Preferred Gold HMO-POS, GoldSecure HMO-POS, GoldValue HMO-POS, Gold PPO, GoldAnywhere PPO, , USA Care℠ PPO, WellSelect PPO, SmartFund MSA and MVP RxCare PDP

MVP Health Care's 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 have residency qualifications specific to the product. Preferred Gold HMO-POS is offered with and without prescription drug coverage (Part D). GoldValue HMO-POS, GoldSecure HMO-POS, GoldPPO,, WellSelect PPO and USA Care PPO all have Part D coverage included. MVP Rx Care is a stand-alone prescription drug plan offered to members with a commercial medical plan through their employer group. SmartFund MSA is a medical-only plan that does not offer Part D prescription drug coverage.

MVP's HMO-POS plans feature a large network of doctors and health care providers locally and across New York state and Vermont. No specialist referrals are required, and the plans provide a point of service benefit that covers members for routine care with non-participating providers. GoldPPO, Gold Anywhere PPO, and WellSelect PPO offer all the benefits of the HMO-POS plans, plus the freedom to see any doctor or provider anywhere in the U.S., anytime for both routine and non-routine care. USA Care members live across the country and may see any provider in the country who accepts Medicare. SmartFund members can utilize the MVP network or may see any provider in the country that accepts Medicare. MVP Rx Care members have access to more than 66,000 pharmacies in our national network.

Contact Information

Call the appropriate number listed below for all MVP Medicare Advantage plan questions:

Customer Care Center for Provider Services	**1-800-684-9286 Phone**
Utilization Management (for prior authorization services)	**1-800-568-0458 Phone** **1-800-280-7346 Fax**
Behavioral Health	**1-800-893-2905 Phone** **1-800-398-2576 Fax**
MVP Medicare Customer Care Center	**1-800-665-7924 Phone** **1-800-662-1220 TTY**
Disease and Case Management	**1-866-942-7966 Phone** **1-800-398-1420 Fax**
Pharmacy	**1-800-401-0915 Fax**

Claims Submission

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.

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.

Identifying MVP Medicare Advantage Providers in the Provider Directory

Providers appearing in red in this resource manual participate with MVP Medicare Advantage plans. Be certain to refer Preferred Gold, GoldSelect and GoldValue members to only those providers for non-routine services. GoldPPO, GoldAnywhere PPO, and WellSelect PPO members may be referred to non-participating providers, though their cost share may be higher. USA Care and SmartFund MSA members may see any provider in the country who accepts Medicare.

Sample: Harold S., MD
ABC Associates
123 Broad St.
Albany, NY 13901
518-555-5555
Provider #: 0123456

MVP is continuously adding providers to its provider network.
Visit **mvphealthcare.com** for the most current listings.

Marketing

MVP's Medicare Sales marketing staff can answer questions and help Medicare-eligible individuals with enrollment. Our experienced Medicare Product Advisors use Medicare-approved materials and are specifically trained in Medicare marketing rules. For details, call MVP Medicare Sales at **1-800-324-3899.** or by TTY at **1-800-662-1220**

Prompt Payment and Claims Submission

Claims will be processed according to the contractual guidelines stipulated in each provider's contract. Refer to this manual's *Section 7* for claim details.

Accurate Encounter Data

The Balanced Budget Act alters Medicare Advantage reimbursement through the evaluation of encounter data. Practitioners are requested to make every effort to provide complete and accurate coding of diagnosis and service information for every patient encounter. Each diagnosis must be coded to the highest level of specificity. Also, MVP uses the data for purposes such as statistical reporting for HEDIS submissions.

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 Section 5, page 5.7, Utilization Management, and Prior Authorization).

- 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.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf
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 (copayments or coinsurance) 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

From Section 170.2 - Balance Billing by Provider Type (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16). Please see below for definitions of provider types per Section 170.2.

- **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 copayment or coinsurance 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 (copayment or coinsurance) 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)
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% 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; coinsurance and copayment 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.

DIRECT ACCESS
Members may directly access specialty care services as well as mammography screenings and influenza vaccines. Physicians will accept payment for influenza and pneumococcal vaccines from MVP and not balance bill the member for any portion thereof. Female members also may directly access an in-network women's health specialist for routine or preventive services.

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. Below are the variations for the provider appeal process:

1. 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.
2. Only the provider will receive an acknowledgment letter(s). No copies of outcome letters will be sent to the member.
3. The provider can appeal as the member's appointed authorized representative or on behalf of the member. The member may appoint a representative:
    a) 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].)
    b) The member and the representative must sign and date the statement.
    c) 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.
4. 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 *Section 9 – Pharmacy Benefits* 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*.

HIV Screening Guidelines

Effective April 13, 2015, all MAOs and section 1876 cost plans must cover both standard and U.S. Food and Drug Administration (FDA)-approved (HIV) rapid screening tests for:

1. A maximum of one annual, voluntary screening for all adolescents and adults between the age of 15 and 65, without regard to perceived risk except for pregnant Medicare beneficiaries mentioned below.
2. Annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines, including:

    - Men who have had sex with men;
    - Men and women having unprotected sex;
    - Past or present injection drug users;
    - Men and women who exchange sex for money or drugs, or have sex partners who do;
    - Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users;
    - Persons who have acquired or requested treatment for sexually transmitted diseases;
    - Persons with a history of blood transfusion between 1978 and 1985;
    - Persons who request an HIV test despite reporting no individual risk factors
        - Persons with new sexual partners
        - Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. This determination is made by the health care practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan.
3. Voluntary HIV screening of pregnant Medicare beneficiaries when the diagnosis of pregnancy is known, during the third trimester, and at labor.

Case Management/Condition Health Management (Disease Management)

MVP utilizes a population health improvement model that includes partnering with internal and external members of the health care delivery team to provide comprehensive population health management. MVP provides members access to case and condition health management (also known as disease management) programs, along with a variety of health and wellness programs that address the needs of the membership throughout the continuum of care.

The goal of MVP's population health management programs aims to maintain and/or improve the physical and psychosocial 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. Caring for members with acute and/or chronic health

conditions sometimes takes an extra helping hand. That's why MVP has a team of nurses, respiratory therapists, social workers certified in case management and/or health coaching and other health care professionals to help you in insure that your members achieve the best health outcomes possible. MVP's telephonic case and condition health management programs offer two telephonic outreach programs:

- **Case Management:** aimed at servicing MVP members who have multiple or complex health, social or economic needs. Through care coordination and facilitating access to needed resources, these programs help those members in greatest need to navigate through the health care system.
- **Condition Health Management (Disease management):** aimed at empowering the member to bring about lifestyle and behavior change as defined by the collaborative care planning and or goal setting that continuously evaluates clinical, humanistic and economic factors affecting overall health. The program provides two service options:
  - Condition specific health information mailed to the member's home (this includes bi-annual condition specific newsletters and health screening reminders). MVP's condition specific newsletters are sent to members with asthma, COPD, depression, diabetes and low back pain.
  - Telephonic outreach by a clinician to members with health conditions. The outreach focuses on prevention of exacerbations and complications, self-management strategies and helping members to make positive lifestyle changes and better control their disease. In addition, condition health management programs assist in connecting members with appropriate community resources and services.

MVP offers condition health management programs for members living with:

- Asthma
- Cancer [Oncology] (during active treatment)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Dialysis
- Heart Events (Post MI, CABPG and Cardiac stents)
- Heart Failure
- Low Back Pain
- HIV/AIDS

In addition, MVP offers services to help members who require different resources than those provided through the condition-specific programs listed above.

- **Acute Case Management** for members who have complications or other serious health concerns. This includes management of members with transplant needs or members with hemophilia.
- **Transplant Case Management** involves complex coordination of care and services. A transplant referral occurs when the PCP or specialist requests a transplant evaluation

and/or prior authorization for a transplant.

- ***Little Footprints℠*** for high-risk pregnancies for women who are pregnant or are considering pregnancy and are high-risk (multiple births, infertility, presence of a co-morbidity, history of miscarriage, etc.). The MVP case manager provides monthly contact with the member, develops an education plan and completes a pregnancy screening medical assessment questionnaire.
  - **Social work services** are available to connect members to community resources and services and assist in addressing member specific social and economic needs.

HOW TO REFER A MEMBER TO A PROGRAM

The process for referral is simple. Call our central triage number: **1-866-942-7966**. Let us see how we can help. MVP will reach out to the member by phone. We will match the member to the most appropriate program and services. This phone line is secure, and you may leave a secure message at this number.

PROGRAM COMPLIANCE

MVP requires providers to cooperate in and abide by all of MVP's programs, protocols, rules, and regulations including: MVP's QI program, credentialing process, peer-review systems, member grievance system and Utilization Management program. Medicare Advantage regulations require MVP to make quality improvement a priority and engage in activities and efforts that demonstrably improve MVP's performance. Providers are also required to take all actions necessary to permit compliance by MVP with applicable law and the standards of regulatory and other external review agencies, such as NCQA.

LAWS AND REGULATIONS

All MVP Medicare Advantage providers are paid by MVP 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; other laws applicable to recipients of federal funds; and all other applicable laws and rules.

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. Examples include: satisfaction survey results; disenrollment statistics and survey results; health outcomes survey results; statistics regarding beneficiary appeals and their disposition; provider payment mechanisms; and various other regulatory reports and data.

AUDITING

To ensure compliance, the Department of Health & 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.

Medicare Advantage Regulatory Issues
This policy contains the statements as required in the *Medicare Managed Care Manual*, Chapter 11 and the *Prescription Drug Benefit Manual*, Chapter 6.

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 ten 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, 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.
. 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 & 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 & 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. Effective 01/01/2012, all Medicare Advantage Organizations were required to submit each encounter to the Centers for Medicare & Medicaid Services (CMS).
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 our medical policy, QA program and medical management program. All standards and guidelines are created in consultation with network providers.

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.

Prompt Payment: Claims will be processed according to the provider contracts. Refer to the Claim Submission and Adjustment guidelines for detailed information on how to submit claims.

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.