MVP's New York State Government Programs (Medicaid and Child Health Plus) Provider Network

Health care providers who have been sanctioned by the New York State Department of Health Medicaid Program may not participate in the MVP Government Programs network. MVP's Government Programs follow all regulations required for commercial HMO products as outlined in this manual. MVP's New York State Government Programs members have access to providers within MVP's Government Programs provider panel. PCPs must refer to providers in this network. If a PCP needs to send a member to a specialist who is not in the Government Programs network, regardless of whether the specialist is part of the commercial network, the PCP must submit an out-of-network prior authorization request.

MVP's New York State Government Programs Plan Types

The following plan types are printed on the member's MVP ID card:

- MVP Medicaid Managed Care (MVPM)
- MVP Medicaid Managed Care SSI (MVPMS)
- MVP Medicaid Health and Recovery Plan (MVP** product name under development)
- MVP Child Health Plus (MVPC)
- Health and Recover Program (HARP)

Member-initiated PCP Changes

A member may change his/her PCP by contacting the Customer Care Center. Upon selection of a new PCP, the member will be issued a new MVP ID card. These changes will also appear on the MVP website. Providers are encouraged to verify members' enrollment at every visit.

PCP-initiated Changes

In the event that a PCP believes that he/she can no longer manage the member's care, the physician should submit a letter to their local Professional Relations Department documenting the reasons necessitating the change. Reasons for a PCP to request a change might include:

- Consistent physical or verbal abusiveness to a provider and/or the providers' staff
- Fraudulent activity
- Repeated non-compliance with treatment plan or keeping appointments
- Repeated non-compliance with MVP administrative guidelines

Providers should include documentation of events and any follow-up taken by the provider and the providers' staff. Additionally, the documentation should show:

- The physician has ruled out any underlying medical conditions that may be impacting the member's behavior
- Any special considerations the office may be able to address regarding any disabilities the member might have
- Any cultural issues that might impact the physician's ability to work effectively with the member
- Any additional training delivered or necessitated for staff to be able to work more effectively with the member

Professional Relations staff will forward the documentation to the medical director for review.

Self-referral and Free Access

MVP Medicaid Managed Care (MMC) members may self-refer for the following services:

- Unlimited for mental health and substance abuse assessment from participating provider (exceptions: ACT, inpatient psychiatric hospitalization, partial hospitalization, HCBS services)
- Routine vision screening with a participating provider every two years
- Diagnosis and treatment of tuberculosis by public health agency facilities
- Family planning and reproductive health services from any participating (par) MVP provider or any Medicaid provider

Restricted Recipient Program

Members identified as restricted recipients are assigned and limited to treatment by specific MVP participating providers. Usually, these members are assigned to specific pharmacies or physicians because of evidence of abuse or fraudulent behavior.

Therefore, when treating MVP MMC members, please follow the following procedures:

- Verify eligibility by using MVP's website (**www.mvphealthcare.com**), using the MVP Member ID (not CIN) presented on the ID card. The word "Restricted" may be present on the member's ID card. MVP's website will inform you if the member is restricted and instruct you to call the Customer Care Center for Providers for additional information on the restriction. Doing so will help ensure that the member has coverage for the date of service and allow you to confirm referral requirements.
- If a member has a restriction and you are not the health care provider that has been assigned to care for the person, you will not receive payment for services you render, unless MVP has issued a referral to you as requested by the designated provider.
- If you are the provider assigned to care for the restricted recipient member, you may submit referrals for specialists using MVP's online referral system or you may fax in your referral request.
- Referrals will be required to all specialties for restricted recipient members that have a physician restriction. If the member has a pharmacy only restriction, then referral requirements follow standard procedure.
- The restricted member must go to their assigned health care provider for treatment. Members in a restricted status have been told which provider they can go to. They are notified in writing, and the provider they are assigned to is told as well.

Public Health

TUBERCULOSIS (TB) SCREENING, DIAGNOSIS AND TREATMENT

Testing: PCPs are expected to perform tuberculin screening of adults in high-risk groups. This includes persons who have signs or symptoms of clinically active TB. TB screening guidelines can be found within the age-specific MVP Preventive Care Guidelines.

Required reporting to local department of health: All participating providers in the MVP network are expected to report positive TB test results and active TB cases to the local County Department of Health (CDOH), as required by state health codes. MVP also expects the PCP and other providers to cooperate with the CDOH to identify case contacts and arrange for or provide services and follow-up care. MVP encourages all physicians to consult with their respective CDOH on TB treatment and preventive therapy. Physicians should call their local county department of social services for the appropriate contact number.

Reporting cases to MVP: MVP requires providers to report active TB cases to the MVP supervisor of case management in order to ensure that: (1) case management is initiated and; (2) appropriate referrals are made to providers within the MVP network, when required (See Section 5 for MVP's referral policy).

Preventive therapy and treatment for active TB: In the absence of HIV or other complications, the PCP or specialist managing the case should provide preventive treatment to members who have a positive skin test, following the Centers for Disease Control (CDC) guidelines or other accepted treatment protocols. MVP encourages PCPs to refer active cases, including drug-resistant cases, to hospital-based programs or specialized TB clinics.

HIV-POSITIVE TB PATIENTS

MVP encourages the physician to refer HIV-positive individuals with TB to providers in designated AIDS centers who have TB treatment expertise. An individual with a dual diagnosis of TB and mental illness may require a referral to a specialized clinic or program.
Members who are non-compliant with Drug Therapy: If there is a need for Directly Observed Therapy (DOT), the case will be referred by the PCP to the city or county DOH for assessment. Providers are required to report positive TB cases to their local public health agency. Refer to the list of Important Numbers at the end of this section for phone numbers that can be called to report TB and other communicable diseases.

Informed Consent for Sterilization and Hysterectomy

Participating physicians, nurse providers and certified nurse-midwives must comply with informed consent procedures for hysterectomy and sterilization as specified in 42 CFR, Part 441, sub-part F and 18 NYCRR §505.13. Providers are required to keep on file copies of the sterilization consent form and/or acknowledgement of the Hysterectomy Information Form for MVP Medicaid Managed Care members who receive these services.
The patient must:

- Be at least 21 years old
- Be informed of the risks and benefits of sterilization
- Sign the mandated sterilization consent form (LDSS-3134) not less than 30 days or more than 180 days prior to performance of the procedure

STERILIZATION AND HYSTERECTOMY

Sterilization and hysterectomy procedures for MVP's NYS government programs members require an administrative prior authorization for all procedures performed on or after May 1, 2013. This is not a medical necessity review.

For sterilization, procedures performed on male and female members, *New York State Sterilization Consent Form (DSS-3134)* must be attached to the prior authorization request form.

For hysterectomies, *New York State Hysterectomy Information Form (DSS-3113)* must be attached to the prior authorization request form.

Prior authorization requests with the required New York State consent form must be faxed to MVP's Provider Services Department at fax number **585-327-5759**.

STERILIZATION
Documentation, Process and Quality Standards Requirements

1. Medicaid Management Information System (MMIS) in conjunction with the above noted Federal and State citations for Medicaid members seeking a sterilization procedure includes the following requirements to be completed by the servicing provider:
    a. **Informed Consent** - The person who obtains consent for the sterilization procedure must offer to answer any questions the member may have concerning the procedure, provide a copy of the New York State Sterilization Consent Form (DSS-3134) and provide verbally all of the following information or advice to the member to be sterilized:
        - Advise that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right for future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be

otherwise entitled. Give a description of available alternative methods of family-planning and birth control;
- Advise that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization;
- Advise that the sterilization will not be performed for a least 30 days except in the circumstances specified below under "Waiver of 30-day Waiting Period."

In addition to provision of this information at the initial concealing session, the physician who performs the sterilization must discuss the above with the member shortly before the procedure, usually during the preoperative examination.

b. **Waiting Period** - The member to be sterilized must have voluntarily given informed consent not less than 30 days or more than 180 days prior to sterilization.
c. **Waiver of 30-Day Waiting Period** - The only exception to the 30-day waiting period are in cases of premature delivery when the sterilization was scheduled for the expected delivery date of emergency abdominal surgery. In both cases, informed consent must have been given at least 30 days before the intended date of sterilization. Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilization's may be performed during the same hospitalization, as long as 72 hours have passed between the original signing of the informed consent and the sterilization procedure.
d. **Minimum Age** - The member to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.
e. **Mental Competence** - The member must not be a mentally-incompetent individual. For the purpose of this restriction, "mentally-incompetent individual" refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
f. **Institutionalized Individual** - The member to be sterilized must not be an institutionalized individual. For the purposes of this restriction "institutionalized individual" refers to an individual who is (1) involuntarily confined or detained, under a civil or criminal stature, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (2) confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
g. **Restrictions on Circumstances in Which Consent is Obtained** - Informed consent may not be obtained while the member to-be-sterilized is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the member's state of awareness.

h. **Foreign Languages** - An interpreter must be provided if the member to-be-sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.
i. **Handicapped Persons** - Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind, or otherwise handicapped individuals.
j. **Presence of Witness** - The presence of a witness is optional when informed consent is obtained.

One copy of the completed *New York State Sterilization Consent Form (DSS-3134)* or *Acknowledgment of Receipt of Hysterectomy Information Form (DSS-3113)* must be given to the member and one copy of the completed form must be kept in the member's medical record.

HYSTERECTOMY

Federal regulations prohibit reimbursement for hysterectomies which are performed solely for the purpose of rendering the member permanently incapable of reproducing; or if there were more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing. Approved procedures will be reimbursed by MVP only if the member (and her representative, if any) has been informed verbally and in writing prior to surgery that a hysterectomy will render her permanently incapable of reproduction. In addition, the member (or her representative, if any) must sign a written acknowledgment of receipt of that information. The requirements for the member's written acknowledgment can be waived if:

a. The woman was sterile prior to the hysterectomy.
b. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible. This must be documented by the surgeon who performs the surgery.
c. Acknowledgment of Receipt of *Hysterectomy Information Form (DSS-3113)*. This form documents the receipt of hysterectomy information by the member or the surgeon's certification of reasons for waiver of the acknowledgment. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

Copies of the New York State Sterilization Consent form or the *Acknowledgement of Receipt of Hysterectomy Information form (DSS -3113)* can be requested from:

New York State Department of Health
Corning Tower, Room 2029
Empire State Plaza
Albany, NY 12237
Attention: Michael Margiasso

Lead Screening

Providers must comply with lead screening follow-up as specified in 10NYCRR, Sub-part 67.1. MVP will reimburse for “point-of-care” blood lead testing of children under age six years and pregnant women when performed by practitioners operating Physician Office Laboratories (POLs) that hold appropriate CLIA certification, and clinics that operate Limited Service Laboratories (LSLs) registered by Wadsworth Center for blood lead analysis. These changes also require properly certified physicians with in office labs and clinics that operate limited services laboratories to report blood lead test results to the NYS Department of Health (NYSDOH).

Child/Teen Health Program

MVP participates in the high-priority New York State Child/Teen Health Program (C/THP) for Medicaid-eligible children under age 21 years, which promotes the provision of early and periodic screening services (well care exams), with diagnosis and treatment of any physical, mental or dental health problems identified during the conduct of well care, to be consistent with nationally recognized standards.

MVP follows the recommendations of the American Academy of Pediatrics (AAP) for preventive care for children and adolescents and promotes the guidelines including the AAP periodicity schedule with plan providers who care for MVP children and adolescents. MVP assesses provider adherence to guideline recommendations through HEDIS-NYS QARR reporting.

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

MVP includes pediatric preventive care guidelines in its *Physician Quality Improvement Manual*. For a paper copy, call the QI Department at **1-800-777-4793, ext. 12247**. The manual also is available online at **www.mvphealthcare.com**. MVP is taking steps to identify members who do not access certain preventive care services, including immunizations. A list of these members will be generated monthly and sent to the appropriate PCP. To ensure children are receiving necessary services, PCPs may be asked to cross reference the information MVP provides with their own records and, if necessary, contact the member and encourage a preventive care visit.

Immunizations for Medicaid Managed Care and Child Health Plus Members

The New York State Vaccines for Children (NYS VFC) immunization program provides free vaccines to physicians who are program participants. Children under 18 who are members of the Medicaid Managed Care and Child Health Plus coverage programs receive vaccines through the NYS VFC program. Physicians may call **1-800-KID-SHOTS (1-800-543-7468)** for more information and to register with this program.

Prevention of Sexually Transmitted Diseases

Providers are responsible for the screening, treatment and education of members regarding the risks of sexually transmitted diseases. Providers are also responsible for reporting cases of sexually transmitted diseases to local public health agencies and cooperating with contact investigations in accordance with all existing state and local regulations.

New York State Confidentiality Law and HIV

The following information is excerpted from the New York State Department of Health AIDS Institute website at **www.hivguidelines.org**.

New York State Public Health Law (Article 27-F)

- Requires that information about AIDS and HIV is kept confidential
- Requires that anyone receiving a voluntary HIV test must first sign a consent form
- Strictly limits disclosure of HIV-related information
- Requires that when disclosure of HIV-related information is authorized by a signed special HIV release, the person receiving the information must keep it confidential

- Only applies to people and facilities providing health or social services, or who obtain the information pursuant to a special HIV release.

The law also requires that physicians and laboratories report the following results to the New York State Department of Health:

- AIDS
- Positive HIV tests
- Viral load tests
- Diagnoses of HIV-related illnesses
- Tests showing t-cell counts under 500

Only tests completed at certified anonymous test sites are exempted from reporting.

Breast Cancer Surgery Facilities

See *Section 5: Utilization Management*.

New York State Title 10 Rules and Regulations Section

85-40 PRENATAL CARE SERVICES

Provider Availability

Obstetric providers must establish and educate patients regarding arrangements for availability of after-hours, on-call and emergency consultation.

Risk Assessment

Every pregnant woman shall receive ongoing assessment of maternal and fetal risk throughout the prenatal period. Such risk assessment shall include, but not be limited to, an analysis of individual characteristics affecting pregnancy (e.g., genetic, nutritional, psychosocial, and historical) and emerging obstetrical/ fetal and medical-surgical risk factors. At registration, a standardized written risk assessment shall be conducted using established criteria for determining high-risk pregnancies based upon generally accepted standards of practice. This risk assessment shall be:

1. Reviewed at each visit
2. Formally repeated early in the third trimester
3. Linked to the care plan and clearly documented in the medical record

Development of care plan and coordination of care

A care plan addressing the proper implementation and coordination of all services required by the pregnant woman shall be developed, routinely updated, and implemented jointly by the pregnant woman and her family, where mutually agreeable to the woman, and all appropriate health care team members. Care shall be coordinated to:

1. Ensure that relevant information is exchanged between the prenatal care provider and other providers or care sites, including the anticipated birthing site;
2. Ensure that the pregnant woman and her family, with her consent, have continued access to information resources and are encouraged to participate in decisions involving the scope and nature of care and services being provided;
3. Encourage and assist the pregnant woman in obtaining necessary medical, nutritional, psychosocial, drug and substance-abuse services appropriate to her identified needs and provide follow-up to ensure ongoing access to services;
4. Provide the pregnant woman with an opportunity to receive prenatal or postpartum home visits when she may derive medical or psychosocial benefit from such visits. The visit shall identify familial and environmental factors that may increase risk to the woman or fetus and the relevant findings shall be incorporated into the care plan;
5. Provide to or refer the pregnant woman for needed services including:

a. Inpatient care, specialty physician and clinic services that is necessary to ensure a healthy delivery and recovery
b. Genetic services
c. Drug treatment and screening services
d. Dental services
e. Mental health and related social services
f. Emergency room services
g. Home care
h. Pharmaceuticals
i. Transportation
j. Provide for the pregnant woman special tests and services as recommended or required by the health commissioner, who shall require such tests and/or services when necessary to protect maternal and/or fetal health. Women shall be provided appropriate medical care, counseling, and education based on test results.
k. Encourage continuity of care and client follow-up, including rescheduling of missed visits throughout the prenatal and postpartum period.

Nutrition Services

The provider shall establish and implement a program of nutrition screening and counseling that includes:

1. Individual nutrition risk-assessment including screening for specific nutritional risk conditions at the initial prenatal care visit and continuing reassessment as needed.
2. Professional nutrition counseling, monitoring and follow-up by a nutritionist or registered dietitian of all pregnant women at nutritional risk.
3. Documentation of nutrition assessment, risk status and nutrition care plan in the patient medical record.
4. Arrangements for services with funded nutrition programs available in the community, including provision for enrollment of all eligible women and infants in the Supplemental Food Program for Women, Infants, and Children (WIC), at the initial visit.
5. Provision of basic nutrition education and counseling for each pregnant woman that includes the following topics:
    a. Appropriate dietary intake and recommended dietary allowances during normal pregnancy
    b. Appropriate weight gain
    c. Infant-feeding choices, including individualized counseling regarding the advantages/disadvantages of breastfeeding

Health Education

Health and childbirth education services shall be given to each pregnant woman based on an assessment of her individual needs. Appropriate educational materials, including videos and written information, shall be used, taking into account cultural and language factors including the pregnant woman's ability to comprehend the information. Such services shall be provided by professional staff, documented in the medical record, and included but not limited to:

- Avoidance of harmful practices and substances including alcohol, drugs, non-prescribed medications and nicotine
- Family planning
- Labor and delivery process
- Obstetrical anesthesia and analgesia

- The newborn screening program, including distribution of newborn-screening educational literature
- Occupational concerns
- Orientation to procedures at the anticipated birth site
- Physical activity and exercise during pregnancy
- The pregnant woman's rights and responsibilities
- Preparation for parenting, including infant development and care and feeding options
- Relaxation techniques in labor
- Risks of HIV infection and risk-reduction behaviors
- Sexuality during pregnancy
- Signs of labor
- Signs of pregnancy complications

Psychosocial Assessment

A psychosocial assessment shall be conducted and include:

1. Screening for social, economic, psychological and emotional problems as well as past or present domestic violence or sexual assault.
2. Referral, as appropriate to a woman's or fetus's needs, to the local department of social services, community mental health resources, support groups, or social/psychological specialists. (Please see *Section 5* for MVP's referral policy.)

HIV Services

The provider shall:

1. Routinely provide the pregnant woman with HIV counseling and education
2. Routinely offer the pregnant woman confidential HIV testing
3. Provide the HIV-positive woman and her newborn the following services or make the necessary referrals (see Section 5 for MVP's referral policy) for these services:
    a. Management of HIV status
    b. Psychosocial support
    c. Case management to assist in coordination of necessary medical, social and drug treatment services

Records and Reports

The provider shall create and maintain records and reports in accordance with this subdivision that are complete, legible, retrievable and available for review upon request by of commissioner of health representatives. Such records and reports shall include:

1. A comprehensive prenatal care record for each pregnant woman documenting the provision of care and services required by this section and maintained in a manner consistent with medical record confidentiality requirements.
2. Special reports and data summaries necessary for the commissioner of health to evaluate the provider's delivery of prenatal services.
3. Program reports including financial, administrative, utilization, and patient care data maintained in such a manner as to allow the identification of expenditure, revenue, utilization, and patient care data associated with health care provided to Prenatal Care Assistance Program* (PCAP) clients.
4. Records of all internal quality-assurance activities.
5. All written policies and procedures required by this section and safeguards to prevent the inappropriate breach of patient confidentiality requirements.
   (*PCAP offers complete pregnancy care and other health care services to women and teens residing in New York state. The Medicaid Obstetrical & Maternal

Services [MOMS] Program provides complete pregnancy services in areas of the state where there are no PCAP health centers. These services are available at no cost to eligible women.)

Postpartum Services

Providers shall coordinate with the neonatal-care provider to arrange for pediatric care services in accordance with generally accepted standards of practice and patient services. A postpartum visit with a qualified health professional shall be scheduled and conducted in accordance with medical needs but no later than eight weeks after delivery. For the interim between delivery and the visit, the provider shall furnish each woman with a means of contacting the provider in case postpartum questions or concerns arise. The postpartum visit shall include but not be limited to:

1. Identifying any of the mother's unmet medical, psychosocial, nutritional, alcohol and drug treatment needs
2. Referring the mother or other infant caregiver to resources for meeting such needs and providing assistance in meeting such needs where appropriate
3. Assessing family-planning needs and providing advice and services or referral where indicated
4. Providing preconception counseling as appropriate and encouraging in a preconception visit, prior to subsequent pregnancies for women who might benefit from such visits
5. Referring infants to preventive and special care services appropriate to their needs
6. Advising the mother of the availability of Medicaid eligibility for infants

Welfare Documentation

Upon member consent, providers are required to supply medical documentation of health, mental health and chemical dependence assessments as follows:

- Within 10 days of request from a member or former member currently receiving or applying for public assistance, the PCP or specialist provider must provide medical documentation concerning the member or former member's health or mental health status to the local department of social services (LDSS) or the LDSS's designee.
- Within 10 days of request of a member or former member who has already undergone or is scheduled to undergo an initial LDSS-required mental and /or physical exam, the member's PCP shall provide a health, mental health or chemical-dependence assessment exam or other services as appropriate to identify or quantify a member's level of incapacitation.

Claim Encounters

Providers are required to submit all claim encounters for Medicaid Managed Care (Medicaid, SSI, HARP) and Child Health Plus products following the claim submission guidelines outlined in this manual.

Special Networks

HEALTHPLEX, INC.

MVP contracts with Healthplex, Inc., to administer all dental services including a full range of preventive, prophylactic, diagnostic and other routine dental care, services and supplies as well as limited orthodontia services for children enrolled in MVP Medicaid Managed Care and MVP Child Health Plus. If a Healthplex dental provider identifies a medical issue he/she will refer the member back to his/her PCP for coordination of the appropriate medical care or referrals.

PHARMACY SERVICES

Refer to *Section 9* of this manual for information on pharmacy benefits and services for MVP State Government Programs members.

Beacon Health Options
MVP contracts with Beacon Health Options to administer all covered mental health and substance abuse treatment.

Superior Vision
MVP contracts with Superior Vision to administer the routine vision and eyewear benefit for MVP Medicaid Managed Care and MVP Child Health Plus. Superior Vision adjudicates routine vision claims and responds to benefit and eligibility inquiries with regard to routine vision. Medical vision services continue to be managed by MVP.

Deficit Reduction Act (DRA) of 2005

The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities that receive Medicaid funds in excess of $5,000,000 annually to establish written policies informing and educating their contractors about federal and state anti-fraud statutes. As a Medicaid Managed Care contractor, MVP is subject to this DRA requirement. In addition, participating providers in MVP's Medicaid Managed Care program are contractors and as such are required to adopt MVP's policy for *Detecting and Preventing Fraud, Waste and Abuse*. This policy provides information regarding several important anti-fraud statutes, such as the False Claims Act, and MVP's policies and procedures for compliance with these laws. This policy is available online at **www.mvphealthcare.com/providers**. Click on the *Reference* link located in the top navigation bar and then select *Detecting and Preventing Fraud, Waste and Abuse*.

Non-Emergent Transportation (NY)

Non-emergent transportation for Medicaid Managed Care and HARP (Product Name Under Development) members is coordinated by the NYS transportation vendor, Medical Answering Services. Specific phone numbers are provided at the end of this section.

BENEFIT COVERAGE
Transportation expenses are covered for Medicaid Managed Care members when essential in order to obtain necessary medical care or services covered under the Medicaid program through the Medicaid Fee for Service program.

TRAVEL EXCLUSIONS AND LIMITATIONS

- Travel for non-authorized care
- Travel to a PCP that the member has selected that is outside the 30 minute, 30 mile travel standard, unless no provider is available within travel standard.

Health and Recovery Plan – (Harmonious Health Care Plan)

A Health and Recovery Plan (HARP) is a special needs plan that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. MVPs HARP product is called Harmonious Health Care Plan

The MVP HARP (Harmonious Health Care Plan) will:

- manage the Medicaid services for people who need them;
- manage an enhanced benefit package of Home and Community-Based Services (HCBS); and

- provide enhanced care management for members to help them coordinate all their physical health, behavioral health and non-Medicaid support needs.

Eligibility for HARP: People must be 21 or older to join a HARP, be insured only by Medicaid and be eligible for Medicaid managed care. They also have to be eligible for a HARP. New York State will initially identify individuals eligible for HARP services based on historical service use. People who are eligible will get a letter in the mail from New York State Medicaid. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan, choose another HARP or opt out of the HARP plan. Individuals will have 30 days to opt out or switch to a new HARP plan. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream before they are locked into the HARP for 9 additional months (after which they are free to change Plans at any time).

Care Management (Harmonious Health Care Plan)

- Individuals identified as HARP eligible must be offered care management through a Health Home designated by NYS
- Individuals working with their care manager will determine which home and community based services they are eligible for
- Upon enrollment into the (insert Product Name) individuals are screened for eligibility and a personalized recovery plan is developed that specifies the scope, type and duration of services the member is eligible to receive.

MVP contracts with Beacon Health Options to administer all covered behavioral health and substance abuse services for HARP, as well as the HCBS services. Together MVP and Beacon will follow the following principles for Harmonious Health Care Plan:

1. Person-Centered Care: Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma.
2. Recovery-Oriented: The system should include a broad range of services that support recovery from mental illness and/or substance use disorders.
3. Integrated: Service providers should attend to both physical and behavioral health needs of members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met.
4. Data-Driven: Providers and plans should use data to define outcomes, monitor performance, and promote health and wellbeing.

Benefit Overview for NYS Government Programs

The table below outlines the benefits covered by each MVP Government program plan. An “X” in a box indicates that service is covered.

SERVICE	MEDICAID	SSI	HARP*	CHPlus
Adult Day Health Care	X - Covered with Prior Authorization	X - Covered with Prior Authorization	X - Covered with Prior Authorization	Not Covered

AIDS Adult Day Care	X - Covered with Prior Authorization	X - Covered with Prior Authorization	X - Covered with Prior Authorization	Not Covered
Audiology services: hearing aids and follow-up visits	X	X	X	One hearing exam/calendar year and any medically necessary follow-up
Chiropractic services	Not covered	Not covered	Not covered	Not covered
Custodial Nursing Home Care	X – Covered with approval from the County LDSS	X – Covered with approval from the County LDSS		Not Covered
Dental*	X*	X*	X*	X*
Doctor visits	X	X	X	X
Durable medical equipment (DME)	X	X	X	X
Emergency room services	X	X	X	X
Emergency transport	Covered under FFS Medicaid X	Covered under FFS Medicaid X	Covered under FFS Medicaid X	X – ground only (air ambulance not covered)
Family planning and reproductive care	X	X	X	X
Foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care
Home Delivered meals	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
Hospice	X	X	X	X
Immunizations	X Immunizations for children under age 18 are covered by the NYS VFC program	X Immunizations for children under age 18 are covered by the NYS VFC program	X	X Immunizations for children under age 18 are covered by the NYS VFC program
EPSDT services through the Child/Teen Health Program and Adolescent Preventive Services	X	X		X
Inpatient Hospital Services	X	X	X	X
Inpatient mental health	X*	X*	X*	X*
Laboratory services	X	X	X	X
Low vision and medical eye care	X	X	X	X
Medically managed inpatient detoxification	X*	X*	X*	X*
Occupational therapy	X Up to total of 20	X Up to total of 20	X Up to total of 20	X

	visits/calendar year	visits/calendar year	visits/calendar year	
Medical Social Services	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
Orthodontia	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization
OTC drugs *See Section 9- Pharmacy*	X	X	X	Not covered except with prescription. Must be for therapeutic and preventive purposes
Outpatient mental health	X*	X*	X*	X*
Outpatient substance abuse services	X*	X*	X*	X*
Personal Care – Level 1	Limit of 8 hours per week	Limit of 8 hours per week	Limit of 8 hours per week	Not covered
Personal Care – Level 2	X	X	X	Not covered
Consumer Directed Personal Assistance	X	X	X	Not covered
Physical therapy	X Up to total of 20 visits/calendar year	X Up to total of 20 visits/calendar year	X Up to total of 20 visits/calendar year	X
Prenatal Care	X	X	X	X
Prescription Drugs *See Section 9 – Pharmacy*	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Commercial formulary
Preventive Health Services	X	X	X	X
Private Duty Nursing	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Prosthetics and Orthotics	X	X	X	Covered as medically necessary w/ exception of wigs, dental prostheses and orthotics prescribed for sports
Radiology services	X	X	X	X
Other preventive services	X	X	X	X
Renal dialysis	X	X	X	X
Routine eye care and glasses*	X	X	X	X
Routine transportation	Covered by fee-for-service Medicaid, contact Medical Answering Services	Covered by fee-for-service Medicaid, contact Medical Answering Services	Covered by fee-for-service Medicaid, contact Medical Answering Services	Not covered
Home health care	X	X	X	Up to 40 visits/year as medically necessary
Smoking cessation	X	X	X	Not covered

counseling	Covered up to 8 visits per calendar year	Covered up to 8 visits per calendar year	Covered up to 8 visits per calendar year	
Smoking cessation products	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	Not covered
Specialist care	X	X	X	X
Speech therapy	X Up to total of 20 visits/calendar year	X Up to total of 20 visits/calendar year	X Up to total of 20 visits/calendar year	X
X-rays	X	X	X	X
Substance Use Disorder services Mandated by LDSS	X*	X*	X*	
Substance Use Disorder (SUD) Inpatient Rehabilitation and Treatment Services	X*	X*	X*	X*
SUD Residential Addiction Treatment Services	X*	X*	X*	
SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	X*	X*	X*	X*
SUD Medically Supervised Outpatient withdrawal	X*	X*	X*	X*
Buprenorphine Prescribers	X	X	X	X*
Crisis Intervention Services	X*	X*	X*	X*
Psychosocial Rehabilitation (PSR)	Not covered	Not covered	X*	Not covered
Community Psychiatric Support and Treatment (CPST)	Not covered	Not covered	X*	Not covered
Habilitation Services	Not covered	Not covered	X*	Not covered
Family Support and Training	Not covered	Not covered	X*	Not covered
Short-term Crisis Respite	Not covered	Not covered	X*	Not covered
Intensive Crisis Respite	Not covered	Not covered	X*	Not covered
Education Support Services	Not covered	Not covered	X*	Not covered
Peer Supports	Not covered	Not covered	X*	Not covered
Pre-vocational Services	Not covered	Not covered	X*	Not covered
Transitional Employment	Not covered	Not covered	X*	Not covered
Intensive Supported Employment (ISE)	Not covered	Not covered	X*	Not covered
Ongoing Supported Employment	Not covered	Not covered	X*	Not covered
Care Coordination for	Not covered	Not covered	X*	Not covered

the HARP Program				
*Refer to special network information				

Important Phone Numbers
MVP GOVERNMENT PROGRAMS

MVP After Hours	1-888-MVP-MBRS (687-6277)
MVP Customer Care Center	1-800-852-7826
Provider Claims	1-800-684-9286
MVP Case Management	1-800-666-1762
MVP Behavioral Health Services – Beacon Health Options	1-800-852-7826
CVS Caremark	1-866-832-8077
Healthplex, Inc. (dental benefits administrator)	1-800-468-9868
Superior Vision	1-866-819-4298
ALBANY COUNTY	
Albany County Department of Social Services (DSS)	518-447-7492
Transportation for MMC members, call Medical Answering Services	1-855-360-3549
DUTCHESS COUNTY	
Dutchess County Department of Social Services (DSS)	845-486-3000
Transportation for MMC members, call Medical Answering Services	1-866-244-8995
GENESEE COUNTY	
Genesee Department of Social Services (DSS)	585-344-2580
Transportation for MMC members, call Medical Answering Services	1-855-733-9404
Child Lead Poisoning Prevention Program	585-344-2580, ext. 5000
JEFFERSON COUNTY	
Jefferson County Department of Social Services	315-782-9030
Transportation for MMC members, call Medical Answering Services	1-866-558-0757
LIVINGSTON COUNTY	
Livingston Department of Social Services (DSS)	585-243-7300
Transportation for MMC members, call Medical Answering Services	1-888-226-2219
Child Lead Poisoning Prevention Program	585-243-7299
MONROE COUNTY	
Monroe Department of Human Services	585-753-6440
Transportation for MMC members, call Medical Answering Services	1-866-932-7740
Child Lead Poisoning Prevention Program	585-753-5087
Department of Health Tuberculosis Control Program	585-753-5161
ONTARIO COUNTY	
Ontario County Department of Social Services (DSS)	585-396-4599
Transportation for MMC members, call Medical Answering Services	1-855-733-9402
Child Lead Poisoning Prevention Program	585-396-4854
ORANGE COUNTY	

Orange County Department of Social Services (DSS)	845-291-4000
Transportation for MMC members, call Medical Answering Services	1-855-360-3543
RENSSELAER COUNTY	
Rensselaer County Department of Social Services (DSS)	518-266-7991
Transportation for MMC members, call Medical Answering Services	1-855-852-3293
ROCKLAND COUNTY	
Rockland County Department of Social Services (DSS)	(845) 364-2000
Transportation for MMC members, call Medical Answering Services	(855) 360-3542
SARATOGA COUNTY	
Saratoga County Department of Social Services	518-884-4148
Transportation for MMC members, call Medical Answering Services	1-855-852-3292
SCHENECTADY COUNTY	
Schenectady County Department of Social Services	518-388-4470
Transportation for MMC members, call Medical Answering Services	1-855-852-3291
SULLIVAN COUNTY	
Sullivan County Department of Social Services (DSS)	(845) 292-0100
Transportation for MMC members, call Medical Answering Services	(866) 573-2148
ULSTER COUNTY	
Ulster County Department of Social Services (DSS)	(845) 334-5000
Transportation for MMC members, call Medical Answering Services	(866) 287-0983
WARREN COUNTY	
Warren County Department of Social Services	518-761-6321
Transportation of MMC members, call Medical Answering Services	1-855-360-3541
WESTCHESTER COUNTY	
Westchester County Department of Social Services (DSS)	1-800- 549-7650
Transportation for MMC members, call Medical Answering Services	1-866-883-7865
NEW YORK STATE	
HIV Confidentiality Hotline	1-800-962-5065
NY State Department of Health AIDS Institute	1-518-402-6814
NYS Domestic Violence Hotline	1-800-942-6906
NYS Domestic Violence Hotline (Spanish)	1-800-942-6906
WIC Hotline	1-800-522-5006
NYS Smokers Quit line	1-866-697-8487
New York State Vaccines for Children Program	1-800-543-7468
