This section specifically addresses:

- QI program description
- Clinical reporting
- Health management
- Medical record standards and guidelines
- Clinical practice and preventive care guidelines
- New technology assessment
- Member rights and responsibilities
- Confidentiality policies

MVP’s Quality Improvement Program
Specific components of the Quality Improvement (“QI”) Program include Preventive Health, Medical Records, Complex Case and Disease Management, Member Connections, Utilization Management, Behavioral Health, Credentialing, Delegation and Member Rights and Responsibilities. Other aspects of the QI Program are found elsewhere in this manual. The QI Committee (“QIC”) and board of directors oversee the QI Program. The QIC is chaired by the Chief Medical Officer or designated Medical Director and includes community physicians from various specialties who represent the different provider organizations participating with MVP. Physicians interested in participating in the QIC are invited to contact the QI Department. The QI Program’s objective is to provide a structured process to objectively and systematically monitor and improve the quality, appropriateness of care and services provided to members. Activities include the following:

- Develop studies and measurements to track, evaluate and analyze quality improvement.
- Design and promote health management programs that will help improve the health of members with chronic conditions and promote the use of appropriate services to members and providers.
- Develop and monitor programs that will improve the quality of behavioral health care services and improve the continuity of behavioral health care with medical care.
- Collect and utilize information to enhance the credentialing, peer review, performance assessment and re-credentialing process.
- Promote a system of timely and appropriate resolution of member complaints and appeals.
- Develop initiatives that will enhance patient safety in various professional care settings.
- Investigate and respond to members’ quality of care complaints.

An annual progress report on achieving QI Program goals is sent to the QIC and board of directors. For a copy of the Executive Summary of the annual evaluation, call the QI Department at 1-800-777-4793, ext. 12247.

Members and providers may participate in the development, implementation, and evaluation of the QI Program. MVP invites providers to comment on its QI process via the website or by phone, at 1-800-777-4793, ext. 12247.

Clinical Reporting Department
The Clinical Reporting Department is a unit within the QI Department that monitors and reports on the delivery of high-quality, cost-effective care and service to our members. The Clinical Reporting Department’s mission is to:

- Provide physicians with up-to-date, complete, and accurate information about the care rendered to their MVP members;
- Assist the physician in identifying opportunities to improve member care;
- Identify benchmarks in each category that exhibit “best practices”; and
• Coordinate physician performance information developed by MVP’s various departments and ensure a uniform message to physicians from MVP.

In conjunction with the Pharmacy and Utilization Management departments, reports are created for primary care physicians ("PCP") that demonstrate how a physician compares to his/her peers on nationally recognized utilization and quality measures.

Clinical Reporting coordinators meet with physicians to discuss the reports, identify opportunities for improvement and educate physicians and office staff on MVP policies and procedures. In addition, contact numbers for MVP programs and services (e.g. Population Health Management, Case Management, Pharmacy and Physician Case Review) are provided. Reports also are prepared for selected high-volume specialties such as, but not limited to, OB/GYN, gastroenterology, orthopedics and cardiology. These reports provide nationally recognized quality indicator results to the groups. For details or a visit from a Clinical Reporting Department staff member, call 1-800-777-4793, ext. 12463.

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:

A. Providers must maintain medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review.

B. Providers must have an organized medical record keeping system.
   1. Medical records must be stored in a secure location inaccessible to the public.
   2. There is a unique medical record for each member, identified by a medical record identifier on each page.
   3. Records are organized with a filing system to ensure easy retrievability. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care.

C. Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the practitioner referred the member. (e.g. home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports).

D. Confidentiality – Practice sites shall meet or exceed state and federal confidentiality requirements, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and are expected to have implemented procedures that guard against unauthorized or inadvertent disclosure of confidential information.

E. Retention of Medical Records – Providers must retain medical records in accordance with contractual obligations and applicable federal and state laws and regulations.
   1. For providers participating in all NY Commercial and NY State Government Program Products: Medical Record Retention is required for a period of six (6) years after date of service rendered to the enrollee, and for a minor, three (3) years after majority or six (6) years after the date of the service, whichever is later.
   2. In Vermont, providers are required to retain record for six (6) years after the date of service and, in the case of minors, until six (6) years after the age of majority.
3. For providers participating in Medicare products, medical record retention is required for a period of ten (10) years after the date of service rendered to any Medicare enrollee.

F. Non-discrimination in Health Care Delivery – MVP, as per CMS and NCQA, expects 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:
1. The medical record should be organized in such a way that data abstraction can be performed efficiently. Each page in the record should contain the patient's name or identification number.
2. The record should be legible (i.e., it can be read by someone other than the writer).
3. Each entry or office note must be dated.
4. All entries in the medical record should contain the author's identification. For all entries dated after July 1, 1999, stamped signatures are not considered appropriate author identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
5. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
6. Significant illnesses and medical conditions should be indicated on the problem list. A problem list should be completed for each patient, regardless of health status. A flow sheet for health maintenance screening is considered part of the problem list. It is acceptable if the practitioner outlines a problem list at each visit in the progress notes or if the practice site keeps a current ongoing problem list on a computerized system.
7. Medical history (for patients seen three or more times) should be easily identified and should include serious accidents, operations and illnesses. For children and adolescents (age 18 and younger), their medical history relates to prenatal care, birth, operations and childhood illnesses.
8. Medication list.
9. Medication allergies and adverse reactions should be prominently noted in the record or on the front cover of the medical record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record, e.g. NKA.
10. For patients age 14 and older, there should be appropriate notation concerning the use of cigarettes, alcohol, and other substances. For patients who have been seen three or more times, there should be a record of inquiry about substance abuse history.
11. For all patients age 18 and younger, there should be a completed immunization record. For patients over 18, there should be a note in the history of immunizations. Because most adults may not have an immunization record, appropriate notation should be made of Flu vaccine, Pneumococcal vaccine (if appropriate) and Tetanus/Diphtheria (“Td”) vaccine every 10 years.
12. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
13. Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
14. No shows or missed appointments must be documented with follow-up efforts to reschedule appointment.
15. Consultation, lab and imaging reports filed in the chart should be initialed by the practitioner who ordered them to signify review. If the reports are presented
electronically or by some other method, there should also be representation of review by the ordering practitioner. Consultation, abnormal lab, and imaging study results should have an explicit notation in the record of follow-up plans.

16. If a consultation/referral is requested, there should be a note from the consultant in the record.

17. Lab and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.

18. Documentation of clinical findings and evaluation for each visit. Working diagnoses should be consistent with findings.

19. 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.

20. There should be no evidence that the patient was placed at inappropriate risk by a diagnostic or therapeutic procedure.

21. *For members over age 18, documentation of whether or not the patient has executed an advance directive. Documentation of any advance directive should be maintained in a prominent part of the member's medical record and should be kept current. Advance Directives can be found in the Provider Quality Improvement Manual on the provider portal of the MVP website.

22. Preventive care/Risk assessment – There is evidence that preventive screening and services are offered in accordance with MVP’s practice guidelines.

*Required for Medicare and Medicaid members

23. *Is there evidence of an annual medication review and date on which it was performed? At least one annual medication review conducted by a prescribing practitioner and the date on which it was performed.

24. *Functional status assessment documented. Components of functional assessment include vision, hearing, mobility, continence, nutrition, bathing, using telephone, preparing meals, managing finances. Functional assessment may be found on a specific tool.

25. *Pain screening assessment documented. Pain assessment usually consists of questions asked by the physician that can be found on the physical. Patient is usually asked the character, severity, location, and factors that improve or worsen the pain. Pain assessment may be found on a specific tool such as a pain scale, visual pain scale, or diagram.

To assess compliance with the standards for Commercial membership, MVP conducts an annual ambulatory medical record review at the offices of PCPs with HMO member panel sizes of 250 or more on the following six core elements:

- Problem list
- History and physical noted for each visit
- Allergy information
- Preventive services/risk screening
- Medication list
- Documentation of clinical findings and evaluation for each visit offered

Additional standards are reviewed for MVP’s Medicare population:

- Evidence of an annual medication review, and the date on which it was performed
- For members age 65 and over, the presence of advance care plan in a prominent part of the medical record or documentation of an advance care planning discussion and the date in which the discussion occurred
- Documentation of functional status assessment
• Documentation of pain screening assessment
• Documentation of fall risk assessment

A practitioner’s medical records are considered to meet MVP’s standards when the score for each of the core elements is 80 percent or higher. Practitioners who scored 100 percent on each element in the previous year will not be reviewed for the core elements in the following year.

**Actions for improving medical records:**
Practitioners who score below 80 percent on any one of the six elements will:

1. Receive a letter with recommendations for improvement with a copy sent to the Regional/IPA/PO medical director.
2. Receive notification that a re-review will be performed in six months on the elements that did not meet standards.

Practitioners who continue to score below 80 percent upon re-review will be contacted for a written corrective plan of action within 30 days. A copy of the request will be sent to the Regional/IPA/PO medical director. Upon receipt, a copy of the corrective action plan will also be forwarded to the Regional/IPA/PO medical director. Failure to cooperate with MVP QI activities or to correct deficiencies noted during the medical record review process will also result in notification of the IPA/PO medical director. Results of the ambulatory medical record review program will be reported to the Quality Improvement Committee.

**Clinical Practice Guidelines**
MVP encourages physicians 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. Some current sources include: the National Institutes of Health, the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the American College of Obstetricians & Gynecologists, the American Academy of Family Practice Physicians, the Centers for Disease Control and Prevention, the New York State Department of Health AIDS Institute and peer-reviewed medical literature.

All of MVP’s clinical practice and preventive care guidelines are maintained in the Provider Quality Improvement Manual (“PQIM”). A paper copy of the manual is available by calling the QI Department at 1-800-777-4793, ext. 12247. The manual is available online at [www.mvphealthcare.com](http://www.mvphealthcare.com). MVP updates its clinical guidelines at least every two years unless required annually. The review process is also initiated when new scientific evidence or national standards are published. Providers are encouraged to check the PQIM periodically for updates and changes. Guideline updates also are published in MVP’s *Healthy Practices* newsletter. Current topics addressed in the manual include:

- Adolescent screening for alcohol abuse
- Adult screening for alcohol and substance abuse
- Careful antibiotic use
- Asthma care
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes care
- End-Stage Renal Disease (ESRD)
- Heart Failure (HF)
• High blood cholesterol
• HIV/AIDS
• Hypertension
• Low-back pain
• Oncology
• Osteoporosis prevention and treatment
• Perinatal care
• Preventive care
• Secondary prevention of cardiovascular disease
• Smoking cessation

MVP’s guidelines are not intended to replace the 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. The ultimate decisions of treatment are up to the treating provider.

MVP Health Care’s New York State 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 Healthcare Effectiveness Data & Information Set (“HEDIS-NYS”) Quality Assurance Reporting Requirements (“QARR”) reporting.

MVP also takes steps to identify members who do not access preventive care services, including well care visits, immunizations and blood lead testing. Through mailed reminders and telephonic outreach, MVP offers assistance with appointment setting and transportation coordination, and works to address any barriers that exist to ensure medically necessary care is delivered.

Commercial Member Rights
The following are specific rights, as they are communicated to MVP members:

1. The right to receive information about the health plan, its services, its practitioners and providers. Members also have the right to receive a copy of the health plan’s member rights and responsibilities and make recommendations to the policy.
   All members receive a certificate of coverage or contract. This document outlines important information about member benefits and how to use them. If the plan requires the member to select a PCP, they may change their selection at any time by calling the Customer Care Center or visiting the health plan’s website www.mvphealthcare.com. Information available on the health plan’s website includes an updated list of participating practitioners and providers, their specialties, locations, and more.

2. The right to be treated with respect, recognition of the member’s dignity and right to privacy.
   Members have a right to be treated with dignity. They have a right to receive quality
medical services, in a professional and courteous manner, regardless of race, sex, religion, age or sexual orientation. All information concerning member medical history and enrollment file is privileged and confidential. The health plan will not release information regarding any member's care without a written statement or release signed by the member, except as required by law.

3. **The right to participate with practitioners in making decisions about the member’s health care.** This includes the right to have a candid discussion about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.

Health care providers are required to tell the member, in terms they will understand, all appropriate treatment options, including those options not covered by the plan. Members have the right to receive information necessary for them to be able to give informed consent prior to the start of any procedure or treatment. The information will be made available to an appropriate person acting on the member’s behalf, should the member not be able to receive the information. Members also have the right to ask for a second opinion before they get any non-emergency treatment or care. No information that could have any bearing on the treatment they receive should be kept from them. Members may refuse treatment to the extent permitted by law and have the right to be informed of the medical consequences should they choose that option.

4. **The right to voice complaints or appeals about the organization or the care they receive.**

The health plan works hard to make sure members get the health care services they need and excellent service. If members are not fully satisfied with the medical or administrative services provided by the health plan, they have a right to a thorough investigation of the complaint or appeal by qualified and impartial staff. If a member comes across a situation that causes concern, they are encouraged to call the Customer Care Center. If the Customer Care Center cannot satisfactorily respond to the concerns or the member is unhappy with our response to the issues, they have a right to file a formal complaint. Normally, complaints are investigated and responded to in writing within 30 calendar days of receipt. If a member does not agree with a previous decision associated with a denial of services or benefits, they have the right to access our two-step appeal process. Appeals are handled in a timely manner based on the health care needs of the member. The investigation and decision of the appeal is completed within 15 calendar days of receipt. Details of the complete complaint and appeals process can be found in the Member Handbook and is also available upon request from the Customer Care Center.

5. **The right to receive medically necessary specialty care.**

If a provider with an appropriate specialty is not available within the health plan’s network to treat a medical condition, members have a right to request authorization for coverage of out-of-plan services.

6. **The right to reasonable and timely access to medically necessary health care services and access to the member’s medical records.**

The health plan sets high standards for our health care professionals and continually monitors the medical care members receive. Often, one phone call is all they’ll need to access treatment quickly. Members also have the right to their medical records, including diagnosis, treatments and prognosis. If a member would like to see their records, they are encouraged to check with their physician’s office. They will be able to give the member these records. If a member needs copies of these records, some offices charge on a per page basis. When it is not advisable to share this information with the member, the information will be shared with the person acting on the member’s behalf.
7. **The right to formulate Advance Directives regarding your care and Health Care Proxy.**

Advance Directives are documents that detail the care member’s wish to receive if they are unable to explain those wishes to their doctor (e.g., comatose). Advance directives can be filled out and given to the member’s doctor at any time. The member may choose a health care proxy who can make decisions for them if they cannot make decisions for themselves. These decisions may include termination or withholding of life support systems, artificial nutrition and hydration. The proxy document may include special instructions, limits of authority, and an expiration date.

**Commercial Member Responsibilities**

The following are responsibilities communicated to MVP Commercial members:

1. **A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**

   Members have a responsibility to notify the health plan of any changes in their status, such as adding or deleting dependents, change in marital status, etc. It is important for members to give their health care provider an honest description of their current symptoms, effects of medication, or results of treatment. Members are encouraged to always give their complete medical history. This may include any relevant medical records, including X-rays or other diagnostic tests.

2. **A responsibility to participate in their health care.**

   Members have a responsibility to follow the plans and instructions for care that they have agreed to with their practitioners. They also have a responsibility to participate in developing mutually agreed-upon treatment goals, to the degree possible.

3. **A responsibility to select a Primary Care Physician.**

   Members have a responsibility to select a participating primary care physician for themselves and their dependents to coordinate their medical care. Please note: Although it is strongly recommended, some MVP plans do not require members to select a PCP.

4. **A responsibility to identify themselves as a health plan member when receiving care.**

   Members have a responsibility to carry their membership card at all times and never permit anyone else to use it.

5. **A responsibility to pay all applicable copayments, coinsurance, and deductibles to their health care providers, as specified in their Subscriber Contract or Certificate of Coverage.**

   Members need to pay their health care provider any copay(s) due. The health plan is billed directly for the rest of the charges. Members may be asked to pay the entire bill at time of service if they get care from an out-of-network provider. Members simply send an original itemized bill with proof of payment to the health plan for processing.

6. **A responsibility to treat all personnel with courtesy and dignity.**

   When you are treated with respect, you are more likely to return that respect. It is the member’s right to expect courtesy. It is their responsibility to act with courtesy toward their practitioners, the practitioners’ office staff, and the health plan staff, including Customer Care Center representatives.

**Medicare Member Rights**

Listed below are the member’s rights and responsibilities, as they are distributed to all MVP Medicare Advantage members upon enrollment and annually:
To get information from MVP in a way that works for you, please call MVP’s Medicare Customer Care Center.

1. You have a right to make recommendations regarding MVP’s member rights and responsibilities policy. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan’s benefits that is accessible and appropriate for you. If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and tell them that you want to file a complaint. TTY users may call 1-877-486-2048.

2. MVP members have the right to be treated with dignity, fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, please call MVP’s Medicare Customer Care Center. If you have a complaint, such as a problem with wheelchair access, our representatives can help.

3. As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services. Call MVP’s Medicare Customer Care Center to learn which doctors are accepting new patients. With Preferred Gold you have the right to go to any specialist without a referral. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers. As a plan member, you have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

4. Federal and State laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.
   - Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
   - The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

   **How do we protect the privacy of your health information?**
   - We make sure that unauthorized people don’t see or change your records.
   - In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given
by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal Statutes and regulations.

You can see the information in your records and know how it has been shared with others
You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

- You have the right to know how your health information has been shared with others for any purposes that are not routine.
- If you have questions or concerns about the privacy of your personal health information, please call MVP’s Medicare Customer Care Center or visit our website at www.mvphealthcare.com.

5. As a member of our plan, you have the right to get several kinds of information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats. If you want any of the following kinds of information, please call MVP’s Medicare Customer Care Center or visit our website at www.mvphealthcare.com:

- **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance rating, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan’s network, see the MVP Health Care Professionals directory (Medicare Advantage Plans).
  - For a list of the pharmacies in the plan’s network, see the MVP Health Care Medicare Advantage Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call MVP’s Medicare Customer Care Center or visit our website at www.mvphealthcare.com.

- **Information about your coverage and rules you must follow in using your coverage.**
  - To get the details on your Part D prescription drug coverage, see the List of Covered Drugs. The List of Covered Drugs tell you what
drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call MVP's Medicare Customer Care Center or visit our website at www.mvphealthcare.com.

- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal.

6. **You have the right to know your treatment options and participate in decisions about your health care.**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand. You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you; your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to you as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if MVP has denied coverage for care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

7. **You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.**

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, **if you want to**, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form online at [www.mvphealthcare.com](http://www.mvphealthcare.com), from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact MVP’s Medicare Customer Care Center to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advanced directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. **What if your instructions are not followed?** If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with the New York State Department of Health at 1-800-206-8125.

7. **You have the right to voice complaints or appeals about MVP or the care that you receive from MVP providers.**

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal or make a complaint—we are required to treat you fairly.

- You have the right to get a summary of information about the appeals and complaints that others have filed against our plan in the past. To get this information, please call MVP’s Medicare Customer Care Center or visit our website at [www.mvphealthcare.com](http://www.mvphealthcare.com).

8. **What can you do if you think you are being treated unfairly or your rights are not being respected?**

If it is about discrimination, call the Office for Civil Rights. If you believe you have been treated unfairly or your rights have not been respected due to your race, disability,
religion, sex, health, ethnicity, creed (beliefs), age or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?
If you think you have been treated unfairly or your rights have not been respected, and it’s not about discrimination, you can get help dealing with the problem you are having:
- You can call MVP’s Medicare Customer Care Center.
- You can call the State Health Insurance Assistance Program at 1-800-701-0501 or 585-244-8400.
- Or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

There are several places where you can get more information about your rights:
- You can call the State Health Insurance Assistance Program at 1-800-701-0501 or 585-244-8400.
- You can contact Medicare.
  - You can visit the Medicare website (www.medicare.gov) to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Publications/Pubs/pdf/10112.pdf.
  - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY users may call 1-877-486-2048.

Medicare Member Responsibilities
The following are your responsibilities as a member of our plan:

a. Get familiar with your covered services and the rules you must follow to get these covered services. Use the Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters three and four give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay. Chapters five and six give the details about your coverage for Part D prescription drugs.

b. If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us. Please call MVP’s Medicare Customer Care Center to let us know.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you with it.

c. Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.

d. Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

e. **Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.**

f. **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals and other offices.

g. **Pay what you owe.** As a plan member, you are responsible for these payments:
   - You must pay your plan premiums to continue being a member of our plan.
   - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
   - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
   - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost. If you disagree with our decision to deny coverage for a service or drug, you can make an appeal.
   - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
   - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

h. **Tell us if you move.** If you are going to move, it’s important to tell us right away. Call MVP’s Medicare Customer Care Center.
   - **If you move outside of our plan service area, you cannot remain a member of our plan.** We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
   - **If you move within our service area,** we still need to know so we can keep your membership record up to date and know how to contact you.

i. **Call MVP’s Medicare Customer Care Center for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

**Medicaid Member Rights**

Medicaid Managed Care members have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services they need from MVP Health Care.
- Obtain complete current information concerning a diagnosis, treatment and prognosis in terms the member can be expected to understand.
- Get a second opinion about their care.
- Give their approval to any treatment or plan for care after that plan has been fully explained.
- Refuse care and be told what the risks of their actions are.
• Get a copy of their medical record, and talk about it with their PCP. They can ask that their medical record be amended or corrected, if needed.
• Be sure that their medical record is private and will not be shared with anyone except as allowed by law, contract, or their approval.
• Use Medicaid Managed Care’s complaint process to settle any complaints or they can complain to the NY State Department of Health or the local Department of Social Services any time they feel they were not fairly treated.
• Use the New York State Fair Hearing system.
• Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
• When it is not advisable to give such information to the enrollee, the information is to be made available to an appropriate person acting on the enrollee’s behalf.
• Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Medicaid Member Responsibilities
Medicaid Managed Care members agree to:
• Work with their PCP to guard and improve their health.
• Find out how their health care system works.
• Listen to their PCP’s advice and ask questions when they are in doubt.
• Call or go back to their PCP if they do not get better, or ask for a second opinion.
• Treat health care staff with the respect they expect themselves.
• Tell MVP’s Customer Care Center if they have problems with any health care staff.
• Keep their appointments. If they must cancel, call as soon as they can.
• Use the emergency room only for real emergencies.
• Call their PCP when they need medical care, even if it is after-hours.

Confidentiality and Privacy Policies
MVP and all of the providers rendering care and services to MVP members share the responsibility and the challenge of protecting personal health information (“PHI”). In compliance with the HIPAA privacy and security rules, MVP has established policies describing how and by whom members’ PHI is handled.

PRIVACY NOTICE
Effective April 14, 2014
Revised October 19, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, MVP Health Insurance Company of New Hampshire, Inc., and Hudson Health Plan, Inc. (collectively “MVP”) respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties and to abide by the terms of this notice.
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and state laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. Health information is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present, or future physical or mental health.

The terms and conditions of this privacy notice supplement any other communications, policies, or notices that MVP may have provided regarding your health information. In the event of conflict between this notice and any other MVP communications, policies, or notices, the terms and conditions of this notice shall prevail.

MVP’s Duties Regarding Your Health Information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic;
- Train all MVP employees in the protection of oral, written, and electronic PHI;
- Limit access to MVP’s physical facility and information systems to the required minimum necessary to provide services;
- Maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI;
- Notify you following a breach of unsecured health information;
- Provide you with this notice of our legal duties and health information privacy rules; and
- Abide by the terms of this notice.
We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will advise you that the notice has been updated, provide you with information on how to obtain the updated notice and will post it on our web site (www.mvphealthcare.com).

HOW WE USE OR DISCLOSE YOUR HEALTH INFORMATION

As a member, you agree to let MVP share information about you for treatment, payment, and health care operations. The following are ways we may use or disclose your health information:

For Treatment: We may share your health information with a physician or other health care provider in order for them to provide you with treatment.

For Payment: We may use and/or disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For Health Care Operations: We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities (including, e.g., surveys), case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review and legal services. We will not use or disclose your health information that is genetic information for underwriting purposes. We also use and disclose your health information to assist other health care providers in performing certain health care operations for those health care providers, such as quality assessment and improvement, reviewing the competence and qualifications of health care providers, and conducting fraud detection or investigation, provided that the information used or disclosed pertains to the relationship you had or have with the health care provider.

Health-Related Benefits and Services: We may use or disclose your health information to tell you about alternative medical treatments and programs or about health related products and services that may be of interest to you.

Disclosures to a Business Associate: We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called “Business Associates”. These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a Plan Sponsor: We may disclose limited information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend or terminate your group health plan and perform enrollment functions on your behalf.

Disclosures to a Third Party Representative: We may disclose to a Third Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person’s involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Email Communications to You: You agree that we may communicate via e-mail with you regarding insurance premiums or for other purposes relating to your benefits, claims or our products/services and that such communications (utilizing encryption software for
our email transmissions) may contain confidential information, protected health
information, or personally identifiable information.
Disclosures Authorized by You: Except for the scenarios described in this notice, HIPAA
prohibits the disclosure of your health information without first obtaining your
authorization. MVP will not use or disclose your health information to engage in
marketing, other than face to face communications, the offering of a promotional gift, or
as set forth in this notice, unless you have authorized such use or disclosure. MVP will
not use or disclose your health information for any reason other than those described
above, unless you have provided authorization. We can accept an Authorization to
Disclose Information Form if you would like us to share your health information with
someone for a reason we have not stated above. Using this form, you can designate
whom you would like us to share information with, what information you would like us to
share, and how long you want us to be able to share your information with that
individual. A copy of this form is available by calling our Member Services Department or
logging on to the MVP web site at www.mvphealthcare.com. You must complete this
form and send it to the address or fax it to the fax number on the form. You can cancel
this Authorization at any time in writing and per the requirements on the form.

SPECIAL USE AND DISCLOSURE SITUATIONS
Under certain circumstances, as required by law, MVP would be required to share your
information without your permission. Some circumstances include:

Uses and Disclosures required by law: We may use and disclose health
information about you when we are required to do so by federal, state or local law.

Public Health: We may disclose your health information for public health
activities. These activities include preventing or controlling disease, injury or disability;
reporting births or deaths; or reporting reactions to medications or problems with
medical products or to notify people of recalls of products they have been using.

Health Oversight: We may disclose your health information to a health oversight
agency that monitors the health care system and government programs for designated
oversight activities.

Legal Proceedings: We may disclose your health information in the course of any
judicial or administrative proceeding, in response to an order of a court or administrative
tribunal (to the extent such disclosure is expressly authorized) and, in certain situations,
in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your health information, so long as applicable
legal requirements are met, for law enforcement purposes.

Abuse or Neglect: We may disclose your health information to a public health
authority, or other government authority authorized by law to receive reports of child
abuse, neglect or domestic violence consistent with the requirements of applicable
federal and state laws.

Coroners, Funeral Directors and Organ Donation: We may disclose your health
information to a coroner or medical examiner to identify a deceased person, determine a
cause of death or as authorized by law. We may also disclose your health information to
funeral directors as necessary to carry out their duties. If you are an organ donor, we
may release your health information for procurement, banking or transplantation.

Research Purposes: In certain circumstances, we may use and disclose your health
information for research purposes.

Criminal Activity: We may disclose your health information when necessary to prevent or
lessen serious and imminent threat to the health and safety of a person or the public.
Military Activity: We may disclose your health information to authorized federal officials if you are a member of the military (or a veteran of the military).
National Security: We may disclose your health information to authorized federal officials for national security, intelligence activities and to enable them to provide protective services for the President and others.
Workers’ Compensation: We may disclose your health information as authorized to comply with workers’ compensation laws and other similar legally-established programs.

WHAT ARE YOUR RIGHTS
The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information, to inspect or copy your health information, or questions about this notice can be made by using the Contact Information at the end of this notice.

Right to Request Restrictions: You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, like a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.
Right to Request Confidential Communications. You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.
Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.
Right to Inspect and Obtain Copies of Your Health Information: You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.
Right to Amend: If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.
Right to a Copy of the Notice of Privacy Practices: You have the right to obtain a copy of this notice at any time.

EXERCISING YOUR RIGHTS
Unless you provide us with a written authorization, we will not use or disclosure your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your
authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice on our web site at www.mvphealthcare.com.

If you believe that your privacy rights have been violated, you may file a complaint by contacting a Member Services Representatives at the address or number indicated on the Contact Information at the end of this notice.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.
Contact Information

<table>
<thead>
<tr>
<th>MVP Medicaid Customer Care Center</th>
<th>1-800-852-7826 (TTY 1-800-662-1220)</th>
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<tbody>
<tr>
<td>MVP Medicare Customer Care Center</td>
<td>1-800-665-7924 (TTY 1-800-662-1220)</td>
</tr>
<tr>
<td>Customer Care Center for All Other MVP Members</td>
<td>1-888-687-6277 (TTY 1-800-662-1220)</td>
</tr>
<tr>
<td>Mail all written communications to: MVP CUSTOMER CARE CENTER PO BOX 2207 SCHENECTADY NY 12301-2207</td>
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</table>
Continuity of Care
Communication is an essential component for quality medical care. Written or verbal communication between PCPs, specialists and other providers helps provide effective follow-up care and improves patient safety.

MVP collects and analyzes data in order to identify opportunities to improve the continuity of care its members receive from medical providers. MVP is studying the differences between provider practices 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 is also analyzing data on reducing potentially preventable readmissions through various projects across the service area.

Hospital Quality Report
MVP offers the HealthGrades rating tool as part of our online directory of health care facilities to help members make smart decisions about their care. HealthGrades assigns up to five stars to rate the quality of clinical services and patient safety at hospitals and other health care facilities nationwide. It also offers estimated costs for medical procedures and treatments at each facility.

The interactive HealthGrades rating tool allows a side-by-side comparison of hospitals in a geographic area for selected conditions based on several quality measures. Individuals can choose a procedure or diagnosis, determine how far they are willing to travel from a specific town or ZIP code, and then view the list of hospitals that are able to meet their needs. HealthGrades' rating and comparison tools utilize data and measures from various sources. A link to these reports is available on MVP’s website provider and member pages. For those without Internet access, call MVP at 1-800-777-4793, ext. 12247 to request a copy of a specific report.

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;
- Identification of staff allowed access to HIV-related information and limits of access;
- Procedure to limit access to HIV-related information to trained staff (including contractors);
- Protocol for secure storage of HIV-related information (including electronic storage);
- Procedures for handling requests for HIV-related information; and
- Protocols to protect persons with, or suspected of having, HIV infection from discrimination.
Behavioral Health and Substance Use Information

New York State and Federal law requires each healthcare provider to develop policies and procedures to ensure confidentiality of related behavioral health and substance use information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors on behavioral health and substance use information;
- Identification of staff allowed access behavioral health and substance use information and limits of access;
- Procedure to limit access to behavioral health and substance use information to trained staff (including contractors);
- Protocol for secure storage of behavioral health and substance use information (including electronic storage); and

Procedures for handling requests for behavioral health and substance use information and protocols to protect persons with behavioral health and/or substance use disorder from discrimination.