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” (i.e: 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, 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.

Revised January 2020
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 provider portal on our website, including a tip sheet, a list of restricted members indicating the date the member was posted to our site, as well as the terms of the restriction. To view the list, log into the secure portal and select the **Provider Resources tab > Manuals & Forms > Volume II of the Provider Office Administrative Manual**. Scroll down to Section 6—Provider Payment Policies, to find the “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.

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 (i.e., web portal listing and modified ID cards) are considered reasonable notice to providers of a member's restricted status.
<table>
<thead>
<tr>
<th>Medicaid Covered Services</th>
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<thead>
<tr>
<th>CDPHP Medicaid Products</th>
<th>CDPHP Select Plan</th>
<th>CDPHP HARP (effective 7/1/16)</th>
<th>New York State Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Eligibility within Product</strong></td>
<td><strong>Not SSI or SSI Related</strong></td>
<td><strong>SSI or SSI-Related</strong></td>
<td><strong>HARP</strong></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Covered, unless admit date precedes Effective Date of Enrollment</td>
<td>Covered, unless admit date precedes Effective Date of Enrollment</td>
<td>Covered, unless admit date precedes Effective Date of Enrollment</td>
</tr>
<tr>
<td>Inpatient Stay Pending Alternate Level of Medical Care</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Physician Services</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Nurse Practitioner Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Midwifery Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Preventive Health Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Second Medical/Surgical Opinion</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Laboratory Services</td>
<td>Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing</td>
<td>Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing</td>
<td>Covered Includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing</td>
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<tr>
<td>Radiology Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula</td>
<td>Covered Prior to 7/1/17, coverage excluded hemophilia blood factors.</td>
<td>Covered Prior to 7/1/17, coverage excluded hemophilia blood factors.</td>
<td>Covered Prior to 7/1/17, coverage excluded hemophilia blood factors. Includes Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™). 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™).</td>
</tr>
<tr>
<td>Smoking Cessation Products</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>CDPHP Medicaid Products</td>
<td>CDPHP Select Plan</td>
<td>CDPHP HARP (effective 7/1/16)</td>
<td>New York State Pays</td>
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<tr>
<td><strong>Member Eligibility within Product</strong></td>
<td><strong>Not SSI or SSI Related</strong></td>
<td><strong>SSI or SSI-Related</strong></td>
<td><strong>HARP</strong></td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>Covered. Up to eight (8) counseling sessions per calendar year, up to two (2) of which can be furnished by a dental practitioner</td>
<td>Covered. Up to eight (8) counseling sessions per calendar year, up to two (2) of which can be furnished by a dental practitioner</td>
<td>Covered. Up to eight (8) counseling sessions per calendar year, up to two (2) of which can be furnished by a dental practitioner</td>
</tr>
<tr>
<td>Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))</td>
<td>Covered Outpatient physical, occupational and speech therapy limited to 40 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.</td>
<td>Covered Outpatient physical, occupational and speech therapy limited to 40 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.</td>
<td>Covered Outpatient physical, occupational and speech therapy limited to 40 visits each per calendar year. Limits do not apply to Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.</td>
</tr>
<tr>
<td>EPSDT Services/Child Teen Health Program (C/THP)</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Gender Reassignment Surgery</td>
<td>Covered Patient must have a diagnosis of gender dysphoria (ICD-9 code 302.85 and meet NYS minimum age requirements</td>
<td>Covered Patient must have a diagnosis of gender dysphoria (ICD-9 code 302.85 and meet NYS minimum age requirements</td>
<td>Covered Patient must have a diagnosis of gender dysphoria (ICD-9 code 302.85 and meet NYS minimum age requirements</td>
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<tr>
<td>Home Health Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Private Duty Nursing Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Hospice</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Emergency Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Post-Stabilization Care Services</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Foot Care Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>CDPHP Medicaid Products</td>
<td>Not SSI or SSI-Related</td>
<td>SSI or SSI-Related</td>
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<tr>
<td>Eye Care and Low Vision Services</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Audiology, Hearing Aids Services &amp; Products</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Family Planning and Reproductive Health Services</td>
<td>Covered</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>Covered (effective 10/01/19)</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>3 Cycles of treatment per lifetime</td>
<td>Covered</td>
<td></td>
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<tr>
<td>21-34 years of age and unable to get pregnant after 12 months of regular, unprotected sex</td>
<td>Covered</td>
<td></td>
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</tr>
<tr>
<td>35-44 years of age and unable to get pregnant after 6 months of regular, unprotected sex</td>
<td>Covered</td>
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</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>Covered through FFS</td>
<td>Covered through FFS</td>
<td></td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Covered through FFS</td>
<td>Administered by Delta Dental 1-800-542-9782</td>
<td></td>
</tr>
<tr>
<td>Dental and Orthodontic Services—includes preventive and routine dental care</td>
<td>Covered</td>
<td>Administered by Delta Dental 1-800-542-9782</td>
<td></td>
</tr>
<tr>
<td>Medical Dental—fracture repair, tumor removal, treatment of congenital disease management</td>
<td>Covered</td>
<td>Coordinated by CDPHP</td>
<td></td>
</tr>
<tr>
<td>CDPHP Medicaid Products</td>
<td>CDPHP Select Plan</td>
<td>CDPHP HARP (effective 7/1/16)</td>
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<tr>
<td>Member Eligibility within Product</td>
<td>Not SSI or SSI Related</td>
<td>SSI or SSI-Related</td>
<td></td>
</tr>
<tr>
<td>Fluoride Varnish Treatment</td>
<td>Covered for children for birth until age 7 years when applied by a dentist, physician or nurse practitioner.</td>
<td>Covered for children for birth until age 7 years when applied by a dentist, physician or nurse practitioner.</td>
<td></td>
</tr>
<tr>
<td>Court-Ordered Services</td>
<td>Covered, pursuant to court order</td>
<td>Covered, pursuant to court order</td>
<td>Covered, pursuant to court order</td>
</tr>
<tr>
<td>LDSS Mandated SUD Services</td>
<td>Covered, pursuant to Welfare Reform/LDSS mandate</td>
<td>Covered, pursuant to Welfare Reform/LDSS mandate</td>
<td>Covered, pursuant to Welfare Reform/LDSS mandate</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Services/Orthopedic Footwear</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Mental Health Services</td>
<td>Covered</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Detoxification Services</td>
<td>Covered</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Rehabilitation and Treatment Services</td>
<td>Covered</td>
<td>Covered, effective 7/1/16 for adults and 7/1/19 for children</td>
<td></td>
</tr>
<tr>
<td>SUD Residential Addiction Treatment Services</td>
<td>Covered</td>
<td>Covered, effective 7/1/16 for adults and 7/1/19 for children</td>
<td></td>
</tr>
<tr>
<td>SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)</td>
<td>Covered</td>
<td>Covered, effective 7/1/16 for adults and 7/1/19 for children</td>
<td></td>
</tr>
<tr>
<td>SUD Medically Supervised Outpatient withdrawal</td>
<td>Covered</td>
<td>Covered, effective 7/1/16 for adults and 7/1/19 for children</td>
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</tr>
<tr>
<td>Buprenorphine Prescribers</td>
<td>Covered</td>
<td>Covered, effective 7/1/16 for adults and 7/1/19 for children</td>
<td></td>
</tr>
<tr>
<td>Experimental and/or Investigational Treatment</td>
<td>Covered on a case by case basis</td>
<td>Covered on a case by case basis</td>
<td>Covered on a case by case basis</td>
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<tr>
<td>Asthma Self-Management</td>
<td>Covered</td>
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### Medicaid Covered Services (continued)

<table>
<thead>
<tr>
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<td><strong>Member Eligibility within Product</strong></td>
<td>Not SSI or SSI Related</td>
<td>SSI or SSI-Related</td>
<td>HARP</td>
<td>Medicaid Fee for Service</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Covered When only Level I services provided, limited to 8 hours per week.</td>
<td>Covered When only Level I services provided, limited to 8 hours per week.</td>
<td>Covered</td>
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<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Consumer Directed Personal Assistance Services</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Observation Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP</td>
<td></td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP</td>
<td>Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP</td>
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<tr>
<td>Adult Day Health Care</td>
<td>Covered</td>
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<td>Covered</td>
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<td>AIDS Adult Day Health Care</td>
<td>Covered</td>
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<tr>
<td><strong>Medical Language Interpreter Services</strong></td>
<td>Covered&lt;br&gt;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.</td>
<td>Covered&lt;br&gt;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.</td>
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</tr>
<tr>
<td><strong>Lactation Counseling</strong></td>
<td>Covered&lt;br&gt;Modifier AF (specialty physician) must be reported when the servicing provider is a physician</td>
<td>Covered&lt;br&gt;Modifier AF (specialty physician) must be reported when the servicing provider is a physician</td>
<td>Covered&lt;br&gt;Modifier AF (specialty physician) must be reported when the servicing provider is a physician</td>
</tr>
<tr>
<td><strong>Tuberculosis Directly Observed Therapy</strong></td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td><strong>Crisis Intervention Services</strong></td>
<td>Covered, effective 7/1/16 for adults and 1/1/20 for children</td>
<td>Covered, effective 7/1/16 for adults and 1/1/20 for children</td>
<td>Covered, effective 7/1/16</td>
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<td><strong>Not SSI or SSI Related</strong></td>
<td><strong>SSI or SSI-Related</strong></td>
<td><strong>HARP</strong></td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
<td></td>
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<tr>
<td>Habilitation Services</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
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<tr>
<td>Family Support and Training</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
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<tr>
<td>Short-term Crisis Respite</td>
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<tr>
<td>Intensive Crisis Respite</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
<td></td>
</tr>
<tr>
<td>Education Support Services</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
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<tr>
<td>Peer Supports</td>
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<td>Covered on a non-risk basis as directed by the State</td>
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</tr>
<tr>
<td>Pre-vocational Services</td>
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<td>Covered on a non-risk basis as directed by the State</td>
<td></td>
</tr>
<tr>
<td>Transitional Employment</td>
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<td>Covered on a non-risk basis as directed by the State</td>
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</tr>
<tr>
<td>Intensive Supported Employment (ISE)</td>
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<td></td>
</tr>
<tr>
<td>Ongoing Supported Employment</td>
<td></td>
<td>Covered on a non-risk basis as directed by the State</td>
<td></td>
</tr>
<tr>
<td>Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program</td>
<td></td>
<td>Covered</td>
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### Medicaid Covered Services (continued)

<table>
<thead>
<tr>
<th>CDPHP Medicaid Products</th>
<th>CDPHP Select Plan</th>
<th>CDPHP HARP (effective 7/1/16)</th>
<th>New York State Pays</th>
<th>Medicaid Fee for Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Eligibility within Product</strong></td>
<td><strong>Not SSI or SSI Related</strong></td>
<td><strong>SSI or SSI-Related</strong></td>
<td><strong>HARP</strong></td>
<td><strong>Medicaid Fee for Service</strong></td>
</tr>
<tr>
<td>Assertive Community Treatment (minimum age is 18 for this adult oriented service)</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered, effective 7/1/16</td>
<td></td>
</tr>
<tr>
<td>Continuing day treatment (minimum age is 18 for medical necessity for this adult oriented service)</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td></td>
</tr>
<tr>
<td>Comprehensive psychiatric emergency program, (CPEP) including Extended Observation Bed</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered by MA FFS prior to 7/1/16 for adult. Covered by MA FFS prior to 7/1/19 for children</td>
<td>N/A (New SPA service)</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Covered for Children effective 7/1/19</td>
<td>Covered for Children effective 7/1/19</td>
<td></td>
<td>N/A (New SPA service)</td>
</tr>
<tr>
<td>Family Peer Support Services</td>
<td>Covered for Children effective 7/1/19 (as New SPA service for Children)</td>
<td>Covered for Children effective 7/1/19 (as New SPA service for Children)</td>
<td>Prior to 7/1/19, covered by MA FFS as 1915(c) Children’s waiver service</td>
<td></td>
</tr>
<tr>
<td>Health Home Care Management</td>
<td>Covered for Children effective 1/1/19</td>
<td>Covered for Children effective 1/1/19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td>Covered for Children effective 7/1/19</td>
<td>Covered for Children effective 7/1/19</td>
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</tr>
<tr>
<td>Other Licensed Practitioner (OLP)</td>
<td>Covered for Children effective 1/1/19</td>
<td>Covered for Children effective 7/1/19</td>
<td></td>
<td>N/A (New SPA service)</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personalized Recovery Orientation Services (minimum age is 18 for medical necessity for this adult oriented service)</td>
<td>Covered for adults effective 7/1/16</td>
<td>Covered for adults effective 7/1/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDPHP Medicaid Products</td>
<td>CDPHP Select Plan</td>
<td>CDPHP HARP (effective 7/1/16)</td>
<td>New York State Pays</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Member Eligibility within Product</td>
<td>Not SSI or SSI Related</td>
<td>SSI or SSI-Related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Covered for Children effective 1/1/19</td>
<td>Covered for Children effective 7/1/19</td>
<td>N/A (New SPA service)</td>
<td></td>
</tr>
<tr>
<td>Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)</td>
<td>Covered for Children effective 7/1/19</td>
<td>Covered for Children effective 7/1/19</td>
<td>OCFS Foster Care</td>
<td></td>
</tr>
<tr>
<td>Youth Peer Support and Training (YPST)</td>
<td>Covered for Children effective 1/1/20</td>
<td>Covered for Children effective 1/1/20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>County</th>
<th>Non-Emergency Transportation Manager (MAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>1-855-360-3549</td>
</tr>
<tr>
<td>Broome</td>
<td>1-855-852-3294</td>
</tr>
<tr>
<td>Clinton</td>
<td>1-866-753-4435</td>
</tr>
<tr>
<td>Columbia</td>
<td>1-855-360-3546</td>
</tr>
<tr>
<td>Essex</td>
<td>1-866-753-4442</td>
</tr>
<tr>
<td>Franklin</td>
<td>1-888-262-3975</td>
</tr>
<tr>
<td>Fulton</td>
<td>1-855-360-3550</td>
</tr>
<tr>
<td>Greene</td>
<td>1-855-360-3545</td>
</tr>
<tr>
<td>Montgomery</td>
<td>1-855-360-3548</td>
</tr>
<tr>
<td>Rensselaer</td>
<td>1-855-852-3293</td>
</tr>
<tr>
<td>Saratoga</td>
<td>1-855-852-3292</td>
</tr>
<tr>
<td>Schenectady</td>
<td>1-855-852-3291</td>
</tr>
<tr>
<td>Schoharie</td>
<td>1-855-852-3290</td>
</tr>
<tr>
<td>Tioga</td>
<td>1-855-733-9398</td>
</tr>
<tr>
<td>Warren</td>
<td>1-855-360-3541</td>
</tr>
<tr>
<td>Washington</td>
<td>1-855-360-3544</td>
</tr>
</tbody>
</table>

**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.
Infertility Services

If you are unable to get pregnant, CDPHP covers services that may help. Effective as of October 1, 2019, CDPHP 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

You may be eligible for infertility services if you meet the following criteria:

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

Authorization Process

A signed physician 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

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 every 6 months or sooner if the enrollee’s condition warrants it. New physician orders and a new in-home 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.

Authorization Process

A signed physician 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
• Documentation of a 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

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 every 6 months or sooner if the enrollee's condition warrants it. New physician orders and a new in-home 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 every 6 months.

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 at least every 6 months.

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

Substance Use Disorder Services

- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid treatment, including methadone maintenance
- Residential substance use disorder treatment
- Outpatient alcohol and drug treatment (Detox)

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.

HCBS services require authorization following state guidance. 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 flesh out 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. All reimbursement for children’s HCBS covered in the managed care benefit package will be non-risk for 24 months from the date of inclusion in the Medicaid Managed Care Organization (MMCO) benefit package. The Plan capitation payment will not include children’s HCBS. These will be paid on a non-risk basis. The benefits are listed below (additional detail can be found in the current Draft HCBS Manual):

- Health Home (if not otherwise eligible under the State Plan)
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Habilitation
- Non-Medical Transportation
- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Financial Management services for the Customized Goods and Services (phased in as a pilot)
- Customized Goods and Services (phased in as a pilot)

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 provide Care Management to children/youth eligible for HCBS.

CDPHP shall reimburse for HCBS in accordance with NYS requirements, which dictate payment be the NYS fee schedule while Plan is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates). The network provider contract shall expressly include language to reflect this state requirement.

**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. Select Plan members can be referred to the CDPHP State Programs department for assignment 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. CDPHP utilization management (UM) or care management (CM) staff contact the State Programs department in order to include such members in the next assignment list for the various health homes.

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 all contracted entities for performance. Health Homes are required to provide quarterly reports for the review of the CDPHP Joint Health Services Committee. Performance issues will be addressed with the health home and plans of correction will be required to resolve deficiencies. Once annually, the health home is expected to personally attend the Joint Health Services Committee. For all other meetings, remote attendance is permitted.

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.
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 at least 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 the 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 wait 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 authorization 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
  - Long-term therapies
  - Day treatment
  - Housing services
  - Medicaid Service Coordination (MSC) program
  - Services received under the Home and Community Based Services Waiver (prior to 7/1/19)
  - Medical Model (Care-at-Home) Waiver Services (prior to 7/1/19)

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

Transition of Children from the Care of a Voluntary Foster Care Agency (VFCA) into Managed Care

Beginning July 1, 2020, children/youth in the care of VFCAs will receive Medicaid benefits through Medicaid Managed Care, unless otherwise exempted or excluded. Non-agency placed foster children are already covered by CDPHP.

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 which the VFCA is licensed to provide. This includes reimbursement for any services paid through a State determined Preventive Residential Supports and Services rate.

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 involved 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/VFCA Foster Care Coordinator's and any Health Home Care Manager throughout the discharge planning process.

Upon disenrollment from the Plan, the CDPHP Foster Care liaison shall coordinate with the LDSS/VFCA Foster Care Coordinator's and any Health Home Care Managers 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/VFCA Foster Care Coordinator(s) 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/VFCA Foster Care Coordinator 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.

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Activity</th>
<th>Mandated Activity</th>
<th>Mandated Time Frame</th>
<th>Who Performs</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hours</td>
<td>Initial screening/screening for abuse/neglect</td>
<td>✓</td>
<td>✓</td>
<td>Health practitioner (preferred) or Child Welfare caseworker/ health staff</td>
</tr>
<tr>
<td>5 Days</td>
<td>Initial determination of capacity to consent for HIV risk assessment &amp; testing</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or designated staff</td>
</tr>
<tr>
<td>5 Days</td>
<td>Initial HIV risk assessment for child without capacity to consent</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or designated staff</td>
</tr>
<tr>
<td>10 Days</td>
<td>Request consent for release of medical records &amp; treatment</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or health staff</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial medical assessment</td>
<td>✓</td>
<td>✓</td>
<td>Health practitioner</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial dental assessment</td>
<td>✓</td>
<td>✓</td>
<td>Health practitioner</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial mental health assessment</td>
<td>✓</td>
<td>✓</td>
<td>Mental health practitioner</td>
</tr>
<tr>
<td>30 days</td>
<td>Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)</td>
<td>✓</td>
<td>✓</td>
<td>Health Practitioner</td>
</tr>
<tr>
<td>30 Days</td>
<td>HIV risk assessment for child with possible capacity to consent</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or designated staff</td>
</tr>
<tr>
<td>30 Days</td>
<td>Arrange HIV testing for child with no possibility of capacity to consent &amp; assessed to be at risk of HIV infection</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or health staff</td>
</tr>
<tr>
<td>45 Days</td>
<td>Initial developmental assessment</td>
<td>✓</td>
<td>✓</td>
<td>Health practitioner</td>
</tr>
<tr>
<td>45 Days</td>
<td>Initial substance abuse assessment</td>
<td></td>
<td></td>
<td>Health practitioner</td>
</tr>
<tr>
<td>60 Days</td>
<td>Follow-up health evaluation</td>
<td></td>
<td></td>
<td>Health practitioner</td>
</tr>
<tr>
<td>60 Days</td>
<td>Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent &amp; assessed to be at risk of HIV infection</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or health staff</td>
</tr>
<tr>
<td>60 Days</td>
<td>Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing</td>
<td>✓</td>
<td>✓</td>
<td>Child Welfare Caseworker or health staff</td>
</tr>
</tbody>
</table>
Medication for Children in Foster Care

CDPHP will ensure access to medically necessary medications wherever the child is placed in foster care, including, as appropriate:

1. Access to OON pharmacies;
2. At least one 30-day refill within the first 90 days of placement, whether or not the child is a new enrollee in CDPHP and consistent with transition fill requirements in the Medicaid Managed Care Model Contract.
3. Authorization processing as quickly as required by the member's condition and consistent with expedited timeframes in the Medicaid Managed Care Model Contract; and
4. Rapid replacement of lost medications as medically necessary, including allowing exceptions to any refill timeframes.

Durable Medical Equipment

CDPHP will authorize any necessary replacement of durable medical equipment including eyeglasses and contact lens, hearing aids and batteries, nebulizers, inhalers, specialized beds, wheel chairs, strollers, lifts, orthotics, supine standers, and other medically necessary equipment.

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 Case Management

CDPHP will make case management service available for children in foster care as determined and requested by the LDSS/VFCA foster care planner/manager, following an assessment or upon recommendation by a provider.

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 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, related to needed physical health and behavioral health services for children in foster care.
- 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.

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.

Revised January 2020
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.

CDPHP Medicaid Copayment Guide

Medicaid members are required to make copayments for some medications and pharmacy items. However, some members are exempt and do not have to make copayments. The following list outlines the services that require copayments and information about who is exempt. Questions may be directed to CDPHP member services at 1-800-388-2994 or the Department of Health's Medicaid Information Line at 1-877-934-7587.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Copayment Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-name prescription drugs</td>
<td>$3 for each prescription and refill</td>
</tr>
<tr>
<td>Generic prescription drugs</td>
<td>$1 for each prescription and refill</td>
</tr>
<tr>
<td>Over-the-counter medications (e.g., for smoking cessation and diabetes)</td>
<td>$0.50 per medication</td>
</tr>
<tr>
<td>Medical supplies (e.g., for diabetic supplies, hearing aid batteries, and enteral formula)</td>
<td>$1 per supply</td>
</tr>
</tbody>
</table>

Copayments do not apply for the following services:
- Family planning drugs and supplies, like birth control pills and condoms
- Drugs to treat mental illness (psychotropic) and tuberculosis

A copayment is not required for members who are:
- Under 21
- Pregnant
- Member of an Office of Mental Health or Office for People with Developmental Disabilities Home and Community Based Services (HCBS) waiver program
- Member of a Department of Health HCBS waiver program for persons with a traumatic brain injury (TBI)
- Unable to pay the copayment at any time and member tells the provider that they are unable to pay

There is a copayment for each new prescription and each refill. If you are required to pay a copayment, effective April 1, 2020, you are responsible for a maximum of $50 per quarter year (i.e., a maximum of $50 every three months).

* Medicaid members who cannot afford to pay their copayment may not be denied a service based on their inability to pay. A provider cannot refuse to give a CDPHP Medicaid member care or services because the member is unable to pay. However, the member will still owe the unpaid copayment amount to the provider, and the provider may ask for payment later or send the member a bill.

Emergency Procedures

Emergency Pharmacy

CDPHP shall immediately authorize a seventy-two (72) hour emergency supply of a prescribed drug when it determines that an emergency condition exists, as defined below (pursuant to § 270 of Article 2-A of the Public Health Law): “Emergency condition” means a medical or behavioral condition, as determined by the Contractor or its pharmacy benefit manager or utilization review agent, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, and for which delay in beginning treatment prescribed by the patient’s health care practitioner would result in:

A) placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;
B) serious impairment to such person's bodily functions;
C) serious dysfunction of any bodily organ or part of such person;
D) serious disfigurement of such person; or
E) severe discomfort. For Enrollees with a behavioral condition, a determination of severe discomfort shall include a situation where the Enrollee is:
   i. experiencing substantial discomfort or the expectation that such discomfort will result without the medication;
   ii. stable on a medication that is prescribed by the Enrollee's current provider, but is transferring to a new provider, or to a new level of care;
Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given
Anthrax
Arboviral infection
Babesiosis
Botulism
Brucellosis
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli 0157:H7 infection
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders
Gonococcal infection
Haemophilus influenzae (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venerum
Malaria
Measles
Meningococcal
Meningitis
Meningococcemia
Monkeypox
Mumps
Pertussis
Plague
Poliomyelitis
Psittacosis
Q Fever
Rabies
Rocky Mountain spotted fever
Rubella
(including congenital rubella syndrome)
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing E.coli (STEC)
Shigellosis
Smallpox
Staphylococcus aureus (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning
Streptococcal infection (invasive disease)
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
Syphilis, specify stage
Tetanus
Toxic shock syndrome
Transmissible spongiform encephalopathies (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia
Typhoid
Vaccinia disease
Vibriosis
Viral hemorrhagic fever
Yersiniosis
Diseases listed in bold type warrant prompt action and should be reported immediately to local health departments by phone followed by submission of the confidential case report form (DOH-389). In New York City, use case report form PD-16.

Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189, which may be obtained by contacting: Division of Epidemiology, Evaluation and Research P.O. Box 2073, ESP Station Albany, NY 12220-2073, (518) 474-4284. In NYC, contact the New York City Department of Health and Mental Hygiene. For HIV/AIDS reporting, call: (212) 442-3388.

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439 or 1-866-881-2809 after hours. In New York City, call 1-866-NYC-DOH1. To obtain reporting forms (DOH-389), call (518) 474-0548.

**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

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
<th>Urgent</th>
<th>Emergency</th>
<th>Follow-Up to Emergency or Hospital Discharge</th>
<th>Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child care</td>
<td>Within four (4) weeks of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Baseline and routine physicals (Adults &gt;21 years)</td>
<td>Within twelve (12) weeks from enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine non-urgent, preventive appointments, except as otherwise provided</td>
<td>Within four (4) weeks of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial family planning visits</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial prenatal visit</td>
<td>Within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial PCP office visit for newborns</td>
<td>Within two (2) weeks of hospital discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-urgent “sick” visit</td>
<td>Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For emergency care</td>
<td></td>
<td></td>
<td>Immediately upon presentation at a service delivery site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services</td>
<td></td>
<td></td>
<td>Immediately upon presentation at a service delivery site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td></td>
<td>Within twenty-four (24) hours of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment Type</td>
<td>Standard</td>
<td>Urgent</td>
<td>Emergency</td>
<td>Follow-Up to Emergency or Hospital Discharge</td>
<td>Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td>Within twenty-four (24) hours of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist referrals (not urgent), except as otherwise provided</td>
<td></td>
<td>Within four (4) to six (6) weeks of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 and OTP (Opioid Treatment Program) Services.</td>
<td></td>
<td>Within one (1) week of request</td>
<td>Within five (5) business days of request</td>
<td>Within five (5) business days of request</td>
<td></td>
</tr>
<tr>
<td>Behavioral health specialist referrals (not urgent):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Use Disorder treatment services</td>
<td></td>
<td>Within two (2) to (4) weeks of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. For PROS programs other than clinic services</td>
<td></td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment Type</td>
<td>Standard</td>
<td>Urgent</td>
<td>Emergency</td>
<td>Follow-Up to Emergency or Hospital Discharge</td>
<td>Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Follow-up visits with a Participating Provider (as included in the Benefit Package)</td>
<td></td>
<td></td>
<td></td>
<td>Within five (5) days of request, or as clinically indicated</td>
<td></td>
</tr>
<tr>
<td>Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work when requested by a LDSS</td>
<td>Within ten (10) days of request by CDPHP member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HARP—Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td>Within five (5) days of request, or as clinically indicated</td>
<td>Within five (5) days of request, or as clinically indicated</td>
</tr>
<tr>
<td>HARP—Educational and Employment Support Services, including Pre-Vocational Services</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HARP—Peer Support Services</td>
<td>Within one (1) week of request</td>
<td>Within 24 hours of request, if services are needed urgently for symptom management</td>
<td></td>
<td>Within five (5) days of request</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td>Within five (5) business days of request</td>
<td></td>
</tr>
<tr>
<td>Other Licensed Practitioner</td>
<td>Within one (1) week of request</td>
<td>Within 24 hours of request</td>
<td></td>
<td>Within 72 hours of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Family Peer Support Services</td>
<td>Within one (1) week of request</td>
<td>Within 24 hours of request</td>
<td></td>
<td>Within 72 hours of request</td>
<td>Within 72 hours of request</td>
</tr>
</tbody>
</table>
### Access and Availability Standards (continued)

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
<th>Urgent</th>
<th>Emergency</th>
<th>Follow-Up to Emergency or Hospital Discharge</th>
<th>Follow-Up to Residential Services, Detention Discharge or Discharge from Justice System Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Peer Support and Training</td>
<td>Within one (1) week of request</td>
<td></td>
<td></td>
<td>Within 72 hours of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Within five (5) business days of request</td>
<td>Within 72 hours of request</td>
<td></td>
<td>Within 72 hours of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Caregiver/Family Supports and Services</td>
<td>Within five (5) business days of request</td>
<td></td>
<td></td>
<td>Within five (5) business days of request</td>
<td>Within five (5) business days of request</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Within one (1) week of request</td>
<td>Within 24 hours (for intensive in-home) and crisis response</td>
<td>Within 24 hours of discharge</td>
<td>Within 72 hours of discharge</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td>Within two (2)–four (4) weeks of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td></td>
</tr>
<tr>
<td>Crisis Respite</td>
<td></td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td></td>
</tr>
<tr>
<td>Planned Respite</td>
<td>Within one (1) week of request</td>
<td></td>
<td></td>
<td>Within one (1) week of request</td>
<td></td>
</tr>
<tr>
<td>Prevocational Services</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td>Within two (2) weeks of request</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td>Within two (2) weeks of request</td>
<td></td>
</tr>
<tr>
<td>Community Self-Advocacy Training and Support</td>
<td>Within five (5) business days of request</td>
<td></td>
<td></td>
<td>Within five (5) business days of request</td>
<td></td>
</tr>
<tr>
<td>Habilitation</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adaptive and Assistive Equipment</td>
<td>Within two (2) weeks of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Accessibility Modifications</td>
<td>Within two (2) weeks of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Within two (2) weeks of request</td>
<td></td>
<td></td>
<td>Within 24 hours of request</td>
<td></td>
</tr>
</tbody>
</table>
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 you cannot require medical records before scheduling an appointment for a Medicaid member. You must grant appointments to patients calling for appointments before requesting their medical records.

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 January 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 January 1, 2019 or until HCBS are included in the capitated 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.

Required Ownership Information Disclosure

A federal regulation (42 CFR 455.104) now requires network providers to disclose, at application/credentialing and re-credentialing, ownership and control information to managed care organizations that contract with the state Medicaid agency. Effective fall 2014, 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), The Excluded Parties List System (EPLS), and either the List of Excluded Individuals and Entities or the Medicare Excluded Database (MED).

The LEIE (or the MED), the EPLS, the U.S. Department of the Treasury’s Office of Foreign Assets Control (OFAC) Sanction Lists and NYS OMIG Exclusion List must be checked 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.

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 http://www.opdv.ny.gov/professionals/health/intro.html)

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.

New York State Domestic Violence Hotlines

Your local hotline can 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

| New York State Coalition Against Domestic Violence | (518) 482-5465 |
| Growing up Healthy Hotline/Maternal and Child Health Hotline | 1-800-522-5006 |
| Lifenet for Mental Health and Domestic Violence, English | 1-800-543-3638 |
| Lifenet for Mental Health and Domestic Violence, Spanish | 1-877-298-3373 |
| New York State Child Abuse and Maltreatment Reporting Center | 1-800-342-3720 |
| New York State Child Abuse Mandated Reporters Express Line | 1-800-635-1522 |
| New York State HIV/AIDS Information Services | 1-800-541-AIDS/2437 |
| New York State Homeless Shelter Emergency Assistance Unit | Contact the local DSS office |
| New York State Immigration Hotline (OTDA) | 1-800-566-7636 or (212) 419-3737 |
| New York State Office for the Aging Senior Citizens Hotline | 1-800-342-9871 |
| New York State Office for the Prevention of Domestic Violence | (518) 457-5800 |
| New York State Office of Alcoholism and Substance Abuse Services (OASAS) | 1-800-522-5353 |
| New York State Office of Temporary and Disability Assistance (OTDA) | 1-800-342-3009 |
| Legal Momentum Immigrant Women Program (National Number) | (202) 326-0040 |
| Prevention Information Resource Center and Parent Helpline | 1-800-342-PIRC/7472 |
| Victim Information and Notification Everyday (VINE) | 1-888-VINE-4NY/846-3469 |

New York State Office of Victim Services

Provides financial compensation to crime victims for certain expenses related to their victimization. Toll free numbers: 1-800-247-8035; Sorenson Videophone: 1-877-215-5251

| Main Office, Albany | (518) 457-8727 |
| New York City Office | (718) 923-4325 |
| Buffalo Office | (716) 847-7992 |

Getting Help from An Advocate

An advocate from a local domestic violence program is a person who has been trained in the area of domestic violence and whose job is to provide support to victims of domestic violence. This support can include but is not limited to:

- crisis intervention;
- individual case management;
- assistance navigating the various systems that victims may choose to access;
- helping victims of domestic violence understand their options and providing appropriate referrals;
- safety planning from a strengths-based and victim centered perspective;
- information about available support groups, counseling, advocacy, children's services, hotline assistance and transportation.

In addition to providing helpful information, some domestic violence advocates have the ability to accompany victims of domestic violence to court, the police station, the emergency room, or to the local department of social services to provide support through the process.

Revised January 2020
Local Domestic Violence Program Hotlines Across New York State:

Albany
- **Equinox Domestic Violence Services** (518) 432-7865. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4188—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Broome
- **Rise** (607) 754-4340 or (877) 754-4340—Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Chenango
- **Chenango County Catholic Charities/Crime Victims Program** (607) 336-1101. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **Liberty Resources—Help Restore Hope Center** 1-855-966-9723—Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Clinton
- **Behavioral Health Services North, Inc. – STOP Domestic Violence** (888) 563-6904—Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Columbia
- **Community Action of Greene County** (this program covers Columbia & Green counties) (518) 943-9211. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Delaware
- **Delaware Opportunities, Inc. – Safe Against Violence** (607) 746-6278 or (866) 457-7233. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Dutchess
- **Family Services of Dutchess County** (Formerly known as Battered Women’s Services) (845) 485-5550. Provides non-residential domestic violence services. OCFS Licensed and Approved.
- **Grace Smith House** (845) 471-3033. Provides residential, transitional and non-residential domestic violence services. OCFS Licensed and Approved.
- **House of Hope, part of House of Faith Ministry, Inc.** (845) 765-0293. Provides residential domestic violence services. OCFS Licensed and Approved.

Essex
- **Behavioral Health Services – STOP Domestic Violence** 1-888-563-6904. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Fulton
- **Family Counseling Center of Fulton County Inc.** (518) 725-5300. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Greene
- **Community Action of Greene County** (this program covers Columbia & Green counties) (518) 943-9211. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4341—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Herkimer
- **Catholic Charities of Herkimer County—Domestic Violence Program of Herkimer County** (315) 866-0458. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Madison
- **Liberty Resources—Help Restore Hope Center** (855) 966-9723. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Montgomery
- **Catholic Charities of Fulton and Montgomery Counties—Domestic Violence Crime Victim Services** (518) 842-3384. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4341—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Oneida
- **YWCA of the Mohawk Valley** (315) 797-7740. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
Orange

- **Safe Homes of Orange County** 1-845-562-5340. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Otsego

- **Opportunities for Otsego, Inc.**—Violence Intervention Program (607) 432-4855. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Rensselaer

- **Unity House of Troy** (518) 272-2370. Provides residential, transitional and non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4341—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Saratoga

- **Wellspring** (518) 584-8188. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **Mechanicville Area Community Service Center Domestic Violence Advocacy Program** (518) 664-4008. Provides non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4341—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Schenectady

- **YWCA of Northeastern New York** (518) 374-3386. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.
- **In Our Own Voices LGBT Domestic Violence Support Line** (518) 432-4341—Provides non-residential domestic violence services (Monday–Friday 9:00 AM–9:00 PM).

Schoharie

- **Catholic Charities of Schoharie County Crime Victims Program** (518) 234-2231. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Tioga

- **A New Hope Center** 1-800-696-7600. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Ulster

- **Family of Woodstock Inc.** (845) 679-2485. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Warren

- **Catholic Charities of Warren, Washington and Saratoga Counties – The Domestic Violence Project** (518) 793-9496. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

Washington

- **Catholic Charities of Warren, Washington and Saratoga Counties – The Domestic Violence Project** (518) 793-9496. Provides both residential and non-residential domestic violence services. OCFS Licensed and Approved.

**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.
**STERILIZATION CONSENT FORM**

**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 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 those 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 __________________________. I hereby consent of my own free will to be sterilized by __________________________, hereby consent of my own free will to be sterilized by __________________________. 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.

  __________________________
  Signature
  __________________________
  Date

  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
  □ 2 Asian or Pacific Islander
  □ 3 Black (not of Hispanic origin)
  □ 4 Hispanic
  □ 5 White (not of Hispanic origin)

- **PHYSICIAN’S STATEMENT**

  Shortly before I performed a sterilization operation upon __________________________, here is __________________________, here is the nature of the sterilization operation __________________________, here is the 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 at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

- **STATEMENT OF PERSON OBTAINING CONSENT**

  Before __________________________, signed the consent form, I explained to him/her the nature of the sterilization operation and the 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 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 knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

- **INFORMED CONSENT**

  Signature of person obtaining consent __________________________
  __________________________
  Date

  Facility __________________________
  Address __________________________

  Name of individual to be sterilized __________________________
  __________________________
  Date of sterilization

  Operation __________________________
  Specify type of operation __________________________

  Signature of person obtaining consent __________________________
  __________________________
  Date

  Race and ethnicity designation (please check)
  □ 1 American Indian or Alaska Native
  □ 2 Asian or Pacific Islander
  □ 3 Black (not of Hispanic origin)
  □ 4 Hispanic
  □ 5 White (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 had 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

- **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 __________________________. I also saw the patient sign the consent form in his/her handwriting.

  Signature of witness __________________________
  __________
  Title __________________________
  __________
  Date __________________________

- **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 __________________________

- **DISTRIBUTION**

  1 – Medical Record File
  2 – Hospital Claim
  3- Surgeon Claim
  4 – Anesthesiologist Claim
  5 – Patient
ACKNOWLEDGEMENT OF RECEIPT OF HYSTEROCTOMY INFORMATION

(NYS MEDICAID PROGRAM)

EITHER PART I OR PART II MUST BE COMPLETED

<table>
<thead>
<tr>
<th>RECIPIENT ID NO.</th>
<th>SURGEON'S NAME</th>
</tr>
</thead>
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### Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION

#### RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, ____________________________, that the hysterectomy to be performed on me will 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**

X

**DATE**

X

**INTERPRETER'S SIGNATURE (if required)**

X

**DATE**

#### 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**

X

**DATE**

### Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on ____________________________ was solely for medical indications. The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement 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 acknowledgement 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**

X

**DATE**

### 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.

<table>
<thead>
<tr>
<th>Child Health Plus Benefits Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Pre-Existing Condition Limitations Permitted</strong></td>
</tr>
<tr>
<td><strong>No Copayments or Deductibles</strong></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>General Coverage</th>
<th>Scope of Coverage</th>
<th>Level of Coverage</th>
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</thead>
<tbody>
<tr>
<td><strong>Pediatric Health Promotion Visits</strong></td>
<td>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.</td>
<td>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 child care, 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.</td>
</tr>
</tbody>
</table>

| 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. |

<p>| Inpatient Mental Health and Alcohol and Substance Abuse 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. |</p>
<table>
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<tr>
<th>General Coverage</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Acute care services provided by an Article 28 General Hospital</td>
<td>Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.</td>
</tr>
<tr>
<td>Professional Services for Diagnosis and Treatment of Illness and Injury</td>
<td>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.</td>
<td>No limitations. Includes wound dressing and casts to immobilize fractures for the immediate 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.</td>
</tr>
<tr>
<td>Hospice Services and Expenses</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>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.</td>
<td>The utilization review process must ensure that the ambulatory surgery is appropriately provided.</td>
</tr>
<tr>
<td>Diagnostic and Laboratory Tests</td>
<td>Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.</td>
<td>No limitations.</td>
</tr>
</tbody>
</table>
| 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. |
<p>| Orthotic Devices 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. |</p>
<table>
<thead>
<tr>
<th>General Coverage</th>
<th>Scope of Coverage</th>
<th>Level of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Services</td>
<td>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (<em>i.e.</em> chemotherapy) will also be covered.</td>
<td>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 non-restorative. No procedure or services considered experimental will be reimbursed.</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Determination of the need for services and whether home-based or facility-based treatment is appropriate.</td>
<td></td>
</tr>
<tr>
<td>Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies</td>
<td>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 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.</td>
<td></td>
</tr>
<tr>
<td>Speech and Hearing Services Including Hearing Aids</td>
<td>Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.</td>
<td>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.</td>
</tr>
<tr>
<td>Pre-Surgical Testing</td>
<td>All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.</td>
<td>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.</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Provided by a qualified physician.</td>
<td>No limitations.</td>
</tr>
<tr>
<td>Second Medical Opinion</td>
<td>Provided by an appropriate specialist, including one affiliated with a specialty care center.</td>
<td>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.</td>
</tr>
<tr>
<td>Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Abuse</td>
<td>Services must be provided by certified and/or licensed professionals.</td>
<td>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.</td>
</tr>
<tr>
<td>General Coverage</td>
<td>Scope of Coverage</td>
<td>Level of Coverage</td>
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<tr>
<td><strong>Home Health Care Services</strong></td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Prescription and Non-Prescription Drugs</strong></td>
<td>Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.</td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
<table>
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<tr>
<th>General Coverage</th>
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</thead>
<tbody>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.</td>
<td>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 reasonably 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.</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>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.</td>
<td>No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).</td>
</tr>
<tr>
<td><strong>Diabetic Supplies and Equipment</strong></td>
<td>Coverage includes 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.</td>
<td>As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.</td>
</tr>
<tr>
<td><strong>Ostomy Equipment &amp; Supplies</strong></td>
<td>Coverage includes ostomy equipment and supplies used to contain diverted urine and fecal contents outside the body from a surgically created opening (stoma).</td>
<td>As prescribed by a health care provider legally authorized to prescribe under Title Eight of the Education Law.</td>
</tr>
<tr>
<td>General Coverage</td>
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<td>Level of Coverage</td>
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<tr>
<td>Diabetic Education</td>
<td>Diabetes self-management education (including diet); reeducation or refresher.</td>
<td>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 dietitian 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.</td>
</tr>
<tr>
<td>and Home Visits</td>
<td>Home visits for diabetic monitoring and/or education.</td>
<td></td>
</tr>
<tr>
<td>Emergency, Preventive</td>
<td>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.</td>
<td>The vision examination may include, but is not limited to: • Case history • Internal and External examination of the eye • Ophthalmoscopic 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</td>
</tr>
<tr>
<td>and Routine Vision Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed Lenses:</td>
<td>Limited to the following amounts:</td>
<td>At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.</td>
</tr>
<tr>
<td></td>
<td>$30 Single lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 Double lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$60 Triple lenses</td>
<td></td>
</tr>
<tr>
<td>Frames:</td>
<td>Limited to the following amount:</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td>Limited to the following amount:</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td></td>
<td>$75.00</td>
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</tr>
<tr>
<td>General Coverage</td>
<td>Scope of Coverage</td>
<td>Level of Coverage</td>
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</tbody>
</table>
| 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, subject to a maximum benefit of 680 hours per calendar year. 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. |

| 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 application at 6 month intervals where local water supply is not fluoridated  
  • Four annual fluoride varnish treatments for children from birth until age 7 when applied by a dentist, physician or nurse practitioner.  
  • 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 dentition 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 |

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<table>
<thead>
<tr>
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<th>Level of Coverage</th>
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<tbody>
<tr>
<td><strong>Dental Care</strong></td>
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</tr>
<tr>
<td>Endodontics</td>
<td></td>
<td>Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td></td>
<td>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 cusp) 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.</td>
</tr>
</tbody>
</table>

**NOTE:** Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.

| Orthodontics     |                  | Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (under-developed upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if the child does not meet the criteria described above. 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 & periodically adjusted) • Removable appliance therapy • Orthodontic retention (removal of appliances, construction and placement of retainers) |

Revised January 2020
**Benefit Package Exclusions**

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 biological and the administration of these drugs and biological 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 some infertility services.
- Services covered by another payment source.
- Durable medical equipment and medical supplies, except as defined.
- Transportation, except as defined.
- Personal or comfort items.
- Services which are not medically necessary.
- Blood and blood products, except as defined.

**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.

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<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Full Name Of Vaccine</th>
<th>Manufacturer</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTAP (Daptacel)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine</td>
<td>Sanofi</td>
<td>90700</td>
</tr>
<tr>
<td>DTAP (Infanrix)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis vaccine</td>
<td>GlaxoSmithKline</td>
<td>90700</td>
</tr>
<tr>
<td>DTaP-Hep B-IPV (Pediarix)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis, Hepatitis B and Inactivated poliovirus vaccine</td>
<td>GlaxoSmithKline</td>
<td>90723</td>
</tr>
<tr>
<td>DTaP-P-HI (Pentacel)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus, Haemophilus Influenza B vaccine</td>
<td>Sanofi</td>
<td>90698</td>
</tr>
<tr>
<td>DTaP-IPV (Quadracel)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus vaccine</td>
<td>Sanofi</td>
<td>90696</td>
</tr>
<tr>
<td>DTaP-IPV (Kinrix)</td>
<td>Diphtheria, Tetanus Toxoid, Acellular Pertussis, Inactivated poliovirus vaccine</td>
<td>GlaxoSmithKline</td>
<td>90696</td>
</tr>
<tr>
<td>e-IPV</td>
<td>Inactivated poliovirus vaccine</td>
<td>Sanofi</td>
<td>90713</td>
</tr>
<tr>
<td>Hepatitis A Ped (Vaqta)</td>
<td>Hepatitis A Pediatric vaccine</td>
<td>Merck</td>
<td>90633</td>
</tr>
<tr>
<td>Hepatitis A Ped (Havrix)</td>
<td>Hepatitis A Pediatric vaccine</td>
<td>GlaxoSmithKline</td>
<td>90633</td>
</tr>
<tr>
<td>Hepatitis B (Ped/Adol) (Engerix B)</td>
<td>Hepatitis B pediatric/adolescent vaccine</td>
<td>GlaxoSmithKline</td>
<td>90744</td>
</tr>
<tr>
<td>Hepatitis B (Ped/Adol) (Recombivax Hb)</td>
<td>Hepatitis B pediatric/adolescent vaccine</td>
<td>Merck</td>
<td>90744</td>
</tr>
<tr>
<td>Hepatitis A-Hepatitis B</td>
<td>Hepatitis A and Hepatitis B combo vaccine (Twinrix)</td>
<td>GlaxoSmithKline</td>
<td>90636</td>
</tr>
<tr>
<td>Hib (Pedvax)</td>
<td>Haemophilus B conjugate vaccine</td>
<td>Merck</td>
<td>90647</td>
</tr>
<tr>
<td>Hib (Acthib)</td>
<td>Haemophilus Influenza B vaccine</td>
<td>Sanofi</td>
<td>90648</td>
</tr>
<tr>
<td>Hiberix—booster only</td>
<td>Haemophilus Influenza B vaccine</td>
<td>GlaxoSmithKline</td>
<td>90648</td>
</tr>
<tr>
<td>HPV- (Gardasil9)</td>
<td>Human Papillomavirus 9-valent</td>
<td>Merck</td>
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</tr>
<tr>
<td>Influenza (Fluzone Quadrivalent)</td>
<td>Age 6 months and older</td>
<td>Sanofi</td>
<td>90687</td>
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<tr>
<td>Influenza (Fluzone Quadrivalent Pediatric dose)</td>
<td>Age 6 to 35 months</td>
<td>Sinofi</td>
<td>90685</td>
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<tr>
<td>Influenza (Fluzone Quadrivalent)</td>
<td>Age 6 months and older</td>
<td>Sinofi</td>
<td>90686</td>
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<tr>
<td>Influenza (Fluarix Quadrivalent)</td>
<td>Age 36 months &amp; older</td>
<td>GlaxoSmithKline</td>
<td>90686</td>
</tr>
<tr>
<td>Influenza (Flulaval Quadrivalent)</td>
<td>Age 6 months and older</td>
<td>GlaxoSmithKline</td>
<td>90688</td>
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<tr>
<td>Influenza (Flucelvax Quadrivalent)</td>
<td>Age 4 years and older</td>
<td>Seqirus usa</td>
<td>90674</td>
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<td>90756</td>
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<tr>
<td>Influenza (Afluria Quadrivalent)</td>
<td>Age 6 to 35 months</td>
<td>Seqirus usa</td>
<td>90688</td>
</tr>
<tr>
<td>Influenza (Afluria Quadrivalent)</td>
<td>Age 6 months and older</td>
<td>Seqirus usa</td>
<td>90688</td>
</tr>
<tr>
<td>Influenza (Flumist Quadrivalent)</td>
<td>Live, Intranasal Age 2 to 46 years</td>
<td>AstaZeneca</td>
<td>90672</td>
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<td>MENB (Trumenba)</td>
<td>Meningococcal group b</td>
<td>Pfizer</td>
<td>90621</td>
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<td>MENB (Bexsero)</td>
<td>Meningococcal group b</td>
<td>GlaxoSmithKline</td>
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<tr>
<td>Meningococcal Conjugate (Menactra)</td>
<td>Meningococcal Conjugate vaccine</td>
<td>Sanofi</td>
<td>90734</td>
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<tr>
<td>Meningococcal Conjugate (Menveo)</td>
<td>Meningococcal Conjugate vaccine</td>
<td>GlaxoSmithKline</td>
<td>90734</td>
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(continued on next page)
<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Full Name Of Vaccine</th>
<th>Manufacturer</th>
<th>CPT Code</th>
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</thead>
<tbody>
<tr>
<td>MMR- II</td>
<td>Measles, Mumps and Rubella vaccine</td>
<td>Merck</td>
<td>90707</td>
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<tr>
<td>MMRV (ProQuad)</td>
<td>Measles, Mumps and Rubella vaccine and varicella virus vaccine</td>
<td>Merck</td>
<td>90710</td>
</tr>
<tr>
<td>Pneumococcal (Prevnar 13)</td>
<td>Pneumococcal conjugate vaccine</td>
<td>Pfizer</td>
<td>90670</td>
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<tr>
<td>Pneumococcal</td>
<td>Pneumococcal polysaccharide vaccine</td>
<td>Merck</td>
<td>90732</td>
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<tr>
<td>Rotavirus (Rotateq)</td>
<td>Rotavirus vaccine</td>
<td>Merck</td>
<td>90680</td>
</tr>
<tr>
<td>Rotavirus (Rotarix)</td>
<td>Rotavirus vaccine</td>
<td>GlaxoSmithKline</td>
<td>90681</td>
</tr>
<tr>
<td>Tetnum and Diphtheria Toxoids (Tenivac)</td>
<td>Tetanus Toxoid and Diphtheria and acellular pertussis vaccine</td>
<td>Sanofi</td>
<td>90714</td>
</tr>
<tr>
<td>Tetnum and Diphtheria Toxoids (TBVAX)</td>
<td>Tetanus Toxoid and Diphtheria and acellular pertussis vaccine</td>
<td>Grifols</td>
<td>90714</td>
</tr>
<tr>
<td>Tdap (Boostrix)</td>
<td>Tetanus Toxoid and Diphtheria and acellular pertussis vaccine</td>
<td>GlaxoSmithKline</td>
<td>90715</td>
</tr>
<tr>
<td>Tdap (Adacel)</td>
<td>Tetanus Toxoid and Diphtheria and acellular pertussis vaccine</td>
<td>Sanofi</td>
<td>90715</td>
</tr>
<tr>
<td>Varicella (Varivax)</td>
<td>Varicella virus vaccine</td>
<td>Merck</td>
<td>90736</td>
</tr>
</tbody>
</table>

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 four 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.
## 2019 CDPHP® Essential Plan Benefit Overview

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>CDPHP Essential Plan 1</th>
<th>CDPHP Essential Plan 2</th>
<th>CDPHP Essential Plan 3</th>
<th>CDPHP Essential Plan 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>$20</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Max. Out-of-Pocket Cost per Individual (Family Max. is 2x Individual)</td>
<td>$2,000</td>
<td>$200</td>
<td>$200</td>
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### SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>COPAY OR COINSURANCE PER VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care*, Annual Physical Exam</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Doctor Visit</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist Doctor Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Clinical/Diagnostic Lab/X-ray/MRI/CT Scan/PET Scan</td>
<td>$25</td>
</tr>
<tr>
<td>Live Video Doctor Visits</td>
<td>$15</td>
</tr>
<tr>
<td>Outpatient Facility, Surgeon</td>
<td>$50</td>
</tr>
<tr>
<td>Inpatient Hospital, Nursing Facility</td>
<td>$150 per admission</td>
</tr>
<tr>
<td>Outpatient Mental Health and Substance Use Services</td>
<td>$15</td>
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<tr>
<td>Emergency Room, Ambulance</td>
<td>$75</td>
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<tr>
<td>Urgent Care</td>
<td>$25</td>
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<tr>
<td>PT/OT/ST</td>
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</tr>
<tr>
<td>Chiropractic Services</td>
<td>$25</td>
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<tr>
<td>Eye Exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dental</td>
<td>Not Covered</td>
</tr>
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</table>

### SUPPLIES AND PRESCRIPTIONS

<table>
<thead>
<tr>
<th>SUPPLIES AND PRESCRIPTIONS</th>
<th>COPAY OR COINSURANCE PER ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>$15, 30 Day Supply 0%</td>
</tr>
<tr>
<td>Hearing Aids (External)</td>
<td>5%</td>
</tr>
<tr>
<td>Eyewear</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prescription Drugs: Generic: Tier 1 - Preferred Brand/Tier 2 - Non-Preferred Brand/Tier 3</td>
<td>$6/$15/$30 0% 0% 0%</td>
</tr>
<tr>
<td>Mail Order</td>
<td>90-Day Supply, 2.5x Copay 90-Day Supply, 2.5x Copay 90-Day Supply, 2.5x Copay 90 Day Supply, $0</td>
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</tbody>
</table>

*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.
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.


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 CVS/Caremark Part D Services®, 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. In conjunction with CVS/Caremark, 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. Each quarter Caremark identifies enrollees with drug/disease contraindications, unsafe dosing regimens, therapeutic drug duplication, etc.

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, and reviewing and revising pharmacy policies in conjunction with the documentation and information from CVS/Caremark Part D Services and their pharmacy and therapeutics committee. 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.

Revised January 2020
A five-tier drug formulary lists 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 60 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 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 submit supporting documentation for the request.

- Many vaccinations, including Zostavax, are covered under the Part D pharmacy benefit. Other vaccines, such as 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. Members cannot be billed up front for vaccines by participating providers. Should you require assistance with submitting Part D vaccine claims to Caremark, 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 chemotherapy 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 CVS/Caremark Mail Service available to enrollees. Providers who have questions can call the CVS/Caremark Mail Service at 1-800-378-5697, or fax a prescription to 1-800-378-0323. CDPHP also uses Caremark Specialty Pharmacy Services for our members who need high-cost selected biotech and injectable drugs. If you have questions or would like to transfer a prescription to Caremark 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 five 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.

**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 ensuring 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.
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.

Standard

- Pre-Service: 14-day time limit
- Payment: 60-day time limit

Initial Coverage Determination

Expedited

- Pre-Service: 72-hour time limit
- Payment requests cannot be expedited

Organization Determination

Appeals

Health Plan Reconsideration

- Pre-Service: 30-day time limit
- Payment: 60-day time limit

Health Plan Reconsideration

- 72-hour time limit
- Payment requests cannot be expedited

Appeal Level 1

- 60 days to file

Independent Review Entity

- Pre-Service: 30-day time limit
- Payment: 60-day time limit

Independent Review Entity

- 72-hour time limit
- Payment requests cannot be expedited

Appeal Level 2

- 60 days to file

Administrative Law Judge

- Amount in controversy requirement must be met

Appeal Level 3

- 60 days to file

Medicare Appeals Council

Appeal Level 4

- 60 days to file

Federal District Court

- Amount in controversy requirement must be met

Appeal Level 5
**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.
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.