This section specifically addresses:

- QI program description
- 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 MVP QI Program has been established to assess MVP member clinical and service needs and to develop, implement, evaluate and report on the various interventions/programs that will lead to improved clinical quality, maximize safe clinical practices, and enhance member experience of service throughout the organization and care and service throughout the network. The purpose of the program is to ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis.

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. QI activities include the following:

- Identify and pursue opportunities for improvement.
- Plan a schedule of activities and projects by way of a QI work plan in order to achieve improvement over time, with ongoing evaluation and annual reporting of progress toward established goals.
- Monitor the availability, accessibility, quality, continuity and coordination of patient care across the continuum.
- Provide information to providers, and training and tools to staff, to support culturally competent communication.
- Assess the appropriate use of resources and the provision of care.
- Develop preventive care guidelines and disseminate to physicians and members.
- Develop and support a structure to adopt and promulgate clinical practice guidelines that are pertinent to the member populations served.
- Develop studies and measurements that are meaningful to track, evaluate and analyze for quality improvement.
- Offer health management programs that will improve the health status of members with chronic conditions and promote the use of those services to members and physicians.
- Work with community health care partners to ensure successful level of care transitions for members, especially those with complex health needs.

- Oversee programs designed to improve the quality of behavioral health care services.
- Work collaboratively with behavioral health delegates to improve the continuity of behavioral health care with medical care.
- Collect and utilize information to enhance the credentialing, peer review performance assessment and recredentialing processes.
- Promote a system of timely, thorough and appropriate resolution of member complaints, grievances and appeals including correction of problems identified.
- Monitor policies and procedures that protect members' privacy and the confidentiality of member information and records to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
- Develop initiatives that will enhance patient safety in various care settings.
- Provide oversight of delegated activities as defined by National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and state regulators.
- Enable MVP to meet governmental agency regulatory requirements and NCQA accreditation standards.

The QI Committee ("QIC") and board of directors oversee the QI Program. The QIC is chaired by the Senior Medical Director of Medical and Quality Management 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.

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. 42588**.

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. 42588**.

Performance Reporting

MVP's performance reporting delivers information to physicians to assist with facilitating the delivery of high quality, cost effective care. The following is a summary of the performance reporting process in place at MVP.

A standard reporting package is produced for providers that are under a value based contract. The package contains reports that focus on emergency room, inpatient, gaps in care, member attribution and a risk report of how sick their members are.

Additionally, for Value Based Payment (VBP) programs MVP's dedicated population health management specialists (PHMS) meet with our providers at least once a month to review available data on quality, efficiency & utilization. Providers currently engaged or in the process of preparing to engage in our VBP programs are provided with overall quality and utilization

review and network comparison; this includes but is not limited to practice pattern evaluation/optimization opportunity and best practices identification.

MVP does utilize CAHPS surveys in support of our Medicaid, Medicare, and Commercial regulatory and NCQA evaluation data across all providers as appropriate.

Providers not affiliated with a VBP continue to receive the Quality Measure Reports. These are provided on the MVP Health Care website.

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. A unique patient identifier is used for each member. The identifier is included on each page of the medical record.
    3. Records are organized with a filing system or search capability to ensure easy retrieval. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care.
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. (ex. home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports).
D. Confidentiality: Providers/Practice sites shall comply with current state and federal confidentiality requirements, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are expected to have implement policies and procedures that guard against unauthorized or inadvertent disclosure of protected health information.
E. Retention of Medical Records – Providers must retain medical records in accordance with contractual obligations and current applicable federal and state laws and regulations.
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 include the patient's full name and identification number. In addition, home address, telephone number(s), employer, marital status, and emergency contact information is maintained.
2. The record is legible to 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 or electronic 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. Problem list: Documents all chronic, serious or disabling conditions and active, acute medical and psychosocial problems. A problem list should be completed for each patient, regardless of health status and updated as necessary. 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. Past medical history (for patients seen three or more times): Should be easily identified and include serious injuries, surgical procedures and illnesses. For children and adolescents (≤18 years of age), past medical history relates to prenatal care, birth, surgical procedures and childhood illnesses.
8. Medication list: Documents all medications including dosage changes and includes the date changes were made. All medications (prescribed and over the counter), herbal therapies, vitamins and supplements must be noted. Dates of initial and refill prescriptions must be included.
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 no history of adverse reactions, this is appropriately noted in the record (ex. NKA, NKDA)
10. For patient's ≥12 years of age, there should be appropriate notation concerning the use of tobacco, alcohol, and substance use. For patients who have been seen three or more times, an assessment of substance abuse history is included.
11. For all patients ≤18 years of age, there should be a complete immunization record. For patients over 18, an immunizations history is maintained (ex. influenza, pneumococcal, tetanus/diphtheria ("Td") immunizations).
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 timeframe for return is noted (ex. weeks, months, or as needed).
14. No shows or missed appointments must be documented with follow-up efforts to reschedule appointment.

15. Specialist, laboratory and imaging reports 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. Specialist, abnormal laboratory, and imaging study results should have an explicit notation in the record of follow-up plans.
16. If a specialist referral is requested, there should be a note from that provider in the medical record.
17. Laboratory 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. The 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. Preventive care/Risk assessment – There is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.
22. Depression screening: May be assessed on a comprehensive physical examination, review of systems, patient health questionnaire, or a formal screening tool (ex. PHQ-9, Beck Depression Inventory) or any part of the following questions a) Little interest or pleasure in doing things? B) Feeling down, depressed or hopeless.
23. Advance Care Planning for age's ≥65: Notation of an advance care planning discussion and date or copy of an executed Advance Directive form. Current Advance Directive forms should be maintained in a prominent part of the member's medical record. Advance Directive forms are available in the Provider Quality Improvement Manual on the provider portal of the MVP website.
24. Annual medication review for age's ≥65: Conducted by a prescribing practitioner and the date performed.
25. Functional status assessment for age's ≥65: Components include vision, hearing, mobility, continence, nutrition, bathing, use of telephone, meal preparation and managing finances. Functional status assessments may be found on a specific tool.
26. Fall risk assessment for age's ≥65: Components include age, fall history, gait, balance, mobility, muscle weakness, osteoporosis risk, impairments related to vision, cognitive or neurological deficits, continence, environmental hazards, number and type of medication.
27. Monitoring of physical activity for ages ≥65: Includes annual assessment of level of exercise or physical activity and counseling related to begin exercise, or increasing/maintaining their level of exercise or physical activity.

Pain screening for age's ≥65: Includes character, severity, location, and factors that improve or worsen pain. Pain assessments may be found on a specific tool such as a pain scale, visual pain scale, or diagram. To assess compliance with the standards for Commercial membership, MVP conducts an annual ambulatory medical record review at the office of PCPs with high volume member panel sizes of 250 or more on the following two core elements:

- *Are records current, detailed, organized, and permit effective and confidential patient care and quality review
- *Depression screening

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. 42588**. The manual is available online at **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"), a program of early and periodic screening, including inter-periodic, diagnostic and treatment services that New York State offers all Medicaid-eligible children under twenty-one (21) years of age. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The services include administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative case management and transportation assistance, to the extent that transportation is included in the Benefit Package. C/THP 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. MVP promotes these guidelines by working with our providers consistently to ensure our members receive the best quality outcomes. MVP assesses provider adherence to guideline recommendations through Health Care 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 Member Services 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 Member Services. If Member Services 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 Member Services.
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 some MVP plans, such as EPO and PPO, do not require members to select a PCP. Members are referred to their certificate of coverage or contract for details.
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 Member Services representatives.

Medicare Member Rights

MVP Health Care encourages members to learn and exercise their rights and responsibilities. Listed below are the member's rights and responsibilities, as they are distributed to all MVP Medicare Advantage members upon enrollment and annually.

Medicare Member Rights

1. Members have a right to make recommendations regarding MVP's member rights and responsibilities policy. Members have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities in a way that works for the Member.

MVP has people and free language interpreter services available to answer questions from non-English speaking members. MVP can also provide information in Braille, in large print or other alternate formats if needed. If a member is eligible for Medicare because of disability, MVP is required to provide information about the plan's benefits that is accessible and appropriate for the member.

If any member has trouble getting information from MVP because of problems related to language or disability, they may call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week to file a complaint. TTY users call 1-877-486-2048.

2. MVP must treat members with dignity, fairness and respect at all times. MVP must obey laws that protect members from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, creed (beliefs), gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence or insurability, or geographic location within the service area.

For more information about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If a member has a disability and needs help with access to care, they may call MVP. If a member has a complaint, such as a problem with wheelchair access, MVP's Customer Care Center can help.

3. MVP must ensure members get timely access to covered services and drugs. As a member of MVP, members have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for covered services. Members can call Member Services to

learn which doctors are accepting new patients. Members also have the right to go to a women's health specialist (such as a gynecologist) without a referral. With an MVP Medicare Advantage plan, members have the right to go to any specialist without a referral. Members 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 care is needed. Members have the right to get prescriptions filled or refilled at any of MVP's network pharmacies without long delays.

4. MVP must protect the privacy of the member's personal health information. Federal and State laws protect the privacy of the member's medical records and personal health information. MVP protects member's personal health information as required by these laws.

The member's "personal health information" includes the personal information provided by the member to MVP when enrolled in the plan as well as medical records and other medical and health information. The laws that protect the member's privacy give them rights related to getting information and controlling how their health information is used. MVP provides a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how MVP protects the privacy of the member's health information.

How does MVP protect the privacy of the member's health information?

- MVP makes sure that unauthorized people don't see or change the member's records.
- In most situations, if MVP provides the members health information to anyone who isn't providing the members care or paying for the members care, MVP is *required to get written permission from the member first*. Written permission can be given by the member or by someone the member has given legal power to make decisions for them.
- There are certain exceptions that do not require MVP to get the members written permission first. These exceptions are allowed or required by law.
    - For example, MVP is required to release health information to government agencies that are checking on quality of care.
    - Because the member is part of our plan through Medicare, MVP is required to give Medicare the member's health information including information about their Part D prescription drugs. If Medicare releases the member's information for research or other uses, this will be done according to Federal statutes and regulations.

The member can see the information in their records and know how it has been shared with others

The member has the right to look at their medical records held at the plan, and to get a copy of their records. MVP is allowed to charge the member a fee for making copies. The member also has the right to ask MVP to make additions or corrections to their medical records. The member can ask MVP to do this and MVP will work with their Health Care provider to decide whether the changes should be made. The member has the right to know how their health information has been shared with others for any purposes that are not routine. If the member has questions or concerns about the privacy of their personal health information, they may call Member Services or visit **mvphealthcare.com**.

5. MVP must give the member information about the plan, its network of providers, and covered services. As a member of MVP, they have the right to get several kinds of information from MVP in a way that works for them. This includes getting the information in languages other than English and in large print or other alternate formats. If the member wants any of the following kinds of information, they can call Member Services or visit **mvphealthcare.com**:

- **Information about MVP.** 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 Advantage health plans.
- **Information about MVP's network providers including network pharmacies.**
  - o For example, the member has the right to get information from MVP about the qualifications of the providers and pharmacies in MVP's network and how MVP pays the providers in the network.
  - o For a list of the providers in MVP's network, members can see the MVP Health Care Professionals Directory (Medicare Advantage Plans).
  - o For a list of the pharmacies in MVP's network, members can see the Pharmacy Directory.
  - o For more detailed information about MVP's providers or pharmacies, the member can call Member Services or visit **mvphealthcare.com**.

- **Information about the member's coverage and rules the member must follow in using their coverage.**
  - To get the details on the members Part D prescription drug coverage, they can see the List of Covered Drugs. The List of Covered Drugs tells the member what drugs are covered and explain the rules they must follow and the restrictions to their coverage for certain drugs.
  - If the member has questions about the rules or restrictions, they may call Member Services or visit **mvphealthcare.com**.
  - In Chapters 3 and 4 of the *Evidence of Coverage* document, MVP explains what medical services are covered for the member, any restrictions to their coverage, and what rules they must follow to get covered medical services.

- **Information about why something is not covered and what the member can do about it.**
  - If a medical service or Part D drug is not covered for the member, or if the coverage is restricted in some way, the member can ask MVP for a written explanation. The member has the right to this explanation even if they received the medical service or drug from an out-of-network provider or pharmacy.
  - If the member is not happy or if they disagree with a decision MVP makes about what medical care or Part D drug is covered for them, the member has the right to ask MVP to change the decision. The member can ask MVP to change the decision by making an appeal. For details on what to do if something is not covered for the member in the way the member thinks it should be covered, they can see Chapter 9 of the *Evidence of*

Coverage document. It gives the member details about how to make an appeal if they want MVP to change a decision.

- If the member wants to ask MVP to pay a share of a bill they have received for medical care or a Part D prescription drug, they can see Chapter 7 of the *Evidence of Coverage* document.

6. MVP must support the member's right to make decisions about their care. The member has the right to know their treatment options and participate in decisions about their health care.

The member has the right to get information from their doctors and other health care providers when they go for medical care. Their providers must explain the member's medical condition and their treatment choices in a way they can understand.

The member also has the right to participate fully in decisions about their health care. To help the member make decisions with doctors about what treatment is best for them; their rights include the following:

- **To know about all choices.** This means the member has the right to be told about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by MVP. It also includes being told about programs MVP offers to help members manage their medications and use drugs safely.
- **To know about the risks.** Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment. Members always have the choice to refuse any experimental treatments.

- **The right to say "no."** Members have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if the doctor advises the member not to leave. The member also has the right to stop taking medication. Of course, if the member refuses treatment or stops taking medication, the member accepts full responsibility for what happens to their body as a result.
- **To receive an explanation if coverage for care is denied.** The member has the right to receive an explanation from MVP if a provider has denied care that the member believes they should receive. To receive this explanation, the member will need to ask MVP for a coverage decision.
- **The member has the right to give instructions about what is to be done if they are not able to make medical decisions for themselves.**
- The member has the right to ask someone such as a family member or friend to help them with decisions about their health care. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. The member has the right to say what they want to happen if they are in this situation. This means that, if the member wants to, they can:
- Fill out a written form to give **someone the legal authority to make medical decisions for them** if they ever become unable to make decisions for themselves.
- **Give their doctors written instructions** about how they want them to handle their medical care if they become unable to make decisions for themselves.

- The legal documents that the member can use to give directions in advance of these situations are called "**advance directives**." There are different type 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 the member wants to use an "advance directive" to give instructions, here is what they can do:
- **Get the form.** If the member wants to have an advance directive, they can get a form from their lawyer, from a social worker, or from some office supply stores. They can sometimes get advance directive forms from organizations that give people information about Medicare. They can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where the member gets this form, they must keep in mind that it is a legal document. The member should consider having a lawyer help them prepare it.
- **Give copies to appropriate people.** Members should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions on their behalf. The member may want to give copies to close friends or family members as well as keeping a copy at home. If the member knows ahead of time that they are going to be hospitalized, and they have signed an advance directive, they can take **a copy with them to the hospital.**
- If the member is admitted to the hospital, the hospital will ask the member whether they have signed an advance directive form and whether they have it with them.
- If the member has not signed an advanced directive form, the hospital has forms available and will ask the member if they want to sign one.

It is the member's choice whether they want to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny care or discriminate against the member based on whether or not they have signed an advance directive.

What if instructions are not followed?
If the member has signed an advance directive, and they believe that a doctor or hospital hasn't followed the instructions in it, they may file a complaint with the New York State Department of Health at (800) 206-8125.

7. The member has the right to make complaints and to ask MVP to reconsider decisions that MVP has made.

If the member has any problems or concerns about covered services or care, Chapter 9 of the *Evidence of Coverage* document tells the member what they can do. It gives the details about how to deal with all types of problems and complaints. What the member needs to do to follow up on a problem or concern depends on the situation. The member might need to ask MVP to make a coverage decision for them, make an appeal to MVP to change a coverage decision, or

make a complaint. Whatever the member does – ask for a coverage decision, make an appeal or make a complaint – **MVP is required to treat members fairly**.

- Members have the right to get a summary of information about the appeals and complaints that others have filed against MVP in the past. To get this information, members can call Member Services or visit **mvphealthcare.com**.

8. What members can do if they think they are being treated unfairly or their rights are not being respected?

If it is about discrimination, members can call the Office for Civil Rights.
If members think they have been treated unfairly or their rights have not been respected due to race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, they 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 their local Office for Civil Rights.

Is it about something else?
If a member believes they have been treated unfairly or their rights have not been respected, and it's not about discrimination, they can get help dealing with the problem they are having:

The member can **call Member Services**.

The member can call the **State Health Insurance Assistance Program** at (800) 701-0501 or (585) 244-8400.

Or, the member **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.

9. How members can get more information about their rights. There are several places where members can get more information about their rights:

- The member can call Member Services or visit **mvphealthcare.com**.
- The member can call the **State Health Insurance Assistance Program** at (800) 701-0501 or (585) 244-8400.
- The member can contact **Medicare**.
    - The member can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf.)
    - Or, the member can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medicare Member Responsibilities

Things members need to do as a member of the plan are listed below. If members have any questions, they can call Member Services. MVP is here to help.

1. Get familiar with covered services and rules the member must follow to get these covered services. Use the *Evidence of Coverage* booklet to learn what is covered and the rules members need to follow to get covered services.

2. If members have any other health insurance coverage or prescription drug coverage besides MVP, the member is required to tell MVP. Members can call Member Services to let MVP know.

MVP is required to follow rules set by Medicare to make sure members are using all of their coverage in combination when members get covered services from MVP. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits members get from MVP with any other health and drug benefits available to the member. MVP will help members coordinate their benefits.

3. Members should tell their doctor and other health care providers that they are enrolled in MVP. Members should show their plan membership card whenever they get medical care or Part D prescription drugs.

4. Members should help their doctors and other providers in their care of them by providing information, asking questions, and following through on their care.

- Members can help their doctors and other health care providers give them the best care, learn as much as they are able to about their health problems and give them the information they need about themselves and their health. Members should follow the treatment plans and instructions that they and their doctors agree upon.
- Members should make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins and supplements.
- Members should understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible. If members have any questions, they should be sure to ask. Their doctors and other health care providers are supposed to explain things in a way they can understand. If members ask a question and don't understand the answer they are given, ask again.

5. Be considerate. MVP expects all our members to respect the rights of other patients. MVP also expects members to act in a way that helps the smooth running of their doctor's office, hospitals, and other facilities.

6. Members should pay what they owe. As a plan member, members are responsible for these payments:

- Members must pay their plan premiums to continue being a member of MVP. In order to be eligible for MVP, members must also 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 MVP.

- For most member's medical services or drugs covered by the plan, members must pay their share of the cost when the service or drug is received. This will be a deductible (a fixed amount), copayment (a fixed amount) or coinsurance (a percentage of the total cost).

- If the member receives any medical services or drugs that are not covered by MVP or by other insurance they may have, they must pay the full cost.

- If the member disagrees with MVP's decision to deny coverage for a service or drug, they can make an appeal. The member can see Chapter 9 of the *Evidence of Coverage* for information about how to make an appeal.
- If the member is required to pay a late enrollment penalty, they must pay the penalty to keep their prescription drug coverage. (This applies to members with Part D coverage only)

- If the member is required to pay the extra amount for Part D because of yearly income, they must pay the extra amount directly to the government to remain a member of MVP.

7. Members should tell MVP if they move. If the member is going to move, it's important to tell MVP right away. Members can call Member Services.

- **If the member moves *outside* of MVP's service area, they cannot remain a member of MVP**. MVP can help the member figure out whether they are moving outside MVP's service area. If the member is leaving MVP's service area, they will have a Special Enrollment Period when they can join any Medicare plan available in their new area. MVP can let the member know if MVP has a plan in their new area.

- **If the member moves *within MVP's* service area, MVP still needs to know** so the member's record is up to date and MVP knows how to contact them.

8. Members can call Member Services for help if they have questions or concerns. MVP also welcomes any suggestions members may have for improving MVP's plan.

Variations:
PPO and MSA members are not required to select a PCP.
GoldAnywhere PPO members may access out of network care at higher cost sharing.

Key Contacts:
Members may call:

Gold Member Services: 1-800665-7924
TTY: 1-800-662-1220
Or visit **mvphealthcare.com**
Providers may call:
Professional Relations Service Center
Toll free: 1-800-684-9286

Medicaid Member Rights

MVP Medicaid members have the following Member Rights:

- To be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- To be told where, when and how to get the services they need from MVP Health Care.
- To be told by their Primary Care Physician what is wrong, what can be done for them, and what will likely be the result in language they understand.
- To get a second opinion about their care.
- To give their approval to any treatment or plan for care after that plan has been fully explained.
- To refuse care and be told what are the risks of their actions.
- To get a copy of their medical record, and talk about it with their Primary Care Physician. They can ask that their medical record be amended or corrected, if needed.
- To be sure that their medical record is private and will not be shared with anyone except as required by law, contract, or their approval.
- To use MVP Medicaid's complaint process to settle any complaints, or to complain to the NY State Department of Health or the local Department of Social Services any time they feel they were not fairly treated.
- To use the New York State Fair Hearing system.
- To appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
- To receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Medicaid Member Responsibilities

MVP Health Care members have the following Member Responsibilities:

• To work with their Primary Care Physician to guard and improve their health.

• To find out how their health care system works.

• To listen to their Primary Care Physician's advice and ask questions when they are in doubt.

• To call or go back to their Primary Care Physician if they do not get better, or ask for a second opinion.

• To treat health care staff with the respect they expect themselves.

• To tell MVP Medicaid Customer Care Center if they have problems with any health care staff.

• To keep their appointments. If they must cancel, call as soon as they can.

• To use the emergency room only for real emergencies.

• To call their Primary Care Physician when they need medical care, even if it is after-hours.

Sources & Other References

NYS DOH Medicaid Managed Care Contract
MVP Medicaid Member Handbook, January 2018

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 authorize 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

MVP Medicaid Customer Care Center **1-800-852-7826** **(TTY 1-800-662-1220)** **Harmonious Health Care Plan Members** **1-844-946-8002**
MVP Medicare Customer Care Center **1-800-665-7924** **(TTY 1-800-662-1220)**
Customer Care Center for All Other MVP Members **1-888-687-6277** **(TTY 1-800-662-1220)**
Mail all written communications to: **MVP CUSTOMER CARE CENTER** **PO BOX 2207** **SCHENECTADY NY 12301-2207**

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. 12069** 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 and maintenance of a list of those who received training;
- Identification of staff by job title and their specific functions who are allowed access to HIV-related information and limits of access;
- A requirement that only full-time or part-time employees, contractors and medical, nursing or health-related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall

have access to confidential HIV-related information while performing the authorized functions listed under paragraph
- Protocol for secure storage of HIV-related information (including electronic storage);
- Procedures for handling requests from other parties for HIV-related information; and
- Protocols to protect persons with, or suspected of having, HIV infection from discrimination by employees/agents/contractors.
- Review of the policies and procedures on at least an annual basis

Reference: HIV/AIDS TESTING, REPORTING AND CONFIDENTIALITY OF HIV-RELATED INFORMATION (Statutory Authority Public Health Law, section 2786 and Article 21, Title III (section2139) Part 63.[8]9 Health care provider and health facility policy and procedures. https://www.health.ny.gov/professionals/ems/pdf/srgpart63.pdf

Behavioral Health and Substance Use Information

New York State and Federal law requires each Health Care provider to develop policies and procedures to assure confidentiality of behavioral health and substance use related 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 to behavioral health and substance use information and limits of access;
- Procedure to limit access of 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.