, that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommended clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).

In addition:

- A Provider board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21
- A Provider certified in addiction treatment must review all inpatient LOC/continuing stay denial for SUD treatment
- Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist
- A Provider must review all denials for services for a medically fragile child, and such determinations must take into consideration the needs of the family/caregiver

Timeframes for prior authorization and concurrent review determinations, both standard and expedited, may be extended for up to 14 calendar days if:

- The Member, the Member's designee, or the Provider requests an extension orally or in writing; or
- MVP can demonstrate or substantiate that there is a need for additional information and how the extension is in the Member's best interest. MVP must maintain sufficient documentation of extension determinations to demonstrate, upon DOH request, that the extension was justified.

MVP will render decisions in accordance with established timeframes out lined in the Medicaid Managed Care Model Contract; ("OHIP") Principles for Medically Fragile Children; under (Early Prevention Services, Diagnostic and Treatment), HCBS (Home and Community Based Services ("HCBS") and (Community First Choice Option) rules; and with consideration for extended discharge planning.

MVP will provide notification to the Member and Provider by telephone and in writing within 14 calendar days after receiving the Service Authorization Request.

The written notice of an adverse determination (initial adverse determination) will include:

- An Appeal Request Form

- Process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review
- The enrollee right to contact DOH, with 1-800 number and how to file a grievance or complaint
- A Non-Discrimination Notice, including a statement that notice is available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. MVP must send notice of denial on the date review timeframes expired.

Medicare Reconsiderations (Prospective, Concurrent, Retrospective, Urgent, and Non-Urgent)

Medicare pre-service and concurrent: Any review request received after the initial adverse determination is considered an appeal. MVP Utilization and Case Management will redirect any Medicare appeals to the Appeals unit for processing.

Medicare post-service: Medical necessity reviews, any payment dispute (or re-review) is processed by the Retrospective Review unit and reviewed within 30 calendar days of the request. See the Reconsiderations Section below for more information.

Services that Require a Referral for MVP Medicaid Managed Care

Restricted recipient Members—Referrals are required to ALL specialties for Members who have a Provider restriction. Providers should verify eligibility by using MVP's website **mvphealthcare.com**, using the MVP ID number (not CIN) on the MVP Member ID card.

Contact MVP's Customer Care Center for Provider at **1-800-247-6550 or email:** restrictedrecipient@mvphealthcare.com to obtain a referral for restricted recipient Members.

Home and Community Based Services

Home and Community Based Services—Referrals to HCBS, functional assessments, HCBS eligibility determinations and plans of care for medically fragile children/ youth are submitted to MVP by faxing the request to **1-855-853-4850** or communityservices@mvphealthcare.com.

Once assessments and plans of care are received, MVP will evaluate services requested and will send the level of service determination to meet regulatory requirements. MVP will work collaboratively with Health Homes, Behavioral Health vendors, Providers, MVP internal Utilization and Care Management and BH Case Manager staff to evaluate the Member's level of care; adequacy of service plans; Provider qualifications; Member's health

and safety and financial accountability and compliance. The review and approval of services will be person centered.

Out-of-Plan Referral Process (Only Applies to Plans Without Out-of-Network Benefits)

The PCP or MVP Participating Specialist must submit a written request to MVP's UM Department using the Prior Authorization Request Form which can be found by visiting **mvphealthcare.com**, then *Providers*, then *Forms*, then *Prior Authorization*. The out-of-plan referral will be approved only if MVP does not have a participating Provider with the appropriate training or experience needed to treat the Member.

For continuity of care purposes, MVP will allow Managed Medicaid children to continue with their care Providers, including medical, BH, and HCBS Providers, for a continuous episode of care. This requirement will be in place for the first 24 months of the transition of children from FFS to MVP. These children will not be required to change Health Homes or the Health Home Care Management Agency at the time of the transition. MVP will reimburse on a single case basis for children enrolled in a Health Home if they are not under contract with MVP.
For Managed Medicaid Children's Physical Health services, network Providers will refer to appropriate community and facility Providers to meet the needs of the child or seek authorization from MVP for out-of-network Providers when participating Providers cannot meet the child's needs. MVP considers the network availability with the appropriate training/experience to meet the Member's needs and confirm the medically necessary service is not available through Network Providers.

Managed Medicaid Foster Care Transition

The Transition of Care process is enhanced for foster care children to ensure continuity of care is achieved. MVP will allow the child to transition to a new primary care Provider and other health care Providers without disrupting the care plan that is in place. Transition of Care needs including the plan of care must be communicated to MVP by the referring Provider, Voluntary Foster Care Agency (VFCA), Health Home or LDSS.

Members under the foster care program who transition from Medicaid Fee-For-Service to managed care could experience a disruption of care when the Member moves from county to county when MVP is not operating in the new county. MVP permits the Member to access Providers with expertise treating children involved in foster care in non-MVP contracted counties as needed to ensure continuity of care for their medically necessary services. The Member may transition to a new primary care Provider and other health care Providers in the non-MVP county to ensure the care plan is carried out and the benefits are received.

In the case of a long-term foster care placement outside of MVP's service area and solely at the discretion of the LDSS or VFCA, MVP will coordinate with the LDSS or VFCA to ensure a smooth transition of enrollment.

Prior Authorization

MVP requires prior authorization for select procedures and health care services. It is the Provider's responsibility to obtain prior authorization no less than five (5) calendar days prior to the procedure. Services requiring prior authorization do not cover benefits until or unless MVP or its UM delegate reviews and grants prior authorization for the service. Providers are responsible for services if rendered without prior authorization. The Member is not liable for services rendered without prior authorization, in accordance with the Provider's contract with MVP and NYS Department of Health laws.

Emergency services are not subject to prior authorization. There will be no payment for services determined to be not medically necessary. Emergent Medical Necessity is defined for all plans as health care and services that are necessary to prevent, diagnose, manage, or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Services requiring prior authorization are listed in the UM Policy Guide, which is updated bi-annually. The guide's most recent version is available on **mvphealthcare.com**, or by calling the Customer Care Center—Provider at **1-800-684-9286**. Please be sure to update the UM Policy Guide each time your office receives a new copy with MVP's *Healthy Practices* digital newsletter. Providers also may check the website for the online Benefits Interpretation Manual to identify the plans that require prior authorization of services.

In-Office Procedure and Inpatient Surgery Lists

Participating Providers and their office staff can access the In-Office Procedures and Inpatient Surgery Lists at **mvphealthcare.com** in the Reference Library section. Contact your Professional Relations Representative if you prefer a paper copy. Please note:

- The In-Office Procedure List: CPT® codes that MVP requires to be performed in the Provider's office. Claims submitted with a place of service other than the Provider's office will be denied unless prior authorization is obtained
- The Inpatient Surgery List: Procedure codes that are not included on the Inpatient Surgical List will require prior authorization for place of service if being requested to be performed in the inpatient site of service
- All procedures are subject to the Member's plan type and benefits

Durable Medical Equipment Dispensed by Providers, Podiatrists, Physical Therapists, and Occupational Therapists

Providers and other practitioners (including, but not limited to, podiatrists, physical therapists, occupational therapists, and chiropractors) may not act as a DME Provider/vendor (exceptions to follow). Please refer to your Provider Contract to determine

if you are eligible to dispense DME products from your office. Basic DME items can be provided for stabilization and safety to prevent further injury, as a convenience to our Members without prior authorization. Examples of such items are simple canes, crutches, walkers (for safe ambulation), "off-the-shelf" bracing, air casts, and walking boots (for joint/muscle immobilization to prevent further injury). These items must be billed with the office visit, using the appropriate HCPCS code, provided they are not listed on the DME prior authorization code list. All other DME, O&P and specialty equipment and services must be obtained from a participating DME, orthotics, prosthetic or specialty Provider/vendor. Physical and Occupational therapists may fabricate and dispense custom hand splints without prior authorization for the following codes:

L3702	L3806	L3901	L3915	L3923	L3931	L3982
L3710	L3807	L3906	L3917	L3925	L3933	L3984
L3760	L3808	L3908	L3919	L3927	L3935	
L3762	L3900	L3913	L3921	L3929	L3980	

Podiatrists may provide and bill for:

- Foot orthotics, using the appropriate "L" HCPCS codes, when the Member's contract includes the Foot
- Orthotic Rider, without prior authorization
- Shoe inserts and shoes for Members who have a diagnosis of diabetes, with or without a Foot Orthotic
- Rider, using the appropriate "A" HCPCS codes, without prior authorization

Ankle Foot orthotics must follow the prior authorization process. Ankle Foot orthotic codes that require prior authorization can be found on the MVP website

Durable Medical Equipment, Orthotics, Prosthetics, and Specialty Vendors

For information regarding DME, prosthetics, orthotics, and specialty equipment, visit MVP Health Care:

- Prior Authorization Request Form (PARF) **mvphealthcare.com/Providers/forms/Admissions** and Prior Authorizations Prior Authorization Code lists—with and without descriptions **mvphealthcare.com/Providers/reference-library/Durable Medical Equipment Prior Authorization List**

Verify Member eligibility and DME benefits before submitting a prior authorization request by calling the Customer Care Center—Provider at **1-800-684-9286** (Medicaid/CHP/HARP eligibility call **1-800-247-6550**). Completed PARF's are faxed to **1-888-452-5947**. Durable Medical Equipment payment policies can be found in the Payment Policies Section.

Completing the Prior Authorization Request Form (PARF)

- If clinically urgent, call the Customer Care Center—Provider at **1-800-684-9286** to advise that an urgent request has been sent. Form can also be emailed to authorizationrequest@mvphealthcare.com
- Be sure to submit all relevant medical documentation (e.g., office notes, lab, or radiology reports) with the completed PARF. Do not fax photos—submit the request electronically by email
- Be sure to indicate a contact name for the UM staff to call
- Be sure to sign and date the PARF
- Upon receipt of the PARF, a determination will be made, and the Provider's office will be notified by phone and mail within the mandated time frames by line of business

Processing of Services/Items that Require Prior Authorizations

Clinical information supporting the prior authorization request should be submitted with each request. Examples of supporting clinical information include, but are not limited to, history of presenting problems, clinical exam and diagnostic test results, operative and pathological reports, treatment plan, progress notes and consultations.
If clinical information required to support the request is not provided with the request, the provider may be asked to furnish additional information. The appropriate Utilization and Case Management department will make up to three (3) attempts to contact the Provider's office to obtain this information. If verbal attempts are unsuccessful, a letter requesting the specific information required to make the determination will be sent to the Provider's office. Additional information must be received within:

24 hours from the request for additional information in cases when phone contact is made/ date on the request for information notice for an urgent request, or
2 business days from the request for additional information in cases when phone contact is made/ date on the request for information notice for a routine request Once the additional information is received, a review will be performed, requests will be forwarded to a medical director for a determination, if necessary. Prior authorization decisions and notifications will be completed within regulatory and accreditation timeframes.

Managed Medicaid

MVP reviews the Home and Community Based Services (HCBS) requests and plan of care (POC) to ensure the following are accounted for:

- HCBS must be managed in compliance with CMS HCBS Final Rule and any applicable state guidance
- Ensures the plan of care was developed in person-centered manner; compliant with federal regulations and state guidance and meets the Members' individual needs;

- Validates the HCBS service is provided in accordance with the POC; and
- To develop a data driven approach to identify serve utilization patterns that deviate from any approved plan of care, conduct outreach will be performed to review any deviations, and require appropriate adjustment to either the service provided or the plan of care.

MVP will continue to cover HCBS and LTSS services as authorized as a part of the NYS 1915(c) waiver for at least 180 days following the date of transition of children's specialty services newly carved into managed care. This coverage includes service frequency, scope, level, quantity, and existing Providers at the time of the transition unless the Member requests changes, or the Provider refuses to work with the plan. At the close of the transition period, a new POC is developed. During the transition period, MVP will authorize any newly carved in children's specialty services that are added to the POC under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for Fee-For-Service children in receipt of HCBS at the time of enrollment. MVP will continue to authorize covered HCBS and LTSS according to the most recent POC. This coverage includes service frequency, scope, level, quantity, and existing Providers at the time of the transition unless the Member requests changes, or the Provider refuses to work with the plan. At the close of the transition period, a new POC is developed.

To ensure a smooth transition of HCBS and LTSS Members from NYS Fee-for-Service to Managed Care, for children receiving HCBS services, MVP will begin accepting POC's as outlined below:

- As of October 1, 2019, for:
    - The newly enrolled Members or
    - Children for whom the Health Home or Independent Entity has obtained consent to share the POC with MVP and the family has selected MVP as their plan through the selection process
- As of October 1, 2019, for a child in the care of a LDSS/ licensed VFCA where MVP has been confirmed by the LDSS/VFCA
- MVP will continue to accept POC's for children in receipt of HCBS in advance of the effective date of enrollment when MVP is notified by another plan, a Health Home Care Manager, or the Independent Entity that consent was received to share the POC with MVP and the family has selected MVP through the selection process, or the child in the care of LDSS/ Licensed VFCA and MVP is confirmed by the LDSS/ VFCA.

POC's are to be faxed to **1-800-280-7346**. Authorizations will be entered once the Member is enrolled in the MVP systems.

Concurrent Review

All inpatient acute medical (excluding normal vaginal and C-section deliveries for all products, except Medicaid Managed Care, Child Health Plus and HARP) require notification to the health plan the next business day following the admission by the facility. Prior notification is still required for admissions or services with non- participating Providers or facilities, and for infants who are transferred to the Newborn Intensive Care Unit (NICU) for all MVP Products. Hospital notification is performed by faxing notifications to the Customer Care Center— Provider at **1-800-280-7346**.

Following timely notification of admission, providers/facilities should fax the supporting clinical documentation to **1-888-207-2889**. MVP performs concurrent reviews to assess medical necessity, evaluate appropriate utilization of services and promote delivery of quality care on a timely basis.

To support inpatient concurrent review decisions, MVP uses nationally recognized evidence-based criteria. Criteria are applied based on the needs of the individual members and an assessment of the local delivery system. For inpatient medical care reviews, MVP uses the following medical review criteria:

- CMS Guidelines
- InterQual Criteria
- MVP Medical Policy

Principles of review include:

1. Identification of medical necessity and appropriate services
2. Clinical suitability of alternative level of care
3. Appropriateness of services in relation to the member's diagnosis, problem or condition and consideration of the individual needs, e.g. comorbidities, age, treatment plan, medical prognosis, etc.
4. Identification of quality-of-care issues.
5. Coordinating care transitions across the continuum to support community reintegration and ensure discharge planning meets the Member's needs.

Concurrent review decisions and notifications are made in a timely manner in accordance with federal, state regulations and accreditation standards.

Notification of outcomes will be delivered in writing and shall meet the language and format requirements of federal and state requirements to ensure ease of understanding. As applicable, written notifications shall be given on standardized form approved by federal and state regulations.

Decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and/or functional appropriateness are solely conducted by medical directors.

Non-emergent acute to acute facility transfers also require prior authorization from MVP. These transfers will be considered as medical necessity only. Transfers from a facility capable of treating the patient

because the patient and/or the patient's family prefer a specific hospital or Provider will not be considered.

** Member financial responsibility, including co-pays, deductibles, and beneficiary liability, varies by line of business.

Non-emergent acute to acute facility transfers also require prior authorization from MVP. These transfers will be considered for medical necessity only. Transfers from a facility capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or Provider will not be considered.

Upon receipt of clinical information for a concurrent review service, a determination will be made, and the facility's UM Department/attending Provider will be notified by phone and mail within:

- One business day for routine requests; or
- 24 hours for urgently needed care

Coverage of ground ambulance or ambulance services may be discussed during these notifications.

Observation Bed Policy

Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to assess a patient's medical condition and provide medically necessary services to a Member whose diagnosis and treatment are not expected to exceed 24 hours, but may extend to 48 hours, and the need for an inpatient admission can be determined within this specific period.

Observation level of care services are a critical component in avoiding unnecessary hospital stays. Types of cases vary from region to region, based on a region's community standards of care and availability of non-acute support services. Cases which usually are managed in an urgent observation stay include, but are not limited to, cellulitis, congestive heart failure, dehydration, diabetes mellitus, fever, fractures, gastrointestinal bleeding, general symptoms, ruling out myocardial infarction, pain (chest, abdominal, back, etc.), pain management, pneumonia, syncope, and urinary tract infection. Observation services that exceed 48 hours may be reviewed retrospectively to determine the medical necessity and appropriateness of level of care.

Observation billing is addressed in the online Medicare Claims Processing Manual at Medicare Claims Processing (Pub. 100-04), Chapter 4-Part B Hospital (Including Inpatient Hospital Part B and OPPS), and Section 290-Outpatient Observation Services and in the New York State Medicaid Update May 2013, Volume 29-Number 5.

Medicare Outpatient Services

Section 290.1 states the following: Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In most cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

New York State Medicaid Managed Care Update

May 2013 Volume 29-Number 5 states the following: Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge or transfer cannot be accomplished within eight hours after presenting in the Emergency Department (ED) but can reasonably be expected within 48 hours. To be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is admitted, transferred to another hospital or discharged from the facility.

Time Frame

Observation bed services are appropriate for hospital stays when care required is greater than six hours (8 hours for Medicaid) and the need for an acute inpatient level of care is not established. The start time will be when the decision is made for observation status and documentation of such should be on the Provider's orders, including the date and time. At the conclusion of the observation stay period the hospital/Provider will notify the health plan if the intent is to admit and/or define required alternative services.

Exclusions

Patients who would be considered "inappropriate" for observation bed status are:

- Patients requiring admission
- Services that are not reasonable or necessary for a patient's diagnosis or treatment, but are provided for the patient's, their family's or Provider's convenience
- Care that is custodial
- Services that are part of another outpatient service, such as ambulatory surgery, routine preparation for diagnostic testing and any post-operative monitoring/recovery periods
- Observation stays that are greater than 48 hours for all lines of business will be reviewed retrospectively

Availability

Observation beds should be available 24 hours a day, including weekends and holidays. Observation bed assignment and/or approval of this care level is not limited by or restricted to a specific location, unit title, or name of the assigned bed to which observation and care occurs.

Authorization

No prior Authorization or notification is required for observation days. The Provider order must indicate the Provider's intent regarding the Member disposition either to place the Member in observation status or to admit the Member to inpatient service the Provider order must identify the date and time of the Member's admission or placement into observation status. Observation stays may be subject to a retrospective clinical review to determine the medical necessity for observation level of care, utilizing InterQual or Medicaid/Medicare criteria. Observation stays in the absence of clear medical necessity are not covered. If the hospital disagrees with MVP's level of care decision, the hospital may exercise its normal appeal rights.

Conversion to Inpatient

The facility is required to notify the health plan of the request for conversion from observation to inpatient. This request is subject to review for medical necessity and will be reviewed when all clinical information is received following the standard UM process for concurrent review. If an observation patient is admitted, the entire observation period will convert to inpatient benefit days. When emergency department services preceded an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed. All observation days that exceed the 48-hour timeframe prior to conversion to inpatient will not be considered charges in calculating a potential cost outlier.

Discharge Planning

For All Commercial, ASO, and Medicaid Plans

An MVP UM Clinical Reviewer is available to work with the attending Provider, the facility's UM department, discharge planning staff, and others to identify MVP benefits that support the Member's discharge planning needs. Hospital personnel responsible for discharge planning will screen all observation-status and acute care patients for potential discharge planning needs. Discharge planning referrals, such as home care evaluations, DME, or IV infusion, may be prior approved by contacting the Concurrent Review Clinical Reviewer assigned to the facility or MVP's Customer Care Center for Provider Services at **1-800-684-9286**.

For Medicare Advantage Members Only

MVP Utilization and Case Management for post-acute care services including Skilled Nursing

Facility (SNF), Inpatient Acute Rehab (IRF), and Home Health services.

Fax: **1-866-942-7826** for pre-service authorization requests for post-acute care
Fax: **1-866-942-7826** for continued stay authorization requests and "other" (NOMNC, NDMC) Fax: **1-866-**942-7826for Healthcare MDS from All PAC and Home Health
Tel: **1-800-684-9286**.

MVP requires notification of Member discharges from the hospital for both elective/planned and unplanned inpatient level of care hospitalizations. Notification of discharge must be made to the health plan within one business day of the Member's discharge from the hospital. The notification may be made by sending a facsimile to **1-800-280-7346**.

The information required from the hospital representative by facsimile includes the following:

- Facility name
- Member (patient) name
- Member contract number
- Date of birth
- Discharge diagnosis, if available
- Admission date
- Discharge date
- Discharge status/disposition

After discharge notification is received from the hospital, the information is entered into the MVP information system. Please note that the claim cannot be processed without a valid discharge date in the system.

Medicare Comprehensive Outpatient Rehabilitation Facility

Comprehensive outpatient rehabilitation facility (CORF) services may be a covered benefit under certain medical contracts. CORF consists of an interdisciplinary team of professionals from the field of physical medicine, neuropsychology, physical therapy, occupational therapy, speech therapy, recreation therapy, and clinical social work. It is a multi-level program designed to provide intensive and more frequent rehabilitation therapies to persons with CVA, acquired brain injury, and other orthopedic and neurological conditions.

These programs provide a comprehensive approach to maximize functional potential, CORF is covered when there is a potential for restoration or improvement of lost or impaired functions. This comprehensive program consists of 4 levels. A referral is made by the Primary Care Provider or hospital attending Provider to the CORF program. MVP Health Care does not require notification of this referral. The referral is made to the Physical Medicine Specialist at the CORF program for consultation. The physiatrist performs a

consultation and recommends the level of CORF service from which the Member can benefit most.

MVP requests the CORF program to refer the program Members to the MVP Case Management Department to coordinate and perform case management services. To make this case management referral, Providers may call **1-866-942-7966**.

The recommendations will consist of four levels of care and must meet the following criteria:

1. Full day evaluation and/or treatment program*

   2–5 days per week (three modalities) and at least 135 minutes total per day

2. Half day evaluation and/or treatment program*

   2–5 days per week (three modalities) and at least 90 minutes total per day

3. Less than half day 2–5 days per week (2–3 modalities) and at least 90 minutes total per day, and does not include social work, recreation therapy, or group services

4. Single Service

*To bill for a half-day evaluation the Member must require and receive at least two of the following services: social work, group services, or recreational services.

In accordance with Medicare Regulation 42 CFR, §422.624, §422.626, §422.620, effective January 1, 2004: The Comprehensive Outpatient Rehabilitation Facility is required to provide MVP's Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two calendar days prior to the last day of coverage/discharge, signed, and dated by the Member (or authorized representative). If there is more than a two-day span between services, the NOMNC should be issued next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. Medicare Regulations do not recognize notification by voicemail. The "valid delivery" of NOMNC must be retained in the Member's medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP within 24 hours of receiving a NOMNC from MVP. Medicare Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at cms.gov/BNI.

Note: A word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

Organization, the Comprehensive Rehabilitation Facility is responsible to issue the Detailed Explanation of Non- Coverage upon receipt from MVP. A copy must be retained in the Member's medical record.

Skilled Nursing Facilities (SNF)

Prior authorization is required for all lines of business.

Benefit Coverage for All MVP Products

MVP will cover:

- SNF semi-private room and board whenever such care meets the skilled criteria as defined by Medicare or InterQual
- All SNF care or rehabilitation services when provided or referred by the PCP or other appropriate
- Provider and approved by MVP and when criteria outlined in this policy are met.
- Skilled services are limited to the number of days as defined in the Member's subscriber contract, certificate of coverage of Summary Plan Description

For Commercial, ASO, and Medicaid Plans

Clinical decisions for benefit coverage at SNFs are based on InterQual criteria.

For MVP Medicare Advantage Plans

MVP follows CMS guidelines, clinical decisions for benefit coverage at Skilled Nursing Facilities

SNFs with a Medicare Ban

MVP will not approve an authorization for any MVP Member to a skilled nursing facility currently sanctioned under a Denial of Payment for New Admissions (DOPNA) by the Centers for Medicare and Medicaid Services (CMS).

Pharmacy Coverage

Medications received during the paid stay are included in the daily rate and should not be billed to the Member's prescription drug plan.

Medicare Advantage Plans: Admission Denial for Medical Necessity

MVP will issue all admission denials for medical necessity and appropriateness based on the medical director's determination.

Key Contacts

To establish benefit eligibility, please refer to the following telephone numbers:

Non-Medicaid/Commercial Plans	MVP Customer Care Center—Provider	**1-800-684-9286**
Medicaid /CHP/HARP Plans	MVP Customer Care Center—Provider	**1-800-247-6550**

For prior authorization, call the MVP Customer Care Center for Provider at **1-800-684-9286.**

Clinical documentation can be faxed to MVP Skilled Nursing Fax Line: **1-866-942-7826**. Tel: **1-800-684-9286**

Administrative Guidelines

Documentation, Process, and Quality Standards Requirements:

- SNF stays require prior authorization for all of MVP's products. Prior authorization is to be obtained by the referring Provider or Hospital through the discharge planning process. SNF's are responsible for ensuring prior authorization is secured prior to accepting the Member to avoid non-payment. SNF's are required to notify MVP when they have accepted a patient by faxing a Prior Authorization Request Form to MVP.
- MVP's Commercial, ASO, and Medicaid products may require a three-day acute care stay for SNF benefit eligibility. Medicare products do not require a three-day acute care stay.

SNF Admission Denials

- On admission, when there is no qualifying three-day acute care hospital stay (for applicable products) or the Member is deemed custodial (applies to all MVP products), the acute care facility and the SNF must notify MVP of the Member's admission. An admission denial will be faxed to the facility. The UR Representative is required to present the verbal and written notice to the Member. (Written denial notice is also mailed to the Member's home)
- For Managed Medicare products, the acute care facility or the SNF is required to deliver the Notice of Denial of Medical Coverage (NDMC) to the Member or Member representative

Health plan information must be included on the Medicare NDMC; a Word document with the plan information may be obtained by calling MVP. Medicare instructions for the NDMC are available online on the Notices Initiatives page at **cms.gov/BNI**. A word document format for the NDMC may be obtained by contacting an MVP Facility Representative or Contract Manager. Appeal Rights are available in the NDMC.

SNF Continued Stay

- Continued stay services require prior authorization, using MVP criteria (Medicare guidelines for Medicare Advantage Members or InterQual criteria for all other lines of business) in consideration of the Member's individual needs and the local delivery system.

Continued stay reviews may be conducted via medical record review by MVP UM staff at the facility and/or by review of clinical documentation submitted to MVP via fax. Documentation submitted to MVP must include the reason for submission of the clinical documentation, i.e., whether the facility is seeking a termination of benefits or an authorization for an extension of stay. If the reason for submission of the clinical documentation is to request termination of benefits, the facility must also indicate the date on which it is requesting the termination to be effective.

- Reviews conducted at MVP require clinical documentation to be received at MVP between one and three business days prior to the next review date. Submitted

clinical documentation must be current, reflecting the past week's clinical interventions, and Member progress relative to each discipline providing care

- Required documentation for determining inpatient SNF continued stay authorizations is the facility's responsibility and must be supplied upon request. Required documentation includes, but is not limited to:
    - Members Name and MVP ID Number
    - Medical orders
    - Medical progress notes
    - Nursing notes and care plan including measurable Member goals (includes Member/ family teaching needs for discharge plan)
    - Medication records
    - Therapy progress notes
    - Discharge planning/social work notes
    - Hospital therapy notes
    - Skilled service progress notes must reflect the daily administration of those skilled services and the Member's daily status/progress in response to the skilled services
- Failure to obtain appropriate authorizations for admission and/or continued stay or level of care changes will result in non-payment for the unauthorized days, and the Member will be held harmless
- For continued stays, the SNF is required to notify MVP when the Member's level of care changed from skilled to custodial. MVP will perform a review to verify medical necessity of the ongoing stay and issue a medical necessity denial notice (for non-Managed Medicare Members) or a notice of non-coverage (for Managed Medicare Members), if applicable
- Failure to notify MVP of level of care changes and faxing the corresponding clinical documentation within 24 hours of the change will result in non-payment for non-skilled (see "Description" section of this policy for "skilled services" definitions) days
- **Valid Delivery of the NOMNC to Member or Authorized Representative**—If the Member can sign the notice or if the authorized representative is present to sign, the Notice must be signed, dated and faxed back to MVP, at **1-866-942-9286**, within 24 hours of the receipt of the Notice
- Valid Delivery to Authorized Representative by Telephone—If the Member is unable to sign and notice of denial is delivered to the authorized representative over the phone the facility representative delivering the notice must sign the Notice with their signature, phone number, date and time the Notice was given. They must also document on the notice, who they spoke to (authorized representative) and their phone number. Documentation must also contain a statement that in the writer's opinion the authorized representative understood the contents of the Notice. The Notice then needs to be mailed to the authorized representative. The Notice with

the above information must be faxed back to MVP, at 1-866-942-7826, within 24 hours of receipt of the Notice

- **Valid Delivery to Authorized Representative by Certified Mail, Return Receipt**—If the Member is unable to sign, and you cannot reach the Member's authorized representative by phone, the Notice must be sent to the authorized representative by Certified Mail, Return Receipt requested. The date that someone at the authorized representative's house signs or refuses to sign the receipt is the date received. Place a copy of the Notice in the Member's medical file and document the attempted telephone contact to the Member's authorized representative. The documentation must include: the name, organization and contact number of the staff person initiating the contact, the name of the authorized representative you attempted to contact, the date and time of the attempted call, and the telephone number. When the Return Receipt is returned by the post office with no indication of a refusal date, then the Member's liability starts on the second working day after the mailing date. The Return Receipt of delivery of the Notice and the Notice itself with above information written on it must be faxed to MVP at **1-866-942-7826**, within 24 hours of the Return Receipt delivery to your facility
- **Valid Delivery if Member or Authorized Representative Refuses to Sign**—If the Member or authorized representative refuses to sign the Notice, the facility representative must document on the Notice, the Member's and/or authorized representative's refusal to sign. The facility representative delivering the Notice must sign the Notice with their signature date and time the Notice was given. The Notice must be faxed back to MVP, at **1-866-942-7826**, within 24 hours of receipt of the Notice

A copy of the acknowledgement form must be kept in the Member's medical record. The SNF will be responsible for services rendered prior to notification of non-coverage to the Member. The SNF can only bill the Member after appropriate notification that the benefits criteria and/or medical necessity are not met. The SNF is responsible for any associated grace days and cannot bill the Member until this requirement is met.

- **For all Medicare Advantage Members**—The SNF must deliver the Notice of Medicare Non-Coverage 2 calendar days prior to discharge in accordance with Medicare Regulation 42 CFR, §422.624, §422.626. The Member has the right to appeal the denial with the Medicare the Beneficiary and Family-Centered Care Quality Improvement Organization.

  The notice must identify MVP along with MVP's address and MVP Member service phone number. Failure to deliver the notice properly may result in non-payment for any overturned days by an appeal organization and the Member will be held harmless.

  Health plan information must be included on the NOMNC; a word document with the plan information may be obtained by calling the Skilled Nursing Line. The Medicare NOMNC and instructions for the NOMNC are available online on the Beneficiary Notices Initiative (BNI) page at cms.gov/BNI. A document format for the NOMNC may be obtained by contacting an MVP Professional Relations Representative.

When a Member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by MVP. The SNF is responsible to issue the Detailed Explanation of Non-Coverage to the Member upon receipt from MVP Health Care. A copy must be retained in the Member's medical record.

- **Member appeals**—While a Member appeal is in process with a Quality Improvement Organization (Livanta, for the state of New York), the SNF should notify MVP Health Care via phone or fax of any level of care change which may change the Member's eligibility status for SNF coverage. MVP Health Care will review for reinstatement of the Members skilled nursing facility benefit.
- The facility is responsible for notifying MVP of the Member's discharge date from the SNF and the Member's disposition upon discharge, within two business days of the discharge. Such notification may be communicated by phone, fax, or other electronic notification as specifically agreed upon by the facility and MVP.
- Requests for a Medicare Swing Bed requires prior authorization and will be reviewed on a case-by-case basis for medical necessity using the following criteria:
    - The Member must have skilled needs as defined above as well as Medicare Guidelines.
    - Requesting facility must provide written documentation from in-plan SNFs (that have beds available) of inability to accept the Member. Requests for Swing Beds will not be covered if there are in-plan SNF beds available.
    - When a hospital is providing extended care services (Swing Beds), it will be treated as a SNF for purposes of applying coverage rules. SNF level of care days in a Swing Bed is to be counted against total SNF benefit days available.
    - If there is an available SNF bed in the geographic region (all contracted SNFs within 50 miles of the hospital), the extended care patient (swing bed) must be transferred within five days of the availability date (excluding weekends and holidays) unless the patient's Provider certifies, within the 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date.

Exclusions and Limitations

Skilled care does not mean custodial care, intermediary care, domiciliary care, or convenience care. Under this policy, the following are not usually considered benefits:

- Custodial care (assisting with activities of daily living such as ambulating, bathing, dressing, feeding, toileting, preparing special diets, and supervising medication that would ordinarily be self-administered)
- Maintenance care or services
- Intermediary care (institutional care in addition to board and lodging in functionally independent persons)
- Domiciliary care (room, board, laundry, and housekeeping services for health-stable persons)

- The above listing should not be considered all-inclusive. The medical director or designee may review indications for any level of care on an individual basis for medical necessity and appropriateness

MVP Medicaid Managed Care

It is the responsibility of the SNF to complete the appropriate paperwork upon determination that an MVP Medicaid:

- Managed Care Member is changing to a permanent (Long Term Nursing Home) status. Permanent placement will only be allowed to MVP participating Providers. (If the SNF facility does not contract with MVP for long term placement, the Member must change to a plan that the facility contracts with for long term placement.) The request for permanent placement must first be prior authorized by MVP by sending the request along with the PRI, 3559, MD Statement of Need and MDS forms. Upon MVP approval, it is the facilities responsibility to complete the application and submit it to the Local Department of Social Services (LDSS) Office in the county where the Member resides

MVP Health Care Process for Hospice Care

Description

An interdisciplinary program of palliative care and supportive services addressing the physical, spiritual, social, and economic needs of terminally ill patients and their families provided in the home or a hospice center.

Indications/Criteria

- Hospice service is a covered benefit that does not require prior authorization
- Member must have a terminal illness with a life expectancy of less than six months
- All aggressive forms of treatment for their illness must have stopped, except for radiation therapy for palliative measures
- A recognized hospice Provider must administer hospice services
- Coverage shall include home care and outpatient services provided by the community hospice agency

Variations for Hospice—Medicare Advantage Members

Members with an active hospice election must select a Medicare-certified hospice Provider. Hospice claims are sent directly to Medicare. Providers of all services to those on hospice must submit their claims directly to Medicare Fee-For-Service for Hospice. Once payment for claims has been received, the Medicare EOMB and a secondary claim should be submitted. MVP will then coordinate benefits to pay the balance due minus the

Member's responsibility. Coverage includes medical supplies related to the hospice care and use of DME equipment, per hospice contracts.
All DME must be provided through a participating Provider or hospice vendor. Drugs traditionally covered under Part B and Part D are covered under the Medicare Part A per-diem payment to the hospice program. For prescription drugs to be covered outside of the Part A per diem and under the Member's Part D benefit, the hospice Provider must provide documentation identifying why the drug is unrelated to the terminal illness or related condition. Prescribers who are unaffiliated with the hospice Provider should also attest that they have coordinated with the hospice Provider and the hospice Provider confirmed that the drug is unrelated to the terminal illness or related condition.

Except for payment for Provider services, payment for hospice care is made at one of four predetermined prospective rates depending on level of care. The four levels of care are:

1. Routine Home Care (Revenue Code 0651)
2. Continuous Home Care (Revenue Code 0652)
3. Inpatient Respite Care (Revenue Code 0655)
4. General Inpatient Care (Revenue Code 0656)

Medical justification for continuous home hospice and all inpatient care must be documented in the Member's hospice medical record.

Discharge for Medicare Advantage Members from Hospice must follow the CMS guidelines for the NOMNC. Medicare Beneficiary Notification forms and instructions can be found on the Beneficiary Notices Initiative (BNI) page at **cms.gov/BNI**.

Note: A Word document format for the NOMNC may be obtained by contacting your MVP Professional Relations Representative.

Palliative Care through Hospice

The Palliative Care Program is to be considered for Members with a serious illness who may have a prognosis of more than six months and may be pursuing curative interventions.
The diagnoses to be considered include, but are not limited to, AIDS, cancer, heart disease, lung disease, renal disease, or a progressive neurological disease. Referrals to the Palliative Care program are accepted from multiple resources: Provider, UM staff, home care agency, hospital discharges planners and hospice.

MVP Medicaid Managed Care, Child Health Plus, and HARP

Children are allowed to receive hospice services while receiving any medically necessary curative services.

MVP Health Care Home Care Referral Process

Overview

MVP provides home care services in accordance with Medicare guidelines, the Home Care BIM and MVP contracted benefits. Home care benefits under the supervision of an RN are available to Members upon meeting eligibility requirements and criteria established to determine medical necessity for skilled services to homebound patients. Short-term, intermittent services by home health aids; physical, occupational, and speech therapists; and durable medical equipment (DME) are available to eligible Members when medically necessary.

Initial Requests for Services

- The PCP or specialist must initiate home care requests. A discharge planner may act as a Provider's agent to initiate a care request
- Select In-Network Home Care Providers (Nursing, PT/OT/SLP and HHA services) do not require prior authorization for Commercial, Medicaid and ASO. Please contact the MVP Home Care Unit for a Provider list at **1-800-684-9286**
- All out-of-network services do require prior authorization, which can be obtained by contacting the MVP Home Care Unit at **1-800-684-9286**
- A facility discharge planner may act as a Provider's agent to initiate a request for care. The case manager will review the information. If additional services are approved, the Member's MVP case is updated. The agency is contacted, and a follow-up letter is sent and/or a response to a standard EDI transaction (ANSI 278). Requests for authorization extensions may be obtained by calling MVP's Home Care Unit at **1-800-684-9286**

Requests for Continuing Services

The home care agency will provide updates, using a standard EDI transaction (ANSI 278), or by phone or fax on a concurrent basis for each case in which additional home care services are requested prior to completion of care or the approved time frame for home services. The PCP, attending Provider, or specialist treating the patient must initiate requests for home care services.

Variation for Home Care Services—Medicare Advantage

MVP provides Utilization Management for Home Health services for Medicare Advantage Members only.

Fax: **1-866942-7826** for pre-service authorization requests

Fax: **1-866942-7826** for continued stay authorization requests and "other" (NOMNC, NDMC)
Fax: **1-866942-7826** is utilized to receive Healthcare MDS from All PAC and Home Health
Tel: **1-800-684-9286**

The Home Care Agency is required to provide MVP Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two days prior to the last day of coverage/discharge, signed, and dated by the Member (or authorized representative). If there is more than a two-day span between services, the NOMNC should be issued next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. Medicare Regulations do not recognize notifications by voicemail. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. The "valid delivery" of NOMNC must be retained in the Member's medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP Health Care within 24 hours of receiving a NOMNC from MVP Health Care.

Medicare Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at cms.gov/BNI.
A Word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative. When a Member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by naviHealth, Inc. The Home Care agency is responsible for Issuing to the Member the Detailed Explanation of Non-Coverage upon receipt from MVP .

MVP Medicaid Managed Care Variation for Personal Care Services

MVP Health Plan, Inc. covers personal care services for Medicaid Managed Care Members. Personal care services must be prescribed by a Participating Provider and services must be performed by a participating Personal Care agency. A personal care assessment must be completed and submitted to the health plan for prior authorization before the initiation of Personal Care Services. Level I (nutritional and environmental support functions) will be considered for coverage based on medical necessity. There will be a limit of up to eight hours per week for Level I personal care services. Prior authorization is obtained by calling **1-914-372-2433**.

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to NYS Medicaid Recipients

Home Health Agencies that provide Personal Care Assistant Services are required to attest that the agency has policies, procedures, programs, and protocols to demonstrate compliance with NYS Medicaid Standards for the following:

- The level of personal care services provided and title of those providing services
- The criteria for selection of persons providing personal care services
- Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402)

- That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions
- The agency assigns appropriate staff to provide personal care services to a Member according to MVP's authorization for the level, amount, frequency and duration of services to be provided
- There is administrative and nursing supervision of all persons providing personal care services
- The agency's administrative supervision assures that personal care services are provided according to
- MVP's authorization for the level, amount, frequency and duration of services to be provided
- The administrative supervision includes the following activities:
    - Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency and duration of the personal care services to be provided;
    - Notifying the MVP when the agency providing services accepts or rejects a patient;
    - When accepted, the arrangements made for providing personal care services; and
    - When rejected, the reason for such rejection
- The agency promptly notifies MVP when the agency is unable to maintain case coverage
- The agency provides nursing supervision to assure Member's needs are being met MVP Health Care Home Infusion Services

MVP Health Care Home Infusion Services

Refer to MVP's Home Infusion Policy. Infusion therapy requires a prescription from a qualified Provider who is overseeing the care of the patient and is designed to achieve Provider-defined therapeutic endpoints. The infusion therapy must be initiated on time within the stipulations of the Providers' orders for 100 percent of cases.

Most home infusion services do not require prior authorization. The health plan reserves the right to audit the vendor's records to ensure compliance with MVP Policies. Prior authorization may be required prior to the administration of specific medications. Refer to the MVP website for a list of specific medications requiring prior authorization. The vendor will work with the prescriber to coordinate the prior authorization.

Home Infusion Services are covered when deemed medically necessary. Coverage of services may vary by Member contract. Home Infusion nursing services are in some instances applied to a Member's home health care benefit. Some prescription drugs are not a part of the base medical benefit. Coverage may exist under Member or employer

riders. MVP reserves the right to limit the availability of certain medications to a specialty pharmacy vendor. For Providers with electronic access, further information surrounding specific benefits/riders may be obtained on the Provider portal, on the MVP website. For Providers without electronic access, contact the Customer Care Center.

The home infusion vendor must report any adverse outcomes (due to wrong dose, administration, faulty equipment, or other issues) within 24 hours of occurrence by contacting MVP's Home Care Unit at **1-800-684-9286**.

Home Infusion and Home Health Care Agency Nursing Visits

All efforts will be made between the infusion vendor and home care agency to coordinate the delivery of care to the Member. When the Member is under the oversight of and opened to a home care agency for non-infusion related care, the home care agency shall administer the medication on the dates the agency is scheduled to have a nurse in the home. Home infusion vendors may subcontract with another agency for all or part of the nursing services. In these instances, the home infusion vendor:

- Assumes responsibility and oversight of care provided
- Bills MVP Health Care for their services
- Is responsible for paying for all subcontracted services

Home Infusion and DME

Infusion Pumps and Supplies may be covered under the Member's DME benefit with a participating DME vendor. Supplies may also be obtained through a network pharmacy and should be billed online to the Pharmacy Benefits Manager (PBM) for Members with a pharmacy benefit through MVP.

Home Infusion and Hospice Services

When a Member elect's hospice, all services and respective charges related to the hospice diagnosis are global to the hospice payment. No separate reimbursement is made to the home infusion vendor.

Home Infusion and Skilled Nursing Facility (SNF) Care

When a Member is in a Skilled Nursing Facility at a skilled (non-custodial) level of care, all services under CMS's consolidated billing and the respective charges are global to the SNF payment. No separate reimbursement is made to the home infusion vendor. If the Member becomes custodial and remains at the SNF for residential purposes, the home infusion vendor may be reimbursed by MVP for the home infusion services. The drugs administered in the SNF for custodial Members must be billed to MVP's PBM and may be subject to a Medicare Part B or Part D determination review.

In accordance with Medicare Regulation 42 CFR, §44.624, §422.626, §422.620, effective January 1, 2004, for MVP Medicare Members: The Home Infusion Agency is required to provide MVP

Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). See above under Home Care.

MVP Medicaid Managed Care

Please refer to the MVP Medicaid Managed Care Formulary for more information.

Retrospective Review

Retrospective review is conducted based on specified type of review by a Registered Nurse (RN), RN Certified Coding Specialist (CCS), or RN Certified Professional Coder (CPC). Reviews can be conducted to verify level of care, place of service assignment, length of stay, services rendered, validation of inpatient/outpatient coding, and accuracy of claim data including submitted charges that impact reimbursement. MVP utilizes facility/Provider medical records, in conjunction with clinical review criteria, MVP Medical Policy utilization review/coding guidelines, and when applicable invoices, itemized bills. Consultations with MVP's Associate Medical Director occur based on case complexity. All medical denials and Level of Care changes are determined by an Associate Medical Director. Coding Denials are reviewed by Certified Coders. A retrospective case that is identified as a potential Quality Improvement, Coordination of Benefits, or Case Management trigger, will be referred to the appropriate unit. The applicable policies address regulatory turnaround timeframes, clinical information collection, assessment, and appeal rights. These reviews are all performed after the service has been rendered and may be pre-or-post payment. Types of retrospective reviews may include but are not limited to:

Post-Service Inpatient Review

Retrospective review of medical records is performed on all inpatient hospital admissions where the claim indicates the following:

- The approved Length of Stay (LOS) days do not match the claim and authorization
- Required match fields (i.e., level of care) on a claim submitted do not match the authorization
- No authorization or pending authorization

Post-Service Outpatient and Emergency Department Review

Retrospective review of outpatient medical records may include but are not limited to the following:

- Emergency Department Services
- Cosmetic procedures or services

- Experimental and investigational procedures or services
- Injury to sound natural teeth services/procedures
- Services identified in MVP's medical policy as requiring a retrospective review
- Observation over 48 hours

MVP Health Care may reverse a pre-authorized treatment upon retrospective review of relevant medical information presented at the time of the Utilization Review if it is materially different from the information presented during the pre-authorization, the information existed at the time of the pre-authorization and was withheld or not available or the Utilization Reviewer was not aware of the existence of the information, and if the information was available the requested service or procedure would not have been authorized.

Based on regulatory guidelines Providers/facilities will receive written notification on retrospective adverse determinations.

DRG Validation

DRG Validation is performed post payment (within six months of paid claim date) on claims submitted by those facilities that have a contractual agreement with MVP for a DRG payment methodology. DRG validation is performed by certified RN coders (CCS) who utilize ICD-10 CM Coding Guidelines/Conventions and coding software which is consistent with industry and regulatory standards. Charts are reviewed for validation of all ICD-10 CM/PCS codes impacting DRG as well as the sequencing of principal and secondary diagnoses. Additional clinical resources used in DRG validation include but are not limited to American Hospital Association Coding Clinics, Faye Brown Coding Handbook, and Merck Manual etc.

Other DRG reimbursement drivers that can be reviewed are birth weights, discharge disposition, transfers, short stay payments and readmissions reviews as per the individual facility contracts or regulatory requirements. When the coder disagrees with the hospital's coding and subsequent DRG assignment, the hospital is notified, in writing, of the DRG reassignment, with rationale, references cited and appeal rights. The claim will be adjusted to the DRG identified in the notification letter.

MVP may request at any time in this process that a Provider query be initiated to clarify diagnoses and/or procedures. The format used for submitting this query shall adhere to the nationally recognized guidelines set forth by AHIMA. The expectation is that the facility will submit the documented Provider query/response along with all other medical record documentation that substantiates the diagnosis/procedures to MVP within 30 calendar days from the date of the request/letter for the facility to initiate a Provider query.

If the facility is not in agreement with MVP's decision and wishes a reconsideration, the facility may submit the entire medical record (if not submitted prior to reconsideration) and/or any additional supporting documentation no later than thirty calendar (30) days from the date of MVP's letter. If, upon review of the facility's reconsideration letter and

supporting documentation, MVP Health Care's RN CCS coder determines the facility's original DRG was appropriate, an agree letter is sent and the claim is readjusted to pay the originally submitted DRG. For those reconsiderations that the RN CCS coder upholds the MVP Health Care DRG assignment, a letter will be sent to the facility notifying as such and will include additional rationale, and references.

If a hospital is not satisfied with the result of the DRG reconsideration, it may commence with a level Two Hospital Appeal, if allowed by contract, which a third-party arbitrator shall conduct. Per the instructions in the closing of the reconsideration letter, the hospital will submit a written request to the designated arbitrator within 30 calendar days from the date of MVP's Level one appeal (reconsideration) determination notice. According to the contractual agreement between the hospital and MVP, the subscriber/Member cannot be held financially responsible for any balance billing.

Other Types of Retrospective Claim Reviews

Transfer Payment
Transfer Payment is based on contract and/or Medicaid or CMS regulations. An acute care transfer is considered a discharge of a hospital inpatient from an acute care non-exempt facility to another acute care non-exempt facility. The total payment to the transferring facility will not exceed the amount that would have paid if the patient had been discharged. If on review, the health plan finds either the discharging or the transferring facility incorrectly billed a transfer case, payment will be adjusted.

Post-Acute Care Transfer
A discharge of a Medicare hospital inpatient is considered to be a transfer when the discharge is assigned as outlined in the CMS Manual (Post-Acute Care Transfer Policy per Center for Medicare and Medicaid Services) to one of the qualifying diagnosis related groups (DRG) and discharge is made under any for the following circumstances:

- To a hospital or distinct hospital unit excluded from the prospective payment system
- To a skilled nursing facility
- To a home with a written plan of care that includes a provision for services from a home health agency 3 calendar days after discharge

If, on review, the health plan determines that the submitted claim had an incorrect discharge disposition, the payment will be adjusted accordingly. The Provider may submit documentation for reconsideration to the attention of MVP's Retrospective DRG Unit.

Cost Outliers

Cost Outliers require the hospital to submit all itemized charges for any case in which a cost outlier review is requested. The hospital receives the DRG payment plus additional payment for cases that exceed the DRG threshold for excessive cost to the hospital as based on the contracted DRG methodology. The case is reviewed to verify accuracy; appropriateness of charges and services billed along with DRG validation. In addition, any days that were not

reviewed for medical necessity concurrently may be reviewed retrospectively and if any days are determined to not be medically necessary, those associated charges will be removed from the total allowable charges, which may affect the hospital's final reimbursement.

Readmission

Readmission is defined when a patient is discharged and readmitted to the same hospital within 30 days, for the same or a related condition for which the patient was treated at the time of the original discharge and the second admission is the result of an inappropriate/premature discharge or for patient/facility convenience or scheduling difficulties. Reviews will be performed in accordance with facility contract and/or CMS/Medicaid/New York State regulations. If the subsequent days between readmissions result in outlier payments those will not be considered in the calculation of the total. Days between the original discharge and the subsequent admission will not be considered in the calculation of the total length of stay for payment.

MVP Health Care will utilize clinical criteria and licensed clinical medical review to determine if the subsequent admission is based on one of the following factors:

- The same, or closely related condition or procedure as the prior discharge.
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- An acute decompensation of a coexisting chronic disease
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period
- An issue caused by a premature discharge from the same facility
- Discharged in an unstable medical condition and did not meet standard/established discharge criteria
- Discharged for patient/facility convenience

For Medicaid Members the New York State Regulation for readmissions will be followed. This includes but is not limited to readmission, which could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period (i.e., home care appropriate following discharge but none ordered resulting in readmission). In addition, any discharge with subsequent readmission due to a delay in service or due to facility or Member convenience would fall under these readmission requirements.

Planned Readmission/ Leave of Absence

When a Member is readmitted within 30 days as part of a planned readmission and/or placed on a leave of absence, the admissions are considered to be one admission, and only one diagnosis related group (DRG) will be reimbursed.

Providers are to submit one bill for covered days and days of leave when the patient is ultimately discharged.

Readmissions occurring within 30 days for symptoms related to or for evaluation and management of the prior stay's medical condition are considered part of the original admission. MVP Health Care considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment. MVP Health Care defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.

MVP Health Care reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission for the same, similar, or related condition as defined above.

Exclusions:

- Admissions for the medical treatment of:
  - Cancer
  - Neonatal/Newborn
  - Obstetrical deliveries
  - Behavioral Health
  - Rehabilitation care
  - Substance abuse
  - Sickle Cell Anemia
  - Transplants
- Patient transfers from one acute care hospital to another
- Patient discharged from the hospital against medical advice
- Planned admissions

Admissions for covered transplant services during the global case rate period for the transplant in the case of readmissions, the Hospital shall be reimbursed the lesser of:

- The total of the case rate payments for the two separate admissions; or
- The payment which would have been received pursuant to this Rate Sheet and Addendum by billing MVP for a single case rate by combining, according to the principal reason for Member admission, those diagnoses, and procedures of the readmission with the diagnoses and procedures of the original admission, and total medically necessary days in the combined admission.

This policy only affects those facilities reimbursed for inpatient services by a DRG or DRG + Case Rate methodology.

If MVP does not consider the case a "Readmission," MVP will pay each discharge separately in accordance with the facility contract/MVP Agreement. Discharges and subsequent admissions between acute care unit and a behavioral health unit or a physical rehabilitation unit in the same hospital are not considered a "Readmission" for purposes of this paragraph.

When a readmission is identified the hospital is notified in writing that MVP Health Care is combining the said DOS, citing the resulting DRG assignment, provide rationale, references and reconsideration/appeal rights.

If a hospital disagrees with MVP's decision regarding a readmission, Hospital may ask for reconsideration as directed within the Readmission letter by submitting a reconsideration request letter with supporting documentation within 30 calendar days from the date of the initial readmission letter.

If a hospital is not satisfied with the result of the readmission reconsideration, it may (as allowed by contract) commence with a level Two Hospital Appeal, with the designated third-party arbitrator. The instructions and timeframe of thirty (30) calendar days from the date of MVP Health Care's response letter are provided in the closing of MVP Health Care's reconsideration response letter. According to the contractual agreement between the hospital and MVP, the subscriber/Member cannot be held financially responsible for any balance billing.
Never Events, Serious Reportable Adverse Events (SRAE), Hospital Acquired Conditions (HAC).
The CMS, New York State Medicaid and other entities maintain different listings of Never Events/Serious Reportable Adverse Events/HACs. MVP will not pay for the cost of care associated with a Never Event. For a detailed summary of the MVP Never Event Policy, refer to the end of this section. MVP reviews all never events to facilitate accurate coding, billing and reimbursement based on individual contracts.

High-Cost Claim Audits

High-Cost Claim Audits are conducted per MVP hospital contracts for the following but not limited to high-cost drugs, level of care/room charges, high-cost services, implants etc. An itemized bill along with the medical record may be requested to verify charges being billed. The facility will be notified by letter of any changes to charges along with the rationale for changes. Facility may request reconsideration per instructions in the closing of the high-cost change letter. If the facility disagrees with adjustment, the facility may submit a reconsideration letter with rationale within thirty calendar days of the date of MVP's letter.

Provider Claims Review (PCR)

MVP provides equitable and consistent reimbursement for all MVP participating and non-participating Providers and facilities while managing health care costs by conducting post service claim review. PCR performs coding reviews on post service, pre-payment claims, as well as on appeals received for finalized (i.e., paid or denied) claims. The PCR CPC staff reviews the claim to determine the accuracy of the coding, modifiers and place of service

and verifies that the billed procedures are coded appropriately based on review of the documentation provided. Current Procedural Terminology (CPT) Guidelines, American Medical Association (AMA), National Correct Coding Initiative (NCCI) edits, McKesson Claims ten Clinical Editing and MVP Policy guidelines are utilized for determinations.

MVP may turn off specific subsets of edits. MVP monitors trending data to identify changes in coding practices. MVP will execute audits on specific Providers or turn the edit on if a trending change warrants. Providers to be audited will be offered advanced notice of initiated audits. MVP will request all documentation to support the coding on the claim.

Providers and facilities may appeal any payment changes as a result of clinical editing, medical necessity or level of care denials by submitting a Claim Adjustment Request Form (CARF) with the clinical and/or coding rationale explaining why the denial is incorrect. The CARF can be accessed on the MVP Provider portal. Please make sure to include any medical reports and/or coding documentation that will substantiate the appropriateness of the appeal. If documentation was originally submitted with the initial denial, Providers need to send additional supporting documentation with the CARF that may not have been provided with the initial denial.

MVP may reverse a pre-authorized treatment, service or procedure on retrospective review, pursuant to section 4905 (5) of the NYS Public Health Law, when: relevant medical information presented to MVP upon retrospective review is materially different from the information that was presented during the pre-authorization review; the information existed at the time of the pre-authorization review but was withheld or not made available; and MVP was not aware of the existence of the information at the time of the pre-authorization review; and had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Medical Audit

Medical audits are performed by MVP or a contracted recovery audit vendor to ensure Providers are following MVP's clinical and coding guidelines when providing services or care. Medical auditing is a cost-effective approach to review/respond to utilization trends for medical services not managed through the traditional Prospective, Concurrent, or Retrospective review processes.

Medical auditing is performed on health services where MVP has elected to relax prior authorization guidelines for those targeted services and for services where MVP has chosen to perform limited post service review. Audits are performed to ensure services are provided in accordance with MVP policies, contracts and billing guidelines.
Examples of services audited include but are not limited to FDA approved implantables, home care, home infusion, select DME, coding and clinical trials.

When MVP or a contracted recovery vendor performs a medical audit, the Provider will be required to supply clinical notes within 30 calendar days of the request. Clinical notes along with any other supporting documentation can be faxed to **1-518-386-7417** or mailed to Medical Audit, 625 State Street, Schenectady, NY 12305. Failure to provide the requested notes may result in recovery of claims paid to the Provider.

If a medical necessity adverse determination is made following audit review of clinical notes, the Provider may appeal the determination following the appeal process in the notice of denial. If the

documentation review results in a coding or payment adjustment, the Provider may file dispute reconsideration and provide any additional documentation to the Medical Audit unit within contracted timeframes. MVP will recover any monies paid to the Provider and the Members will be held harmless.

Care Management Programs

MVP Health Care with internal and external Members of the health care delivery team to provide comprehensive Case Management. MVP's care management programs aim to maintain and/or improve the physical and psychological well-being of our Members through tailored and cost-effective health solutions. MVP strives to address the health needs of its Members at all points along the continuum of health and well-being, through participation of, engagement with, and targeted interventions for the population. These programs are offered at no cost to the Member and there are no co-payments for these services. Member may choose to opt-out at any time.
Caring for Members with acute and/or chronic health conditions sometimes takes an extra helping hand. That's why MVP has a team of registered nurses (RN), respiratory therapists, licensed social workers, licensed mental health professionals (LMHP), dietician and patient engagement specialists to help ensure that your patients achieve the best health outcomes possible.

Additional information about these programs is provided below. To refer to any of the MVP programs contact our central triage number at **1-866-942-7966** or email PHMReferrals@mvphealthcare.com.

Case Management—Complex/Longitudinal Programs

The Case Management program was created to ensure that the highest quality of care is provided to Members who have multiple or complex health care needs. The goal of Case Management is to help Members regain optimum health, or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring, and follow-up.

The Complex Care Program supports Members with serious illnesses or injuries such as but not limited to hemophilia, HIV, complex cancer treatment, ALS, end stage renal disease and stroke. Case Managers provide care coordination to ensure that MVP Members are effectively accessing the appropriate outpatient and Provider services. Members will be offered Complex Care after an acute episode if ongoing self-management support is needed.
The Complex Care Program assists with the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. Case Managers provide self-management support to Members with multiple chronic conditions (CHF, COPD, CAD, Diabetes and Asthma); ensuring the Member/caregiver is able to independently self-manage their conditions. In addition, MVP Medicaid Members are often found to have significant medical and social needs that drive their health care utilization. MVP has case managers dedicated to meeting these Members' needs especially those Members enrolled in the

HARP program and/or a Health Home. Clinicians also work collaboratively with Health Homes (HH) and our Behavioral Health team to support complicated medical and psychosocial Member needs.

Case managers utilize the principles of case management to increase the effectiveness of communication with plan Members. In addition to providing support to Members in the form of care coordination and facilitating access to needed resources, Case Management aims to achieve the following objectives:

- Ensure cost effective solutions through appropriate utilization and coordination of health care resources and application of health care benefits
- Identify gaps in services or communication and create systems to correct them
- Improve the continuity of care received by Members by providing a contact person for Providers, staff, patients, and families throughout the episode of care
- Provide impartial advocacy, facilitation and education to Members and their families
- Be aware of the financial needs of Members and maximize benefits and health care resources to limit out-of-pocket expenses
- Improve medication adherence, safety and quality of life.

Transplant Case Management

Transplantation involves complex and highly specialized care and requires time-intensive coordination for multiple health concerns. MVP's Case Management department has dedicated Case Managers that specialize in Transplant Case Management. A transplant referral occurs when the PCP or specialist requests a transplant evaluation and/or prior authorization for a transplant.
The Transplant Case Manager should be consulted for benefit questions or other transplant-related issues. An individual case manager follows up with each transplant recipient by phone and/or correspondence for up to one- year post-transplant.

Procedure for Transplant

Following the request for prior authorization, the MVP Case Manager will begin gathering the medical information for review.

Upon identification of a potential transplant candidate, the attending Provider is required to submit a request to MVP's Case Management Department by calling **1-866-942-7966** for prior authorization of non-urgent evaluations for transplant. If it is an urgent request, that should be stated during the phone call. Regardless of transplant facility, before a transplant evaluation or transplant procedure can be performed, an approval must be obtained. If after the transplant evaluation a transplant is planned, the results of the evaluation are sent to the case manager to ensure the review is complete prior to any additional services rendered.

In addition to MVP's contracted facilities, MVP uses the Optum HealthCare to access centers of excellence for transplant services and to provide information and resources on centers of excellence for specific types of transplant. For information about Optum HealthCare participating

facilities, Providers may call the case manager at **1-866-942-7966** or visit Optum Health Care's website at: myoptumhealthcomplexmedical.com.

Little Footprints℠ for High-Risk Pregnancies

MVP offers a high-risk prenatal care program called Little Footprints, which provides additional clinical expertise for expectant mothers.

The goal of the Little Footprints program is to promptly identify female Members at risk of a high-risk pregnancy (multiple births, infertility, history of miscarriage, etc.) and provide the Member with care coordination and
prenatal education. The program involves telephonic contact with an MVP Case Manager or bilingual Maternity Care Coordinator (for Spanish speaking Members). The Case Manager follows each Member individually and develops an education plan in conjunction with the pregnancy assessments and screenings.

Ongoing telephone calls are scheduled with the Member to encourage healthy behavior and provide education on topics such as fetal development, diet, nutrition, and exercise. Members are followed post-delivery and are assessed for post-partum depression. Members are advised to follow up with their Providers post-delivery and verify that an appointment with the pediatrician has been scheduled. Expectant mothers are mailed educational information packets upon enrollment and delivery. Those Members who are not eligible or declined the Little Footprints program are referred to the Healthy Starts program for an educational packet via mail. The Healthy Starts program gives mothers-to-be information to help them stay healthy, learn about pregnancy, and prepare for delivery. Medicaid Members who are not eligible or decline the Little Footprints program will receive the same packets as those enrolled in the Little Footprints program.

Rochester Providers caring for Members enrolled in the Medicaid Managed Care program are encouraged to notify MVP of all pregnancies (not limited to high risk) by faxing a copy of the Member's Prenatal Health Risk Assessment form to the Customer Care Center—Provider at **1-800-247-6550**. This process provides prompt referral of a pregnant Member to the Little Footprints program.

The maternity management program follows the evidence-based guidelines published by the American Academy of Pediatrics ("AAP") and the American College of Obstetricians and Gynecologists ("ACOG") Guidelines for Perinatal Care, Seventh Edition, October 2012.

Breastfeeding Support

MVP recognizes the importance of breastfeeding babies, and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. We have a comprehensive lactation support program providing breastfeeding support and equipment through Corporate Lactation Services. Through this relationship with Corporate Lactation Services, MVP is able to offer nursing mothers state-of-the-art breastfeeding equipment and access to internationally board-certified lactation consultants and registered nurses 365 days a year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of the infant/baby. Members can call in with questions or concerns until weaning. All of these

services are offered at no additional charge to our Members. To enroll, Members can visit corporatelactation.com and click on *subsidy login*, then enter the pass code **MVP2229** or call **1-888-818-5653**. Additional breastfeeding support is available by video using the myVisitNow℠ video platform through American Well.

Social Work Services

Social Work services are available to connect Members to community resources and services and assist with addressing Member specific social and economic needs. The social work team can assist Members with the following:

- Department of Social Services: fee-for-service Medicaid, food stamps and the Home Energy Assistance Program (HEAP)
- Housing: Section 8, Housing Authority, home modification/weatherization and homelessness
- Co-payment relief: prescription assistance programs and facility co-payments for things like hospital stays
- Social Security Administration: disability and Medicare
- Senior support programs
- Cancer resources
- Advance directives, written plans documenting the Member's wishes in terms of health care treatment if they cannot speak for themselves
- Transportation

Health Management (Disease Management) and Health Coaching

MVP's telephonic Health Management (Disease Management) programs are structured to empower the Member to bring about lifestyle and behavior change, provide condition-specific education and assist Members with achieving evidence-based care guideline outcomes. Clinical interventions are aimed at collaborative care planning and/or goal setting that continuously evaluates clinical, humanistic and economic factors affecting overall health. The health management programs provide two service options:

1. Information mailed to the Member's home, including bi-annual condition specific newsletters and health screening reminders; and
2. Telephonic one-on-one outreach by a health coach. The telephonic outreach program focuses on prevention of exacerbations and complications, self-management strategies and helping Members to make positive lifestyle changes and better control their condition. In addition, condition health management programs assist with connecting Members with appropriate community resources and services.

MVP's health management programs identify and outreach to Members living with:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Diabetes
- Heart Failure
- Low Back Pain

Transition Care

The Transition Care Program is a program for Members recently discharged from the hospital to provide education and support to reduce their risk for readmission. Outreach is provided through telephonic outreach. The MVP Transition Care team consists of clinicians focused on helping to support Members after a hospital admission. Services include assisting the Member with understanding discharge instructions, medication adherence, encouraging prompt Provider follow-up and coordination of care, assessing risks post-discharge in the home environment and providing the patient with self-management tools and coaching. MVP has an embedded RN at Albany Medical Center, Rochester General Hospital. The case manager completes bedside visits to Members at risk for readmission and educates the Member on the transition of care program. The bedside nurse provides the transition nurse with a discharge medication list and any pertinent information obtained during bedside rounding that may assist the transition nurse.

Care Advantage

The Care Advantage Program is available to ASO employer groups as an add-on. The focus of this program is to promote health, wellness, informed decision-making, preventive care, healthy lifestyle choices and complex case management while optimizing quality and efficiency. This program provides a proactive, integrated, Member- centric approach utilizing the nurse as the primary point of contact. Registered nurse case managers, known as Care Coordinators, are dedicated and assigned to the employees of the organization as well as to their covered dependents. The Care Coordinators provide direct assistance to participants and their treating Providers with the management of the enrollee's health care, as well as provide and/or coordinate a wide array of health care-related support and educational services. They act as proactive partners with the Members and are available to help them navigate through the healthcare delivery system, understand their benefit coverage, and coordinate with other relevant Providers and care managers involved in their treatment, such as EAP Providers, behavioral health Providers, disease management coordinators, etc.

Member Identification

There are three ways a Member may be identified as a candidate for one of the MVP Case or Condition Management programs:

1. A health care Provider may refer a Member to the program

2. The Member (or designated caregiver) may self-refer to the program

3. The Population Health Analytics team at MVP may identify a Member for management using a variety of data points (health risk assessment data, claims, authorization data, laboratory data, predictive modeling and more). Upon identification, a clinician will reach out to the Member to engage in a telephonic program.

How to Refer a Member to a Program

The process for referral is simple. Call our central triage number at **1-866-942-7966**. Let us know how we can help. MVP will reach out to the Member by telephone. We will match the Member to the most appropriate program and services. This telephone line is secure, and you may leave a secure message at this number. To assist Providers with the referral process, a one-page referral guide is available on the MVP website.

Communication between MVP and Providers

MVP recognizes the importance of communication between the clinicians and the Provider/Provider offices. That is why we may be in contact with the office (by fax, letter, or phone) to alert you to a change in status and to collect pertinent medical data that may assist us with management of the Member.

The MVP care management offer multiple-risk stratification dimensions as well as tailored Member-centric interventions. Providers are encouraged to refer Members to the programs provided.

MVP offers several Provider tools, including clinical guidelines and assessment tools, to help Providers identify Members requiring specialized services. The tools and guidelines are available at **mvphealthcare.com**. A sample list of guidelines follows but not limited to:

- Adolescent health
- Back Pain (Low Back program)
- Behavioral Health
- Depression program
- Cardiac Care (Cardiac and Heart Failure programs)
- Careful antibiotic usage
- Caring for older adults

- Diabetes
- Infectious disease
- Kidney care
- Oncology/Cancer Prevention
- Preventive health (adult/childhood preventive care guidelines)
- Quality Improvement in the clinical setting
- Respiratory (Asthma/COPD programs)
- Women's Health

In addition to the guidelines, MVP offers assessment tools to assist with the identification of potential alcohol abuse. These tools, also found on MVP's website, include the:

- CAGE questionnaire for assessment of potential alcohol abuse in adults
- CRAFFT questionnaire for assessment of potential alcohol abuse in adolescents

Health Home Services for Government Program Members (Medicaid Managed Care, Child Health Plus, HARP)

Health Homes are a care management service model whereby all a Member's caregivers communicate with one another to ensure that all the Member's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all the services the Member needs to stay healthy, out of the emergency room, and out of the hospital. Health Home participation is voluntary.

MVP is contracted with multiple Health Homes in our service area. The contracted Providers are listed on the MVP website. Upon enrolling in any of MVP's Government Programs, MVP's Member Service Department performs New Member Orientation calls and gathers pertinent medical history information from our new Members. Additionally, Members are asked to complete a health risk assessment (HRA). When an HRA is returned, this is reviewed for case management opportunities. MVP's case managers will identify any special needs or barriers to receiving treatment. The Member's PCP may be contacted to coordinate and review health concerns which are identified on the health risk assessment form. MVP Medicaid Members identified with two chronic conditions or one serious persistent mental health condition or as HIV positive are referred to a Health Home by utilizing the MVP Health Home Upward Referral Form. This form is available on the MVP website.

In addition, MVP's Medicare Services and Supports team will review claims history and authorizations to monitor and identify a Member's need for care management services based on:

Diagnostic Eligibility

- Two or more chronic conditions

or

- One single qualifying chronic condition:
    - HIV/AIDS or
    - Serious Mental Illness (SMI) (Adults) or
    - Sickle Cell Disease (both Adults and Children) or
    - Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Frequent Utilization Eligibility

- No primary Care Provider
- No connection or inadequate connectivity with specialty doctor
- High utilization of Emergency Department (3–6 visits in previous year)
- Repeated recent hospitalizations (2–3 inpatient stays in previous year)
- Recent discharge from psychiatric hospitalization
- Assertive Community Treatment (ACT)

MVP's Clinical, Behavioral, Member Services, and Provider Services teams who interact with our Members, Providers, hospitals, and pharmacies will refer a Member to a Health Home who meet the criteria above and/or one of the qualifying factors below:

- No connection or inadequate connectivity with specialty doctor
- Recent release from incarceration
- Poor compliance with treatment or medications or difficulty managing medications
- Homeless or inadequate social/family/housing support
- Learning or cognition issues
- Deficits in activities of daily living such as dressing, eating, etc.
- Cannot be effectively treated in an appropriate resourced patient centered medical home
- Court Ordered Assisted Outpatient Treatment

Providers can make referrals to a Health Home by utilizing the MVP Health Home Upward Enrollment Referral Form located on the MVP website.

PCPs for MVP Government Programs have additional responsibilities including:

Services for Foster Care Children

Participating Providers must work with local department of social services (LDSS) staff to provide comprehensive medical assessment for children in foster care as specified in 18 NYCRR §441.22 and 507.

Child Protective Services

Participating Providers must comply with the Statewide Central Register of Child Abuse and Maltreatment.

24/7 Nurse Advice Line

MVP Members have access to a 24/7 Nurse Advice Line operated by CareNet Health, Inc. The 24/7 Nurse Advice Line allows Members to obtain the health information and education they need to make better health care decisions. Members and Providers may call the Customer Care Center on their ID card or via email through the MVP website.

Online Doctor Visits

MVP now offers myVisitNowSM to fully insured Commercial, Medicare, Medicaid, and Essential Health Plans. MyVisitNow is a smart phone application that supports a video chat service connecting a Member to a doctor or other health care professional. The service is intended for use with non-emergent situations that will benefit from the expertise of a clinical professional. Since the inception of the program, myVisitNow has included Behavioral Health Therapy, Lactation Consultations, and Nutrition and Diet in addition to the core Urgent Care offerings. Psychiatry and Spanish mobile experience were also added to the platform. Since the interaction occurs via video, the health care professional may be able to offer diagnoses, treatment plans or a prescription. Members are provided with a post-visit summary that can be shared with their Primary Care Provider. As with the 24-hour Nurse Advice line, this service is not intended to replace the relationship between a Member and his or her Primary Care Provider or health care professional. Additionally, all interactions are encrypted and secure, providing privacy and confidentiality.

Bariatric Surgery Network

MVP established a network of hospitals that are approved sites for MVP Members to receive bariatric surgery. To obtain a list of the hospitals participating in MVP's Bariatric Surgery Network, visit **mvphealthcare.com**

For MVP's Medicaid Managed Care, Providers must follow the MVP Medical Policy. Medicaid Managed Care and HARP Members requires that the surgical team (including surgeons, anesthesiologists, and radiologists) be MVP-participating Providers.

Before referring an MVP patient for bariatric surgery and before obtaining prior authorization, call Customer Care Center—Provider at **1-800-684-9286** to determine if the Member's benefits require him/her to have the surgery performed in one of the hospitals in MVP's Bariatric Surgery Network. Coverage is subject to each Member's specific MVP benefit plan as indicated in their subscriber contract or certificate of coverage.

MVP Breast Cancer Surgery Facilities

In accordance with NYS DOH requirements for Medicaid Managed Care programs, MVP may no longer authorize inpatient or outpatient mastectomy and lumpectomy procedures for its Medicaid Managed Care Members at hospitals and ambulatory surgery centers identified as low volume by the New York State Department of Health. A listing of the designated approved and unapproved facilities may be found at Unrestricted and Restricted Breast Cancer Surgery Facilities for Medicaid Recipients (ny.gov). Please note that the facility must be contracted for MVP Government Program Members as well as on the approved list in order to be authorized to treat MVP Medicaid Managed Care Members.

Medical Affairs

New Technology Assessment

MVP follows a formal process to evaluate new technology and reassess existing technologies to determine whether such technologies are covered services and/or should be addressed in the Benefit Interpretation Manual. This includes medical/surgical procedures, drugs, medical devices, and behavioral health treatments. A copy of this policy is available on request.

MVP's technology policies are reviewed at least annually, with comprehensive updates triggered more often by changes in published medical evidence-based journals. Requests to review new technology or to reassess established technology are received from participating Providers, MVP medical directors, UM staff and other MVP personnel.

Our team of medical professionals conducts research of the published scientific evidence, information from government regulatory bodies, and prepares a draft of the technology assessment/benefit interpretation policy. The new/updated technology is considered for its impact on health outcomes, health benefits and risks, and effectiveness compared to existing procedures and/or products. The draft policy is presented to the Medical Policy Task Force for review and forwarded to practicing Provider consultants from appropriate specialties for review and comment. Policies are then distributed to MVP medical directors and key UM staff, Professional Relations, Claims, Corporate Affairs and Legal Affairs for a 14-day review and comment period. The Medical Policy Task Force reviews the recommendations from the above and appropriate recommendations are incorporated into the proposed policy. The revised policy is then presented to the Medical Management Committee (MMC) Work Group for review and discussion. Once approved the policy is forwarded to the MMC for consideration. Comments are considered and as appropriate incorporated into the medical policy. MMC Membership includes practicing Providers from representative specialties, including at least one Provider from each of the MVP service areas and MVP staff. MVP's Pharmacy and Therapeutics (P&T) Committee reviews all new drugs including new chemical entities, new formulation, and combination products. Prior to each meeting, new drug coverage policies and policy revisions are distributed to P&T Members for review and comment.

Policy recommendations that are accepted by the MMC and P&T are presented to the Quality Improvement Committee (QIC) for final approval. QIC may approve the policies when they are presented or send them back through their respective processes for

additional research and revision before reconsidering them at a future meeting. Once the QIC approves a medical policy, Providers are informed through the Healthy Practices newsletter or online at mvphealthcare.com of the new/revised medical policy and effective date. The policy is then posted in online BIM for Providers. Formulary and pharmacy policy updates also are found online.

"Never Events" (also referred to as Serious Reportable Adverse Events) and Hospital Acquired Conditions (HACs)

See related Policy – Provider Preventable Conditions

Reconsiderations Statutory

For New York fully insured products, if MVP denies a claim for services on the basis that such services are or were:

- Not medically necessary; or
- Experimental or investigational, without offering to discuss the denial with the Provider who specifically recommended the health care service, procedure or treatment under review, then that Provider may request a statutory reconsideration of the claim denial. The Provider and the MVP clinical peer reviewer who made the initial denial will conduct a statutory reconsideration.

For post-service claims, statutory reconsideration will occur within 30 business days of the Provider's request. For pre-service claims, Urgent Care, and Concurrent Review, statutory reconsideration will occur within one business day of receipt of the request. If MVP upholds the initial denial after completing the statutory reconsideration, then the Provider will be sent a written notice of the determination.

Supplemental

For all MVP health insurance and HMO products in New York, and Vermont, MVP offers hospitals a supplemental reconsideration process. If MVP denies a claim for services on the basis that such services were:

- Not medically necessary; or
- Experimental or investigational, then the hospital may request a supplemental reconsideration of the claim denial and submit additional information in support of the denied claim without having to formally submit a hospital appeal

MVP will respond to requests for supplemental reconsideration within 30 business days of receipt. If MVP upholds the initial denial after completion of the supplemental reconsideration, then the hospital will receive written notice of the determination. Supplemental reconsideration is not available after a hospital has submitted a statutory reconsideration or filed a hospital appeal. Moreover, MVP will immediately terminate its review of the supplemental reconsideration upon receipt of a hospital appeal.

Commencement of a Statutory or Supplemental Reconsideration

To request either type of reconsideration described above, a hospital must call the appropriate MVP UM department and advise them that reconsideration is sought. A hospital must submit its reconsideration request within 45 calendar days of receipt of the claim denial or MVP's remittance advice. A hospital is not required to submit either a statutory or supplemental reconsideration to submit a hospital appeal or to submit an appeal on behalf of a Member. Additionally, the submission of either type of reconsideration does not postpone the time period to file either a hospital appeal or an appeal on behalf of a Member.

Revision Summary

Review Date	Summary
August 14, 2026	• Determination must be submitted within fourteen (14) calendar days of the initial determination. • Cases involving inpatient stays, while the member remains hospitalized for all lines of business, or within fourteen (14) calendar days of discharge for all lines of business excluding Medicare. • Review and determination will be completed as expeditiously as possible, but no later than three (3) business days after the receipt of all required clinical information. • After fourteen (14) calendar days have elapsed, the original determination is considered final. Any further review whether with a peer-to-peer review or informal reconsideration will no longer be eligible for processing through those channels and will be treated as a formal appeal. • Informal reconsiderations and peer-to-peer reviews do not take the place of a formal appeal. Nor does it affect the appeal timeframe. Once an appeal has been initiated, the provider forfeits the opportunity to initiate an informal reconsideration or peer to peer review.