Section 3
Government Programs

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Section 3

Medicaid

Select Plan is a CDPHP program for recipients who receive Medicaid in certain counties of New York state. By participating in Select Plan, there is no loss of benefits or cost to Medicaid members. As a participating provider, you will be listed in the *Select Plan Directory of Participating Practitioners and Providers*. The withhold applies to Select Plan as it does in the commercial HMO product.

HARP is a CDPHP Medicaid product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use). Like Select Plan, CDPHP will manage most of the HARP member's Medicaid services. Unlike Select Plan, HARP members have available an enhanced benefit package of Home and Community Based Services (HCBS). CDPHP Medicaid-HARP will provide enhanced care management, through a Health Home or directly, to help members coordinate all their physical health, behavioral health and non-Medicaid support needs. Access to the enhanced HCBS services is determined through assessment by a CDPHP-contracted Health Home.

HARP members must be Medicaid recipients aged 21 or older who are eligible to enroll in Medicaid managed care. They also have to meet specific eligibility criteria relating to their behavioral health needs.

The Select Plan and HARP characters on the ID card are alphanumeric. This number is the member's client identification number (CIN) preceded by a "D" (e.g.: DAG11111Y). Refer to Section 2 for copies of the ID cards.

Throughout this Section, unless otherwise indicated, Medicaid includes Select Plan *and* HARP.

Referrals

Medicaid members may self-refer for the following services:

- Emergency care;
- Women's health care (e.g., routine check-ups with an OB/GYN and pregnancy care), family planning, maternal depression screening, and HIV and STD screening;
- Tuberculosis diagnosis and treatment;
- Routine eye care;
- Behavioral health services—unlimited assessments from participating providers. This does not apply to ACT, inpatient psychiatric hospitalization, partial hospitalization, or Behavioral Health Home and Community Based Services, for which no self-referrals for assessments are permitted.
- Smoking cessation—medication, supplies and counseling can be accessed without a referral.
- Article 28 clinics operated by Academic Dental Centers;
- Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York.

The following pages outline some of the benefits provided through CDPHP's Medicaid Programs. Members may call Member Services at **(518) 641-3800 or 1-800-388-2994** with questions. Providers can contact Provider Services at **(518) 641-3500 or 1-800-926-7526**.

Transitional Care—Enrollee New to Plan

CDPHP will permit new members to continue an ongoing course of treatment with their current, non-participating health care provider for a transitional period for the following four circumstances:

- They were in the second trimester of pregnancy at the effective date of enrollment. The transitional period includes provision of post-partum care related to delivery.
- They have a life-threatening disease or condition. The member can ask to keep their provider for up to 60 days.
- They were being treated for a behavioral health condition at the effective date of enrollment. The member can ask to keep their provider through treatment or for up to 2 years.
- At the effective date of enrollment, regular Medicaid was paying for the member's home care and that care needs to be continued for at least 120 days. In that case, the member can keep the same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.

Transitional care is subject to the practitioner's agreement to the following: acceptance of CDPHP's fee schedule and terms; compliance with CDPHP's rules, policies and procedures, including quality management program, and resource coordination policies and procedures; and medical records accessibility.

CDPHP will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level of care is approved for such care.

Restricted Recipient Program

The Recipient Restriction Program (RRP) is a New York State Medicaid mechanism that identifies members who have a pattern of abusing Medicaid and restricts them to one or more health care providers where they can access their benefits. This can affect both primary and specialty care services.

If you treat CDPHP Medicaid members, please verify whether these members are restricted **prior** to rendering care.

CDPHP takes the following steps:

- Annual reminders of the program and its rules will be issued via *Network in the Know*, the CDPHP provider newsletter.
- Key information is available on the secure CDPHP provider website (portal), including a tip sheet and a list of restricted members that indicates the start date, end date, and terms of the restriction. To view the Restricted Enrollee List:

  > Log into the secure CDPHP provider website

  > In the left-hand margin, select the **Resources** tab

  > Under Resources, select **Payment Policies**.

  > Scroll down the page and open the pdf file titled **Restricted Enrollee List**

- Providers who do not have access to the secure provider site may contact the CDPHP provider services department at 1-800-926-7526 or (518) 641-3500 to request access or to have the information mailed to them.
- CDPHP member ID cards will reflect restricted status as appropriate; however, reliance solely on the member ID card will be insufficient to verify restricted status. Members may be restricted after initial enrollment and could continue using an old card after the restriction begins. The secure provider site list will provide the most definitive information on restriction status.

Medicaid members who have been assigned to a designated healthcare provider (e.g., physician or clinic, pharmacy, hospital) are **REQUIRED** to receive care only from the designated healthcare provider or through referral to another medically appropriate provider (e.g., transportation, laboratory services, DME services, inpatient hospital services [non-emergent], and/or pharmacy services). The Medicaid Management Information System (MMIS) number must be listed as the referring provider. If a claim is received without the primary care provider's name listed as the referring provider, the claim will deny.

Please note that when providing services to a member who is restricted to a primary physician or facility, the NPI of the referring professional must be entered. If a member is restricted to a facility, the NPI of the facility's referring professional must be entered. The ID of the facility cannot be used (New York State Medicaid General Billing Guidelines, pg. 17).

A claim for services rendered to an RRP member by a provider to whom the RRP member is not restricted will be denied if the date of service for the RRP member is after the date such member was posted to the secure CDPHP website as described above. The above-described methods (e.g., web portal listing and modified ID cards) are considered reasonable notice to providers of a member's restricted status.

Medicaid Covered Services

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment	Covered, unless admit date precedes Effective Date of Enrollment	Covered, unless admit date precedes Effective Date of Enrollment	Stay covered only when admit date precedes Effective Date of Enrollment
Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered	
Physician Services	Covered	Covered	Covered	
Nurse Practitioner Services	Covered	Covered	Covered	
Midwifery Services	Covered	Covered	Covered	
Preventive Health Services	Covered	Covered	Covered	
Second Medical/ Surgical Opinion	Covered	Covered	Covered	
Laboratory Services	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered through 3/31/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing
Radiology Services	Covered	Covered	Covered	
Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered through FFS	Covered through FFS	Covered through FFS	Prior to 4/1/17, hemophilia blood factor covered through MA FFS. Prior to 7/1/16, MA FFS covered SSI recipients for Risperidone microspheres (Risperdal® Consta®,) paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™).
Smoking Cessation Products	Covered	Covered	Covered	
Smoking Cessation Counseling	Covered. Unlimited.	Covered. Unlimited.	Covered. Unlimited.	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Rehabilitation Services (not including Psychosocial Rehabilitation (PSR)	Covered Outpatient physical, occupational and speech therapy visits are unlimited per calendar year.	Covered Outpatient physical, occupational and speech therapy visits are unlimited per calendar year.	Covered Outpatient physical, occupational and speech therapy visits are unlimited per calendar year.	
EPSDT Services/ Child Teen Health Program (C/THP)	Covered	Covered		
Gender Reassignment Surgery	Covered Patient must have a diagnosis of gender dysphoria (ICD-10 code F64.1) and meet NYS minimum age requirements	Covered Patient must have a diagnosis of gender dysphoria (ICD-10 code F64.1) and meet NYS minimum age requirements	Covered Patient must have a diagnosis of gender dysphoria (ICD-10 code F64.1) and meet NYS minimum age requirements	
Home Health Services	Covered	Covered	Covered	
Private Duty Nursing Services	Covered	Covered	Covered	
Hospice	Covered	Covered	Covered	
Emergency Services	Covered	Covered	Covered	Covered
Post-Stabilization Care Services	Covered	Covered	Covered	Covered
Foot Care Services	Covered	Covered	Covered	Covered
Eye Care and Low Vision Services	Covered	Covered	Covered	
Durable Medical Equipment (DME)	Covered	Covered	Covered	
Audiology, Hearing Aids Services & Products	Covered	Covered	Covered	
Family Planning and Reproductive Health Services	Covered	Covered	Covered	Covered
Infertility	Covered through FFS	Covered	Covered through FFS	Covered

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Non-Emergency Transportation	Covered through FFS	Covered through FFS	Covered through FFS	Covered
Emergency Transportation	Covered through FFS	Covered through FFS	Covered through FFS	Covered
Dental and Orthodontic Services—includes preventive and routine dental care	Covered Administered by Delta Dental 1-800-542-9782	Covered Administered by Delta Dental 1-800-542-9782	Covered Administered by Delta Dental 1-800-542-9782	
Medical Dental—fracture repair, tumor removal, treatment of accidental injury and Congenital disease management	Covered Coordinated by CDPHP	Covered Coordinated by CDPHP	Covered Coordinated by CDPHP	
Fluoride Varnish Treatment	Covered for children for birth until age 7 years when applied by a physician, physician assistant, registered nurse, or nurse practitioner. Covered for six months to 20 years of age when applied by a dentist.	Covered for children for birth until age 7 years when applied by a physician, physician assistant, registered nurse, or nurse practitioner. Covered for six months to 20 years of age when applied by a dentist.		
Court-Ordered Services	Covered, pursuant to court order	Covered, pursuant to court order	Covered, pursuant to court order	
LDSS Mandated SUD Services	Covered, pursuant to Welfare Reform/ LDSS mandate	Covered, pursuant to Welfare Reform/ LDSS mandate	Covered, pursuant to Welfare Reform/ LDSS mandate	
Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered	Covered	
Mental Health Services	Covered	Covered	Covered	
SUD Inpatient Detoxification Services	Covered	Covered	Covered	
SUD Inpatient Rehabilitation and Treatment Services	Covered	Covered	Covered	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
SUD Residential Addiction Treatment Services	Covered	Covered	Covered	
SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Covered	Covered	Covered	
SUD Medically Supervised Outpatient withdrawal	Covered	Covered	Covered through FFS	
Buprenorphine Prescribers	Covered	Covered	Covered	
Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis	Covered on a case by case basis	
Asthma Self-Management	Covered	Covered	Covered	
Renal Dialysis	Covered	Covered	Covered	
Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.		
Personal Care Services	Covered When only Level I services provided, limited to 8 hours per week.	Covered When only Level I services provided, limited to 8 hours per week.	Covered When only Level I services provided, limited to 8 hours per week.	
Personal Emergency Response System (PERS)	Covered	Covered	Covered	
Consumer Directed Personal Assistance Services	Covered	Covered	Covered	
Observation Services	Covered	Covered	Covered	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	
Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	
Adult Day Health Care	Covered	Covered	Covered	
AIDS Adult Day Health Care	Covered	Covered	Covered	
Community Health Worker	Covered for members under 21 years of age, adult members with chronic conditions, justice-involved, those with unmet health-related social care needs, and individuals experiencing community violence. NYS Medicaid members are eligible for CHW services during pregnancy and up to 12 months after the end of pregnancy, regardless of the pregnancy outcome.	Covered for members under 21 years of age, adult members with chronic conditions, justice-involved, those with unmet health-related social care needs, and individuals experiencing community violence. NYS Medicaid members are eligible for CHW services during pregnancy and up to 12 months after the end of pregnancy, regardless of the pregnancy outcome.	Covered for members under 21 years of age, adult members with chronic conditions, justice-involved, those with unmet health-related social care needs, and individuals experiencing community violence. NYS Medicaid members are eligible for CHW services during pregnancy and up to 12 months after the end of pregnancy, regardless of the pregnancy outcome.	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	
Medical Language Interpreter Services	Covered Language interpreter services must be provided during scheduled appointments and by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible. The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.	Covered Language interpreter services must be provided during scheduled appointments and by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible. The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.	Covered Language interpreter services must be provided during scheduled appointments and by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible. The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.	
Lactation Counseling	Covered Modifier AF (specialty physician) must be reported when the servicing provider is a physician	Covered Modifier AF (specialty physician) must be reported when the servicing provider is a physician	Covered Modifier AF (specialty physician) must be reported when the servicing provider is a physician	
Tuberculosis Directly Observed Therapy	Covered	Covered	Covered	
Crisis Intervention Services	Covered	Covered	Covered	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Harm Reduction Services and Treatment (CPST)	Covered, include plan of care and counseling services	Covered, include plan of care and counseling services	Covered, include plan of care and counseling services	
Psychosocial Rehabilitation (PSR)			Covered on a non-risk basis as directed by the State	
Community Psychiatric Support and Treatment (CPST)			Covered on a non-risk basis as directed by the State	
Habilitation Services			Covered on a non-risk basis as directed by the State	
Family Support and Training			Covered on a non-risk basis as directed by the State	
Short-term Crisis Respite			Covered on a non-risk basis as directed by the State	
Intensive Crisis Respite			Covered on a non-risk basis as directed by the State	
Education Support Services			Covered on a non-risk basis as directed by the State	
Peer Supports			Covered on a non-risk basis as directed by the State	
Pre-vocational Services			Covered on a non-risk basis as directed by the State	
Transitional Employment			Covered on a non-risk basis as directed by the State	
Intensive Supported Employment (ISE)			Covered on a non-risk basis as directed by the State	
Ongoing Supported Employment			Covered on a non-risk basis as directed by the State	
Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program			Covered	

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Assertive Community Treatment (minimum age is 18 for this adult oriented service)	Covered	Covered	Covered	
Continuing day treatment (minimum age is 18 for medical necessity for this adult oriented service)	Covered	Covered	Covered	
Comprehensive psychiatric emergency program, (CPEP) including Extended Observation Bed	Covered	Covered		Covered by MA FFS prior to 7/1/16 for adult. Covered by MA FFS prior to 7/1/19 for children
Community Psychiatric Support and Treatment (CPST)	Covered	Covered		N/A (New SPA service)
Family Peer Support Services	Covered	Covered		Prior to 7/1/19, covered by MA FFS as 1915(c) Children's waiver service
Health Home Care Management	Covered	Covered		
Intensive Psychiatric Rehabilitation Treatment (IPRT)	Covered	Covered		
Other Licensed Practitioner (OLP)	Covered	Covered		N/A (New SPA service)
Partial hospitalization	Covered	Covered		
Personalized Recovery Orientation Services (minimum age is 18 for medical necessity for this adult oriented service)	Covered	Covered		
Psychosocial Rehabilitation (PSR)	Covered for Children effective 1/1/19	Covered for Children effective 7/1/19		N/A (New SPA service)
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	Covered for Children effective 7/1/19	Covered for Children effective 7/1/19		OCFS Foster Care

Medicaid Covered Services *(continued)*

CDPHP Medicaid Products	CDPHP Select Plan		CDPHP HARP (effective 7/1/16)	New York State Pays
Member Eligibility within Product	**Not SSI or SSI Related**	**SSI or SSI-Related**	**HARP**	**Medicaid Fee for Service**
Youth Peer Support and Training (YPST)	Covered for Children effective 1/1/20	Covered for Children effective 1/1/20		
Residential Crisis Support These are overnight services that treat adults	Covered for persons who are age 18 or older with symptoms of emotional distress; Effective 12/01/2020. These symptoms cannot be managed at home or in the community without help.	Covered for persons who are age 18 or older with symptoms of emotional distress; Effective 12/01/2020. These symptoms cannot be managed at home or in the community without help.	Covered for persons who are age 18 or older with symptoms of emotional distress; Effective 12/01/2020. These symptoms cannot be managed at home or in the community without help.	
Intensive Crisis Residence These are overnight services that treat adults	Covered for persons who are age 18 or older who are having severe emotional distress; Effective 12/01/20.	Covered for persons who are age 18 or older who are having severe emotional distress; Effective 12/01/20.	Covered for persons who are age 18 or older who are having severe emotional distress; Effective 12/01/20.	
Children's Crisis Residence These are overnight services that treat children	This is a support and treatment program for people under age 21; Effective 12/01/20. These services help people cope with an emotional crisis and return to their home and community.	This is a support and treatment program for people under age 21; Effective 12/01/20. These services help people cope with an emotional crisis and return to their home and community.		

NOTE: The ordering practitioner and servicing provider are responsible for assuring that, in their best professional judgement, the ordered and requested medical, dental and remedial care, services or supplies will meet the Enrollee's medical needs; reduce the Enrollee's physical or mental disability; restore the Enrollee to his or her best possible functional level; or improve the Enrollee's capacity for normal activity; and that the ordered or requested services or supplies are necessary to prevent, diagnose, correct or cure a condition in light of the Enrollee's specific circumstances and the Enrollee's functional capacity to make use of the requested care, services or supplies.

Transportation

Emergency: If there is an emergency and the member needs an ambulance you must call 911.

Non-Emergent: If a CDPHP Medicaid member needs a bus, taxi, ambulette, or public transportation to get to a medical appointment, the member or provider must contact Medical Answering Services (MAS). If possible, when contacting MAS, the member or provider should call at least three days in advance of the medical appointment, and provide the Medicaid identification number (ex. AB12345C), appointment date and time, address where the member is going, and the provider that they are seeing. For MAS contact information, please see the chart below.

County	Non-Emergency Transportation Manager (MAS)
Albany	1-866-932-7740
Columbia	1-866-932-7740
Fulton	1-866-932-7740
Greene	1-866-932-7740
Montgomery	1-866-932-7740
Rensselaer	1-866-932-7740
Saratoga	1-866-932-7740
Schenectady	1-866-932-7740
Schoharie	1-866-932-7740
Warren	1-866-932-7740
Washington	1-866-932-7740

Residential Health Care Facility Services (Nursing Home)

Rehabilitation:

CDPHP covers short-term, or rehab stays, in a skilled nursing home facility.

Long-Term Placement (Select Plan only):

CDPHP covers long-term placement in a nursing home facility for members 21 years of age and older. **Long-term placement means they will live in a skilled nursing home.**

Eligible Veterans, Spouses or Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans Nursing Home.

Covered nursing home services include:

- medical supervision;
- 24-hour nursing care;
- assistance with daily living;
- physical therapy;
- occupational therapy;
- speech-language pathology and other services.

To get these nursing home services, the services must be ordered by a physician and authorized by CDPHP.

Members must also be found financially eligible for long-term nursing home care by their County Department of Social Services to have Medicaid and/or CDPHP pay for these services. When a member is eligible for long-term placement, they must select one of the nursing homes that are in CDPHP's network. If they want to live in a nursing home that is not part of CDPHP's network, they may transfer to another plan that works with the nursing home you have chosen to receive your care.

CDPHP does not have a Veterans Home in its network. If the member is an Eligible Veteran, a Spouse of an Eligible Veteran, or a Gold Star Parent of an Eligible Veteran and they want to live in a Veterans Home, they may transfer to another Medicaid Managed Care health plan that has a Veterans Home in its network.

National Diabetes Prevention Program (NDPP) Services

If members are at risk for developing Type 2 diabetes, CDPHP covers services that may help.

CDPHP will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The **National Diabetes Prevention Program** is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

Members may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, they meet one of the following criteria:

- Have had a blood test result in the prediabetes range within the past year, **or**
- Have been previously diagnosed with gestational diabetes, **or**
- Score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Infertility Services

If a member is unable to get pregnant, CDPHP covers services that may help. Effective April 1, 2023, Medicaid Fee-for-Service will cover some drugs for infertility. This benefit will be limited to coverage for three cycles of treatment per lifetime. CDPHP will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

- Office visits
- Radiographs of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

Members may be eligible for infertility services if they meet the following criteria:

- Are 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- Are 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

Personal Care Services (PCS)

Personal care services are covered for CDPHP Medicaid enrollees who, due to the presence of a medical condition, need additional assistance with activities of daily living (e.g., personal hygiene, dressing, housekeeping, meal preparation) to live independently at home. Services must be essential to the maintenance of the patient's health and safety in his or her own home.

To initiate services, for enrollees 18 years or older, New York Independent Assessor (NYIA) should be contacted by calling 1-888-222-8350 Monday – Friday from 8:30 am to 8:00pm and Saturday from 10:00am-6:00pm. Once NYIA is notified, they will initiate the assessment process which includes:

- An assessment for PCS will be done by a nurse from the New York Independent Assessor (NYIA) utilizing the Community Health Assessment (CHA)
- A clinical exam and Practitioner Order (PO) will be done by a clinician from the NYIA after the assessment

The NYIA will schedule both a CHA and a Clinical Appointment for the member and both will be completed within 14 days of contact with the NYIA. A separate visit to the members primary care provider to get a Physician's Order form is no longer needed when the services were initiated by NYIA. This may be required in certain circumstances until NYIA starts performing reassessments.

To initiate services, for members under 18 years of age, A **signed Practitioner Order, utilizing NYS DOH- 4359** form certifying that the enrollee can be cared for at home must include the following:

- Current medical conditions
- Treatment and medication regimens
- Stable medical condition
- Prohibited activities or functional limitations
- Dietary needs
- Order form must be written within 30 days of the physician's examination of the enrollee

Authorization Process

Upon receipt of a completed Practitioner Order and Community Health Assessment completed by the New York Independent Assessor, CDPHP will review the information to determine if NYIA is recommending PCS. If NYIA recommends PCS, CDPHP will arrange a time to develop the plan of care (POC) and person-centered service plan (PCSP) utilizing the CHA and PO.

During the development of the POC utilizing the CHA and PO we'll determine the amount of care needed by:

- Review and interpretation of the Practitioner Order
- Review and interpretation of the community health assessment
- Documenting the contribution of informal caregivers
- Evaluation of tasks and assistance needed by the enrollee
- Documentation of a stable medical condition
- Determining the amount, frequency, and duration of services

Upon completion of the POC and review of supporting documentation CDPHP will determine if the member meets the criteria for services. If appropriate, CDPHP will arrange for a licensed home care agency to provide the approved aide services. The NYIA Independent Review Panel (IRP) will review the plan of care if it has more than 12 hours of care per day on average for the first time.

For enrollees under 18 years of age, upon receipt of completed physician orders, CDPHP will arrange for an in-home assessment utilizing the NYS Universal Assessment System, to determine the amount of care needed by:

- Review and interpretation of the physician's order
- Review and interpretation of the completed in-home assessment
- Documenting the contribution of informal caregivers
- Evaluation of tasks and assistance needed by the enrollee
- Determining the amount, frequency, and duration of services

Upon receipt and review of the completed in-home assessment and supporting documentation CDPHP will determine if the member meets the criteria for services. If appropriate, CDPHP will arrange for a licensed home care agency to provide the approved aide services.

Services must be reauthorized at least annually or sooner if the enrollee's condition warrants it. New practitioner orders and a new community health assessment must be completed.

Consumer-Directed Personal Assistance Services (CDPAS)

Consumer-Directed Personal Assistance Services are covered for CDPHP Medicaid enrollees who, due to the presence of a medical condition, need additional assistance with activities of daily living (e.g., personal hygiene, dressing, housekeeping, meal preparation) to live independently at home. CDPAS is intended to permit chronically ill or physically disabled enrollees receiving home care services greater flexibility and freedom of choice in obtaining such services.

A member in need of personal care services, home health aide services, or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. CDPAS allows for more flexibility in regards to the care a member can receive under this program. Care typically provided by a licensed provider (e.g., Registered Nurse, Licensed Practical Nurse, Licensed Aide) can be provided by a CDPAS aide.

To initiate services, for enrollees 18 years or older, New York Independent Assessor (NYIA) should be contacted by calling 1-888-222-8350 Monday – Friday from 8:30 am to 8:00pm and Saturday from 10:00am-6:00pm. Once NYIA is notified, they will initiate the assessment process which includes:

- An assessment for CDPAS will be done by a nurse from the New York Independent Assessor (NYIA) utilizing the Community Health Assessment (CHA)
- A clinical exam and Practitioner Order (PO) will be done by a clinician from the NYIA after the assessment

The NYIA will schedule both a CHA and a Clinical Appointment for the member and both will be completed within 14 days of contact with the NYIA. A separate visit to the members primary care provider to get a Physician's Order form is no longer needed when the services were initiated by NYIA. This may be required in certain circumstances until NYIA starts performing reassessments.

To initiate services, for members under 18 years of age, A signed Practitioner Order, utilizing NYS DOH- 4359 form certifying that the enrollee can be cared for at home must include the following:

- Current medical conditions
- Treatment and medication regimens
- Stable medical condition
- Prohibited activities or functional limitations
- Dietary needs
- Order form must be written within 30 days of the physician's examination of the enrollee

Authorization Process

Upon receipt of completed Practitioner Order and Community Health Assessment completed by the New York Independent Assessor, CDPHP will review the information to determine if NYIA is recommending CDPAS. If NYIA recommends CDPAS, CDPHP will arrange a time to develop the plan of care (POC) and person-centered service plan (PCSP) utilizing the CHA and PO.

During the development of the POC utilizing the CHA and PO we'll determine the amount of care needed by:

- Reviewing and interpreting of the Practitioner Order
- Review and interpretation of the community health assessment
- Documenting the contribution of informal caregivers
- Evaluating tasks performed and assistance needed by the enrollee.
- Documentation of a stable medical condition
- Determining the amount, frequency, and duration of services

Upon completion of the POC and review of supporting documentation CDPHP will determine if the member meets the criteria for services. If appropriate, CDPHP will provide enrollee with their patient centered care plan that must be followed. The enrollee is responsible for recruiting, hiring, and training qualified individuals who will provide care to the enrollee.

For enrollees under 18 years of age, upon receipt of completed physician orders, CDPHP will arrange for an in-home assessment utilizing the NYS Universal Assessment System, and completion of a patient centered care plan to determine the amount of care needed by:

- Reviewing and interpreting of the physician's order, completed in-home assessment and patient centered care plan
- Documenting the contribution of informal caregivers
- Evaluating tasks performed and assistance needed by the enrollee
- Determining the amount, frequency, and duration of services

Upon receipt and review of the completed in-home assessment and supporting documentation CDPHP will determine whether the member meets the criteria for services. If appropriate, CDPHP will provide enrollee with their patient centered care plan that must be followed. The enrollee is responsible for recruiting, hiring, and training qualified individuals who will provide care to the enrollee.

Services must be reauthorized at least annually or sooner if the enrollee's condition warrants it. New practitioner orders and a new community health assessment must be completed.

Adult Day Health Care and AIDS Adult Day Health Care

Adult Day Health Care (ADHC) or AIDS Adult Day Health Care (AIDS ADHC) is covered for CDPHP Medicaid Enrollees with physical or mental impairment (e.g., children, people with dementia, or AIDS patients) that need medically-supervised services. Services provided include: nursing, transportation, leisure activities, physical therapy, speech pathology, nutrition assessment, occupational therapy, medical social services, psychosocial assessment, rehabilitation and socialization, nursing evaluation and treatment, coordination of referrals for outpatient health, and dental services. ADHC and AIDS ADHC are designed to assist individuals live more independently in the community or eliminate the need for residential health care services.

Authorization Process

A signed physician order for ADHC or AIDS ADHC services must be submitted to CDPHP to initiate the enrollee assessment for participation in these programs. The physician order must include the following:

- Evaluation for Adult Day Health Care of AIDS Adult Day Health Care
- Applicable Diagnosis

Upon receipt of signed physician orders CDPHP will arrange for the enrollee to attend a participating ADHC or AIDS ADHC program for up to two visits for an initial assessment to be completed and a person-centered comprehensive care plan to be developed. If more visits are needed to complete the assessment and care plan, the ADHC or AIDS ADHC may request CDPHP to authorize up to a total of five visits within 30 days.

Upon completion of the assessment, if the ADHC or AIDS ADHC provider agrees the member is in need of these services, the provider must request authorization of services from CDPHP.

Upon receipt of the completed assessment and the person-centered comprehensive care plan, CDPHP will review the request and make a determination for ongoing services (number of visits per week, duration, and types of services).

Reassessment Process

CDPHP will ensure that the need for ADHC or AIDS ADHC services is reassessed at least once every six months. A new physician order is not required to continue ADHC or AIDS ADHC services. Reassessments are conducted by the ADHC or AIDS ADHC provider. If the provider believes services should continue, a new assessment and person centered care plan must be submitted to CDPHP for authorization of services for the new period.

The ADHC or AIDS ADHC provider must notify CDPHP if it is recommending the member be discharged from the program.

CDPHP will notify the provider if continued treatment will not be authorized and issue any required notice.

Personal Emergency Response System

Personal Emergency Response System (PERS) is the provision and maintenance of electronic communication equipment in the home of certain high-risk individuals to secure help in the event of a physical, emotional, or environmental emergency. A PERS has three components: a small radio transmitter, a console that is connected to a telephone, and an emergency response center that monitors calls.

CDPHP covers PERS for certain Medicaid Enrollees:

- Only enrollees currently receiving personal care or consumer-directed personal care are eligible for personal emergency response services.

Authorization Process

Authorization of PERS is completed in coordination with the authorization process for personal care/consumer-directed personal assistance. A separate PERS assessment is completed during the in-home assessment visits annually.

Upon completion of the completed PERS assessment, CDPHP will determine whether the enrollee meets the criteria for PERS. If the enrollee meets the criteria, CDPHP will coordinate with a participating PERS agency to start services.

Qualifying for personal care services does not necessarily mean an enrollee automatically qualifies for PERS services. Services must be reauthorized annually.

Behavioral Health Care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

Mental Health Care

- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services in a community home or in family-based treatment
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment services
- Individual and group counseling
- Crisis intervention services
- Children and Family Treatment and Support Services (CFTSS)

Substance Use Disorder Services

- Crisis Services/Detoxification
  - o Medically Managed Withdrawal and Stabilization Services
  - o Medically Supervised Inpatient Withdrawal and Stabilization Services
  - o Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
  - o Stabilization
  - o Rehabilitation
  - o Reintegration
- Outpatient Addiction Treatment Services
  - o Outpatient Clinic
    - Intensive Outpatient Treatment
    - Ancillary Withdrawal Services
    - Medication Assisted Treatment
  - o Outpatient Rehabilitation Services
  - o Opioid Treatment Programs (OTP)

Applied Behavior Analysis (ABA) Services

Effective January 1, 2023, eligible CDPHP plans will cover Applied Behavior Analysis (ABA) therapy provided by a:

- Licensed Behavioral Analyst (LBA), or
- Certified Behavioral Analyst Assistant (CBAA) under the supervision of an LBA.

Who can get ABA?
Benefits for Applied Behavior Analysis (ABA) are available to individuals of any age and for any diagnosis where ABA is an appropriate treatment modality.

ABA services include:

- Assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant,
- Individual treatments delivered in the home or other setting,
- Group adaptive behavior treatment, and
- Training and support for family and caregivers.

Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs

Eligible CDPHP plans will cover Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs. This treatment can be provided face-to-face or via telehealth, from an OASAS outpatient program or, if necessary, an OASAS impatient or residential program. A referral from a primary care provider is not needed to obtain this treatment.

Home and Community Based Services (HCBS)—HARP Only

Behavioral Health HCBS are covered for CDPHP HARP enrollees to help maintain those with serious mental illness and substance use disorder in home and community settings.

HCBS requires a person-centered approach to care planning, service authorizations and service delivery targeting life goals such as educational, social, vocational, and self-maintenance. Enrollee with functional impairments that substantially interfere with or limit one or more major life activities are eligible for these services.

Eligibility for HCBS is determined using the state-developed brief assessment tool, administered by the member's Health Home care manager. For members who have chosen not to participate with a Health Home, CDPHP can still use the Health Home solely for the assessment and care plan development. If determined to be eligible, a full HCBS assessment is completed.

The health home care manager, in collaboration with the member, and in consultation with HCBS service providers (who will determine the frequency, scope and duration of services), develops a comprehensive and integrated plan of care that includes physical and behavioral health service, the recommended HCBS and selected in-network providers.

The completed care plan is forwarded to CDPHP for review per Resource Coordination policy 1370/20.000489, Behavioral Health Home and Community Based Services for Adults. CDPHP works collaboratively with the member and the Health Home care manager to finalize an approved plan of care.

When approved, the Health Home care manager ensures that enrollee is referred to services listed and monitors the plan of care to ensure the enrollee is receiving approved HCBS. Service authorization will be re-reviewed at least every year and as enrollee's condition warrants.

CDPHP shall monitor the utilization of HCBS services to determine adherence with the approved plan of care. State designated providers of HCBS are expected to timely notify CDPHP of HARP members who fail to keep appointments and are under-utilizing approved HCBS services.

Home and Community Based Services (HCBS)—Children

Services previously delivered under agency-specific 1915(c) waivers will be aligned and moved under the authority of the NYS 1115 Waiver. Since October 1, 2019, the date Children's HCBS were included in the Medicaid Managed Care benefit package, Medicaid Managed Care Plans were required to pay, at minimum, government rates for HCBS, and reimbursement occurred on a non-risk basis. Effective October 1, 2024, Children's HCBS are expected to be added to managed care capitation rates. The benefits are listed below (additional detail can be found in the current NYS Children's Health and Behavioral Health Services Billing and Coding Manual, as well as the Children's Home and Community Based Services Manual):

- Health Home
- Accessibility Modifications*
- Adaptive and Assistive Equipment*
- Caregiver/Family Supports and Services
- Habilitation
- Non-Medical Transportation
- Palliative Care

- Prevocational Services
- Respite
- Supported Employment

All HCBS under the 1115 MRT Waiver are available to any child/youth determined eligible. Eligibility is based on Target Criteria, Risk Factors, and Functional Limitations. Individuals must meet institutional and functional eligibility criteria for LOC under the Demonstration using either: 1) the Child and Adolescent Needs and Strengths New York (CANS-NY) tool; or 2) the Office for People with Developmental Disabilities (OPWDD) Level of Care/Medical Care Screen eligibility tool for children with developmental disabilities who may be medically frail or in foster care. Health Homes will most typically provide care management for children/youth eligible for HCBS services, but the MCO will be responsible for care management if the child/youth or parent declines Health Home care management.

** Effective July 1, 2024, service is carved out of Medicaid Managed Care, and the review, payment, and approval of the service is managed by Children's Health Home of Upstate New York (CHHUNY) who will serve as the designated FMS provider in conjunction with the NYS DOH*

Community Oriented Recovery and Empowerment (CORE) Services - HARP and HARP-eligible only

CORE Services were added to the Medicaid Managed Care benefit package for HARP members, effective September 2022, and are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

CORE Services are authorized under the 1115 Demonstration Waiver and replaced Adult Behavioral Health HCBS as a benefit for HARP and HARP-eligible HIV-SNP enrollees. Four HCBS transitioned to CORE - Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services-Peer Support. This will improve access to services and use the expertise of clinicians and rehabilitation practitioners to support the eligibility and intake process.

Enrollees eligible for CORE services will still receive care management services through the Health Home and through CDPHP. The NYS Eligibility Assessment is not required to access CORE services, and therefore, an enrollee with an H2 or H3 code is not prevented from accessing CORE services. To be eligible for CORE services, individuals must be enrolled in HARP, and be HARP-eligible and enrolled in an HIV-SNP. Individuals enrolled in HARP or are HARP-eligible and HIV-SNP enrolled are eligible for CORE Services with an LPHA recommendation regardless of H-code status.

Health Home Care Management

CDPHP coordinates some Select Plan members' physical and behavioral health services using employed case managers or contracted health homes. CDPHP will assign all HARP members to a health home upon enrollment, as well as ensuring that all Waiver-enrolled youth are connected to a Health Home. Select Plan members can be referred to the CDPHP Care Management team for assistance with a health home referral at any time, based on identified need for health home services. These include members meeting the state's health home eligibility criteria (e.g., one or more chronic health conditions and key diagnoses) or high emergency room utilization, difficulty navigating the health care system, homelessness and other psychosocial needs.

In accordance with state requirements, the health home provider is accountable for member engagement, coordination of all needed services, and the creation of plans of care through the use of a dedicated care manager. Health homes have policies and procedures to support effective collaboration, including case review meetings, with the member's providers and CDPHP. The Health Home ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services. The Health Home provider has a system to track and share information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs. Health Homes also have obligations for timely completion of InterRAI assessments and plans of care for HARP HCBS eligibility, in accordance with state guidance.

CDPHP monitors the performance of the Health Home and the Health Home service providers using the appropriate financial, programmatic and oversight tools and measures. All such tools and measures used shall be shared with the Health Homes to facilitate and foster proactive ongoing continuous improvement efforts.

Payment for health home services shall be in accordance with NYS Department of Health requirements, including but not limited to state issued guidance on billing and payment levels for health home services and guidance relating to payments to providers transitioning from one of the 1915(c) waivers being transitioned to Medicaid managed care as of January 1, 2019.

To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. CDPHP will execute a single case agreement for children enrolled in a Health Home when the Health Home is not under contract with CDPHP.

Medically Fragile Children

Included below, in its entirety, are the New York State-required principles applicable to the review of services for certain children in Select Plan. CDPHP complies with these requirements in its UM program. See also the policy entitled, "Review Process For Resource Coordination 1370/20.000213.

Office of Health Insurance Programs Principles for Medically Fragile Children

A "medically fragile child" (MFC) is defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria: (1) is technologically dependent for life or health sustaining functions, (2) requires a complex medication regimen or medical interventions to maintain or to improve their health status, (3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

Health plans shall do the following with respect to MFC:

A. In accordance with the requirements of C/THP and EPSDT as described in Section 10.4 of the DOH Model Contract, cover all services that assist MFCs in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. Health Plans must continue to cover services until that child achieves age-appropriate functional capacity.

B. Shall not base determinations solely based upon review standards applicable to (or designed for) adults to MFC. Adult standards include, but are not limited to, Medicare rehabilitation standards and the "Medicare 3 hour rule". Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

C. Accommodate unusual stabilization and prolonged discharge plans for MFC, as appropriate. Areas plans must consider when developing and approving discharge plans include, but are not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for an MFC at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for an MFC; the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other inappropriate setting for an MFC, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds or pediatric ventilator units).

MMCOs must develop a person centered discharge plan for the child taking the above situations into consideration.

D. It is Health Plan's network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility; payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the plan to identify an appropriate provider. MMCOs are required to approve the use of out-of-network (OON) providers if they do not have a participating provider to address the needs of the child.

E. MMCOs must ensure that MFCs receive services from appropriate providers that have the expertise to effectively treat them and must contract with providers with demonstrated expertise in caring for MFCs. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authori-zation from the MMCO for out-of-network providers when participating providers cannot meet the child's needs. The MMCO must authorize services as fast as the enrollee's condition requires and in accordance with established timeframes in the Medicaid Managed Care Model Contract.

CDPHP shall designate a Liaison for Medically Fragile Children to provide access to a plan liaison for Health Homes, providers and families seeking authorization of services necessary to support children in community based settings. This liaison shall serve as the main plan contact to supplement other plan resources for provider and families as they seek to access care for medically fragile children. Providers can access the liaison via the single source referral line, 1-888-94-CDPHP (1-888-942-3747)

Benefits Provided through Medicaid Fee-For-Service

- Emergency and Non-Emergency Transportation
- Developmental Disabilities
  - o Long-term therapies
  - o Day treatment
  - o Housing services
  - o Medicaid Service Coordination (MSC) program
  - o Services received under the OPWDD Home and Community Based Services Waiver
  - o Prescription Medications (effective 4/1/2023)

Benefits Not Covered by CDPHP or Medicaid

- Personal/comfort care items while hospitalized
- Cosmetic surgery that is elective
- Routine foot care unless medically necessary
- Chiropractic services
- Services from a non-participating provider, unless it is a provider they are allowed to see, as described elsewhere in this manual, or CDPHP or the member's primary care provider (PCP) sent them to such non-participating provider
- Services that required approval in advance and approval was not obtained

Foster Care

Voluntary Foster Care Agency (VFCA) Transition into Managed Care

As of July 1, 2021, children/youth in the care of VFCAs receive Medicaid benefits through Medicaid Managed Care, unless otherwise exempted or excluded. Non-agency-placed children/youth in foster care have been covered through Medicaid Managed Care since 2013.

A **Voluntary Foster Care Agency** is a foster care agency responsible for the temporary custody and care of children/youth placed in foster care either by order of a court (involuntary) or because their parents are willing to have them cared for temporarily outside the home (voluntary).

CDPHP is responsible for reimbursing VFCA for all medically necessary services provided to CDPHP members for whichthe VFCA is licensed to provide. This includes reimbursement for any services paid through a State determined Preventive Residential Supports and Services rate.

Contracts with 29-I agencies

To align with Managed Care enrollment of children in the care of a VFCA, VFCAs may choose to become licensed health care facility providers through New York State Public Health Law (PHL) Article 29-I, which will allow them to provide Core Limited Health Related Services (CLHRS) and Other Limited Health Related Services (OLHRS), as well as to enter into agreements with Medicaid Managed Care Plans. CDPHP shall ensure contracts are executed with all 29-I agencies in its service area, as well as offer contracts to additional counties representing common referral patterns for children in the plan.

CDPHP shall execute SCAs with licensed VFCAs as needed for children placed outside of the service area. The CDPHP foster care liaison will facilitate all internal processes necessary to ensure a member placed in a non-participating VFCA is afforded the same access to services (e.g., assessments, care by local essential community providers) as one placed in a participating facility. This may include coverage of services provided by non-participating providers in the event CDPHP does not have participating providers available.

Foster Care Placement and Discharge

If an enrolled child in foster care is placed in another county, and CDPHP operates in that new county, CDPHP allows the child to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.

If an enrolled child in foster care is placed outside of CDPHP's service area, CDPHP shall permit the child to access providers with expertise treating children in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.

In the case of a long-term foster care placement outside of CDPHP's service area, and solely at the direction of the local department of social services (LDSS) or VFCA, CDPHP will coordinate with the LDSS or VFCA for a smooth transition of enrollment.

Upon notice of a child leaving foster care, the CDPHP Foster Care Liaison shall coordinate with the VFCA Managed Care Liaison and Health Home Care Manager, if applicable, throughout the discharge planning process.

Upon disenrollment from the Plan, the CDPHP Foster Care liaison shall coordinate with the LDSS Foster Care Coordinator and/or VFCA Managed Care Liaison, as well as any Health Home Care Manager to ensure that the LDSS/VFCA and the new Plan are aware of the transition so the current service plan/POC can be coordinated.

Upon discharge from foster care, or disenrollment from CDPHP, if the child is considered unstable by either the health care provider or the LDSS/VFCA, or has a chronic condition, the CDPHP Foster Care Liaison shall coordinate with the LDSS Foster Care Coordinator and/or VFCA Managed Care Liaison and any Health Home Care Managers to ensure that continuity of care plans are in place.

ID Cards

For current Plan enrollees entering foster care, the CDPHP shall issue replacement identification cards or alternative documentation upon request of the LDSS Foster Care Coordinator and/or VFCA Managed Care Liaison by the next business day following the request.

Assessments

CDPHP will authorize and cover all foster care intake assessments necessary at the time of the child's entry into foster care including initial screens, comprehensive diagnostic assessments and any additional assessments identified by the Office of Children and Family Services (OCFS), and/or the LDSS/VFCA. These assessments will be provided to members within the timeframes specified by OCFS or the County, consistent with the state guidance (i.e., NYS MMCO Children's System Transformation Standards). (See Foster Care Initial Health Services Time Frames Chart.) Following these assessments, CDPHP will facilitate access to providers and coordinate care for recommended treatment. CDPHP will reimburse the intake screens, the complete diagnostic assessments, and any additional mandated assessments as identified by the LDSS/VFCA for these members.

Initial Health Services Time Frames

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Who Performs
24 Hours	Initial screening/screening for abuse/neglect	✔	✔	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	For children under the age of 13, conduct HIV risk assessment	✔	✔	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	✔	✔	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	✔	✔	Health practitioner
30 Days	Initial dental assessment	✔	✔	Health practitioner
30 Days	Initial mental health assessment	✔		Mental health practitioner
30 days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	✔	✔	Health Practitioner
45 Days	Initial developmental assessment	✔		Health practitioner
45 Days	Initial substance use disorder assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner

OCFS Regulations regarding HIV Counseling and Testing of children and youth in foster care have been revised to reflect the May 2017 updates to Public Health Law. VFCA/LDSS are required to conduct an HIV risk assessment on children under the age of 13 within 5 days of entering foster care placement and annually thereafter. All patients age 13 or older receiving primary care services must be offered HIV testing at least once as a routine part of health care.

In addition to the above, there are assessments/evaluations that are required to be completed during the course of the foster care placement. These assessments are time-sensitive and impact a child's health, safety, and well-being. CDPHP does not require prior authorization for these assessments.

Examples of ongoing assessments include:

- Following absent without consent (AWOC)
- For purposes of determining eligibility for residential placements (OPWDD, OMH, OASAS and OCFS placement)

- Updated/repeated assessments/evaluations are routine and standard. Children/youth in foster care often require multiple assessments/evaluations as they may experience changes in functionality and/or clinical presentation that impact service intensity.

Durable Medical Equipment

CDPHP will authorize any necessary replacement of durable medical equipment including specialized beds, wheel chairs, strollers, lifts, orthotics, supine standers, and other medically necessary equipment. Items such as hearing aids and batteries, neutralizers, and inhalers will be covered through Medicaid Fee-for-Service. For a full list of items, visit https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf

Hospitalization

In the event of a hospitalization or inpatient stay, CDPHP together with LDSS/VFCA, and/or a member's health home will coordinate appropriate discharge plan including, if needed, identification of an appropriate residential setting and timely access to medically necessary follow-up services.

Urgent Services

CDPHP will provide authorization necessary for reimbursement of medically necessary covered services immediately needed by the child in coordination with LDSS/VFCA (i.e., urgent services).

Medical Care Management

CDPHP will make care management services available to all children/youth in foster care, as well as upon discharge from foster care, to ensure access to all necessary services.

VFCA Reimbursement

CDPHP shall reimburse 29-I agencies at the NYS Medicaid FFS rates for Core Limited Health-Related Services for the four-year transition period from July 1, 2021 through June 30, 2025. Core Limited Health-Related Services are covered on a per diem basis for eligible children served by a 29-I Health Facility, and are inclusive of Nursing Services, Skill Building by a Licensed Behavioral Health Practitioner (LBHP), Medicaid Treatment Planning and Discharge Planning, Clinical Consultation/Supervision Services, and VFCA Managed Care Liaison/Administration services. CDPHP shall reimburse 29-I agencies for Other Limited Health-Related Services for the four-year transition period at the Medicaid FFS fee schedule (where available), unless alternative arrangements have been made between CDPHP and such providers and have been approved by DOH and OCFS (e.g., value-based payment arrangements). Other Limited Health-Related Services that the 29-I Health Facility is authorized by the State to provide may include Children and Family Treatment and Support Services (CFTSS), Children's Waiver Home and Community Based Services (HCBS), and other Medicaid State Plan services, including screening diagnosis, and treatment services related to a child or youth's physical, developmental, and behavioral health.

CDPHP Foster Care Liaison

CDPHP uses dedicated fax and secure email protocols for communication between the CDPHP Foster Care Liaison and representatives from OCFS/LDSS/VFCA to support the following purposes:

- For receiving transmittal forms identifying new enrollments or disenrollments, changes in placement or address, and changes in health status or provider.
- To notify the LDSS/VFCA of any health or other concerns in order to care for the child appropriately.
- To resolve gaps or barriers to timely access that are related to needed physical health and behavioral health services for children in foster care, which shall include identification of providers with special expertise in treating children in foster care, when appropriate.
- To facilitate prospective enrollment of children in foster care that are new to managed care.
- To send Welcome Letters and identification cards to the LDSS Foster Care Coordinators within 14 days of enrollment and provide a form of temporary identification for a new enrollee in foster care and transmit it to the LDSS/VFCA Foster Care Coordinator by the next business day following the request or as needed to allow immediate access to services.
- To work with the CPDHP health care network strategy team to ensure a sufficient network capacity to meet the time frames for completion of required foster care initial health assessments.

Providers can contact CDPHP for assistance with issues related to foster care using their traditional points of contact. Staff shall transfer such contacts to the State Programs Foster Care Liaison for timely action. CDPHP shall work with all providers (called VFCA essential community providers by the NYSDOH) who serve children in foster care to ensure continued access to care.

Claims

All claims will be submitted to CDPHP. Physicians will follow the same claim submission and follow-up time frames as for our commercial members. Refer to Section 9, Claims Submission, for specifics.

Emergency Procedures

Behavioral Health Crisis Calls

When an emergency behavioral health call is received:

- **If enrollee is threatening suicide or is in imminent danger:**
  - o ***During*** normal business hours (8:00am to 6:00pm) – the CDPHP representative will attempt to obtain the caller's location, requesting a manager/supervisor call 911. The representative stays on the line until help arrives.
  - o ***After*** normal business hours - CONTACT Lifeline staff will follow their normal policies/procedures, including outreach to 911.
- **If enrollee is not in imminent danger:**
  - o ***During*** normal business hours (8:00am to 6:00pm) – the enrollee is warm transferred to a behavioral health specialist for assessment and to provide referral information.
  - o ***After*** normal business hours – on-call staff calls CONTACT Lifeline, the after-hours crisis hotline,while the enrollee is on the line, providing enrollee's name, ID number, phone number and a description of the issue. Enrollee is advised that CONTACT Lifeline staff will directly assist the enrollee.

Reporting Communicable Diseases, Developmental Delays, and Abuse

Physicians play a critical role in the prompt reporting of communicable diseases, suspected cases of developmental delay or disability in children, and suspected incidents of child abuse. *The primary responsibility for reporting rests with the physician.*

Please be aware of the requirements of New York State Sanitary Code (10NYCRR 2.10) regarding the reporting of communicable diseases, including suspected cases and certain carriers, to local health departments. Learn more and download the necessary form at www.health.state.ny.us/professionals/diseases/reporting/communicable/.

Learn more about the New York State Early Intervention Program (EIP) at www.health.ny.gov/community/infants_children/early_intervention/.

For details about mandated reporting of physical abuse, please go to https://ocfs.ny.gov/publications/Pub1159/OCFS-Pub1159.pdf

For communicable disease reporting requirements, go to: https://www.health.ny.gov/forms/instructions/doh-389_instructions.pdf

Maintenance of Records

Participating providers are required to maintain appropriate records including:

- Records related to services provided to enrollees, including a separate medical record for each enrollee;
- All documents concerning enrollment fraud or the fraudulent use of any CIN;
- All documents concerning duplicate multiple CINs;
- Appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds.

Access and Availability Standards

Appointment Type	Standard	Urgent	Emergency	Follow-Up to Emergency or Hospital Discharge	Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Well child care	Within four (4) weeks of request				
Adult Baseline and routine physicals (Adults >21 years)	Within twelve (12) weeks from enrollment				
Routine non-urgent, preventive appointments, except as otherwise provided	Within four (4) weeks of request				
Initial family planning visits	Within two (2) weeks of request				
Initial prenatal visit	Within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester				
Initial PCP office visit for newborns	Within two (2) weeks of hospital discharge				
Non-urgent "sick" visit	Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated				
For emergency care			Immediately upon presentation at a service delivery site		
For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services			Immediately upon presentation at a service delivery site		
Urgent care		Within twenty-four (24) hours of request			
Non-urgent "sick" visit					

Access and Availability Standards *(continued)*

Appointment Type	Standard	Urgent	Emergency	Follow-Up to Emergency or Hospital Discharge	Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement
For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs		Within twenty-four (24) hours of request			
Specialist referrals (not urgent), except as otherwise provided	Within four (4) to six (6) weeks of request				
Non-urgent mental health or Substance Use Disorder visits with a Participating Provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic	Within one (1) week of request			Within five (5) business days of request	Within five (5) business days of request
Behavioral health specialist referrals (not urgent): A. For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Use Disorder treatment services B. For PROS programs other than clinic services	 Within two (2) to (4) weeks of request Within two (2) weeks of request				

Access and Availability Standards *(continued)*

Appointment Type	Standard	Urgent	Emergency	Follow-Up to Emergency or Hospital Discharge	Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Follow-up visits with a Participating Provider (as included in the Benefit Package)				Within five (5) days of request, or as clinically indicated	
Provider visits to make health, mental health and substance use disorder assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS	Within ten (10) days of request by CDPHP member				
HARP CORE Services: Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Family Support and Training, Empowerment Services - Peer Support	Within two (2) weeks of request			Within five (5) days of request, or as clinically indicated	Within five (5) days of request, or as clinically indicated
HARP HCBS: Habilitation, Education Support Services, Pre-vocational Services, Intensive Supported Employment, Ongoing Supported Employment	Within two (2) weeks of request				
Partial Hospitalization				Within five (5) business days of request	
Other Licensed Practitioner	Within one (1) week of request	Within 24 hours of request		Within 72 hours of request	Within 72 hours of request
Family Peer Support Services	Within one (1) week of request	Within 24 hours of request		Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training	Within one (1) week of request			Within 72 hours of request	Within 72 hours of request
Psychosocial Rehabilitation (PSR)	Within five (5) business days of request	Within 72 hours of request		Within 72 hours of request	Within 72 hours of request

Access and Availability Standards *(continued)*

Appointment Type	Standard	Urgent	Emergency	Follow-Up to Emergency or Hospital Discharge	Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Caregiver/Family Advocacy and Support Services	Within five (5) business days of request	Within 72 hours of request		Within five (5) business days of request	Within five (5) business days of request
Community Psychiatric Support and Treatment (CPST)	Within one (1) week of request	Within 24 hours (for intensive in-home) and crisis response		Within 72 hours of discharge	Within 72 hours of request
Intensive Psychiatric Rehabilitation Treatment (IPRT)	Within two (2)–four (4) weeks of request			Within 24 hours of discharge	
Crisis Respite		Within 24 hours of request	Within 24 hours of request	Within 24 hours of request	
Planned Respite	Within 24 hours of request			Within one (1) week of request	
Prevocational Services	Within two (2) weeks of request				Within two (2) weeks of request
Supported Employment	Within two (2) weeks of request				Within two (2) weeks of request
Habilitation	Within two (2) weeks of request				
Palliative Care	Within two (2) weeks of request			Within 24 hours of request	

Appointment Waiting Times

Members with appointments shall not routinely be made to wait longer than one hour. Providers seeing HARP members must have policies and procedures to address when CDPHP HARP members present for unscheduled, non-urgent care in order to promote access to appropriate care.

Expect Medicaid Managed Care Test Calls

For CDPHP participating providers in Medicaid, please be aware that the state imposes special requirements for access to care. The New York State Department of Health contacts provider offices to verify participation in CDPHP Medicaid and to check your compliance with appointment time frames.

These test calls may be confusing for office staff, as the caller will not use our product names. Your front office staff need to know that when a provider accepts CDPHP Medicaid, that means you accept Select Plan and HARP members. If the state uses the term "mainstream managed care" they are referring to the CDPHP Medicaid Select Plan product. For HARP members, they should use the HARP term.

It is also important to remember that providers must not require a new patient to complete prerequisites to schedule an appointment, such as: a copy of their medical record; a health screening questionnaire; and/or an immunization record. The New York State Department of Health considers prerequisites to scheduling appointments as barriers to gaining access to health care services.

Select Plan Network Requirements for the Children's System Transformation

In accordance with the minimum network requirements identified in the NYS MMCO Children's System Transformation Standards, CDPHP shall comply with the following:

CDPHP shall pay at least the Medicaid fee-for-service (FFS) fee schedule for 24 months from October 1, 2019, or as long as New York State mandates (whichever is longer) for the following services/providers:

i. New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports

ii. OASAS clinics (Article 32 certified programs)

iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)

iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

CPDHP shall contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

CDPHP shall reimburse for HCBS in accordance with the NYS fee schedule while CDPHP is not at risk for the service costs (e.g., for at least two years from the children's transition date of October 1, 2019 or until HCBS are included in the capitated rates). NYS has extended the deadline required for Managed Care Plans to pay government rates for Children's HCBS effective for dates of service through September 30, 2024. Effective October 1, 2024, Children's HCBS are expected to be added to managed care capitation rates.

CDPHP shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. CDPHP shall pay at least the FFS fee schedule for 24 months from January 1, 2019, for all SCAs, or as long as New York State mandates (whichever is longer).

Required Ownership Information Disclosure

A federal regulation (42 CFR 455.104) now requires network providers to disclose, at application/credentialing and recredentialing, ownership and control information to managed care organizations that contract with the state Medicaid agency. CDPHP includes this requirement in its credentialing process.

Providers who participate in the Medicaid FFS Program may meet this requirement by providing CDPHP with a copy or update of the standard Medicaid FFS enrollment form. Otherwise, the following information must be provided:

- Name (individual or corporation)
- Address (for corporate entities, this must include, as applicable, business address, every business location and P.O. Box address)
- DOB and SS# (individual)

- Tax ID # (corporation with ownership/control interest in disclosing entity and any subcontractor in which provider has a 5% or more interest)
- Familial relationships (spouse, parent, child or sibling) among persons with ownership or control interest in the provider
- Familial relationships (spouse, parent, child or sibling) between persons with ownership or control interest in the provider and persons with ownership or control interest in any subcontractor in which the provider has a 5% or more interest
- Name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the provider has an ownership or control interest

In addition, within 35 days of a request made by the New York State Department of Health, Office of the Medicaid Inspector General, or Department of Health and Human Services, participating providers must provide the following to the CDPHP:

- ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12-month period prior to the request; and
- any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor, during the five-year period ending on the date of the request.

Please refer to 42 CFR 455.101 for definitions of key terms under 42 CFR 455.104.

Certification Regarding Individuals Who Have Been Debarred or Suspended by Federal or State Government

Participating providers are required to have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, The National Plan and Provider Enumeration System (NPPES), System for Award Management (SAM), the List of Excluded Individuals and Entities (LEIE), and any other such databases as the Secretary may prescribe.

Check the LEIE, SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and NYS OMIG Exclusion List no less frequently than monthly. Providers must report to CDPHP when a match occurs.

CDPHP staff will conduct a biannual survey of a random sample of network providers to evaluate compliance with these requirements. Compliance issues identified as a result of such survey will prompt re-education efforts for the affected providers. Areas representing broad lack of understanding of these compliance obligations will prompt more frequent notices to providers on this topic.

Collection and Disclosure of Criminal Conviction Information

In accordance with CDPHP's policies on credentialing and recredentialing, all practitioners must disclose to CDPHP any history of felony convictions. Pursuant to requirements of the New York State Department of Health (NYS DOH), CDPHP will directly notify the NYS DOH of any criminal conviction information collected during the initial credentialing and subsequent recredentialing process, within 20 days of disclosure to CDPHP.

I. CDPHP will review disclosed criminal conviction information including, but not limited to:

A. Felony
- Conviction
- Guilty plea
- Plea of nolo contendere

B. Misdemeanor, in past ten years
- Conviction
- Guilty plea
- Plea of nolo contendere
- Found liable or responsible for: civil offense, reasonably related to qualifications, competence, functions, duties as a medical professional, fraud, act of violence, child abuse, sexual offense or sexual misconduct
  Note: Excludes minor traffic violations

C. Court-martialed
- For actions related to duties as a medical professional

II. CDPHP will disclose identified criminal conviction information to the NYS DOH within 30 days, or 20 working days, whichever is less.

Communication with Patients

Participating providers who wish to let their patients know of their affiliations with one or more Managed Care Organizations (MCO) must list each MCO with whom they have contracts. Participating providers who wish to communicate with their patients about managed care options must advise patients taking into consideration ONLY the MCO that best meets the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one plan over another.

Participating providers may display CDPHP outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the participating provider has a contract. Upon termination of a Provider Agreement with CDPHP, a provider that has contracts with other MCOs that offer Medicaid Managed Care (MMC) products may notify their patients of the change in status and the impact of such change on the patient.

Cultural Competency Requirements

As mandated by the New York State Department of Health, CDPHP requires all Medicaid providers attest to completion of annual cultural competency training for all staff who have regular and substantial contact with CDPHP members.

To satisfy this training requirement, download the U.S. Department of Health & Human Services Think Cultural Health training module at: thinkculturalhealth.hhs.gov/education. The free, online training offers several provider specific programs. Behavioral health providers may utilize the Think Cultural Health training or cultural competency training for behavioral health providers previously approved by New York state.

An attestation of training should be submitted by an authorized representative on behalf of all individuals encompassed under a practice's Tax Identification Number (TIN). Each staff member who completes this training does NOT need to submit the attestation. To submit the attestation electronically visit: https://insights.cdphp.com/c/r/CulturalCompetencyAttestation.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Services through the Child Teen Health Program (C/THP) and Adolescent Preventive Services—18 NYCRR § 508.8 (Select Plan Only)

The Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens, and diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age.Care and services in this program are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

Participating providers are required to provide C/THP services to enrollees under twenty-one (21) years of age when:

1. The care or services are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition.
2. The care or services are essential to the overall physical, cognitive and mental growth and developmental needs of the enrollee.
3. The care or service will assist the enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the enrollee and those functional capacities that are appropriate for individuals of the same age as the enrollee.

Providers must comply with the C/THP program standards and must do at least the following with respect to all Enrollees under age 21:

1. Educate enrollees who are pregnant women or who are the parents of enrollees under age 21 about the program and its importance to a child's or adolescent's health.
2. Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure children are kept current with respect to their periodicity schedules.
3. Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments. This also applies to dental service appointments for children and adolescents.
4. Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen
5. Achieve and maintain an acceptable compliance rate for screening schedules during the contract period.
6. Comply with the American Medical Association's Guidelines for Adolescent Preventive Services which require annual well adolescent preventive visits which focus on health guidance, immunizations, and screening for physical, emotional, and behavioral conditions.

Domestic Violence Community Resources (Information found at https://opdv.ny.gov/survivors-victims

Domestic violence (DV) is a public health issue which negatively impacts a patient's health outcome. Victims of DV are more at risk of a wide range of physical, mental, reproductive, and other health consequences over their lifetime than non-victims. Women and men of all races, ages, sexual orientations, and marital and socioeconomic statuses are at risk for domestic violence. However, some populations report higher rates of victimization.

It is important to examine the impact of domestic violence on all patients, as well as high-risk populations such as pregnant women, children, women with sexually transmitted infections (STIs), immigrants, and limited English proficient (LEP) victims.

As a healthcare provider, you have a crucial role in the successful treatment and ***safety*** of your patients.

Access the NYS Domestic Violence Program Directory: https//www.nyscadv.org/find-help/program-directory.html

Local hotlines can also provide you with information on domestic violence resources in your community. For the hotline number of your local domestic violence program, call the New York State Domestic Violence Hotline at 1-800-942-6906, English & Español/Multi-language Accessibility: Deaf or Hard of Hearing: 711

Welfare Reform (Applies to Medicaid Only)

The LDSS is responsible for determining whether each public assistance or combined public assistance/Medicaid applicant is incapacitated or can participate in work activities. As part of this work determination process, the LDSS may require medical documentation and/or an initial mental and/or physical examination to determine whether an individual has a mental or physical impairment that limits his/her ability to engage in work (12 NYCRR §1300.2(d)(13)(i)). CDPHP is not required to provide the initial district mandated or requested medical examination necessary for an enrollee to meet welfare reform work participation requirements.

Participating providers, upon MMC enrollee consent, are required to provide medical documentation and health, mental health and chemical dependence assessments as follows:

Within ten (10) days of a request of an MMC enrollee or a former MMC enrollee who is currently receiving public assistance or who is applying for public assistance, the MMC enrollee's or former MMC enrollee's PCP or specialist provider, as appropriate, shall provide medical documentation concerning the MMC enrollee or former MMC enrollee's health or mental health status to the LDSS or to the LDSS' designee. Medical documentation includes but is not limited to drug prescriptions and reports from the MMC enrollee's PCP or specialist provider.

Within ten (10) days of a request of an MMC enrollee who has already undergone, or is scheduled to undergo, an initial LDSS required mental and/or physical examination, the MMC enrollee's PCP shall provide a health, or mental health, and/or chemical dependence assessment, examination, or other services as appropriate to identify or quantify an MMC enrollee's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. The LDSS, may, upon written notice to the CDPHP, specify the format and instructions for such an assessment.

Informed Consent

Per Section 35.7 of the Medicaid Managed Care Model Contract, CDPHP must require participating providers to comply with the informed consent procedures for Hysterectomy and Sterilization as specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13. Providers who perform hysterectomy or other sterilization procedures are required to obtain informed consent from all Medicaid members undergoing a hysterectomy or other sterilization procedure. Additionally, a copy of the signed forms must be submitted with the claim. Any claims submitted without the applicable completed forms will be denied.

LDSS-3134 (2/01)

STERILIZATION CONSENT FORM

PATIENT NAME	CHART NO.	RECIPIENT ID NO.
HOSPITAL/CLINIC		

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I asked for the
(doctor or clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____Date: _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐1 American Indian or Alaska Native ☐ 4 Hispanic

☐2 Asian or Pacific Islander ☐ 5 White (not of Hispanic origin)

☐3 Black (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT■

Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowlingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon
_____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the
Operation
nature of the sterilization operation _____, the
Specify type of operation
fact that it is intended to be a final irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date sterilization was performed.

(2) This sterilization was preformed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable and fill in information requested):

☐ 1. Premature delivery
Individual's expected date of delivery: _____

☐ 2. Emergency abdominal surgery: _____
(describe circumstances): _____

_____ _____
Physician *Date*

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION

I, _____ do certify that on _____ I was present while the counselor read and explained the consent form to _____ and saw the patient sign the consent form in his/her handwriting.
(patient's name)

SIGNATURE OF WITNESS	TITLE	DATE
X		

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE
X		X	

DISTRIBUTION: 1 – Medical Record File 2 – Hospital Claim 3- Surgeon Claim 4 – Anesthesiologist Claim 5 – Patient

DSS-3113 (REV. 4/94)

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

(NYS MEDICAID PROGRAM)

EITHER PART I OR PART II MUST BE COMPLETED

RECIPIENT ID NO.	SURGEON'S NAME

Part I: RECIPIENT'S ACKNOWLEDGMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGMENT STATEMENT

It has been explained to me, _____, that the hysterectomy to be performed on me will
(RECIPIENT NAME)
make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me and all my questions have been answered to my satisfaction prior to the surgery.

RECIPIENT OR REPRESENTATIVE SIGNATURE	DATE	INTERPRETER'S SIGNATURE (if required)	DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

SURGEON'S SIGNATURE	DATE
X	

Part II: WAIVER OF ACKNOWLEDGMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on _____ was solely for medical indications. The
(RECIPIENT NAME)
hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgment of Receipt of Hysterectomy information from her and have her complete
Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

☐ 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility) _____

_____

☐ 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgment was not possible. (briefly describe the nature of the emergency)

_____

_____

☐ 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

SURGEON'S SIGNATURE	DATE
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

Child Health Plus

Program Description

Child Health Plus is a New York State insurance program providing health coverage to uninsured children up to the age of 19. The program provides a full range of medical services, including inpatient and outpatient services, preventive services, specialty, behavioral health, lab, X-ray, dental, and pharmacy services with no copayment by the member.

Referrals

Child Health Plus members are subject to the same referral system as our commercial HMO members. Referrals will be needed for specialty care, prior authorization for non-participating practitioner/provider services, etc. Members can contact member services at 1-800-388-2994 with questions.

Child Health Plus Benefits Package

No Pre-Existing Condition Limitations Permitted No Co-payments or Deductibles Effective January 1, 2025

General Coverage	Scope of Coverage	Level of Coverage
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the Advisory Committee on Immunization Practices recommended immunization schedule.	Includes all services related to visits. Includes immunizations which must be provided within 90 days from publication in the Morbidity and Mortality Weekly Report, well childcare, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, lead screening, and reproductive health services, with direct access to such reproductive health services.
Inpatient Hospital or Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. A private room will be covered if medically warranted. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy: general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-section. Also, coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Inpatient Mental Health and Alcohol and Substance Use Services	Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	No limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.
Residential Rehabilitation Services for Youth (RRSY)	Services to be provided in a facility issued a Part 817 operating certificate from the Office of Addiction Services and Supports (OASAS), pursuant to Article 32 of the Mental Hygiene Law.	Includes all services provided by the RRSY, as described in OASAS Part 817. These services include, but are not limited to, clinical services, recovery support services, educational and vocational assessments and services, Medication for Addiction Treatment (MAT) and food and nutrition services. Clinical services include individual, group, and family counseling, assessment and referral services for patients and significant others (e.g., parent/guardian(s), sibling(s), partner(s), etc.), medical and psychiatric consultation, and HIV and AIDS, hepatitis C, tuberculosis, and other communicable diseases education, risk assessment, supportive counseling and referral. Services must be clinically indicated and specified in the individualized treatment/recovery plan and/or progress notes. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT	Coverage includes comprehensive and integrated combination of treatment, rehabilitation, case management, and support services primarily provided in the client's residence or other community locations by a mobile, multi-disciplinary mental health treatment team.	Services support individual recovery through an assertive, person-centered approach that assists individuals to cope with the symptoms of their mental illness or serious emotional disturbance and reacquire the skills necessary to function and remain integrated in the community. ACT Services are intended to benefit individuals with serious Behavioral Health challenges and a treatment history that includes psychiatric Hospitalization and Emergency Room Care, involvement with the criminal justice system, alcohol or substance use, homelessness, at risk of, or history of institutional level of care or residential placement or lack of engagement in traditional outpatient services. Services must be referred by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. A full list of provider types covered under licensed practitioner of the healing arts can be found in Attachment 3.1-A of the New York Medicaid State Plan under Assertive Community Treatment in section 13.d Rehabilitative Services, or page five on the link below: https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2022-04-11_spa_21-15.pdf Coverage of ACT services is not covered if the child does not meet the criteria described below: (i) meet the definition of persons with serious mental illness as set forth in section 1.03 of the Mental Hygiene Law; (ii) have been referred or approved by the Single Point of Access entity for enrollment in ACT services; and (iii) are active clients of the ACT provider. No limitations. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the Office of Mental Health ACT Program Guidelines found here https://omh.ny.gov/omhweb/act/act_program_guidelines_2007_collateral.pdf for a more detailed description of services.	
Inpatient Rehabilitation	Acute care services provided by an Article 28 General Hospital	Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for Medically Necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediat treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed Medically Necessary.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Hospice Services and Expenses	Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.	Hospice Services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.

General Coverage	Scope of Coverage	Level of Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which: • Can withstand repeated use for a protracted period of time; • Are primarily and customarily used for medical purposes; • Are generally not useful in the absence of illness or injury; and • Are usually not fitted, designed or fashioned for a particular person's use. DME intended for use by one person may be custom-made or customized.	Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME. DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to: Fitted/Customized leg brace — Not fitted/Customized cane Prosthetic arm — Wheelchair Footplate — Crutches
	Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.	Covered without limitation except that there is no coverage for cranial prosthesis (i.e. wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery.
	Orthotic Devises are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.	No limitations on orthotic devices except that, devices prescribed solely for use during sports are not covered.

General Coverage	Scope of Coverage	Level of Coverage
Medical Supplies	Medical Supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.	Medical supplies coverage examples include, but are not limited to: • Diabetic Supplies • Enteral Formulas and Supplies • Wound dressings and disposable care accessories • Airway clearance device filters • Disposable collection and storage bag for breast milk A fiscal order for medical supplies may be refilled when the prescriber has indicated on the order the number of refills and the member has requested the refill. All refills must be appropriately referenced to the original order by the dispenser.
	Diabetic Supplies and Equipment	Insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents. As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.
	Ostomy Equipment and Supplies	Ostomy equipment and supplies used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma). As prescribed by a health care provider legally authorized to prescribe under title eight of the education law.
	NOTE: Refer to New York State Medicaid Program Procedure Code Manual for a more detailed description of covered services. https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf	
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) will also be covered.	No limitations. These therapies must be Medically Necessary and under the supervision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. No procedure or services considered experimental will be reimbursed.
	Hemodialysis	Determination of the need for services and whether home-based or facility-based treatment is appropriate.
	Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies.	Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home by a Home health Care agency, a properly trained parent or legal guardian of a child, or a properly trained child that is physically and developmentally capable of self-administering such products.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Speech and Hearing Services Including Hearing Aids	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If Medically Necessary, more than one hearing aid will be covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or nonrestorative.
Pre-Surgical Testing	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical Opinion	Provided by an appropriate Specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.
Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Use	Services must be provided by certified and/or licensed professionals.	No limitations. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if Hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contract must provide 40 such visits in any calendar year, if such visits are Medically Necessary.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Diabetic Education and Home Visits	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits Medically Necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.
Prescription and Non- Prescription Drugs	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be Medically Necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein, or which contain modified protein.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Emergency Medical Services	For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person.	No limitations.

General Coverage	Scope of Coverage	Level of Coverage
Ambulance Services	Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.	Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law. Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in: • Placing the health of the person afflicted with such condition in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. ***Transportation Between Hospitals:*** When a Child Health Plus enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient. If the admitting hospital sends an inpatient round trip to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services. ***The following ambulance transports are considered emergency transports; therefore, preauthorization is not required:*** • Transport from an Emergency Room to a Psychiatric Center • Transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center. • Transportation from an Emergency Room to an Emergency Room. • Transportation from an Emergency Room to Another Facility.

General Coverage	Scope of Coverage	Level of Coverage
Air Ambulance Services	Fixed wing air ambulance services and rotary wing air ambulance services	Air ambulance transportation must meet the following criteria: • The patient has a catastrophic, life-threatening illness or condition; • The patient is at a hospital that is unable to properly manage the medical condition; • The patient needs to be transported to a uniquely qualified hospital facility and ground transport is not appropriate for the patient; • Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; or • Life-support equipment and advanced medical care is necessary during transport. ***The following fixed wing air ambulance services are reimbursable when the transport physically occurs:*** • Base Fee (lift-off/call-out); • Patient loaded mileage; • Physician (when ordered by hospital); • Respiratory therapist (when ordered by the hospital, and only when the hospital is unable to supply); or • Destination ground ambulance charge (only when the destination is out of state). ***The following helicopter (rotary wing) air ambulance services are reimbursable:*** • Lift off from base; or •Patient occupied flight mileage.
	NOTE: Refer to the New York State Medicaid Program Transportation Manual Policy Guidelines for a more detailed description of services. https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf	
Emergency, Preventive and Routine Vision Care	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: • Case history • Internal and External examination of the eye • Opthalmoscopic exam • Determination of refractive status • Binocular balance • Tonometry tests for glaucoma • Gross visual fields and color vision testing • Summary findings and recommendations for corrective lenses
	Prescribed Lenses	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve-month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
	Contact Lenses	Covered when Medically Necessary.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Dental Care	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but not limited to:
		• Prophylaxis: scaling and polishing the teeth at 6-month intervals.
		• Topical fluoride treatment: when professionally administered in accordance with appropriate standards. Services must be provided by:
		  • Physicians and nurse practitioners for members 0 through 6 years of age.
		  • Dentists and dental hygienists (under general supervision of the dentist) in the dental office through age 19.
		  • Fluoride varnish is reimbursable to physicians and nurse practitioners once per three (3) month intervals under CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional).
		  • For dentists and dental hygienists, benefit is limited to gel, foam, and varnish and must be a minimum interval of three (3) months between all fluoride treatments under CDT codes D1206 (Professionally applied fluoride varnish) and/or D1208 (Topical application of fluoride excluding varnish).
		  Fluoride treatments that are not reimbursable under the program include:
		  • Treatment that incorporates fluoride with prophylaxis paste;
		  • Topical application of fluoride to the prepared portion of a tooth prior to restoration;
		  • Fluoride rinse or "swish"; and,
		  • Treatment for desensitization
		• Sealants on unrestored permanent molar teeth.
		• Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintain space for normally developing permanent teeth.

	Routine Dental Care	• Dental examinations, visits and consultations covered once within 6-month consecutive period (when primary teeth erupt) • X-ray, full mouth x-rays at 36-month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt) • All necessary procedures for simple extractions and other routine dental surgery not requiring Hospitalization including preoperative care and postoperative care • In office conscious sedation • Amalgam, composite restorations and stainless steel crowns • Other restorative materials appropriate for children
	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where Hospitalization is not required.

Child Health Plus Benefits Package *(continued)*

General Coverage	Scope of Coverage	Level of Coverage
	Prosthodontics	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Fixed: Fixed bridges are not covered unless 1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
	Orthodontics for severe physically handicapping malocclusions	Prior approval for orthodontia coverage is required. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday. Procedures include but are not limited to: • Rapid Palatal Expansion (RPE) • Placement of component parts (e.g. brackets, bands) • Interceptive orthodontic treatment • Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) • Removable appliance therapy • Orthodontic retention (removal of appliances, construction and placement of retainers) With the exception of D8210 (Removable appliance therapy), D8220 (Fixed appliance therapy) and D8999 (Unspecified orthodontic procedure, by report), orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.
	NOTE: Refer to the New York State Medicaid Dental Policy and Procedure Code manual for a more detailed description of services.	

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Other Licensed Practitioner (OLP)	Services performed by a non-physician Behavioral Health Provider for treatment necessary to address the prevention (to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable Behavioral Health disorder and reduce risk factors that can lead to the development of a Behavioral Health disorder), diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity. An assessment of needs may result in the recommendation of further Medically Necessary services, such as rehabilitative services. Services are delivered in a trauma informed, culturally and linguistically competent manner.	Includes services delivered by a Non-Physician Licensed Behavioral Health Provider (NP- LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. The clinical services provided under OLP are intended to help prevent the progression of Behavioral Health needs through early identification and intervention and may be provided to children/youth in need of assessment for whom Behavioral Health conditions have not yet been diagnosed. Services are also intended to provide treatment for children/youth with an existing diagnosis for whom flexible community-based treatment is needed to correct or ameliorate conditions identified during an assessment process, such as problems in functioning or capacity for healthy relationships. Limits/Exclusions: • Group limit refers to number of participants, regardless of payor. Groups should not exceed eight. Consideration may be given to smaller limit of members if participants are younger than eight years of age. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. • Groups may include family/collaterals, as long as the contact is directly related to the child/youth's treatment plan goals, for the benefit of the child/youth. • Inpatient hospital facilities are allowed for licensed professional other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is Medically Necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately. • Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered. • All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free-standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Child Health Plus. • If a child requires Medically Necessary services that are best delivered in the school setting by a community provider, the service needs to be detailed on the treatment plan. • If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's Individualized Education Plan (IEP) (504 plan services are not reimbursable by Child Health Plus). • Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Outpatient and Residential Crisis Intervention (CI)	Services for children/ youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it. A child/ youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning.	Includes services for engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Crisis Intervention includes five modalities: Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Residential Crisis Support and Intensive Residential Crisis. Limits/Exclusions: • The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature. • Services may not be primarily educational, vocational, recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training). Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps. • The child/youth's chart must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services with a developed plan should follow. Substance Use should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis Team members should be trained on screening for substance use disorders. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Community Psychiatric Supports and Treatment (CPST)	Services that are goal-directed supports and solution- focused interventions intended to address challenges associated with a Behavioral Health need and to achieve identified goals or objectives as set forth in the child/youth´s treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.	Services include the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g., provider office sites), and/or socializes. Limits/Exclusions: • The provider agency will assess the child prior to developing a treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A child with a developmental disability diagnosis without a co-occuring Behavioral Health condition is ineligible to receive this rehabilitative service. • Groups may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation • Group limit refers to number of participants, regardless of payor. Groups cannot exceed eight. • Consideration should be given to smaller limit of members if participants are younger than eight years of age. • Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator • Groups may include family/collaterals, with or without the child present, as long as the contact is directly related to the child/youth's goals and treatment plan • Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. The Institute of Medicine (IOM) defines 'evidence-based practice' as a combination of the following three factors: 1. best research evidence, 2. best clinical experience, and 3. consistent with patient values (IOM, 2001) Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person´s capacity to cope with or prevent symptom manifestation Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Psychosocial Rehabilitation (PSR)	Services are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or Behavioral Health barriers associated with a child/youth's Behavioral Health needs.	Includes services for restoration, rehabilitation, and support for a child/youth´s functional level as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of CPST. Services are delivered in a trauma informed, culturally and linguistically competent manner. Limits/Exclusions: • The provider agency will assess the child prior to developing a treatment plan for the child with the PSR worker implementing the intervention identified on the treatment plan. • A child with a developmental disability diagnosis without a co -occurring Behavioral Health condition is ineligible to receive this rehabilitative service. • Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth. • Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. • Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan • Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit necessary to correct or ameliorate conditions discovered during the initial assessment visit Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Community Psychiatric Supports and Treatment (CPST)	Services that are goal-directed supports and solution-focused interventions intended to address challenges associated with a Behavioral Health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.	Services include the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g., provider office sites), and/or socializes. Limits/Exclusions: • The provider agency will assess the child prior to developing a treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A child with a developmental disability diagnosis without a co-occuring Behavioral Health condition is ineligible to receive this rehabilitative service. • Groups may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation • Group limit refers to number of participants, regardless of payor. Groups cannot exceed eight. • Consideration should be given to smaller limit of members if participants are younger than eight years of age. • Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator • Groups may include family/collaterals, with or without the child present, as long as the contact is directly related to the child/youth's goals and treatment plan • Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. The Institute of Medicine (IOM) defines 'evidence-based practice' as a combination of the following three factors: 1. best research evidence, 2. best clinical experience, and 3. consistent with patient values (IOM, 2001). Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Psychosocial Rehabilitation (PSR)	Services are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or Behavioral Health barriers associated with a child/youth's Behavioral Health needs.	Includes services for restoration, rehabilitation, and support for a child/youth's functional level as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of CPST. Services are delivered in a trauma informed, culturally and linguistically competent manner. Limits/Exclusions: • The provider agency will assess the child prior to developing a treatment plan for the child with the PSR worker implementing the intervention identified on the treatment plan. • A child with a developmental disability diagnosis without a co-occurring Behavioral Health condition is ineligible to receive this rehabilitative service. • Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth. • Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. • Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan • Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Family Peer Support Services (FPSS)	Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.	Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. Services are delivered in a trauma informed, culturally and linguistically competent manner. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth´s treatment plan. Limits/Exclusions: • The provider agency will assess the child prior to developing the treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A child with a developmental disability diagnosis without a co-occurring Behavioral Health condition is ineligible to receive this rehabilitative service. • A group cannot exceed more than 12 individuals in total. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/ nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. Services shall be reimbursed in accordance with government rate-setting methodology.
Children and Family Treatment and Support Services (CFTSS): Youth Peer Support (YPS)	Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.	Youth Peer Support activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth´s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood. Limits/Exclusions: • The provider agency will assess the child prior to developing the treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A youth with a developmental disability diagnosis without a co-occuring Behavioral Health condition is ineligible to receive this rehabilitative service. • Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/ nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the New York State Children's Behavioral Health Transition to Managed Care website for additional information on covered services and billing guidance: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/index.htm	

General Coverage	Scope of Coverage	Level of Coverage
29-I Health Facility Core Limited Health-Related Services	Services include the five Core Limited Health-Related Services listed below: 1. Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates) 2. Nursing Services 3. Treatment Planning and Discharge Planning 4. Clinical Consultation/ Supervision Services 5. VFCA Child Health Plus Liaison/Administrator	The child's/youth's health/Behavioral Health record, treatment plan, service plan and/or plan of care must reflect that the services provided: • were Medically Necessary and appropriate, and • were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law Health/Behavioral Health Care Services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. These standards include: • State-mandated licensure requirements any other State-mandated certification and programmatic requirements that impact: o the types of providers that can deliver the services; o the specific nature of the services; and o the programmatic framework within which the services can be delivered, including supervision requirements. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the New York Medicaid Program 29-I Health Facility Billing Guidance for a more detailed description of covered services and billing guidance https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm	
Diagnosis and Treatment of an Autism Spectrum Disorder	Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders	Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • Behavioral Health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and • Pharmacy care. Applied behavioral analysis shall be covered. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/ or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.

General Coverage	Scope of Coverage	Level of Coverage
Home and Community Based Services (HCBS)	Support and provide services to children/youth in non-institutionalized settings that enable them to remain at home and in the community or for children/youth being discharged from an institutional setting who require these services to safely return to their home and community. Children/youth who are eligible for HCBS must have a physical health, developmental disability, and/or mental health diagnosis with related significant needs that place them at risk of hospitalization or institutionalization, or that HCBS is needed for the child/youth to return safely home and to their community from a higher level of care. (Institutionalization refers to children/youth at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility). HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors, and 3) functional criteria. The HCBS eligibility groups are as follows: 1. Level of Care (LOC): children/youth that meet institutional placement criteria There are four subgroups for children/youth within the LOC group: 1) Serious Emotional Disturbance (SED) 2) Medically Fragile Children (MFC) 3) Developmental Disability (DD) and Medically Fragile 4) Developmental Disability (DD) and Foster Care	Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, respite care services, training for family members, assistive technology, and minor modifications to the home or a vehicle). Services intended to assist children/youth in being successful at home, in school, and in other natural environments to help maintain them in the community and avoid higher levels of care and out-of-home placements. Services are family-driven, youth-guided, and culturally and linguistically appropriate. Services are individualized to meet the physical health, developmental, and behavioral health needs of each child/youth. Services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child/youth. Children's Home and Community Based Services (HCBS) include the following services: • Adaptive and Assistive Technology • Caregiver/Family Advocacy and Support Services • Community Habilitation • Day Habilitation • Environmental Modifications • Non-Medical Transportation • Palliative Care: Counseling and Support Services • Palliative Care: Expressive Therapy • Palliative Care: Massage Therapy • Palliative Care: Pain & Symptom Management • Pre-Vocational Services • Planned Respite • Crisis Respite • Supported Employment • Vehicle Modifications

Child Health Plus Benefits Package Exclusions
Effective January 2025

The following services will NOT be covered:

- Experimental medical or surgical procedures.
- Experimental drugs.
- Drugs which can be bought without prescription, except as defined.
- Prescription Drugs used for purposes of treating erectile dysfunction.
- Prescription Drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
- Private duty nursing.
- Home Health Care, except as defined.
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
- Services in a skilled nursing facility.
- Cosmetic, plastic, or reconstructive surgery, except as defined.
- In vitro fertilization, artificial insemination or other means of conception and infertility services.
- Services covered by another payment source.
- Non-Emergency Medical Transportation.
- Personal or comfort items.
- Services which are not Medically Necessary.

Vaccines for Children Program

The Vaccines for Children Program (VFC) began October 1, 1994, and provides vaccines at no cost to eligible children enrolled in Medicaid or Child Health Plus "A." According to the New York State Medicaid Physicians' Manual, doctors delivering Medicaid services must participate in the VFC program, which provides them with free routine childhood vaccines for the immunization of Medicaid recipients and other eligible children younger than 19 years of age. The program was extended to Child Health Plus enrollees August 1, 2006.

As a part of our continuing Medicaid compliance effort, Capital District Physicians' Health Plan, Inc. (CDPHP) is required to evaluate whether the billing practices of all Medicaid participating providers are in compliance with the VFC guidelines.

Physicians are allowed to bill CDPHP only for the administration of these vaccines and not the cost of the vaccines since they are supplied to providers at no charge (refer to CDPHP Pharmacy Policy #1350/20.000042.) When administering vaccines to a Child Health Plus member under the age of 19, you must add modifier "SL" (State Supplied Vaccine) to the procedure code representing the vaccine administered.

Vaccines Available through the NYS Bureau of Immunization for VFC/CHPlus Eligible Children

All Vaccine Availability Is Pending Funding and/or Supply To Place Orders, Call 1-800-543-7468.

Vaccine	Full Name Of Vaccine	Manufacturer	CPT Code
Dengvaxia	Dengue Tetravalent vaccine, Live	Sanofi Pasteur	90587
DTAP (Daptacel)	Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine	Sanofi	90700
DTAP (Infanrix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine	GlaxoSmithKline	90700
DTaP-Hep B-IPV (Pediarix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Hepatitis B and Inactivated poliovirus vaccine	GlaxoSmithKline	90723
DTaP-P-HI (Pentacel)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus, Haemophilus Influenza B vaccine	Sanofi	90698
DTaP-IPV (Quadracel)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus vaccine	Sanofi	90696
DTaP-IPV (Kinrix)	Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus vaccine	GlaxoSmithKline	90696
DTap-IPV-HB-HEPB	Vaxelis	Merck	90697
e-IPV (IPOL)	Inactivated poliovirus vaccine	Sanofi	90713
Hepatitis A Ped (Vaqta)	Hepatitis A Pediatric vaccine	Merck	90633
Hepatitis A Ped (Havrix)	Hepatitis A Pediatric vaccine	GlaxoSmithKline	90633
Hepatitis B (Ped/Adol) (Engerix B)	Hepatitis B pediatric/adolescent vaccine	GlaxoSmithKline	90744
Hepatitis B (Ped/Adol) (Recombivax Hb)	Hepatitis B pediatric/adolescent vaccine	Merck	90744
Hepatits A-Hepatitis B	Hepatitis A and Hepatitis B combo vaccine (Twinrix)	GlaxoSmithKline	90636
Hib (Pedvax)	Haemophilus B conjugate vaccine	Merck	90647
Hib (Acthib)	Haemophilus Influenza B vaccine	Sanofi	90648
Hiberix—booster only	Haemophilus Influenza B vaccine	GlaxoSmithKline	90648
HPV- (Gardasil9)	Human Papillomavirus 9-valent	Merck	90651
Influenza (Fluzone Quadrivalent)	Age 6 months and older	Sanofi	90687
Influenza (Fluzone Quadrivalent Pediatric dose)	Age 6 to 35 months	Sanofi	90685
Influenza (FluLaval Quadrivalent)	Age 6 months and older	GlaxoSmithKline	90688
Influenza (Flucelvax Quadrivalent)	Age 6 months and older	Seqirus usa	90674 90756
Influenza (Afluria Quadrivalent)	Age 6 months and older	Seqirus usa	90688
Influenza (Afluria Quadrivalent)	Age 36 months and older	Seqirus usa	90688
Influenza (Flumist Quarivalent)	Live, Intranasal Age 2 to 49 years	AstraZeneca	90672
MENB (Trumenba)	Meningococcal group b	Pfizer	90621
MENB (Bexsero)	Meningococcal group b	GlaxoSmithKline	90620
Meningococcal Conjugate MenQuadfi	Groups A, C, W, and Y	Sanofi	90619
Meningococcal Conjugate (Menveo)	Groups A, C, Y, and W-135	GlaxoSmithKline	90734

Vaccine	Full Name Of Vaccine	Manufacturer	CPT Code
Meningococcal (Penbraya)	(Groups A, B, C, W and Y-135)	Pfizer	90623
MMR-II	Measles, Mumps and Rubella vaccine	Merck	90707
MMR (Prioriz)	Measles, Mumps and Rubella	GlaxoSmithKline	90707
MMRV (ProQuad)	Measles, Mumps and Rubella vaccine and varicella virus vaccine	Merck	90710
MPOX (Jynneos)	MPOX	Bavarian Nordic	90611
Pneumococcal (Vaxneuvance)	Pneumococcal conjugate vaccine	Merck	90671
Pneumococcal (Prevnar 20)	Pneumococcal conjugate vaccine	Pfizer	90677
Pneumococcal (PNEUMOVAX)	Pneumococcal polysaccharide vaccine	Merck	90732
RSV (Beyfortus)	Respiratory Syncytial Virus (RSV)	Sanofi Pasteur	90380 90381
RSV (Abrysvo)	Respiratory Syncytial Virus (RSV)	Pfizer	90678
Rotavirus (Rotateq)	Rotavirus vaccine	Merck	90680
Rotavirus (Rotarix)	Rotavirus vaccine	GlaxoSmithKline	90681
Tetanus and Diphtheria Toxoids (Tenivac)	Tetanus and Diphtheria Toxoids	Sanofi	90714
Tdap (Boostrix)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	GlaxoSmithKline	90715
Tdap (Adacel)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	Sanofi	90715
Varicella (Varivax)	Varicella virus vaccine	Merck	90736

This list may be updated from time to time.

If you fail to add the modifier SL when billing for the above codes, the claim will be processed, and the administration fee paid, but not the cost of the vaccine. The voucher will display an explanation of "Government Supplied Vaccine."

If you need information about obtaining free vaccine materials through the VFC program, please call the NYS DOH hotline for this program at 1-800 KID SHOTS (1-800-543-7468) or visit www.cdc.gov/vaccines/programs/vfc/default.htm.

Essential Plan

The Essential Plan provides quality health insurance to individuals who do not qualify for Medicaid. There are five different types of Essential Plan, and costs for each plan are dependent on family size and income.

This contract only covers in-network benefits. To receive in-network benefits, members must receive care exclusively from participating providers in our Essential Plan network who are located within our service area.

Care covered under this contract *(including hospitalization)* must be provided, arranged, or authorized in advance by the member's primary care physician and, when required, approved by CDPHP. In order to receive the benefits under this contract, members must contact their primary care physician before obtaining the services, except for services related to an emergency or urgent condition as described in the Emergency Services and Urgent Care section of this contract. Except for care for an emergency or urgent condition described in the Emergency Services and Urgent Care section of this contract, the member will be responsible for paying the cost of all care that is provided by non-participating providers.

Eligibility

Individuals may qualify for coverage if they are 19 to 64 years of age, a New York state resident, do not already have health insurance, and are not eligible for Medicaid. The Essential Plan is available in 16 counties within the CDPHP service area: Albany, Broome, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Warren, and Washington.

CDPHP® Essential Plan Benefit Overview

	CDPHP Essential Plan 200-250	CDPHP Essential Plan 1	CDPHP Essential Plan 2	CDPHP** Essential Plan 3	CDPHP** Essential Plan 4
Eligibility	Single person with annual income between $30,121-$37,650	Single person with annual income between $22,591-$30,120	Single person with annual income between $20,783-$22,590	Single person with annual income between $15,060-$20,783	Single person with annual income between $15,060
Monthly Premium	$0	$0	$0	$0	$0
Max. Out of Pocket per Individual	$2,000	$360	$200	$200	$0
SERVICES	**COPAY OR COINSURANCE PER VISIT**				
Preventative Care*, Annual Physical Exam	$0	$0	$0	$0	$0
Primary Care Doctor Visit	$15	$360	$0	$0	$0
Specialist Doctor Visit	$25	$25	$0	$0	$0
Clinical/Diagnostic Lab X-ray/MRI/CT Scan/PET Scan	$25	$25	$0	$0	$0
Live Video Doctor Visits	$15	$15	$0	$0	$0
Outpatient Facility, Surgeon	$50	$50	$0	$0	$0
Inpatient Facility, Surgeon	$150 per admission	$150 per admission	$0 per admission	$0 per admission	$0 per admission
Outpatient Mental Health and Substance Use Service	$15	$15	$0	$0	$0
Emergency Room, Ambulance	$75	$75	$0	$0	$0
Urgent Care	$25	$25	$0	$0	$0
PT/OT/ST	$15	$15	$0	$0	$0
Chiropractic Services	$25	$25	$0	$0	$0
Eye Exams ***	$0	$0	$0	$0	$0
Dental	$0	$0	$0	$0	$0
SUPPLIES AND PRESCRIPTIONS	**COPAY OR COINSURANCE PER ITEM**				
Durable Medical Equipment (DME)	5%	5%	$0	$0	$0
Diabetic Supplies	$15, 30 Day Supply	$15, 30 Day Supply	0%	0%	0%
Hearing Aids (External)	5%	5%	0%	0%	0%
Eyewear* **	0%	0%	0%	0%	0%
Prescription Drugs: Generic - Tier 1/Preferred Brand- Tier 2/Non Preferred Brand-	$6/$15/$30	$6/$15/$30	$1/$3/$3	$1/$3/$3	$0/$0/$0
Mail Order	90 Day Supply, 2.5x Copay	90 Day Supply, 2.5x Copay	90 Day Supply, 2.5x Copay	90 Day Supply, 2.5x Copay	90 Day Supply, $0

** For certain preventive care visits and services, as defined under section 2713 of the Affordable Care Act, there is 100% coverage with no cost sharing*

*** Available to those not eligible for Medicaid due to immigration status; dental services provided by Delta Dental*

**** Vision services and eyewear provided by Davis Vision*

CDPHP Medicare Advantage HMO and PPO Plans

Definition of Product:

The CDPHP Medicare Advantage platform is not an insurance policy that merely pays Medicare deductible and coinsurance (a supplemental plan) charges. CDPHP has entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs. Under this contract, CMS makes a monthly payment to CDPHP for each CDPHP Medicare Advantage beneficiary who is enrolled in CDPHP. This CDPHP Medicare Advantage contract requires CDPHP to provide comprehensive health services to persons who have Medicare Parts A and B benefits and who reside in the CDPHP Medicare service area. CDPHP covers all services and supplies offered by Medicare, plus some services and supplies not covered by Medicare.

Although CMS pays CDPHP a monthly payment for each enrolled member, the member is still responsible for payment of his/her Medicare Part B premium and a monthly premium payable to CDPHP.

Medicare will not pay for medical services while an individual is a member of a CDPHP Medicare Advantage plan, with the exception of hospice. Medicare will continue to maintain responsibility for all hospice services and clinical trials. Note that CDPHP remains responsible for prescription drugs for conditions unrelated to hospice services for members with Part D coverage.

CDPHP offers Medicare HMO and PPO products to residents in Albany, Broome, Chenango, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Tioga, Warren, and Washington counties. PPO products are also offered to residents in Allegany, Chemung, Monroe, Ontario, Schuyler, Steuben, and Yates counties. CDPHP Care Advantage HMO C-SNP is offered to residents in Albany, Rensselaer, Saratoga, and Schenectady counties.

In addition, Medicare HMO and PPO group products are available to employer group and/or union retirees in the above referenced counties, as well as Dutchess, Orange, and Ulster counties.

Health Benefits and Options:

CDPHP Medicare Advantage benefits take the place of the member's Original Medicare Part A and Part B coverage and may provide additional benefits that Original Medicare does not offer.

- Both HMO and PPO offer a variety of copayment/coinsurance options, with or without Part D prescription drug coverage.
- Both offer worldwide coverage for emergency medical care. HMO members have out-of-area urgent and emergency care. Medicare Advantage PPO benefits cover doctor visits outside of the CDPHP network at a higher cost. Balance billing may also apply if the doctor does not accept Medicare's assignment of benefits.
- With both plan types, no charge applies for CMS-defined zero-dollar cost-share services such as annual wellness visits, Pap smears, mammograms, prostate cancer screening, and immunizations, including influenza and pneumonia vaccines provided by in-network providers. These services are denoted within the member's Evidence of Coverage using this symbol .
- For the HMO plans, a PCP coordinates the member's care and refers to network specialists as needed. PPO members do not have to designate a CDPHP PCP but are encouraged to select one.

Pharmacy Services:

The CDPHP pharmacy services department manages prescription drugs for CDPHP Medicare Advantage Plan enrollees with Part D. Prescriptions are filled through our pharmacy network and submitted for online adjudication with Capital Rx, our contracted pharmacy benefits management company. All globally adjudicated prescription claims are prospectively reviewed at the point of service for drug-to-drug interactions and proper drug utilization. The pharmacy services department performs retrospective drug utilization reviews quarterly on selected topics. This retrospective drug utilization program includes practitioner notification for unsafe or improper utilization patterns.

The pharmacy services department maintains the CDPHP Medicare Advantage Plans prescription drug formularies at the direction of the CDPHP pharmacy and therapeutics (P&T) committee. The committee includes a network cross-section of practicing physicians and pharmacists whose primary purpose is to ensure that the most clinically appropriate and cost-effective drugs, in accordance with all CMS regulations and laws, will be available for CDPHP Medicare Advantage Plan enrollees with Part D drug coverage. The P&T committee is responsible for reviewing new drugs, establishing drug formulary status, recommending programs for appropriate medication therapy management including opioid overutilization, and reviewing and revising pharmacy policies. The members of the CDPHP P&T committee are bound by a confidentiality and conflict of interest agreement, which is reviewed annually, and meets CMS rules regarding Part D plans.

The CDPHP Part D formularies list the drugs that are covered for CDPHP Medicare Advantage Plan members with Part D drug coverage. Groups can purchase additional prescription benefits to gain access to enhanced drug coverage for certain drugs normally excluded by Part D.

The formulary is updated at the beginning of each calendar year. All new drugs are excluded from the CDPHP Medicare Advantage Plans formularies until reviewed by the P & T committee, and at that time a decision is made to include or exclude the new drug from the formulary. Members are notified of changes at least 30 days prior to any negative formulary changes. Practitioners may find the searchable CDPHP Medicare Advantage Plan formulary in the Provider section of www.cdphp.com, under Prescription Forms and Lists, or in the Medicare section of www.cdphp.com, under Prescription Drug Coverage.

Quantity limitations and prior authorizations apply. A provider may request a prior authorization, medical exception, step therapy exception, or quantity exception by using a CDPHP Prior Authorization/medical exception/coverage determination, form (available at www.cdphp.com) or another method of documenting all the information required to review such a request. A member can request a prior authorization, medical exception, or quantity exception, but the prescriber must sub-mit supporting documentation for the request.

- Many vaccinations, including Shingrix, are covered under the Part D pharmacy benefit. Other vaccines, such as COVID-19, influenza, and pneumonia, and those used as treatment to an injury or illness, such as rabies and tetanus, are covered as a medical benefit. The vaccines covered as a Part D pharmacy benefits are found on the CDPHP Medicare Advantage Plans formulary. Should you require assistance with submitting Part D vaccine claims to Capital Rx, please contact your CDPHP provider relations specialist.
- Some drug products are deemed by CMS to be covered by a Medicare Advantage plan under Part B (medical benefit). Examples are: drugs that are used in a DME device, such as inhalation solutions used in a Medicare approved nebulizer; immunosuppressant therapy drugs for an enrollee who receives an organ transplant; a limited number of oral chemo -therapy drugs (e.g., Temodar); and oral antiemetic drugs used within 48 hours of chemotherapy treatments as a full replacement for intravenous antiemetic drugs. These drugs are all subject to the CMS rules for coverage.
- Certain drugs could be considered Part B or Part D depending on the use or location of service. These drugs require prior authorization to determine whether they should be covered under the medical or pharmacy benefit.

Details on the above can be located in the Medicare section of www.cdphp.com under "Prescription Drug Coverage."

CDPHP makes the Walmart Home Delivery Service available to enrollees. Providers who have questions can call 1-866-289-2319, fax a prescription to 1-800-406-8976, or E-prescribe to: Walmart Pharmacy Mail Order 2625. CDPHP also uses CVS Specialty Pharmacy for our members who need high-cost selected biotech and injectable drugs. If you have questions or would like to transfer a prescription to CVS Specialty Pharmacy for an enrollee, please call 1-800-237-2767.

Enrollees of CDPHP Medicare Advantage Plans with prescription drug coverage may be eligible for Medication Therapy Management (MTM) program services. These services are available to members who meet certain criteria—such as having multiple chronic diseases from a selected list of diseases, taking eight or more Part D drugs, and expected to reach a certain expense for Part D drugs costs (established annually by CMS) per year. This program is designed to ensure that drugs utilized by enrollees are appropriately used to optimize therapeutic outcomes and to reduce the risk of adverse events. This program is provided free of charge to eligible enrollees.

Dual-Eligible Members:

Certain CDPHP Members are eligible for both Medicare and Medicaid ("Dual-Eligible Members"). Provider shall not hold Dual-Eligible Members liable for Medicare Part A and Part B cost-sharing amounts when the State is responsible for paying such amounts. For services provided to these members, Provider shall either accept the CDPHP Medicare reimbursement rates as payment in full or bill the appropriate State source.

Provider Information:

CDPHP practitioners with full hospital-admitting privileges to the hospitals in the CDPHP Medicare Advantage HMO and CDPHP Medicare Advantage PPO networks are invited to provide services to our CDPHP Medicare Advantage members.

Member Referrals:

CDPHP Medicare Advantage HMO members may only be referred to visit practitioners, providers, and hospitals that participate in the CDPHP Medicare Advantage HMO provider network. Please confirm that the specialist/hospital does participate in the CDPHP Medicare Advantage HMO network prior to referring a member for treatment. Exceptions may be made for urgent care needed out of the area and emergencies.

CDPHP Medicare Advantage PPO members are not required to obtain a referral for treatment, and visits to out-of-network providers are allowed under this plan. Prior authorization is required for certain services. For more information, please contact our provider services department.

Culturally Competent Access:

Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how these accessibility requirements can be met include provision of translator services, interpreter services, teletypewriters or TTY connections.

Risk Assessment:

After the enrollment process, each member is asked to complete a health survey which the member receives in his/her new member packet. This is a tool that assists CDPHP in identifying those individuals who may require additional medical services. Completed health surveys are reviewed by CDPHP case managers. Members who are identified as potential high-risk cases will receive an in-depth telephonic assessment by a case manager who will identify if they require case management services to assume compliance with prescribed treatment plans. A physician may authorize members for case management if they identify members with complex social and/or medical needs who may benefit from community referrals and proactive monitoring. This procedure will assist the PCP and CDPHP with the proper management of the patient's care in order to meet his/her medical needs. The information contained in the health survey will not affect the patient's coverage or the level of physician's reimbursement. In addition, all new members receive a telephone outreach call as part of our Health AllySM program. A different risk assessment will be conducted to better identify the needs of each member.

Special Requirements for CDPHP Care Advantage (HMO C-SNP):

Chronic condition verification of C-SNP members must be obtained by CDPHP through the use of the pre-enrollment qualification assessment tool. If verification is not received within the first 60 days of enrollment, the member will be termed.

All CDPHP Care Advantage (HMO C-SNP) members must complete a Health Risk Assessment (HRA) at time of enrollment and annually. The HRA serves as the foundation for the member's Individual Care Plan (ICP).

Providers are requested to participate in the Interdisciplinary Care Team (ICT) to ensure the special needs of the SNP member are being met across the continuum of care.

All C-SNP members will be assigned a care manager, who is responsible for the creation and dissemination of the ICP, as well as convening meetings of the ICT throughout the year.

All C-SNP members must have a face-to-face encounter at least annually. Face-to-face encounters include annual wellness visits, and other clinical and non-clinical interactions.

Nondiscrimination Policy:

CDPHP and other entities that do business with the federal government are required to have policies and procedures in place demonstrating that they do not discriminate in the delivery of health care services. You can view our Nondiscrimination Policy by logging into the secure provider portal of www.cdphp.com. Please call the CDPHP provider services department at (518) 641-3500 or 1-800-926-7526 to request a paper copy.

In order to comply with our own policy, CDPHP will be assessing our participating provider offices to ensure that you also have and follow nondiscrimination policies and procedures of your own. CDPHP quality enhancement staff will be asking about this during random site visits. Educational and corrective action plans will be implemented for those offices found to be out of compliance.

If you do not currently have a nondiscrimination policy, please arrange to implement one. You can find helpful information and a sample policy by going to the federal website www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/tamainpage.html.

Medicare Compliance Training Requirement for Providers, Practitioners, and Facilities

As a health plan that contracts with CMS to offer Medicare Advantage coverage, CDPHP is required to have a compliance program to prevent, detect, and correct non-compliance with CMS program requirements. All participating provider practices should also be assuring that their staff and physicians adhere to all applicable laws and regulations that govern the program. To assist you in achieving compliance, we offer an online provider training program.

If you do not already have a CMS compliance training process in place, please ensure that all staff view our compliance presentation within 90 days of hire and at least annually thereafter. The training module is a PowerPoint presentation posted in the provider section of www.cdphp.com under "Get Your Job Done" > "Working with CDPHP." At the end of the presentation is an attestation form and tracking tool that you can use to document each employee's completion of the training. This documentation should be retained for 10 years and made available upon request by CDPHP or CMS.

CMS also requires all providers participating in the CDPHP network to complete and attest to the CDPHP Care Advantage (HMO C-SNP) Model of Care Training available at https://www.cdphp.com/providers/get-your-job-done/hmo-c-snp-provider-education

Member Educational Initiatives:

Upon receipt of an approved member application, a CDPHP representative will contact new enrollees to educate them regarding product benefit information, as well as other important aspects of their new coverage.

Disaster Response Policy: Access to Care and Part D Drug Coverage

As a Medicare Advantage Organization (MAO), CDPHP is required by The Centers for Medicare & Medicaid Services (CMS) to have established processes to monitor the Federal Emergency Management Agency (FEMA) website at www.fema.gov in the event of a Presidential declaration of emergency or state of disaster and ensure that affected members receive open access to care without disruption.

The intent is to remove barriers to needed care and protect health care providers and pharmacies, including non-contracted providers, from incurring any financial penalty if conditions make it impossible or impractical to follow program requirements.

Access to Medical Care Within the Provider Network

In the event of a Presidential declaration of emergency or state of disaster CDPHP must:

- Allow medical care to be furnished by non-participating, non-contracted doctors, providers, and facilities.
- Waive in full, or in part, any prior authorization and prior notification requirements without penalty to the provider or member.
- Temporarily reduce plan-approved OON cost sharing amounts to an amount equal to the plan-approved in-network cost sharing level.

Access to Pharmacy and Medications

In the event of a Presidential declaration of emergency or state of disaster, CDPHP must ensure that members have adequate access to covered Part D Drugs dispensed at any in or out-of-the network pharmacies and may:

- Allow members to refill prescriptions at the point-of-sale prior to the established refill date.
- Allow members to obtain the maximum extended day supply, if requested and available at the time of refill.

In addition to adhering to the CMS Federal Disaster Response requirements, CDPHP encourages doctors, providers, and facilities to contact CDPHP in the event of extenuating or unusual circumstances that may impede adherence to program requirements and/or affect access to care.

CDPHP Medicare Advantage members have the *right* to:

Treatment With Dignity and Respect

- Be treated with dignity, respect, and fairness at all times.
- Exercise these rights regardless of their race or color, age, gender, sexual orientation, religion, national origin, or any mental or physical disability.

Privacy of Their Medical Records and Personal Health Information

- Be provided with a notice that tells about these rights and explains how CDPHP protects the privacy of their health information under federal and state laws.
- Look at their medical records and to get a copy of the records, if requested.
- Ask CDPHP or plan physicians to make additions or corrections to your medical records.
- Know if their health information has been given out and used for non-routine purposes.

See Plan Providers, Get Covered Services, and Get Prescriptions Filled Within a Reasonable Period of Time

- Choose a plan provider and obtain full information from their provider when seeking medical care.
- Go to a women's health specialist (such as a gynecologist) without a referral.
- Have timely access to plan providers and to all services covered by the plan.

Know Their Treatment Choices and Participate in Decisions About Their Health Care

- Participate fully in decisions about their health care. Providers must explain things in a way members can understand.
- Know about all of the treatment choices that are recommended, regardless of cost or whether they are covered.
- Be told about any risks involved in care. Also, to be told in advance if any proposed medical care or treatment is part of a research experiment, and to refuse such treatment, if requested.
- Refuse treatment, including the right to leave a hospital or other medical facility, even if their physician advises against it. They also have the right to stop taking medication. If they refuse treatment, they accept responsibility for what happens as a result of refusing treatment.
- Receive a detailed explanation from CDPHP if they believe that a plan provider has denied care that the member believes he/she is entitled to receive.

Use Advance Directives (Such As a Living Will or Power of Attorney)

- Use an advance directive form to authorize someone with the legal authority to make decisions for the member.
- Choose whether or not to complete an advance directive.

Make Complaints

- Make a complaint regarding a problem related to coverage or care. This may include appeals and grievances, depending on the situation.
- Be treated fairly if they make a complaint.
- Get a summary of information about the appeals and grievances that they have filed against CDPHP in the past.

Get Information About Their Health Care Coverage and Costs

- Receive an explanation from CDPHP about any bills they may receive for services not covered by CDPHP. This may include information about our financial condition, our health care providers and their qualifications, how we pay our physicians, and how CDPHP Medicare Advantage compares to other health plans.

CDPHP Medicare Members have the *responsibility* to:

- Become familiar with their coverage and the rules they must follow to get care as a member, including review of covered services as stated in their Evidence of Coverage document.
- Provide physicians or other health care practitioners the information needed for their care.
- Follow the treatment plans, instructions, and care that they have agreed upon with their physician(s).
- Ask physicians and other providers to answer any questions they may have and to explain treatment in a way they can understand.
- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.
- Pay their plan premiums and any copayments owed for covered services, as well as the full cost of services that are not covered.
- To notify, or ask a family member authorized to act on their behalf to notify, the PCP or CDPHP within 48 hours of receiving emergency services or as soon as is reasonably possible.
- Let CDPHP know if they have any questions, concerns, problems, or suggestions.

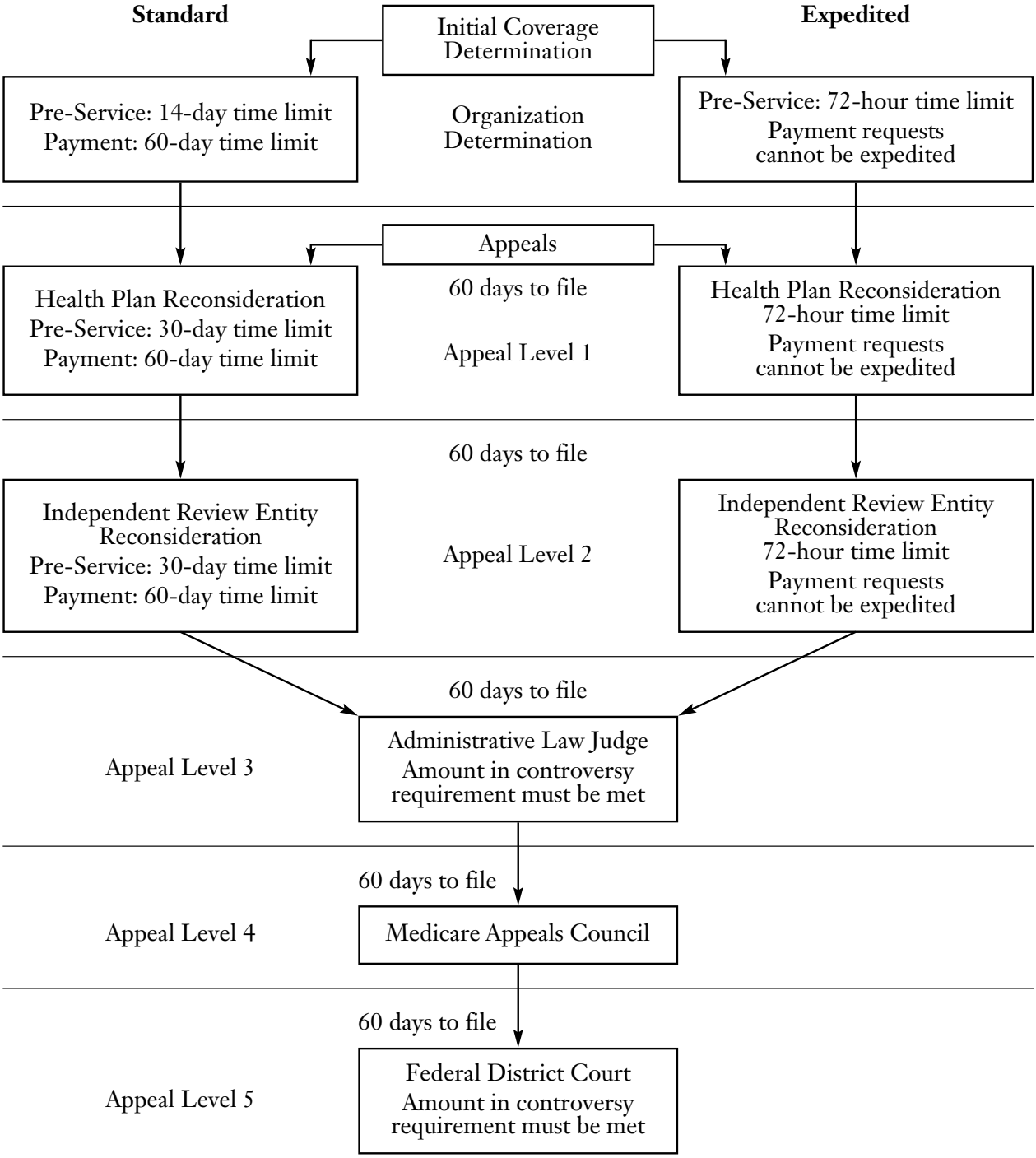
Resolving Differences

The following information describes the member appeal process as detailed in the member's Evidence of Coverage. CDPHP may need to contact you during the appeal process to obtain medical records to facilitate a thorough review of a member's appeal.

You may ask CDPHP for an expedited appeal when you believe the member's health could be seriously harmed by waiting for a standard decision. Expedited appeals can be made by calling (518) 641-3950 or 1-888-248-6522, or fax your request to the attention of "Medicare Appeals and Grievances" at (518) 641-3507.

Part C

The following chart summarizes the process for Part C appeals.



Quality Improvement Organization Complaint Process

If members are concerned about the quality of the care they have received, they also may file a complaint with the State Quality Improvement Organization:

Livanta
BFCC-QIO Program
9090 Junction Drive
Annapolis Junction, MD 20701
1-866-815-5440

Quality Improvement Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Quality Improvement Organization review process is often lengthy and may not resolve a member's individual problem, but it may help to stop any improper practices.

CDPHP Quality Complaint Process

Members may also file a written quality complaint with CDPHP. A complaint can be sent to:

CDPHP
Attn: Medicare Appeals and Grievances
P.O. Box 66209
Albany, NY 12206

A member services representative will coordinate an investigation of the issue with the appropriate staff. The member or member designee will be given a written notice of the results of the investigation within 30 days of the receipt of all information necessary to make a decision.

CDPHP Medicare Advantage Fast Track Appeal Process for Services Rendered by a Home Health Agency and/or Skilled Nursing Facility

CDPHP Medicare Advantage members have the right to an expedited review by Livanta, a quality improvement organization, when they disagree with a decision by CDPHP that Medicare coverage of services from a home health care agency or skilled nursing facility should end.

In accordance with CMS, CDPHP has developed the following process to comply with the specific rules and time frames for CDPHP, participating facilities, and members:

- The provider/facility will deliver a Notice of Medicare Non-Coverage (NOMNC) to the member at least 2 days in advance of the end date of coverage services.
- The provider/facility will be responsible for obtaining a signature from the member.
- If the member/authorized representative disagrees with the end date of service, the member/authorized representative must contact IPRO by noon of the day before coverage ends.
- Additionally, upon request by CDPHP, the facility must immediately provide detailed documentation to CDPHP and Livanta, no later than 4 p.m. of the date of the request, via fax: CDPHP, (518) 641-3203; or Livanta, 1-866-815-5440 or TTY 1-866-868-2289.

Rights of Medicare Advantage Members to Complain if They Think They Are Being Discharged From the Hospital Prematurely

Members who are hospitalized, have the right to get all the hospital care covered by CDPHP Medicare Advantage that is necessary to diagnose and treat their illness or injury. The day they leave the hospital (the "discharge date") is based on when their stay in the hospital is no longer medically necessary. This part explains what they should do if they believe they are being discharged too soon.

Information members should receive during a hospital stay

When Medicare members are admitted to the hospital, they should receive a notice from the hospital called the *Important Message from Medicare*. This notice explains:

- Their right to get all medically necessary hospital services covered.
- Their right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That their doctor or the hospital may arrange for services they will need after leaving the hospital.
- Their right to appeal a discharge decision.

Review of their hospital discharge by the Quality Improvement Organization

If a Medicare Advantage member thinks that they are being discharged too soon, they must ask CDPHP to give them a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice explains:

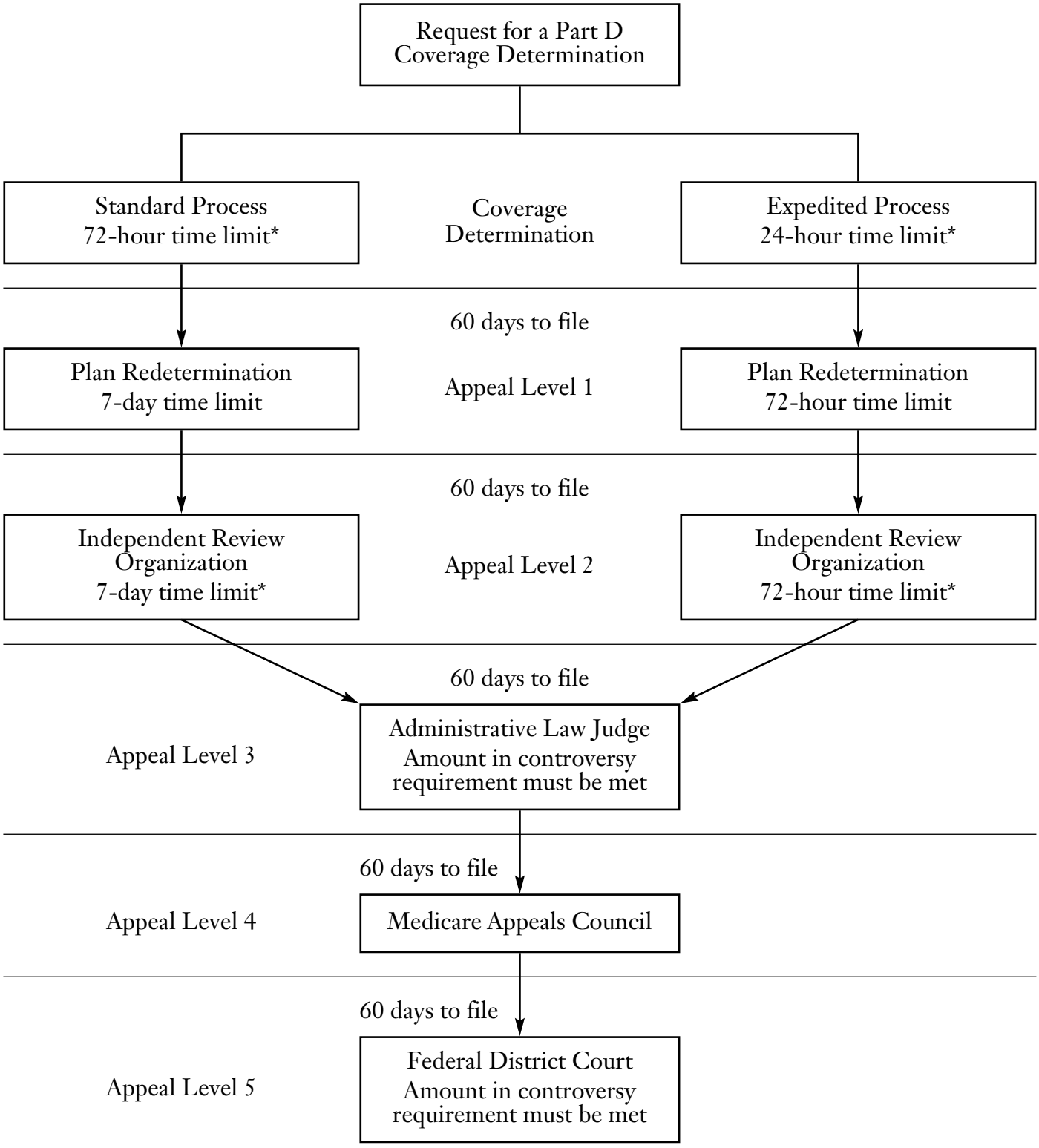
- Why they are being discharged.
- The date that CDPHP will stop covering their hospital stay (stop paying CDPHP's share of their hospital costs).
- What they can do if they think they are being discharged too soon.
- Who to contact for help.

The member (or someone they authorize) may be asked to sign and date this document, to show that they received the notice. Signing the notice does not mean the member agrees they are ready to leave the hospital—it only means that they received the notice. If they do not get the notice after saying they think they are being discharged too soon, they should ask for it immediately.

The member has the right by law to ask for a review of their discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if they act quickly, they can ask an outside agency called the Quality Improvement Organization to review whether the discharge is medically appropriate.

Part D

The following chart summarizes the process for Part D appeals.



*The adjudication time frames generally begin when the request is received by the Plan sponsor. However, if the request involves an exception to the Plan's formulary, the adjudication time frame begins when the Plan sponsor or independent review organization receives the doctor's supporting statement.

What is the "Quality Improvement Organization"?

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of CDPHP or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In New York state, the QIO is Livanta. The doctors and other health experts from Livanta review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

Getting a QIO review of a hospital discharge

If the member wants their hospital discharge reviewed, they must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeals Rights* gives the name and telephone number of the QIO and tells the member what they must do.

- The member must ask the QIO for a **"fast review"** of whether they are ready to leave the hospital. This "fast review" is also called a "fast appeal" because they are appealing the discharge date that has been set for them.

Medicare Supplemental Plans

CDPHP Medicare Advantage now offers Medicare Supplemental Plans A, B, F, and N in select areas. These plans typically cover the coinsurance percentage (remaining 20 percent) after the original Medicare payment. Plan N does not require a coinsurance, but instead has a flat dollar copayment ($20 for doctor office visits and $50 for visits to the emergency room).

Please submit bills for Medicare Supplemental members directly to Medicare. Claims will come to CDPHP as the Medicare Supplemental carrier via Medicare Crossover for secondary payment. If CDPHP rejects a claim because the initial claim did not reach the company through the Medicare Crossover process, please resubmit as a paper claim accompanied by the Medicare Explanation of Payment.

The CDPHP Medicare Supplemental plans will cover everything that Medicare covers. Prior authorization and specialist referral requirements do not apply. Any payment disputes or appeals for services not covered should be directed to Original Medicare.