

VILLAGECAREMAX

PROVIDER MANUAL

**SEE WHAT'S
POSSIBLE WHEN
HEALTH CARE
GETS PERSONAL.**

www.villagecaremax.org



VillageCareMAX Managed Long Term Care (MLTC)

VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)

VillageCareMAX Medicare Total Advantage MAP Plan (HMO D-SNP)

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Section 1: Quick Reference Guides

Quick Reference Guide



VillageCareMAX Managed Long Term Care (MLTC)
VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)
VillageCareMAX Medicare Total Advantage MAP Plan (HMO D-SNP)

Quick Reference Guide for Providers

The VillageCareMAX Provider Portal

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more.

The portal is available 24 hours a day, 7 days a week and can be accessed by visiting <https://secure.healthx.com/villagecareprovider>.

Department	Contact Information	Hours of Operation
Member Enrollment & Eligibility Verifications	Verify VillageCareMAX Enrollment on EMEDNY: MLTC Plan Code: VL MA Plan Code: H2168 MAP Plan Code: VM	24 hours / 7 days
Utilization Management Medical and Behavioral	Tel: 800-469-6292 Fax: 718-517-2709	7 days a week 8 am to 8 pm
Claims/ Provider Services	Tel: 855-769-2500	Mon – Fri 9 am to 5 pm
Care Management	Tel: 800-469-6292 Fax: 212-337-5711	Mon – Fri 9 am to 5 pm *Call Member Services during other hours for assistance
Pharmacy Services • MedImpact Pharmacy Benefits Manager	Tel: 888-807-6806	Mon – Fri 8 am to 8 pm
Member Services	Tel: 800-469-6292 Fax: 212-337-5711	7 days a week 8 am to 8 pm
Dental Services • Healthplex Dental Benefits Manager	Tel: 888-468-2183	Mon – Fri 8 am to 6 pm
Transportation Services (non-emergency) • National MedTrans Network Benefit Manager	Tel: 877-916-7999	Mon – Fri 8 am to 8 pm
Optometry/Vision Services • EyeQuest Vision Benefits Manager	Tel: 888-260-5152	Mon – Fri 8 am to 8 pm
Laboratory Services • Bio-Reference Laboratories • LabCorp	Tel: 800-229-5227 Tel: 800-222-7566	24 hours/7 days Mon – Fri 8 am to 5 pm

Revised:11/2019

   www.villagecaremax.org

[Section 1: Quick Reference Guides](#)

Prior Authorization List The following services require prior authorization (contact Utilization Management). For a complete list of services with additional details, please see the VillageCareMAX Provider Manual, Section 10. For a complete list of DME codes that require prior authorization, please see Appendix 10 in the Provider Manual.	
Frequently utilized MLTC Services	Frequently utilized MA & MAP Services
• DME • Nursing Home Care • Home Health Care • Adult Day Health Care & Social Day Care • Non-emergency Transportation • Rehabilitation Therapy (PT, OT, ST) • Respiratory Therapy • Nutrition • Social and Environmental Supports • Home Delivered & Congregate Meals • Private Duty Nursing • Community-based Long-Term Services and Supports (LTSS) • Respite services • Tele-Monitoring • Home Infusion	• DME • Hospital admissions • Skilled Nursing Facility admissions • Surgeries • Outpatient Behavioral Health services • Auth required after 20 visits for non-physician services • Alcohol and Substance Abuse services • Rehabilitation Therapy (PT, OT, ST) • Auth required after 20 visits • Cardiac & Pulmonary Rehabilitation • Auth required after 20 visits • Home Health Care • Organ Transplant • Chiropractic services • Diagnostic Services (MRI/MRA, EMG, PET Scan, Nuclear Medicine) • Mobile Radiology
To facilitate care management, VillageCareMAX requests notification to Utilization Management of all hospital admissions in accordance with the following timeframes: • Elective Admissions: 5 days prior to the admission • Urgent Admissions: any time prior to the admission but not later than 1 business day after admission • Emergent Admission: within 1 business day of the emergent admission	
Pharmacy Services	
• VillageCareMAX MLTC members obtain prescription drugs through their Medicare Prescription Drug Plan (Part D) and/or New York State Medicaid. • VillageCareMAX MA and MAP members obtain prescription drugs through the VCMAX plan. Pharmacy network and prescription drug benefits are administered by MedImpact. (888) 807-6806 TTY 711. • The formulary (including prior authorization and other requirements) as well as a listing of participating providers and pharmacies can be found via www.villagecaremax.org.	
Claims	
Mail paper claims (CMS-1500 or UB-04) and claims correspondence to: ILS - VillageCareMAX P.O. Box 21516 • Eagan, MN 55121	Electronic claims submissions: Use VillageCareMAX Change HealthCare payer ID: 26545
• For MLTC claims, if VillageCareMAX is not primary, submit the claim within 90 days of the date on the Explanation of Payment (EOP)/Remittance Notice and include EOP with your claim. • For MAP claims, VillageCareMAX is the payer for all covered services. • For MA claims, VillageCareMAX is the primary payer. • NPI and Tax ID must be included on all claims.	

Section 1: Quick Reference Guides

Provider Portal Quick Reference Guide



   www.villagecaremax.org

PROVIDER PORTAL Quick Reference Guide

The VillageCareMAX Provider Portal

The VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more. The portal is available 24 hours a day, 7 days a week. Providers must complete the registration process to receive access to the portal. All provider information will be verified by the plan before user account can be activated. This verification process may take up to 72 hours to complete.

How do I sign up?	Registration is quick and easy! • Visit www.villagecaremax.org (or use the direct link https://secure.healthx.com/villagecareprovider) • Click on the "For Providers" tab • Click on Provider Login link located on the homepage • On the right side of the web portal homepage, click Provider User Account Sign-Up and follow the step by step instructions to complete your one time registration.
Features of the Portal	Once registered, providers have instant access to • Member/Participant Eligibility Status • Authorization Status • Claims Status • Claim inquiry request
Using the Eligibility, Benefits, Claims, and Prior Authorizations Searches	
How do I verify eligibility?	Click on the Eligibility & Benefits link. Here, you may search for member eligibility, which may be downloaded to your computer.
How do I check claim status?	Click on the Claims link. Here you may search for a member's claim by entering their Member ID. To narrow your search, enter the Member ID, start and end dates of service. Once you locate your claim, select to view the claim details (date claim received, payee name, payment address, bulk check amount and more).
How do I check authorization status?	Click on the Prior Authorizations link. Here you may search for member's authorizations by entering their Member ID. To narrow your search, enter the Member ID, start and end dates.
How do I submit a claim inquiry?	You can also submit a claim inquiry by simply clicking on " <i>click here to ask a question about this claim</i> " at the top of Claim Detail screen. Your inquiry will be reviewed and responded to by the Provider Services Claims Department within the required timeframes.

If you have any questions, please call the Provider Services Claims Department at 1-855-769-2500

Section 2: VillageCareMAX Overview

VillageCareMAX Overview

Village Senior Services Corporation d/b/a VillageCareMAX is a New York not-for-profit corporation licensed by the New York Department of Health pursuant to Article 44 of the Public Health Law. The sole corporate member of VillageCareMAX is Village Care of New York, Inc., (“VCNY”) a New York not-for-profit corporation that provides management and administrative services to VillageCareMAX and other VCNY affiliates and subsidiaries (collectively, “VillageCare”).

The mission of VillageCare is to promote healing, better health and well-being to the fullest extent possible by providing a caring and supportive environment where all those we serve, along with their families and partners, are respected for their uniqueness and are encouraged to treat themselves and others with kindness and respect.

VillageCare has been providing quality health care to older adults and to those with other chronic diseases and conditions, including HIV/AIDS, who are in need of continuing care and rehabilitation services. VillageCare is a pioneering and innovative continuing care organization that offers post-acute care, community services and managed care options to people living in New York City.

Currently, VillageCareMAX offers three (3) managed care products to individuals in the Bronx, Kings, New York and Queens counties in New York:

- VillageCareMAX MLTC Plan provides Medicaid-covered services only. These include, but are not limited to, long term care services such as Personal Care, Home Health Care, rehabilitation therapies, care in a Skilled Nursing Facility, Personal Emergency Response System (PERS), Home Delivered Meals, and Social & Environmental Supports.
- VillageCareMAX Medicare Health Advantage Plan provides Medicare-covered services only. These include all Medicare Part A & B services, and Part D prescription drugs. Providers must bill New York State directly for Medicaid cost sharing and services covered through Medicaid/Medicare Fee for Service (FFS). In addition, members receive supplemental benefits not covered by Medicare or Medicaid such as over-the-counter health related items and acupuncture.
- VillageCareMAX Medicare Total Advantage provides all Medicare-covered and Medicaid-covered services. These include all Medicare Part A & B services, Part D prescription drugs; and all Medicaid-covered services, including community-based long term care. Providers must bill New York State directly for Medicaid cost sharing and services covered through Medicaid/Medicare Fee for Service (FFS). In addition, members receive supplemental benefits not covered by Medicare or Medicaid such as over-the-counter health related items and acupuncture.

VillageCareMAX is designed to coordinate healthcare services for chronically ill adults who wish to remain in their own home and communities for as long as possible.

Section 2: VillageCareMAX Overview

- Member's healthcare needs are coordinated by a dedicated Care Manager in collaboration with an Interdisciplinary Team (ICT). The ICT is led by the Care Manager and may include Primary Care Provider (PCP), Behavioral Health Professional, Member's family and caregivers, Member's personal care aide, and other service Providers and individuals as requested by the Member. The ICT works together to develop a plan of care consisting of covered and non-covered services designed specifically to meet the Member's healthcare needs.
- All Members enrolled in VillageCareMAX must have a physician who is willing to collaborate with VillageCareMAX. Collaboration by a physician means that the physician is willing to write orders for covered services and non-covered services, to refer to VillageCareMAX's Participating Providers and to work with the VillageCareMAX Interdisciplinary Care Team to coordinate all care.

Section 3: Enrollment Eligibility Criteria

VillageCareMAX MLTC Enrollment Eligibility

To be eligible for enrollment in the VillageCareMAX MLTC Plan, an individual must:

1. Be 18 years of age or older
2. Be a resident of Bronx, Brooklyn, Manhattan or Queens
3. Have full Medicaid coverage as determined by the Local Department of Social Services (in New York City, this is the Human Resources Administration known as “HRA”)
4. Show a need and require one of the following Community Based Long Term Care Services (CBLTCS) for more than 120 days from the effective date of enrollment.
 - ✓ Nursing services in the home
 - ✓ Therapies in the home (physical, occupational or speech therapies)
 - ✓ Health aide services in the home
 - ✓ Personal care services in the home
 - ✓ Consumer Directed Personal Assistance Services (CDPAS)
 - ✓ Adult day health care
 - ✓ Private duty nursing
5. For persons with Medicaid only or those with Medicare and Medicaid who are 18 to 20 years old, he/she must be assessed as eligible for nursing home level of care, at the time of enrollment, as determined by the New York State assessment tool, and need CBLTCS for more than 120 days as listed in #4 above.

VillageCareMAX MLTC Members usually need help with two or more of the following:

• Grooming	• Bathing	• Ambulation
• Dressing Upper Body	• Dressing Lower Body	• Toileting
• Eating	• Transferring	• Housekeeping
• Transportation	• Laundry	• Light Meal Prep
• Shopping	• Using the Telephone	

VillageCareMAX MLTC Members often also have one or more chronic medical and/or psychiatric conditions and/or cognitive impairments.

Section 3: Enrollment Eligibility Criteria

VillageCareMAX Medicare Health Advantage Enrollment Eligibility

To be eligible for enrollment in VillageCareMAX Medicare Health Advantage Plan, an individual must:

1. Be eligible for both Medicare Part A and Medicare Part B
2. Be eligible for full Medicaid benefits or a Medicare Savings Program
3. Be a resident of Bronx, Brooklyn, Manhattan or Queens
4. A United States citizen or lawfully present in the United States
5. Not have End-Stage Renal Disease (ESRD) at the time of enrollment

VillageCareMAX Medicare Total Advantage Enrollment Eligibility

To be eligible for enrollment in VillageCareMAX Medicare Total Advantage, an individual must:

1. Be 18 years of age or older
2. Have full Medicaid benefits as determined by the Local Department of Social Services (in New York City, this is the Human Resources Administration known as “HRA”)
3. Be eligible for both Medicare Part A and Medicare Part B
4. Be a resident of Bronx, Brooklyn, Manhattan or Queens
5. Be a United States citizen or lawfully present in the United States
6. Be eligible for nursing home level of care
7. Be able to stay safely at home and in the community at the time of enrollment
8. Show a need and require community-based or facility-based Long Term Services and Supports (LTSS) for more than 120 days from the effective date of enrollment; or nursing facility clinically eligible and get facility-based LTSS. Community-based LTSS include:
 - ✓ Nursing services in the home
 - ✓ Therapies in the home (physical, occupational or speech therapies)
 - ✓ Health aide services in the home
 - ✓ Personal care services in the home

Section 3: Enrollment Eligibility Criteria

- ✓ Consumer Directed Personal Assistance Services (CDPAS)
- ✓ Adult day health care
- ✓ Private duty nursing

9. Not have End-Stage Renal Disease (ESRD) at the time of enrollment

10. Enroll in the Medicare Advantage plan under VillageCareMAX Medicare Total Advantage

If you have a patient who you believe is eligible and may benefit from one of the VillageCareMAX plans, refer the person to us and we will tell them about our program and initiate the enrollment process.

To refer a patient, please:

- » Send an email to vcmxrefer@villagecare.org, or
- » Call 1-800-4MY-MAXCARE (1-800-469-6292), or
- » Fax referrals to 1-347-226-5181.

Please use the form in Appendix 1 to submit referrals to the plan.

Section 4: Enrollment Eligibility Verification

Eligibility Verification

Providers are responsible for verifying Member eligibility prior to every encounter. Eligibility can be verified through EMEDNY – NY State Medicaid Eligibility Verification System at any time.

• VillageCareMAX MLTC Plan
» ePACES Plan Code: VL
» Provider Number: 03420399
• VillageCareMAX Medicare Health Advantage
» CMS Contract ID: H2168 001
• VillageCareMAX Medicare Total Advantage
» ePACES Plan Code: VM
» CMS Plan ID: H2168 002
» Provider Number: 04682248

- EMEDNY toll-free 1-800-997-1111

For instructions, see the following web site:

[https://www.emedny.org/providermanuals/5010/MEVS/MEVS_DVS_Provider_Manual_\(5010\).pdf](https://www.emedny.org/providermanuals/5010/MEVS/MEVS_DVS_Provider_Manual_(5010).pdf)

Providers may also call Provider Services during normal business hours at 1-855-769-2500 with any questions.

Section 4: Enrollment Eligibility Verification

Member ID Cards

VillageCareMAX MLTC Member ID Card

SAMPLE	
 New York Managed Long-Term Care Plan	 LIVE THE LIFE YOU WANT!
Member Name: JOHN DOE	
Member CIN#: AB12345C	Effective Date: xx/xx/xx
Member Services: 1-800-4MY-MAXCARE (1-800-469-6292) TTY: 1-800-662-1220	
WWW.VILLAGECARE.ORG	
Member Services and Utilization Management: 1-800-4MY-MAXCARE (1-800-469-6292) TTY: 1-800-662-1220	
Dental Services: 1-800-468-9868 Vision Services: 1-888-260-5152 Transportation Services: 1-877-916-7599 Provider Services: 1-855-769-2500 Claims: PO Box 5536, Hauppauge, NY 11788 VISIT: www.villagecare.org for more information	
Emdean Submitter ID: 26545	
<i>This card does not guarantee coverage. Coordination of Benefits may apply.</i>	

VillageCareMAX Medicare Health Advantage Member ID Card

Front of Member Identification Card

SAMPLE	
 <Plan Name> (HMO SNP)	
Member Name: <FName> <LName> Member ID: <Subscriber ID #> Health Plan (80840): 7538162273 Effective Date: <Enrollment Date>	 RxBin: 015574 RxPCN: ASPROD1 RxGRP: VCM02
PCP Name: <PCP Name> PCP Phone: <PCP Phone>	
Copays: See your Evidence of Coverage for information on cost sharing. Medicaid COB applies. Visit www.villagecaremax.org for more info.	
CMS Contract #: H2168 <001> <002>	

Back of Member Identification Card

This card does not guarantee coverage. In an emergency, call 911 or go to the nearest emergency room.

Member Services:	1-800-469-6292	(TTY: 711)
Physician Call Line:	1-844-484-7362	(TTY: 711)
Pharmacy Help Desk:	1-888-807-6806	(TTY: 711)
Dental Services:	1-800-468-9868	(TTY: 711)
Website:	www.villagecaremax.org	

Provider Services: 1-855-769-2500
Send Claims To: ILS – VillageCare, PO Box 21516, Eagan, MN 55121
Change Healthcare Electronic Payer ID: 26545

VillageCareMAX Medicare Total Advantage Member ID Card

Front of Member Identification Card

SAMPLE	
 <Plan Name> (HMO SNP)	
Member Name: <FName> <LName> Member ID: <Subscriber ID #> Health Plan (80840): 7538162273 Effective Date: <Enrollment Date>	 RxBin: 015574 RxPCN: ASPROD1 RxGRP: VCM02
PCP Name: <PCP Name> PCP Phone: <PCP Phone>	
Copays: See your Evidence of Coverage for information on cost sharing. Medicaid COB applies. Visit www.villagecaremax.org for more info.	
CMS Contract #: H2168 <001> <002>	

Back of Member Identification Card

This card does not guarantee coverage. In an emergency, call 911 or go to the nearest emergency room.

Member Services:	1-800-469-6292	(TTY: 711)
Physician Call Line:	1-844-484-7362	(TTY: 711)
Pharmacy Help Desk:	1-888-807-6806	(TTY: 711)
Dental Services:	1-800-468-9868	(TTY: 711)
Website:	www.villagecaremax.org	

Provider Services: 1-855-769-2500
Send Claims To: ILS – VillageCare, PO Box 21516, Eagan, MN 55121
Change Healthcare Electronic Payer ID: 26545

Section 5: Covered Benefits

List of Covered Benefits for VillageCareMAX Managed Long Term Care Plan (MLTC), Medicare Health Advantage Plan (D-SNP), and Medicare Total Advantage Plan (MAP).

The complete listing of benefits and description for all plans can be viewed in the Evidence of Coverage or Member Handbook located at <http://www.villagecaremax.org/>.

KEY

X = Covered Benefit

NC = Not Covered

X* =*This service may only be partially covered under this Plan. Providers may contact Utilization Management at 1-800-469 6292 or visit our website at <http://www.villagecaremax.org> for more information.

Benefits	MLTC	MAP	D-SNP
24/7 Physician Hotline	NC	X	X
Acupuncture	NC	X	X
Adult Day Health Care	X	X	NC
Ambulatory Surgery Center	NC	X	X
Anesthesia	NC	X	X
Angiograms and Embolization	NC	X	X
Assistive Technology (AT)*	X	X	NC
Audiology Services (Exam)	X	X	NC
Basic Radiology Services	NC	X	X
Blood Transfusion	NC	X	X
Cardiac Rehabilitation Services	NC	X	X
Chemotherapy	NC	X	X
Chiropractic Services	NC	X	X
Community Transitional Services (CTS)*	X	X	NC
Consumer Directed Personal Assistance Services (CDPAS)	X	X	NC
CT Scan	NC	X	X
Dentistry¹	X	X	X
Diabetes Programs and Supplies	X	X	X
Diagnostic Services	NC	X	X
Dialysis	NC	X	X
Discogram/Myelogram	NC	X	X
Durable Medical Equipment (DME)	X	X	X
Electromyogram (EMG)	NC	X	X
Emergency Ambulance Services	NC	X	X
Emergency Care	NC	X	X

¹ See Appendix 13 for updated NYS Medicaid program dental policy notice.

[Section 5: Covered Benefits](#)

Benefits	MLTC	MAP	D-SNP
Environmental Modifications (EMods)*	X	X	NC
Hearing Aids / Batteries	X	X	NC
Home Delivered and Congregate Meals	X	X	NC
Home Health Care	X	X	X
Home Infusion Services	X*	X	X
Hospital Services	NC	X	X
Immunizations	NC	X	X
Infusion	X*	X	X
Inpatient Bariatric Surgery	NC	X	X
Inpatient Hospital Care	NC	X	X
Inpatient Mental Health Care	NC	X	X
Inpatient Organ Transplants	NC	X	X
Inpatient Reconstructive Surgery	NC	X	X
Inpatient Skilled Nursing Facility	X	X	X
Inpatient Substance Abuse and Rehab	NC	X	X
Lab Services	NC	X	X
Medical Social Services	X	X	X*
Mental Health Care	NC	X	X
Mobile Radiology (EKG and X-Rays)	NC	X	X
Moving Assistance (MA)*	X	X	NC
MRI/MRA	NC	X	X
Nerve block/Epidurals	NC	X	X
Non-Emergency Transportation / Ambulance Services	X	X	X
Nuclear Medicine	NC	X	X
Nurse Practitioner	NC	X	X
Nutrition	X	X	X*
Occupational Therapy	X	X	X
Orthopedic Footwear	X	X	X
Part B Drugs (when billed by a physician or facility)	NC	X	X
Partial Hospitalization	NC	X	X
Personal Care Services	X	X	NC
Personal Emergency Response Services (PERS)	X	X	NC
Pet Scan	NC	X	X
Physical Therapy	X	X	X
Physician Assistant	NC	X	X
Physician Specialist Services	NC	X	X
Podiatry Services	X	X	X
Primary Care Physician Services	NC	X	X
Private Duty Nursing	X	X	NC

Section 5: Covered Benefits

Benefits	MLTC	MAP	D-SNP
Prosthetics/ Medical Surgical Supplies	X	X	X
Psychiatry	NC	X	X
Pulmonary Rehabilitation Services	NC	X	X
Respiratory Therapy	X	X	X*
Skill Acquisition Maintenance and Enhancement (SAME)*	X	X	NC
Social and Environmental Supports	X	X	NC
Social Day Care	X	X	NC
Speech Therapy	X	X	X
Substance Abuse Care	NC	X	X
Telehealth	X	X	X
Tuberculosis screening & clinical management	NC	X	X
Ultrasound	NC	X	X
Urgent Care	NC	X	X
Vehicle Modifications (VMods)*	X	X	NC
Vision Services	X	X	X
Worldwide Emergency/Urgent Care	NC	X	X

KEY

X = Covered Benefit

NC = Not Covered

X* =*This service may only be partially covered under this Plan. Providers may contact Utilization Management at 1-800-469-6292 or visit our website at <http://www.villagecaremax.org> for more information.

Please see [Appendix 10](#) for a list of those DME services that require prior authorization.

*Benefits are covered under Community First Choice Option (CFCO) effective upon the latter of January 1, 2020 or DOH approval.

[Section 5: Covered Benefits](#)

2020 Annual Notice of Changes (ANOC) effective January 1, 2020:

Medicare Health Advantage - Plan 001 (DSNP)			
Benefit	2019 Benefit/Coverage Limits	2020 Benefit/Coverage Limit	Change for 2020
Over-the-Counter (OTC) items	\$120 per month for approved items	\$130 per month for approved items	Increased limit
Comprehensive Dental	Prosthodontics & Endodontic services not covered by Medicaid (like dentures & crowns).	\$2,000 limit on comprehensive dental services such as dentures, crowns & oral surgery	Increased coverage
Preventive Dental	1 oral exam/cleaning/X-ray every 6 months	1 oral exam/cleaning/X-ray every 6 months	No change
Vision	Annual eye exam and \$300 per year for eyewear	Annual eye exam and \$300 per year for eyewear	No change
Transportation	4 one way trips every 3 months	10 one-way trips every 6 months with a maximum of 20 one-way trips per year	Increased limit
Acupuncture	15 visits per year	48 visits per year	Increased limit
24/7 Physician Hotline	24/7 access to speak to a doctor about non-emergency health related concerns	24/7 access to speak to a doctor about non-emergency health related concerns	No change
Fitness Membership	Fitness membership at participating locations or home fitness kits	Fitness membership at participating locations or home fitness kits	No change
Hearing	Not Covered	Annual routine hearing exam. Up to \$1,500 per year for 2 hearing aids limited to \$750 per ear	New benefit
Worldwide Emergency/Urgent Coverage	Not Covered	Up to \$50,000 per year for emergency/urgent care coverage when outside of the United States and its territories	New benefit

Medicare Total Advantage - Plan 002 (MAP)			
Benefit	2019 Benefit/Coverage Limits	2020 Benefit/Coverage Limit	Change for 2020
Over-the-Counter (OTC) items	\$150 per month for approved items	\$175 per month for approved items	Increased limit
Comprehensive Dental	Prosthodontics & Endodontic services not covered by Medicaid (like crowns)	Prosthodontics & Endodontic services not covered by Medicaid (like crowns)	No change
Vision	Annual eye exam and \$300 per year for eyewear	Annual eye exam and \$300 per year for eyewear	No change
Acupuncture	15 visits per year	48 visits per year	Increased limit
24/7 Physician Hotline	24/7 access to speak to a doctor about non-emergency health related concerns	24/7 access to speak to a doctor about non-emergency health related concerns	No change
Worldwide Emergency/Urgent Coverage	Not covered	Up to \$50,000 per year for emergency/urgent care coverage when outside of the United States and its territories	New benefit

Section 5: Covered Benefits

VillageCareMAX Model of Care

VillageCareMAX has implemented an evidence-based model of care (MOC) for its health plans. Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve and sustain Member health outcomes across the care continuum in accordance with the requirements set forth by the CMS and DOH. The program provides primary, specialty and acute medical care services, Medicaid-covered long-term care services and supports as well as other benefits. It coordinates these services to address acute medical needs and manage chronic conditions while allowing Members to remain safe and secure in their own homes.

MOC elements include:

- Description of the plan-specific target population
- Measurable goals;
- Staff structure and care management goals;
- Interdisciplinary Care Team (ICT);
- Provider network having specialized expertise and use of clinical practice guidelines and protocols;
- MOC training for personnel and provider network;
- Health risk assessment;
- Individualized care plan;
- Integrated communication network;
- Care management for the most vulnerable subpopulations;
- Performance and health outcomes measurement; and
- Education, monitoring and evaluation of self-direction.

MOC goals are:

- Improve access to essential services such as medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve seamless transitions of care across healthcare settings, providers, and health services;
- Improve access to preventive health services;
- Ensure appropriate utilization of services; and
- Improve beneficiary health outcomes as selected by the plan.

Section 5: Covered Benefits

Care Manager and Interdisciplinary Care Team

Each VillageCareMAX Member is assigned to a Care Manager and Interdisciplinary Care Team that will include health care professionals (Member's primary care provider, nurses, social workers, psychologists or therapists, other specialists as appropriate) and a Member Services Representative. The Interdisciplinary Care Team has ongoing responsibility for ensuring that the Member's health risks are identified on ongoing basis and that the Member's healthcare needs and risks are appropriately addressed by the plan of care.

As the primary coordinator of care, the Care Manager's responsibilities include:

- Ensuring the ongoing identification of health risks by conducting in-home and telephonic assessments;
- Developing a plan of care for the Member and facilitating authorization of covered benefits;
- Implementing the Member's plan of care and coordinating services across the continuum of services;
- Monitoring the delivery of services for quality and effectiveness;
- Integrating feedback, observations, and recommendations of other professionals involved in managing the care of the Member, including Participating Providers, PCPs, Specialists and Providers of non-covered services; and
- Coordinating discharge planning from hospital or nursing home stays and facilitating transitions of care.
 - Subject to any limitations imposed by applicable law or program requirements, VillageCareMAX may, at any time, request that Provider transfer a Member to another provider or discharge the Enrollee to his/her home when VillageCareMAX determines that such transfer or discharge would be in the best interests of the Member. Neither VillageCareMAX or its affiliates, nor the Member shall have any liability for any charges or fees of Provider incurred after the date on which such transfer or discharge reasonably could have been effectuated.

Member Services Representatives

Member Services Representatives serve as liaisons between the Member and their Care Manager, and assist in facilitating communication across the Interdisciplinary Care Team. Member Services Representatives provide information about VillageCareMAX policies, available services, and Participating Providers, make and confirm service arrangements, and answer questions and resolve problems presented by Members.

Section 5: Covered Benefits

Health Risk Assessment

VillageCareMAX uses the Universal Assessment System (UAS) to conduct evaluations of the Member's medical history, clinical issues, diagnoses, functional status, psychosocial issues and cognitive status, and potential health risks that may be amenable to intervention, such as tobacco use, obesity and decreased medication adherence. The information collected using UAS is the basis for development of the individualized plan of care, including the identification of Member-specific problems and goals. In addition to the UAS, the plan conducts a home safety evaluation and completes a personal care tasking tool. The plan conducts an assessment upon enrollment and every 6 months and whenever there has been a significant event (e.g., hospitalization, a fall, etc.).

Individualized Care Plan

Based on the results of the assessments, each Member is placed into one of three (3) Care Management groups and assigned Care Manager (CM), who is either a registered nurse or a certified social worker. Care Managers working with the Member, his/her caregivers and the ICT, develop a Person-Centered Service Plan. A Person-Centered Service Plan is a written description in the care management record of Member-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a Member in order to achieve such goals.

Performance and Health Outcome Measurement

VillageCareMAX continuously reviews the progress that has been made toward meeting the goals of its Model of Care, and issues related to the MOC structure, provider network, and communications mechanisms. The Plan will review the results of its performance measures to assure that we continue to promote, improve and sustain Member health outcomes.

Section 7: Participating Provider Responsibilities

Responsibilities of All Participating Providers

Participating Providers are responsible for providing care, the coordination of benefits and, depending of the program in which the Member is enrolled, for maximizing a Member's Medicare, Medicaid or other primary insurance sources.

Participating Providers must comply with all New York State Department of Health and/or CMS requirements regarding physician's orders. Authorization from VillageCareMAX does not exempt a Participating Provider from being required to obtain physicians orders. This includes but is not limited to services provided by licensed home care agencies and providers of personal care services, home care services, rehabilitation therapies, Durable Medical Equipment, Prosthetics, Orthotics, and supplies.

Members of VillageCareMAX lines of business are responsible for their cost-sharing amounts when they receive services covered by VillageCareMAX. For VillageCareMAX MLTC members, VillageCareMAX will be the last entity to be billed. The Member's primary insurance or Medicare will be billed first, followed by Medicaid or any other insurance that a member has.

Care coordination and management is critical to the health and well-being of VillageCareMAX Members. Participating Providers agree to fully cooperate with VillageCareMAX Care Management and Quality Management activities. Participating Providers agree to this even in those cases where the service is covered entirely by a primary payer, such as Medicare, and there is no payment from VillageCareMAX because the primary coverage pays for the service in its entirety.

All Participating Providers are responsible for effectively communicating with the Care Manager/Interdisciplinary Care Team, along with the Member Services staff regardless of primary payer, in order to ensure health risks are identified and addressed, to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, access appropriate reimbursement sources for services, increase continuity of care and progress toward goal achievement. Participating Providers should notify VillageCareMAX Care Management immediately upon learning of changes in the Member's condition, including hospitalizations, falls and other health or social/environmental risks.

In case of an Emergency, Provider shall refer the Enrollee to an appropriate provider of Emergency Services. As soon as possible, but in no event later than one (1) business day after making such referral, Provider shall notify VillageCareMAX of such referral by emailing vcmaxrefer@villagecare.org, calling 1-800-4MY-MAXCARE (1-800-469-6292) or faxing referral to 1-347-226-5181 using the form designated in the Provider Manual

If Provider cannot provide a Member with any covered or authorized service, Provider shall immediately notify VillageCareMAX by calling 1-800-4MY-MAXCARE (1-800-469-6292) to notify the VillageCareMAX Program Physician on call, and Provider shall promptly send to

Section 7: Participating Provider Responsibilities

VillageCareMAX written notification setting forth the date of such verbal notification and the name of the VillageCareMAX Program Physician notified. In addition, Provider shall cooperate with the Member and VillageCareMAX in obtaining appropriate care for such Member.

A Member may refuse care that has been specified in his/her plan of care. If this happens, Providers should notify VillageCareMAX immediately. VillageCareMAX will not place or terminate services that the Member refuses until after the Member, their family or authorized representative has been fully informed of the health risks and consequences involved in such refusal and the Member, upon being fully informed, continues to refuse care. All Participating Providers must notify VillageCareMAX immediately if a Member refuses an authorized service.

Section 7: Participating Provider Responsibilities

All Participating Providers are required to:

- Comply with all regulatory and professional standards of practice and are responsible to acquire physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or third party reimbursement. The Care Manager/Interdisciplinary Care Team may assist in obtaining orders if the Participating Provider has been unsuccessful; however, obtaining orders is the responsibility of the Participating Provider.
- Collaborate with Care Management and participate in the care planning processes.
 - VillageCareMAX's Care Manager will authorize and coordinate the provision of services rendered under the Participating Provider Agreement. This responsibility includes authorizing the specific amount of services that will be utilized by the Enrollee, including the number of units of service to be provided, as outlined in Exhibits A of this Agreement, and the authorized time period during which these services are to be provided.
- Follow evidence-based clinical practice standards when providing care.
- Notify VillageCareMAX immediately whenever there is identification of a clinical, social, or environmental issue of serious concern, change in Member status, refusal of service, inability to access a Member's home or inability to provide service for any reason.
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member.
- Cooperate with VillageCareMAX on any grievance, or appeal as required. Incident reports must be submitted to VillageCareMAX within ten (10) working days of request.
- Communicate to VillageCareMAX any complaint made by or on behalf of the Member.
- Cooperate with VillageCareMAX Quality Assurance Department and quality improvement programs as needed.
- Assure that all Participating Provider's employees and agents involved in direct contact with Members carry proper identification.
- Notify VillageCareMAX of the provision of any services normally requiring prior authorization but which were provided on an urgent basis (before authorization could be obtained) within forty-eight (48) hours.
- Cooperate with VillageCareMAX credentialing and recredentialing processes.
- Participate in all required VillageCareMAX training programs including physical accessibility, which is defined in accordance with the US Department of Justice ADA guidance for providers, in the following areas:
 - Provision of reasonable accommodations to Members with hearing, vision, cognitive and psychiatric disabilities
 - Utilizing waiting room and exam room furniture that meets the needs of all Members, including those with physical and non-physical disabilities
 - Accessibility along public transportation routes and/or providing enough parking
 - Utilizing clear signage and way finding (e.g. color and symbol signage) throughout facilities; and
 - Any other requirements included in the ADA Accessibility Attestation Form.

Section 7: Participating Provider Responsibilities

- Check governmental exclusion lists on a monthly basis, including the U.S. Dept. of Health and Human Services Office of the Inspector General (“OIG”) List of Excluded Individuals and Entities and the NY Office of the Medicaid Inspector General (“OMIG”) List of Exclusions to ensure that no employee/staff is excluded from participation in government programs.

Roles and Responsibilities of PCPs, Specialists and Covering Physicians/Providers

Primary Care Physicians

Primary Care Physicians (PCPs) provide comprehensive primary care services to VillageCareMAX Members without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

The PCP’s role and scope of responsibilities include:

- Develop Member’s care and treatment plans, including preventive care
- Coordinate, monitor and supervise the delivery of primary care services to each Member
- Follow evidence-based clinical practice standards when providing care, if such standards exist for the services the Member’s needs
- Maintain Member’s current medical records, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the Provider contract and Section 8 of the Provider Manual
- Refer Members for specialty care when appropriate
- Coordinate with specialty providers when appropriate
- Coordinate and communicate with Care Manager and participate in ICT meetings.
- Provide complete information about proposed treatments and prognosis for recovery to our Members or their appointed representatives
- Ensure that Member’s medical and personal information is kept confidential, as required by state and federal laws
- Provide or arrange for coverage of services, twenty-four (24) hours per day, seven (7) days per week.
- To ensure PCPs meet accessibility and availability requirements, PCPs must provide the following:
 - A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP;
- Participate in all required training programs, including those that are specific to PCPs including:
 - How to identify behavioral health needs;
 - How to assist the Member in obtaining behavioral health services;

Section 7: Participating Provider Responsibilities

- How to identify community-based and facility-based Long Term Care Services and Supports (LTSS)
- How to assist the Member in obtaining community-based and facility-based LTSS

Providers are required to inform VillageCareMAX of any changes to their practice, including, but not limited to changes in:

- Professional business ownership/ TIN changes
- Business address or the location where services are provided
- Specialty

Covering Physicians/Providers

In the event that a participating provider is temporarily unavailable to provide care to VillageCareMAX Members, the participating provider should make arrangements with another qualified provider to provide services on their behalf, unless there is an emergency.

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists diagnose and treat conditions specific to their area of expertise. Referrals to In-Network Specialists are not required.

Home Care Provider Responsibilities

In addition to the above, All Home Care Participating Providers are responsible for:

- Obtaining physician orders. (CDPAP/ Fiscal Intermediaries are not responsible for obtaining MD orders)
- Providing aide clinical supervision visits as required by law.
- Developing the home aide plan of care for requested services and maintaining duty sheets. For split shifts, the day and night duty sheets should be maintained.
- Ensuring that family members of VillageCareMAX Members who are aides are not assigned to handle the care of their family member.
- Notifying Members in advance of the name of assigned staff. Members should be notified before 3:00 pm on the day prior to the provision of services.
- Notifying Members in advance of the need for replacement staff and the name of replacement staff. Members should be notified before 3:00 pm on the day prior to the receipt of services from replacement staff. If the staff change will be permanent, providers need to notify VillageCareMAX of the staffing change.
- Confirming the daily attendance of staff. To assure the safety of our Members, VillageCareMAX recommends that all Home Care Participating Providers implement an electronic attendance program in addition to other manual random verifications. Agencies

Section 7: Participating Provider Responsibilities

not utilizing electronic attendance programs must verify attendance of staff daily for all VillageCareMAX Members for whom they serve. Agency protocols on aide attendance verification must be available to VillageCareMAX upon request. Agencies should begin calling to verify staff attendance within 15 minutes of his/her start time. If the aide is not on site, the agency should notify VillageCareMAX within 15 minutes of receipt of this information.

- Submitting evaluation and progress notes within one business days of the request by VillageCareMAX for authorization purposes and within 5 business days of the request for quality assurance purposes.
- Cooperating fully with the VillageCareMAX Care Management Department, verbally or in writing regarding the Member's progress even if the episode of care does not result in any payment by VillageCareMAX to the Participating Provider.

Please see [Appendix 7](#) for the LHCSA Operational Guidelines.

Behavioral Health Provider Responsibilities

VillageCareMAX provides our Members with coverage for mental health and substance abuse programs with access to a full continuum of mental health and substance abuse services through our network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. VillageCareMAX expects that Members will receive timely access to clinically appropriate behavioral health care services, in order to achieve improved outcomes for our Members.

Participating providers will provide treatment that is medically necessary exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, disease or its symptoms, where treatment is in accordance with generally accepted standards and practices that are clinically appropriate, with regard to type, frequency, extent, site and duration. The practitioner will take into consideration the Member's cultural background and language.

Individual behavioral health professionals caring for VillageCareMAX Members are required to:

- Coordinate and communicate with the Member's Care Manager and
- Participate in the Interdisciplinary Care Team (ICT) if they wish to do so, and if the Member has approved his/her participation on the ICT. Please see Section 5 for more information about the VillageCareMAX interdisciplinary care team.

Certain behavioral and mental health providers are required to maintain a system of 24-hour on-call services for Members in active treatment. VillageCareMAX expects all providers who are required to meet this regulatory requirement, or those providers who offer this service through best practice, to ensure that all Members in treatment are aware of how to contact the treating or covering provider after-hours and during provider vacations.

Section 7: Participating Provider Responsibilities

Crisis intervention services: Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a Member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.

Participating provider can be an individual practitioner, private group practice, community based organization, licensed outpatient agency, or facility that has been credentialed by VillageCareMAX and agrees to provide mental health and/or substance abuse services to Members, to accept reimbursement directly from VillageCareMAX according to the contracted rates. Participating providers must maintain approved credentialing status to remain active network participants.

See Section 9 “[Authorization Requirements](#)” for additional information.

Residential Health Care Facility (RHCF) Provider Responsibilities

For short term stay:

- Determining the type of health insurance coverage, the prospective resident has and whether or not the RHCF is authorized to serve the Member.
- Submitting initial evaluations, assessments and plan of care (including short and long term goals) within 1 week of admissions. Subsequent progress notes and/or plan of care updates are submitted at least weekly / or within 5 days of admission to VillageCareMAX for authorization purposes.
- Obtaining authorization for any covered service outside of the daily rate.
- Assisting in the Medicaid recertification process.

For long term placement:

- Determining eligibility for Institutional Medicaid and other third party coverage and whether or not the RHCF is authorized to serve the Member.
- Submitting conversion applications for Members placed for long-term care.
- Identifying the admission as a MLTC admission.
- Collecting the Net Available Monthly Income (NAMI will be deducted from payments).
- Submitting resident monthly summaries to the VillageCareMAX Care Manager.
- Including the VillageCareMAX Care Manager in case conferences.
- Obtaining authorization for any covered service outside of daily rate.
- Assisting in the Medicaid recertification process.

As long as we are responsible for charges, monthly status updates will be requested.

Note: VillageCareMAX Members must be eligible for Institutional Medicaid to remain in an RHCF for long term care.

Section 7: Participating Provider Responsibilities

Adult Day Health Care Provider Responsibilities

- Clinic visits defined as care on an occasion of service of less than three hours duration; or
- Part day care, defined as clinic care extending for more than three hours, but less than five hours; or
- Full day care, defined as clinic care extending for more than five hours, but less than 24 hours; or
- Evening care, defined as clinic care provided after 5 p.m. but not including an overnight stay; or
- Night care, defined as clinic care for less than 24 hours in a day in a residential health care facility and including, as a minimum, an overnight stay in the facility.

Adult Day Health Care Providers are also required to:

- Arrange for the indirect or direct provision of the following services to Members:
 - Medical services including admission and medical history, physical examinations, consultations by medical specialists when needed, and necessary orders for medication, diet, physical therapy, occupational therapy, and supportive services;
 - Nursing services, under the direct supervision of a registered professional nurse, based on periodic and continuing evaluations of each Member's need for nursing care;
 - Dental care, services provided in accordance with State guidelines for dental care;
 - Rehabilitation therapy and speech-language pathology services, including the arrangement of transportation;
 - Pharmaceutical services, with supervision in taking prescribed drugs and in administering medication, as appropriate;
 - Supportive services, including laboratory, X-ray, and other such services.
 - Placement of the services listed above must occur within fourteen (14) days of the request.
- Develop or arrange for the development of a written review and evaluation plan within thirty (30) days for each Member.
- Review and evaluation no less than yearly and more often as indicated by changes in the conditions or circumstances of the Member.
- Develop and maintain a health record for each Member that records current health reports and information pertaining to a Member's care with planning promptly entered, dated, and signed by the individual providing the information or prescribing the service and kept in a place convenient for use by authorized staff.

Section 7: Participating Provider Responsibilities

Social Day Care Provider Responsibilities

- Complying with New York State Office of Aging Social Adult Day Care Regulations. Please contact the plan or the New York State Office of Aging website to obtain a copy of these requirements.
- Assessing client functional capability and impairment.
- Reassessing functional capacity when appropriate including when there is a question of the client's capacity to no longer participate safely in the program.
- Developing individual service plans with consumers as well as caregivers or informal supports. The service plans should:
 - Be developed within 30 days;
 - Be reviewed at least annually;
 - Promotes the highest functional level possible;
 - Builds on existing capabilities or development of new capabilities or compensating;
 - Specify outcomes expected
- Providing services to functionally impaired individuals that must include: socialization, supervision, and personal care assistance. Optional services may include transportation.
- Providing nutritious meals for members who are attending the program at normal meal times and includes offering snacks and liquids for all members at appropriate times.
- Requiring and maintaining accurate attendance records which require separate sign-ins by members for inbound transportation, outbound (return home) transportation, and attendance at the Social Adult Day Care program
- Plan of care signed by the member or member's representative

Podiatry Provider Responsibilities

Podiatry Participating Providers are responsible for:

- Providing services only by a qualified licensed and currently registered podiatrist.
- Making appointments within seven (7) days of the date of the call to make the appointment; twenty-four (24) hours in the case of emergency.
- Providing services and supplies as medically needed and as an integral part of comprehensive medical care.
- Providing services only upon referral by physician, physician's assistant, nurse practitioner or nurse midwife.
- Ordering or arranging for clinical laboratory necessary for the diagnosis or treatment of conditions of the foot.
- Assuring covered services do not include routine hygienic care of the feet in the absence of pathology.

Section 7: Participating Provider Responsibilities

DME and Medical Supply Provider Responsibilities

- Verifying primary payer coverage and eligibility prior to delivery.
- Acquiring physician orders whenever required by regulation or local, state or federal law and/or third party reimbursement.
- Exhausting all other payment sources prior to billing VillageCareMAX.
- Timely delivery of requested products.

Note: It is the responsibility of the Participating Provider to determine whether Medicare covers the item or service being billed if a member has coverage with another plan that is primary to VillageCareMAX. If the service or item is covered or if the Participating Provider does not know if the service or item is covered, the Participating Provider must first submit a claim to Medicare, as VillageCareMAX is always the payer of last resort if a member has coverage with another plan that is primary to VillageCareMAX. If the item is normally covered by Medicare but the Participating Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the VillageCareMAX Care Manager prior to delivery.

Home Delivered Meals Provider Responsibilities

Home delivered meals providers are responsible for:

- Providing nutritionally balanced meals that meet one-third of the daily Recommended Dietary Allowance (RDA). The program will provide a variety of hot and frozen meals that can be re-heated in the home.
- Making meal deliveries each weekday except for agreed upon holidays, or as specified in contract. Monitoring home-delivered meal clients. Meal deliverers have direct, face-to-face contact with the client at the time of delivery.
- Communicating with case manager or caseworker about changes in need or when a client suspends service due to hospitalization, or an extended visit away from home.
- Serving a variety of appealing foods and making approved menus available to clients. Clients have the opportunity to offer input on meal planning and meal service.
- Delivering meals within the timeframe stated to clients. Explaining the agency's policies and procedures to clients.
- Having emergency procedures (i.e. weather or vehicular breakdown). Clients are notified when meals cannot be delivered or cannot be delivered on time.
- Having deliverers who are appropriately trained and supervised.
- Preparing food according to principles of nutritional health and safety standards.

Section 7: Participating Provider Responsibilities

Transportation Provider Responsibilities

- Arriving within thirty (30) minutes of the requested pick up time.
- Providing all requested in and out of borough transportation requests, including special needs transports.
- Assuring that all transportation is to medical appointments unless specifically noted in the authorization.
- Notifying VillageCareMAX when a requested trip is to a non-medical destination.
- Notifying VillageCareMAX when a Member cancels or does not show for a pick up.
- Notifying VillageCareMAX when it is determined, upon arrival, that the driver is unable to transport a Member safely.
- Obtaining documentation for each trip provided, including the following:
 - Member's name and VillageCareMAX identification number,
 - Date of transport
 - Pick-up address and time of pick-up
 - Drop-off address and time of drop-off
 - Vehicle license plate number, and
 - Full name of the driver (printed, not signature)

VillageCareMAX requires that all Ambulette and Car Service Participating Providers follow the safety criteria in accordance with the New York City Taxi and Limousine Commission Safety and Emissions Division when transporting Members, including the following securement systems:

- Four (4) tie down straps for each wheelchair position.
- A passenger seat belt and shoulder harness shall also be provided for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device, which secures the mobility aid itself.

Additional Transportation Requirements:

Each vehicle must be equipped (installed) with the following:

- Body fluid/spill kit reflector triangle kit (three (3) triangles).
- First aid kit.
- Fire extinguisher.

Section 8: Appointment Availability Standards

Appointment Service Standards

Participating Providers shall provide service to Members in accordance with the standards set by VillageCareMAX, except when a longer timeframe is required by the Member. These standards are outlined below:

1. Primary Care Physicians must:
 - Maintain office hours not less than two days per week, eight hours per day, at each primary care office.
 - Notify VillageCare MAX Provider Relations of changes to office hours within ten (10) days.
2. PCPs and OB/GYNs must provide 24 hours a day 7 days a week access to services and instruct Members **on what to do to obtain services after business** hours and on weekends.
3. **Waiting time for an appointment**: Not more than one (1) hour.
4. **Specialist referrals (not urgent)**: Within two (2) to four (4) weeks of request.
5. **Emergency services**: upon presentation at a service delivery site.
6. **Urgent services**: appointment within twenty-four (24) hours of request.
7. **Non-urgent “sick” visit**: appointment within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
8. **Routine non-urgent, preventive appointment**: within four (4) weeks of request.
9. **Mental Health and Substance Abuse**:
 - Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a participating Provider: within five (5) days of the request, or as clinically indicated.
 - Non-urgent mental health or substance abuse visits with a participating provider: within two (2) weeks of request.
 - Mental Health Clinic must provide a clinical assessment within five (5) days for individuals within the following designated groups:
 - Individuals in receipt of services from a mobile crisis team not currently receiving treatment.
 - Individuals in domestic violence shelter not currently receiving treatment.

Section 8: Appointment Availability Standards

- Homeless individuals and those present at NYC homeless shelters who are not currently receiving treatment.
 - Individuals aging out of foster care who are not currently receiving treatment.
 - Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment.
 - Individuals referred by rape crisis centers.
 - Individuals referred by the court system.
10. **Participating Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a Member's ability to perform work:** Within ten (10) days of request
11. **Home Health Care:** Initial visit must occur within twenty-four (24) hours of request.
12. **Audiology:**
- Appointments within seven (7) days of request;
 - Emergency within forty-eight (48) hours of request
13. **Optometry:**
- Appointments within seven (7) days of request
 - Emergency within twenty-four (24) hours
14. **Dental**
- Appointments within fourteen (14) days of request
 - Emergency within twenty-four (24) hours of request.
15. **Podiatry:**
- Appointments within seven (7) days of request
 - Emergency within twenty (24) hours
16. **Adult Day Health Care:** Placement must occur within fourteen (14) days of request.
17. **Social Day Care:** Placement must occur within fourteen (14) days of request.
18. **DME and Medical Supply:** Delivery must occur within seventy-two (72) hours of request, unless custom ordered.
19. **Prosthetics and Orthotics:** Measurement within fourteen (14) days of request.
20. **Social and Environmental Support:** Delivery within fourteen (14) days of request unless custom ordered.

Section 8: Appointment Availability Standards

21. **Meals (Home and/or Congregate):** Provided on the date and time requested by VillageCareMAX.
22. **Skilled Nursing Facility:** Placement of any medically necessary admission appropriate to the facility within twenty-four (24) hours of the submission of all required documentation.
23. **Nutritional Counseling:** Service must be provided within fourteen (14) days of request.
24. **Physical, Occupational & Speech Therapy (not in home):** Initial visit within seven (7) days of request.
25. **Physical, Occupational & Speech Therapy (in home):** Initial visit must occur within seventy (72) hours of request.
26. **Social Work:** - Services must be provided within fourteen (14) days.
27. **Respiratory Therapy:** Initial visit must occur within forty-eight (48) hours of request.
28. **Transportation:** Pick up within thirty (30) minutes of scheduled time.
29. **Personal Care initial visit:** Must occur on the date and time requested by VillageCareMAX.
30. **Private Duty Nursing:** Date and time as requested by VillageCareMAX.
31. **Clinical notes:** Submitted within forty-eight (48) hours of any assessment visit.
32. **Progress notes and summaries:** Submitted every two (2) weeks thereafter unless otherwise requested or there is a change in Member health status.

Section 9: Authorization Requirements

Prior Authorization

Member is not required to get a referral in order to access covered services. However, prior authorization rules apply to some services. You should always check with VillageCareMAX regarding authorization rules prior to providing a service. Please see the “Prior Authorization Process” described below for information on how to request a prior authorization.

It is important to note that New York State Medicaid coverage limits apply to services covered by VillageCareMAX. Please see the New York State EMEDNY Provider Manuals and CMS Medicare Coverage Manuals for more information on coverage limits.

A **Service Authorization Request** (coverage decision request) is when a Member or Provider on Member’s behalf requests approval of a treatment or service. To get a service authorization request, you may call our toll-free Member Services number at 1-800-469-6292 or send your request via Fax to 718-517-26709. We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**. Please refer to grid below for [Service Authorization Timeframes](#).

A **Prior Authorization** (approval in advance) is a request by the Member or Provider on the Member’s behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period. Some covered services require Prior Authorization before a Provider you provide them to our Members. Please refer to [Section 10](#) for Services that require Prior Authorization. You can also contact Utilization Management at 1-800-469-6292 to confirm if a service requires Prior Authorization.

A **Concurrent Review** is a request for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission. Sometimes we will do a review on the care a Member is receiving to determine if the Member still requires the care. We may also review other treatments and services Members already received (**retrospective review**).

Medically Necessary means services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap.

A **Request for Service** is a request from a Member, representative, or Provider on a Member’s behalf for:

- A new service; or
- A continuation, increase or extension of a service (more of the same) during a current authorization period.

Section 9: Authorization Requirements

An **Action** is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

Process to Request Prior Authorization

Providers can request a prior authorization by calling: 1-800-4MY-MAXCARE (1-800-469-6292).

Authorization for payment of services, revised authorizations and authorization terminations are faxed to all Providers. Each authorization will have the following information:

- Authorization or request number;
- Authorization effective and expiration date;
- Name, address, and VillageCareMAX Member identification number;
- Service code and description of service;
- Amount, frequency and duration of service;
- Name and address of the Provider to be authorized payment;
- The name of the Member Services staff person entering authorization.

Additional information will be documented in the “Notes” section of the authorization. This information would include relevant clinical information and the reason for the authorization to the Provider.

In addition, if the request is unusual, time sensitive, especially complicated or requires a particular customization, additional written or verbal communication with the Provider will take place.

Providers should review the authorization to confirm the Provider name, date(s) of service, service code and number of units authorized. If any of these fields do not match the service/item requested, call VillageCareMAX immediately and request a corrected authorization.

Services that require authorization must have an authorization on record in order for services to be paid. If the service is requested outside of business hours, an authorization should be requested on the next business day. See sample authorization in [Appendix 2](#).

VillageCareMAX’s Utilization Management process consists of the ongoing evaluation of the use of covered benefits to assure that Members receive the appropriate services of the highest quality and most cost effective care possible.

Section 9: Authorization Requirements

VillageCareMAX provides coverage for appropriate and medically necessary services to Members, and responds to requests for new or additional services in compliance with Article 49, 10 NYCRR Part 98, and VillageCareMAX's contract with the New York State Department of Health and / or the Centers for Medicare and Medicaid Services.

Any Action taken by VillageCareMAX regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL§4900(2)(a).

Adverse determinations, other than those regarding medical necessity or experimental/investigational services, must be made by a licensed, certified or registered health care professional when such determination is based on an assessment of the Member's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit (where coverage is dependent on an assessment of the Member's health status) and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals and out-of-network services.

VillageCareMAX has established written criteria and ensures that staff utilizes criteria consistently in responding to requests for service. VillageCareMAX provides information about criteria upon request at no charge to Members, their representatives and providers.

To facilitate care management, VillageCareMAX requests notification to Medical Management of all hospital admissions in accordance with the following timeframes:

- Urgent Admissions: Any time prior to the admission but not later than 1 business day after admission
- Emergent Admission: Within 1 business day of the emergent admission

Service Authorization Timeframes

Service Authorization Timeframes	MLTC	Health Advantage (DSNP)	Total Advantage (MAP)
Standard Determination	14 Calendar Days	14 Calendar Days	14 Calendar Days
Standard Determination with Extension	Additional 14 Calendar Days	Additional 14 Calendar Days	Additional 14 Calendar Days
Expedited Determination	72 hours	72 hours	72 hours
Expedited Determination with Extension	Additional 14 Calendar Days	Additional 14 Calendar Days	Additional 14 Calendar Days

Section 9: Authorization Requirements

VillageCareMAX MLTC, Health Advantage & Total Advantage Prior Authorization Timeframes

Standard Determination: When a request for a service is made, VillageCareMAX will inform the Member or their designee and the Member's health care Provider of the decision by phone and in writing as fast as the Member's condition requires but within three (3) business days of receipt of all necessary information and no later than fourteen (14) days from receipt of the request.

Standard with Extension: Upon request from the Member or his/her Provider, or if VillageCareMAX can justify a need for additional information and document how the delay is in the interest of the Member, VillageCareMAX may extend the time frame by up to an additional fourteen (14) calendar days from the date the extension notice is sent and within three (3) business days of receipt of all necessary information. If the extension is initiated by VillageCareMAX, the Member will be notified in writing about the reason for the delay.

Expedited Determination - Automatic: VillageCareMAX will automatically expedite any request by a Physician to expedite the determination. VillageCareMAX will make the determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, but no later than three (3) business days after receiving the request.

Approved Expedited Requests: If a Member or his/her Provider requests an expedited determination, without physician support, VillageCareMAX will determine if the decision should be expedited. The decision will be based on whether applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If the Member's request for an expedited decision is approved, VillageCareMAX will make the determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, within one (1) business day of receipt of necessary information but no later than three (3) business days after receiving the request.

Denied Expedited Requests: If the Member or his/her Provider's request for an expedited determination is denied, the Member will be informed verbally and in writing within three (3) business days of receipt of the request and the request will be transferred to a standard time frame of fourteen (14) days.

Reduction, Termination or Suspension of a Previously Authorized Service Within a Service Authorization Period

When VillageCareMAX intends to reduce, suspend or terminate a previously authorized service, the Member will receive a written notice at least ten (10) days prior to the intended action (the notice will be generated and mailed fifteen (15) days prior to the intended action to assure sufficient delivery time of the notice).

Section 9: Authorization Requirements

In the event of Member fraud, the Member will receive a written notice at least five (5) days prior to the intended action (the notice will be generated and mailed ten (10) days prior to the intended action to assure sufficient delivery time of the notice).

VillageCareMAX may mail a written notice no later than the date of the Action in the event of:

- Death of the Member
 - If the provider learns of a VillageCareMAX Member's death, please contact the plan. VillageCareMAX will cancel any authorizations currently in place for the Member.
 - If VillageCareMAX learns of a Member's death, we will contact the Member's providers and cancel any authorizations that are currently in place.
- A signed written request from the Member requesting service termination or giving information requiring termination or reduction of services;
- The Member's admission to an institution where the Member is ineligible for services;
- The Member's address is unknown or mail is returned as undeliverable;
- The Member has been accepted for Medicaid services by another jurisdiction; or
- The Member's physician prescribes a change in the level of medical care.

Services Fully or Partially Covered by Medicare or Other Primary Insurance

Participating providers are responsible for:

- Verifying Primary Payer Insurance coverage and eligibility and
- Acquiring any needed Physician orders

VillageCareMAX MLTC participating providers should exhaust all other payment sources prior to billing VillageCareMAX.

In the event that a VillageCareMAX MLTC Participating Provider has knowledge that a Medicare covered service has already been obtained through Medicare, or other payer, and the allowable time period for replacement has not expired, the VillageCareMAX MLTC Participating Provider must contact the VillageCareMAX Care Manager prior to any reorder.

Section 10: List of Services that Require Prior Authorization

The complete listing of services that require prior authorization for all plans can be viewed in the Evidence of Coverage or Member Handbook located at www.villagecaremax.org.

VillageCareMAX Managed Long Term Care Plan (MLTC), Medicare Health Advantage Plan (D-SNP), and Medicare Total Advantage Plan (MAP) Prior Authorization Grid

Disclaimer – Prior authorization is not a guarantee of payment. Benefits are determined by the member's eligibility. Policies are subject to change. Please note there are exceptions for certain services as outlined below.

Key

X= Prior authorization required

NA= Covered but no Prior authorization required

NC= Not Covered

Services	MLTC	MAP	DSNP
24/7 Physician Hotline	NC	NA	NA
Acupuncture	NC	NA	NA
Adult Day Health Care	X	X	NC
Ambulatory Surgery Center	NC	X	X
Assistive Technology (AT)	X	X	NC
Audiology Services (Exam)	NA	NA	NA
Cardiac Rehabilitation Services	NC	X	X
Chiropractic Services	NC	X	X
Community Transitional Services (CTS)*	X	X	NC
Consumer Directed Personal Assistance Services (CDPAS)	X	X	NC
Dentistry	NA	NA	X
Diabetes Programs and Supplies	NA	X	X
Diagnostic Services	NC	X	X
Discogram/Myelogram	NC	X	X
Durable Medical Equipment (DME) / Medical Supplies²	X	X	X
Electromyogram (EMG)	NC	X	X
Environmental Modifications (EMods)*	X	X	NC
Hearing Aids³	X*	X*	X*
Home Delivered and Congregate meals	X	X	NC
Home Health Care	X	X	X
Home Infusion Services	X	X	X
Infusion	X	X	X

² See Appendix 10 for full list of DME services requiring prior authorization.

³ Effective September 1, 2019, the following codes do not require prior authorization: V5241, V5246, V5247, V5256, V5257, V5265

Section 10: List of Services that Require Prior Authorization

Services	MLTC	MAP	DSNP
Inpatient Bariatric Surgery	NC	X	X
Inpatient Hospital Care	NC	X	X
Inpatient Mental Health Care	NC	X	X
Inpatient Organ Transplants	NC	X	X
Inpatient Reconstructive Surgery	NC	X	X
Inpatient Skilled Nursing Facility	X	X	X
Inpatient Substance Abuse and Rehab	NC	X	X
Lab Services (Molecular Pathology, Cryptogenic studies and Genomic Sequencing Procedures)	NC	X	X
Lab Services (All other services)	NC	NA	NA
Medical Social Services	NA	X	X
Mobile Radiology (EKG and X-Rays)	NC	NA	NA
Mobile Radiology (All other services)	NC	X	X
Moving Assistance (MA)*	X	X	NC
MRI/MRA	NC	X	X
Non-Emergency Transportation / Ambulance Services	X	X	X
Nuclear Medicine	NC	X	X
Nutrition	X	X	X
Occupational Therapy	X	X	X
Orthopedic Footwear	X	X	X
Part B Drugs (when billed by a physician or facility)	NC	X	X
Partial Hospitalization	NC	X	X
Personal Care Services	X	X	NC
Personal Emergency Response Services (PERS)	X	X	NC
Pet Scan	NC	X	X
Physical Therapy	X	X	X
Private Duty Nursing	X	X	NC
Pulmonary Rehabilitation Services	NC	X	X
Respiratory Therapy	X	X	X
Skill Acquisition Maintenance and Enhancement (SAME)*	X	X	NC
Social and Environmental Supports	X	X	NC
Social Day Care	X	X	NC
Speech Therapy	X	X	X
Substance Abuse Care	NC	X	X
Telehealth	X	X	X
Vehicle Modifications (VMods)*	X	X	NC
Vision Care - Eye wear	NA	NA	X
Worldwide Emergency/Urgent Care	NC	NA	NA

*Services covered under Community First Choice Option (CFCO) effective January 1, 2020.

Section 11: Claims Submission

Participating Providers must inform VillageCareMAX of any changes in Tax ID, corporate name and/or addresses as soon as they are known. Please allow thirty (30) days for record updates.

Please note the following general Claims Timeframes below. **Please refer to your contract to confirm specific language.**

Line of Business	Timely Claim Submission within	Processing Times (within)	Reconsideration/ Appeal of Claim (within)	Reconsideration/ Appeal Processing Times (within)
MLTC	90 days	30 (Eclaims); 45 (Paper)	45 days	60 days
DSNP	90 days	30 (Eclaims); 45 (Paper)	60 days	60 days
MAP	90 days	30 (Eclaims); 45 (Paper)	60 days	60 days

Electronic Submission of Claims

Participating Providers may submit electronic claims. Use VillageCareMAX Change Health Care Submitter ID: 26545. Electronic Claims must be submitted in 837I or 837P format. Please refer to [Appendix 3](#) for information on implementing EFT and ERA.

All Claims must include:

- Member name and VillageCareMAX Member ID number.
- Provider Name, Tax ID Number and NPI number.
- Valid ICD-10 Diagnosis Codes.
- A date of service that falls within the effective and expiration date printed on the authorization.
- The Service Code.
- The number of units (cannot exceed the total units or units per day on the authorization).
- Copy of the Primary Payer EOB for coordinated claims.

Section 11: Claims Submission

Paper Claims and Claims for Services Covered in Part by Primary Payer

Claims for authorized services must be submitted to VillageCareMAX *generally* within ninety (90) days from the date of service, but providers should always review their contracts for the specific timely filing timeframes indicated in the provider contract.

All paper claims, correspondence, and Claims Disputes and Appeals should be submitted to:

ILS - VillageCareMAX
P.O. Box 21516
Eagan, MN 55121

If you have any questions, please call Provider Services at 1-855-769-2500

In addition, the VillageCareMAX Provider Online Portal is a great resource for providers to review claims statuses, authorization statuses, and Member Eligibility statuses. Please visit our portal at: <https://secure.healthx.com/villagecareprovider>

All Dental claims should be submitted to:

Healthplex, Inc.
Attention: CLAIMS DEPT.
P.O. Box 9255
Uniondale, NY 11553-9255

VillageCareMAX may pay claims denied for untimely filing where the Participating Provider can demonstrate that a claim submitted after the date specified in their provider contract resulted from an unusual occurrence.

VillageCareMAX MLTC claims for services partially covered by Medicare or another Primary Payer, must be accompanied by a Medicare or other Primary Payer EOB and cannot be submitted electronically.

Authorizations are not needed for Secondary claims submissions. Secondary claims are processed according to the EOB provided with the claim submission. If an EOB is not attached and an authorization is on file, the claim will be processed as primary.

Paper claims must be submitted in one of the following formats:

1. CMS-1500 Form: The CMS-1500 claim form is used to bill for most non-facility services including, but not limited to:

- Ambulatory Surgery Centers
- DME and Medical Supplies
- Individual Practitioners

Section 11: Claims Submission

- Home-Delivered/Congregate Meals
- Laboratories
- Physician/Professional Services
- Personal Electronic Response Systems (PERS)
- Rehabilitation Therapy in an Outpatient Clinic Setting
- Rehabilitation Therapy - home or private office setting
- Social & Environmental Supports
- Transportation Providers

Note: All fields must be completed including Place of Service and Valid Diagnosis Code.

CMS publishes a guide to help providers complete the CMS-1500 form. Please see the following website for more information - <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>

2. UB-04 Form: The UB-04 claim form is used by institutional providers to bill for all hospital inpatient, outpatient and emergency room services including, but not limited to:

- Adult Day Health Care
- Home Care Agencies
- Hospitals
- Skilled Nursing Facilities
- Social Adult Day Care
- Other Facilities

CMS publishes a guide to help providers complete the UB-04 form. Please see the following website for more information - <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf>

Prompt Payment of Claims

Electronic claims will be paid within thirty (30) days of receipt.

Paper claims will be paid within forty-five (45) days of receipt.

Electronic Funds Transfer

Please complete the form in [Appendix 3](#) to have payments deposited directly into your bank account.

Balance Billing

In no event can a Provider bill VillageCareMAX Members for any balance remaining on a claim.

Section 11: Claims Submission

Claim Service Code Guidelines

An important element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is required for accurate reimbursement. Please refer to your current CPT, ICD or HCPCS code books for specific code descriptions.

Please Note the following:

- All codes are subject to change based on regulatory requirements.
- ICD-10 diagnosis codes must be included on all medical claims.
- NYS DOH standard universal billing codes must be included on all claims for home care and adult day health care services.

Pharmacy Prescription Drug Claims

According to the Federal Deficit Reduction Act, VillageCareMAX MLTC is required to obtain National Drug Codes on all claims for certain physician administered drugs for the purpose of billing manufactures for Medicaid Drug Rebates.

Any claims for drugs or vaccines that are not administered in a pharmacy must include the NDC code in addition to any CPT or HCPCS codes. The claim will be rejected without this code.

Please note that NDCs should be collected and reported where HCPCS (J0000-J9999) and BETOS (01E/O1D) codes are billed for these Categories of Service.

NOTE: Drug encounters with a “UD” procedure code modifier (340B purchased drug) are exempt from NDC reporting requirements.

01 – Physician Services
03 – Podiatry
04 – Psychology
06 – Rehabilitation Therapy
07 – Nursing

41 – Nurse Practitioner/Midwives
75 – Clinical Social Worker
85 – Freestanding Clinic
87 – Hospital OP/ER Room

Claims Inquiry

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more as indicated below. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting <https://secure.healthx.com/villagecareprovider>.

Section 11: Claims Submission

- The status of a claim for which no payment or denial of payment has been received within 45 days;
- Payment missing on the Explanation of Payment for claim or claim line submitted via batch;
- You were denied payment for a claim and subsequently realized that there was an error on the authorization;
- Provision of a service is different from the service requested (changed hours or days, completed visit after expiration date, etc.);
- Denials or partial payments due to authorization issues;
- Member status; and
- Fee schedule issues

Please Note: VillageCareMAX is not required to change an authorization if a different service was provided.

Services that Require Prior Authorization

Services that require authorization must have a valid authorization on record in order for services to be paid. If the service is requested outside of business hours, an authorization should be requested on the next business day. Please see [Section 10](#) to verify if a covered service requires authorization. You may contact 1-800-469-6292 to obtain all necessary authorizations.

Changes to an Authorization or Retroactive Authorizations

Changes or retroactive authorizations will only be considered if there is documentation that VillageCareMAX intended to authorize the service provided. If your claim matches the authorization, compare all fields of the claim line printed on the Explanation of Payment to your claim. If any of the fields (date of service, service code, amount charged, etc.) are not the same as what you submitted on your claim, call Provider Services at 1-855-769-2500. Provide the claim number and the information that was entered incorrectly.

Common Reasons for Claims Denial

PAY CODE	PAY CODE DESCRIPTION
11	Timely Filing Limit Exceeded
16	Dup Claim Previous Paid or Service in Global Surgery Package
14	Denied – Please See Detailed Message Code

Section 11: Claims Submission

PAY CODE	PAY CODE DESCRIPTION
17	Required Notification, Referral, Authorization not on File or Denied
41	Member Not Effective On This Date of Service – Please Verify Coverage
31	Denied – See Detailed Message Code
35	Service Exceeds The Authorized Number of Units or Days
94	Please Resubmit with HIPAA Valid Procedures and Diagnosis Code(s)
93	Claim Unprocessable Required Date Elements Missing or Invalid
13	Benefit Limit Maximum Reached
96	Member Is Not On File
44	Date of Service After The Member's Date of Death
46	No Allowable Amount in the Fee Schedule
32	Duplicate Claim
95	Please Resubmit with Physician Indicated

NOTE: A corrected authorization does not automatically reprocess denied claims. You must also submit a corrected claim.

Section 12: Claims Appeals

Claim Appeals

The following timely filing guidelines are general for the MLTC, Health Advantage, and Total Advantage lines of business; however, providers should always refer to their contracts for exact timeframes.

If your claim was processed and you disagree with how it was processed, you may submit a claim appeal through the provider portal, which can be accessed by visiting <https://secure.healthx.com/villagecareprovider>. All claim appeals generally must be submitted within forty-five (45) days of receipt of a claim determination for MLTC and within sixty (60) days of receipt of a claim determination for Health Advantage & Total Advantage and must include the following information:

- Claim number
- Authorization number
- Member name
- VillageCareMAX Member ID number
- Exact date(s) of service (do not give range)
- Codes billed
- Units billed
- Amount billed
- Reason for appeal (including any supporting documentation to support your appeal).

To submit a correction to a previously processed electronic claim using a HCFA 1450/UB-04 claim form, use bill type (XX7). HCFA 1500 Claim Form, please use resubmission code 7.

To submit a correction to any other previously processed claim, send the corrected paper claim to the Correspondence Department at ILS – VillageCareMAX, P.O. Box 21516, Eagan, MN 55121.

Time Frames for Claim Submission & Reconsideration of Claim

Timely Claim Submission: Generally, providers must submit all claims within ninety (90) days from the date of service for prompt adjudication and payment. Please refer to your contract for exact timeframes.

However, claims for services that are submitted later than the time period set forth in the provider's agreement with VillageCareMAX will not be paid. In no event will VillageCareMAX pay claims submitted more than one hundred eighty (180) days after the date of service.

Section 12: Claims Appeals

Late Claim Submissions: Please note that claims that were denied or returned to the provider for additional information when re-processed are adjudicated according to the original date of service. Having submitted a claim that was not clean does not constitute an exception to the timely filing requirements listed above. Late claim submission will be reviewed by management only in cases where timely submission was outside of provider's control. Any requests for consideration must follow the claim reconsideration process and documentation requirements listed below.

Reconsideration of a Claim: At times, a provider may be dissatisfied with a decision made by VillageCareMAX regarding a claim determination. Some of the common denials and reasons for reconsideration include incorrectly processed or denied claim, incorrect paid amount, late claim submission, or failure to obtain prior authorization. Providers who are dissatisfied with a claim determination made by VillageCareMAX must submit a written request for review and reconsideration with all of the supporting documentation to VillageCareMAX within forty-five (45) calendar days of receipt of a claim determination for MLTC and within sixty (60) calendar days of receipt of a claim determination for Health Advantage and Total Advantage.

Claim Reconsideration/Appeals must be in writing and should be sent to:

ILS - VillageCareMAX
Provider Services Department
P. O. Box 21516
Eagan, MN 55121

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- Provider's name, address, and telephone number
- Provider's identification number
- Member's name and VillageCareMAX identification number
- Date(s) of service
- VillageCareMAX claim number
- A copy of the original claim or corrected claim, if applicable
- A copy of the VillageCareMAX EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification
- Evidence that initial claim was submitted on time
- A written statement explaining why you disagree with VillageCareMAX's claim determination.

VillageCareMAX will investigate all written requests for Review and Reconsideration, and issue a written explanation stating that the claim has been either reprocessed or the initial denial has

Section 12: Claims Appeals

been upheld, generally within sixty (60) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

VillageCareMAX will not review or reconsider claims determinations which are not submitted according to the procedures set forth above. If a provider submits a request for review and reconsideration after the forty- five (45) calendar day time frame for MLTC or the sixty (60) calendar time frame for Health Advantage and Total Advantage, the request is deemed ineligible and will be dismissed.

Regardless of the outcome of the claims review, in all cases, providers may not bill members for services rendered.

VillageCareMAX will not accept appeals from providers that are not made in writing and that fail to address the reason for the appeal.

If VillageCareMAX is instructed by the New York State Department of Health (DOH) or the New York State Office of the Medicaid Inspector General (OMIG) to withhold payments due to a pending investigation, VillageCareMAX will:

- Provide notice to the provider of the withhold within five (5) days of taking such action unless requested in writing by a law enforcement organization to delay such notice. The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation
- Withhold all pending and future payments until such time as DOH or OMIG approve their release

In such cases, the provider should direct questions and appeals to:

Office of the Medicaid Inspector General
Office of Counsel
800 North Pearl Street
Albany, New York 12204
ATTN: Withhold Appeal

Claim Contacts

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting <https://secure.healthx.com/villagecareprovider>.

Section 13: Adverse Reimbursement Change

Adverse Reimbursement Change to Health Care Professionals Agreement

An adverse reimbursement change is one that “could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional.”

VillageCareMAX health care professionals will receive notice from VillageCareMAX at least ninety (90) days prior to an adverse reimbursement change to a health care professional’s agreement (check your provider contract). A health care professional for purposes of this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.

If the health care professional objects to the change that is the subject of the notice, the health care professional may give written notice to VillageCareMAX to terminate the agreement effective upon the implementation of the adverse reimbursement change. Providers should review the terms of their contract, but most health care professionals are required to provide written notice to VillageCareMAX within 30 days of the date the notice was received. The above paragraph will not apply when the adverse reimbursement change is:

- Otherwise required by law, regulation or applicable regulatory authority;
- Required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association’s Current Procedure Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
- Provided for in the Participating Provider agreement between VillageCareMAX and the participating provider or a participating IPA and the participating provider through the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a health care professional relative to this provision.

Section 15: Third Party Insurance

Medicaid Surplus and NAMI

VillageCareMAX assumes responsibility for billing Medicaid spend-down amounts for community based VillageCareMAX Members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Participating Providers shall not bill or collect such amounts from the Member.

The Residential Health Care Facility or Skilled Nursing Facility is responsible for collecting the Net Available Monthly Income (NAMI) from Members that are designated to be in permanent placement. A Member deemed to be in permanent placement when the Member and the plan agree that the Member will not be returning to the community. VillageCareMAX will deduct the Member's NAMI from the payment to the facility for services provided and billed to the plan.

VillageCareMAX Medicare Health Advantage (HMO SNP) participating providers are not responsible for billing Medicaid spend-down amounts for members enrolled in this plan.

As of January 1, 2017, the New York State Department of Health revised the requirements for reporting Nursing Home encounters. Nursing Home Providers are now required to report the NAMI amount on the claim. VillageCareMAX will continue to deduct NAMI from the claims prior to release of payment to the provider.

NAMI should be reported as 'Recurring Monthly Income', using a value code of '23', with the amount reported in the 'Value Amount' section, Field 39, 40 or 41 on the Institutional Claim form as indicated below:

- Value Code:
 - Code 23 should be used to indicate that the member's NAMI amount is entered under Amount.
- Value Amount:
 - Enter the NAMI amount determined by the local district.
 - In cases where the member's budget has increased, the new amount, rather than the current budgeted amount, should be entered.
 - If billing occurs more than once a month, enter the full NAMI amount on the first claim submitted for the month.
 - For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the local district.

Please note that claims without accurate NAMI will be denied.

Section 15: Third Party Insurance

Participating Providers are required to bill Medicare for MLTC members or any other third party insurance that is primary to Medicaid.

Medicare and Other Primary Payer Services

VillageCareMAX MLTC Participating Providers:

VillageCareMAX Members will continue to access their services fully or partially covered by Medicare through fee for service Medicare or another Medicare plan that the Member may be enrolled in. Participating Providers may bill VillageCareMAX for any required secondary payments not covered by other insurance as stipulated in the Participating Provider Agreement.

VillageCareMAX is the payer of last resort. It is the Participating Provider's responsibility to determine Primary Payer coverage and eligibility. Co-insurance claims do not require authorization. A copy of the primary and secondary insurers Explanation of Payment must accompany all co-insurance claims. Claims with applicable Coordination of Benefits (COB) must be submitted within 90 days of COB determination.

Section 16: Marketing Guidelines

Marketing Guidelines: Participating Providers and VillageCareMAX

VillageCareMAX is subject to the contractual terms and conditions of both the New York State Department of Health and Centers for Medicare and Medicaid Services (CMS), including their marketing guidelines. The information below is a general guideline to help participating providers meet the requirements of these regulatory agencies.

Permitted Marketing Activities

Participating Providers

- May distribute brochures provided by VillageCareMAX. VillageCareMAX is required to obtain CMS and/or DOH approval for any brochures and marketing material that is made available to beneficiaries and includes information about the plan or describes plan benefits.
- The provider is required to provide patients with a list of all the plans he/she/it has contracts with.

VillageCareMAX

- May conduct marketing activities at a Participating Provider's site with the permission of the Participating Provider. Marketing activities can only take place in areas where direct services to the beneficiaries are not provided (see below).

Prohibited Marketing Activities

Participating Providers

Plan Members often look to their health care professionals for information and advice about their health care choices. To the extent that a participating provider can help a Member with an objective assessment of their health care needs, providers are encouraged to do so. However, participating providers should remain neutral when assisting Members with enrollment decisions. When providing this information to beneficiaries, the provider should inform the beneficiary of all the plans in which he/she participates.

Section 16: Marketing Guidelines

In addition, participating providers must not:

- Offer sales/appointment forms to Members
- Accept HMO SNP or MLTC enrollment applications
- Make phone calls or direct, urge or attempt to persuade a Members to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of VillageCareMAX
- Offer anything of value to induce members to select an individual as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from VillageCareMAX for Member enrollment activities
- Distribute materials/applications within an exam room setting
- Develop or use any marketing materials that have not been approved by VillageCareMAX

Guidelines associated with provider marketing activities and additional information can be found in the Medicare Marketing Manual located on the CMS website - <https://www.cms.gov>.

VillageCareMAX:

- Will not market in hospital emergency rooms, treatment rooms, patient rooms, skilled nursing facility or adult care facility patient rooms, medical professional offices, adult day health care and social day care sites.
- Will not use “Cold Call” telephoning and door-to-door distribution of material. Solicitation is not permitted.
- Cannot offer monetary incentives to the Participating Providers to market VillageCareMAX services or refer prospective Members to VillageCareMAX.

Provider Affiliations

VillageCareMAX may allow contracted providers to announce new or continuing relationships with the plan. New affiliation announcements are for those contracted providers that have entered into a new contract with VillageCareMAX. Contracted providers can announce a new affiliation agreement within the first 30 days of the new contract agreement with VillageCareMAX. New contracted providers can communicate once through direct mail, email or a phone announcement that lists only one plan. However, in future direct mail or email communications, contracted providers must include a list of all the plans with which they contract.

Section 16: Marketing Guidelines

Any piece of affiliation communication material that describes VillageCareMAX in any way (e.g. benefits or formularies) must be approved by CMS and/or DOH, and must include the appropriate disclaimer found in Section 50 of the Medicare Marketing Guidelines.

VillageCareMAX is responsible for ensuring that all Plan marketing materials are compliant and approved by CMS.

Participating providers should contact VillageCareMAX for more information about the plans we offer. We can provide you with information about our plan options, eligibility requirements and covered benefits.

Section 17: Member Confidentiality

Confidentiality of Member Information

Participating Providers shall ensure the confidentiality of all Member related information by maintaining all Member specific information and Member records in accordance with New York State Public Health Law and the New York State Social Services Law and HIPAA (Health Insurance Portability Accountability Act). Member information shall be used or disclosed by a Participating Provider only with the Member's consent unless otherwise required by law and only for purposes directly connected with Participating Provider's performance and obligations under VillageCareMAX Participating Provider Agreement.

Participating Providers will inform and train their employees and other workers to comply with the confidentiality and disclosure requirements of New York State statutes and HIPAA.

Member authorization for disclosure is not required for access to health information by:

- Medicare or CMS;
- The New York State Department of Health;
- Accreditation surveyors; and
- Federal, State and Local government agencies authorized to conduct investigations of Medicaid Managed Long Term Care or Medicare Advantage HMO SNP plans.

Section 18: Member Rights and Responsibilities

VillageCareMAX MLTC Member Rights

Participating Providers will uphold the Member's rights and responsibilities as outlined below.

As a Member of VillageCareMAX, the Member has the right to:

- Receive medically necessary care;
- Privacy about the Member's medical record and treatment;
- Timely access to care and services;
- Receive information on available treatment options and alternatives presented in a manner and language understood by Member;
- To receive information in a language the Member understands; oral translation services must be free of charge;
- Receive information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Receive a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to receive the services they need from VillageCareMAX, including how they can receive covered benefits from Non-Participating Providers if they are not available in the Participating Provider Network;
- Complain to VillageCareMAX, the Centers for Medicare and Medicaid Services, the New York State Department of Health or the New York City Human Resources Administration, the right to use the New York State Fair Hearing System or in some instances request a New York State External Appeal;
- Appoint someone to speak for them about their care and treatment; and
- Make advance directives and plans about their care.

VillageCareMAX Medicare Health Advantage and VillageCareMAX Total Advantage Plan Member Rights

As a Member of VillageCareMAX Medicare Health Advantage and VillageCareMAX Total Advantage, Participating Providers will uphold the Member's rights and responsibilities as outlined below. Specifically, each Member must be guaranteed the right:

Section 18: Member Rights and Responsibilities

- To request and receive written and oral information about the Plan, its network providers, covered services and the Member's rights and responsibilities in a manner the Member understands.
- To receive materials and/or assistance in a foreign language and in Alternative Formats, such as Braille or large print if necessary.
- To be treated with fairness and respect at all times.
- To get timely access to a Member's covered services and drugs
- To protect the privacy of a Member's private health information
- To the support of the plan regarding a Member's right to make decisions about his/her care.
- The right to make complaints and to ask the plan to reconsider decisions made by the plan.
- To get information about what a Member should do if he/she believes they have been treated unfairly or a Member feels his/her rights have not been respected.
- To get more information about a Member's rights

Member Responsibilities

VillageCareMAX MLTC Members, Village Care MAX Medicare Health Advantage Members and VillageCare Total Advantage members are responsible to:

- Use Participating Providers who work with VillageCareMAX;
- Become familiar with the plan's covered benefits and rules to be followed in order to get these covered benefits
- Tell VillageCareMAX if they have any other health insurance coverage or prescription drug coverage in addition to the plan in which they are enrolled.
- Tell their doctor or other health care provider that they are enrolled in a VillageCareMAX plan.
- Help their doctor and other providers by giving them information, asking questions and following through on their care.
- Be considerate.
- Call VillageCareMAX Member Services with any questions or concerns.
- Receive authorization from their Physician, Care Manager or Interdisciplinary Care Team before receiving a covered service requiring such authorization;
- Tell VillageCareMAX about their care needs and concerns and work with the VillageCareMAX Care Management Department in addressing them;
- Notify VillageCareMAX when they go away, move or are out of town;
- Make all required payments to VillageCareMAX; and
- Cooperate with any requests for documentation related to maintaining Medicaid eligibility.
- In no event can a Provider bill VillageCareMAX Members for any balance remaining on a claim.

Section 18: Member Rights and Responsibilities

Cultural Competency

VillageCareMAX is committed to providing the healthcare service needs of all Members, regardless of their ethnic, cultural or religious beliefs or language spoken. This includes:

- Being familiar and understanding of other cultures and ethnic groups,
- Understanding the communication styles of different ethnic groups, and
- Facilitating communication with individuals who require translation and translated materials.
- Acceptance of different perceptions and views about health care.

To facilitate cultural competency, VillageCareMAX provides training to both our staff and participating providers.

VillageCareMAX works with providers to share information and education about cultural competency. VillageCareMAX will offer ongoing programs in cultural competency requirements during provider orientation, scheduled training sessions and updates as necessary. Participating providers are required to work with VillageCareMAX to meet this requirement.

VillageCareMAX serves a diverse population. To meet the needs of our Members, VillageCareMAX provides access to interpreter services and assistance to Members with a visual or hearing impairment. Members are encouraged to use the interpreter services to best understand their health care needs.

Members who require interpreter services should call Member Services at 1-800-469-6292. Our hours are 8:00 am to 8:00 pm, 7 days a week. Members with a hearing or speech impairment should call 711 for assistance. 711 is the New York Relay Service where a specially training operator will connect the Member to the person he/she is calling and assist with the communication. Providers can use the 711 phone number to communicate with their patients.

VillageCareMAX can link providers to translation services, through bilingual Member services staff and a telephonic translation service. Providers can access this by calling the main Member Services phone number listed above.

The VillageCareMAX MLTC handbook is available in English, Spanish and Chinese. The VillageCareMAX Medicare Health Advantage (HMO SNP) Evidence of Coverage is available in English, Spanish, Chinese and Korean. The VillageCareMAX Total Advantage Evidence of Coverage is available in English, Spanish and Chinese.

Members should call Member Services if they need a handbook in different languages, large print or Braille.

Section 18: Member Rights and Responsibilities

[Section 19: Grievance and Appeals](#)

VillageCareMAX Grievances and Appeals

LINE OF BUSINESS	CATEGORY	TIME FRAMES
MLTC	- Expedited - Same day - Standard - Grievance Extension - Grievances Appeals	Expedited: Resolved within 48 hours from the receipt of all necessary information, but no later than 7 calendar days from the receipt of the grievance.
		Same Day: Resolved same day/within 24 hours to the member's satisfaction
		Standard Grievance: 45 calendar days to resolve a standard grievance. An Acknowledgement letter is sent to the member within 15 days of the received of the grievance and a Resolution is send to the member within 45 calendar days from receipt of all necessary information.
		Grievance Extension: If additional information is required to make a determination, the Plan, Provider or the member can request an extension, which will allow an extra 14 calendar days.
		Grievances Appeal: If a Member is not satisfied with the Plan's decision about a grievance, the member can request a second review by filing a grievance appeal. VCMAX has 30 business days to complete an appeal and an acknowledgement is sent to the member within 15 days of the received of the grievance. A member can also request an Expedited appeal which will need to be resolved within 2 Business days
DSNP and MAP	- Expedited - Standard - Grievance Extension	Expedited Grievance: Resolved within 24 to 48 hours after receipt of all necessary information but no later than 7 calendar days

[Section 19: Grievance and Appeals](#)

LINE OF BUSINESS	CATEGORY	TIME FRAMES
	Grievances Appeals	Standard Grievances: Must be resolved within 30 calendar days. An acknowledgement letter is sent to the member within 15 business days of the receipt of the grievance.
		Grievance Appeal and Grievance Extension is the same as the MLTC Program

Grievances

A grievance is any communication by a Member to VillageCareMAX about dissatisfaction with the care and treatment received from VillageCareMAX staff or Providers of covered services, which does not amount to a change in scope, amount, and duration of service or other actionable reason.

A Member or a Provider on the Member's behalf may make a grievance verbally or in writing. Members are advised of their right to file a grievance at the time of enrollment and are advised of their rights and responsibilities annually. Members are advised as to how to file a grievance, and of their ability to receive assistance from VillageCareMAX staff, if necessary. All grievances will be resolved without disruption to the Member's plan of care. Members will be free from coercion, discrimination or reprisal in response to a grievance.

All grievances (both same day and non-same day resolution) are logged, tracked and reported. VillageCareMAX will designate appropriate personnel who were not involved in the previous level of decision-making to review grievances in supervisory capacity and on grievance appeal. If the grievance or grievance appeal relates to clinical matters, the personnel assigned to process them will include duly registered health professionals.

Grievances (non-same day resolution) can be standard or expedited. Standard grievances, including both those reported verbally or written, are acknowledged in writing within fifteen (15) business days of receipt of the grievance or less by VillageCareMAX. Grievances are addressed as quickly as required by the Member's condition. A standard determination is to be made within forty-five (45) calendar days of the receipt of all necessary information and no more than sixty (60) calendar days from receipt of a grievance. The standard grievance decision will be communicated by telephone and in writing within three (3) business days of the decision. The review period for VillageCareMAX grievance determination can be increased by an additional fourteen (14) calendar days if it is in the Member's best interest. The Member, the Provider on the Member's behalf or VillageCareMAX may request the extension. The reason for the extension must be documented. When the extension is initiated by VillageCareMAX, a notice

Section 19: Grievance and Appeals

will be sent to the Member or the Provider advising of the extension, the reason for the extension and specify how it is in the best interest of the Member. If a decision on the grievance is reached before the written acknowledgement was sent, VillageCareMAX will send the written acknowledgement with the grievance determination. A VillageCareMAX decision to initiate an extension is made when it is established that inadequate information is available to make an informed decision.

If the standard response time to the grievance would seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, VillageCareMAX will expedite the grievance. The Member or the Provider may request that a grievance be expedited. If VillageCareMAX agrees to expedite the grievance, the expedited grievance determination will be made within forty-eight (48) hours of receipt of all necessary information and no more than seven (7) calendar days from receipt of the grievance. The expedited grievance decision will be communicated by telephone and in writing within three (3) business days of the decision.

If the expedited grievance decision is made before the written acknowledgement is sent, both the acknowledgement and expedited grievance decision will be combined. If the Member or the Provider on the Member's behalf, requests that the grievance be expedited and VillageCareMAX does not agree, VillageCareMAX will notify the Member or the Provider verbally within two (2) days and in writing within fifteen (15) days that the grievance decision was not expedited and the grievance will be handled within the standard grievance decision timeframes.

The plan will use grievance data to identify trends and opportunities for program improvement. VillageCareMAX will review the grievance data that includes Provider type, specific Providers, and VillageCareMAX staff identified as responsible parties in the grievance.

Medicare Health Advantage & Medicare Total Advantage

VillageCareMAX provides meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which VillageCareMAX provides health care services.

VillageCareMAX procedures include the following:

- Ability to accept any information or evidence concerning the grievance orally or in writing not later than 60 calendar days after the event;
- Ability to respond within 24 hours to an enrollee's expedited grievance whenever:

Section 19: Grievance and Appeals

- VillageCareMAX A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
 - VillageCareMAX A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration;
- Prompt, appropriate action, including a full investigation of the grievance as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written request is received, unless extended as permitted under 42 CFR 422.564(e)(2);
- Timely transmission of grievances to appropriate decision-making levels in the organization;
- Notification of all concerned parties *upon completion of the investigation*, as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 calendar days from the date the grievance is filed.
- Prompt notification to the enrollee or their representative regarding an organization's plan to take up to a 14 calendar day extension on a grievance case;
- Documentation of the need for any extension taken (other than one requested by the enrollee) that explains how the extension is in the best interest of the enrollee; and
- Procedures for tracking and maintaining records about the receipt and disposition of grievances. VillageCareMAX discloses grievance data to Medicare beneficiaries upon request and is able to log or capture enrollees' grievances in a centralized location that is readily accessible.

Appeals of Grievances

A grievance appeal is a written communication from the Member that the Member disagrees with the decision of VillageCareMAX in response to the grievance filed. Once the Member files a grievance appeal, VillageCareMAX must look again at the determination to decide if the decision was the correct one.

Members are instructed during enrollment of their right to appeal a grievance determination if the Member is dissatisfied with the determination of a grievance. Member are advised how to file a grievance appeal and if needed, told how to obtain assistance from VillageCareMAX staff. VillageCareMAX staff will review the grievance appeal with no disruption in the Member's care and Members will be free from coercion, discrimination or reprisal by the program.

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The Member has the right to present their reasons for the grievance appeal both in person and in writing during the grievance appeal process. The Member has the right to examine all records that are part of the grievance appeal process. The Member has the right to have a designated representative.

There are two (2) types of grievance appeal processes. They are:

- Standard grievance appeal decisions which are made within thirty (30) business days of the date of receipt of necessary information.
- Expedited grievance appeal decisions (if the Member, Provider on behalf of the Member or VillageCareMAX feel that the time interval for a standard grievance appeals process could result in serious jeopardy to the Member's health, life or ability to attain, maintain or regain maximum function) are made within two (2) business days of receipt of all necessary information.

For both the standard and expedited process, the Member must submit a written grievance appeal form request within sixty (60) business days from the receipt of the initial grievance decision. The appeal request form is sent with all notices of action, denial of service requests or grievance determinations not made in the Members favor. Members may request an appeal verbally and VillageCareMAX staff will complete the appeal request form on the Member's behalf.

VillageCareMAX MLTC: Appeals of Actions and Adverse Determinations

An **Appeal** is a request for the plan to review the reason for an action in order to decide if the action was correct. An appeal of an action can be made orally or in writing.

Adverse determination means a determination by the plan that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

Representative: An individual appointed by the Member or other party, or authorized under State or other applicable law, to act on behalf of a Member or other party involved in the appeal. A Member may appoint any individual (such as a relative, friend, advocate, an attorney or any physician).

Overview

A Member, their Representative or a provider on the Member's behalf may appeal within forty-five (45) days of the date of VillageCareMAX action. The Member Handbook contains descriptions of the appeals procedures to ensure that Members are fully informed of their right to file an appeal. Members are informed of their appeal rights in writing annually, upon request and every time a service is denied or services are terminated, reduced or suspended. There will be no change in a Member's services or in the way VillageCareMAX staff or providers treat a

Section 19: Grievance and Appeals

Member because he/she makes an appeal. VillageCareMAX will not retaliate or take any action against a Member for requesting an appeal.

During VillageCareMAX review, the Member or their Representative may give us information in writing or in person, and may see the Member's record at VillageCareMAX. Upon request, VillageCareMAX will give the Member the chance to discuss their appeal in their own language.

The review will be conducted by an individual who is qualified to render a decision and is not the original decision maker. Appeals regarding clinical matters will be decided by persons qualified to review the appeal, including licensed, certified or registered health care professionals who were not involved with prior determinations and are not subordinate to the person who made the initial adverse determination or action.

The Member or their representative may request a standard or expedited appeal in writing or verbally. If VillageCareMAX upholds its initial adverse organization determination, either in whole or in part, or VillageCareMAX fails to provide the Member with a decision on the appeal within the relevant time frame, the Member has the right to continue an appeal by asking for a New York State External Review if the reason VillageCareMAX denied coverage was that it was not medically necessary, or it was experimental or investigational.

Before a Member may make an External Appeal to New York State:

- The Member must file a Standard Appeal with VillageCareMAX and get VillageCareMAX final adverse determination; or
- If the Member had an Expedited Appeal and is not satisfied with VillageCareMAX decision, the Member can choose to file a Standard Appeal with VillageCareMAX or go directly to a NYS external appeal; or
- The Member and VillageCareMAX may agree to skip VillageCareMAX appeals process and go directly to a NYS External Appeal.

The Member may also ask for a New York State Medicaid Fair Hearing if an appeal is denied. The Member may ask for both a NYS External Appeal and a NYS Medicaid Fair Hearing. However, if the Member asks for both, it will be the decision of the Fair Hearing officer that counts.

The Member may be able to continue receiving previously authorized services while waiting for a NYS Fair Hearing decision if the Member asks for a New York State Fair Hearing within ten (10) days from the date the Member received our decision about the appeal; or by the date the change in care or services is scheduled to occur. If the Fair Hearing decision is not in the Member's favor, the Member may have to pay the costs of any continued benefits received solely as a result of requesting a Fair Hearing about those benefits.

MLTC Appeal Timeframes

Section 19: Grievance and Appeals

Appeals must be received by VillageCareMAX within forty-five (45) days of VillageCareMAX action. If the request is made after forty-five (45) days, the appeal will not be considered.

1. Standard Appeal of an Action for Denial of Service:

- VillageCareMAX will acknowledge the Member's appeal in writing within 15 days of receipt of the appeal.
- VillageCareMAX will make a determination and notify the Member of the decision verbally and in writing as expeditiously as the Member's health requires, but no later than thirty (30) calendar days after VillageCareMAX receives the appeal.
- Standard with Extension: VillageCareMAX may extend this time frame by up to fourteen (14) calendar days upon request by the Member or if there is a need for additional information and the extension of time benefits the Member.
- If VillageCareMAX overturns the initial adverse organization determination, the requested service will be authorized as expeditiously as the Member's health requires, but no later than thirty (30) calendar days of the date the request for reconsideration was received (or no later than upon expiration of an extension).

2. Expedited Appeal – Request for Service:

- Automatic Expedited Appeal: VillageCareMAX will automatically expedite a request for appeal:
- If the appeal request is for a concurrent authorization.
- Upon request by a physician to expedite the determination.
- Expedited Request Approved: If a Member requests an expedited appeal, without physician support, VillageCareMAX will determine whether applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If the Member's request for an expedited appeal is approved or automatically given as above, VillageCareMAX will make the determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, but no later than two (2) business days of receipt of all necessary information and no later than three (3) business days after receiving the request
- Expedited Request Denied: If the Member's request for an expedited determination is denied, the Member will promptly be informed verbally and in writing within three (3) business days, and the request will be transferred to a standard time frame (30 days). The Member will be informed of the right to file an expedited grievance if the Member disagrees with the denial of an expedited appeal decision
- If VillageCareMAX overturns the initial adverse determination, the Member will be verbally notified promptly on the day of the determination and will be sent written notification within two (2) business days of the decision

Section 19: Grievance and Appeals

3. Appeal of an Action to Terminate, Reduce or Suspend Service:

- A Member may request that aid continue while an appeal is being reviewed. The request must be made prior to the effective end date of services on the Member's written notification terminating, reducing or suspending services
- Services will be continued:
 - Until the appeal is withdrawn by the Member or
 - Until ten (10) days after an appeal decision is mailed if the decision is not in the Member's favor unless a New York State Fair Hearing has been requested.

4. NYS External Appeal:

If a Member is not satisfied with VillageCareMAX decision, the Member may appeal using the NYS External Appeals process by requesting an appeal within forty-five (45) days of VillageCareMAX decision on their appeal.

The NYS External Appeal will be decided in thirty (30) days from the date the State Insurance Department receives the application. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information.

- a. The Member and VillageCareMAX will be told the final decision within two (2) days after the decision is made.
- b. The Member can get a faster decision if the Member's doctor says that a delay will cause serious harm to the Member's health. The external appeal reviewer will decide an expedited appeal in three (3) days or less.

5. Fair Hearing

The Member must request a Fair Hearing within sixty (60) days of VillageCareMAX decision to uphold the denial.

- a. The Member may be able to continue receiving previously authorized services while waiting for a New York State Fair Hearing decision if the Member asks for a NYS Fair Hearing:
 - Within ten (10) days from the date the Member received our decision about the appeal; or
 - By the date the change in care or services is scheduled to occur
2. The Fair Hearing officer will notify the Member and VillageCareMAX of the decision within one (1) day of making the decision.

Section 19: Grievance and Appeals

VillageCareMAX Medicare Health Advantage Plan (D-SNP) and Medicare Total Advantage Plan (MAP) Plan Appeals.

***Please refer to your contract to confirm specific language.**

Plan Internal Appeal (Level 1 Appeal)

Members, their providers, and their representatives have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. The appeal must be requested within 60 calendar days of postmark date of Notice of Action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 calendar days of the notice's postmark date or by the intended effective date of the Action, whichever is later.

VillageCareMAX will send a written acknowledgement of appeal to the Member within 15 calendar days of receipt unless a decision is reached sooner. The Plan will make a decision on appeal and notify the Member of its decision as fast as his/her condition requires, but no later than within 72 hours of the receipt of the expedited appeal and no later than 30 calendar days from the date of the receipt of the standard appeal. Benefits will continue pending an appeal if requested within 10 calendar days of the Action notice's postmark date or by the intended effective date of the Action, whichever is later.

VillageCareMAX, Members or providers may take up to 14-calendar day extension, if the Plan can justify the need for additional information and if the extension is in the Member's interest, or if Member or provider requests it. In all cases, the extension reason must be well-documented, and when the Plan requests the extension it must notify the Member in writing of the reasons for delay and inform the Member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

VillageCareMAX will notify Members orally of expedited appeal decision and send written notice within 2 calendar days of its decision for standard and expedited appeals.

Independent Review Entity (Level 2 Appeal)

Any adverse decision in whole or in part by VillageCareMAX is automatically forwarded to the Independent Review Organization (IRE). This is an independent organization that is hired by Medicare to review our decision for the Level 1 appeal.

VillageCareMAX will send Acknowledgement of Automatic Level 2 appeals. If the appeal request was a "fast" appeal at Level 1, the plan will automatically process the request as a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives the appeal. If the appeal request was a "standard" appeal at

Section 19: Grievance and Appeals

Level 1, the plan will automatically process the request as a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 days of it receives your appeal. However, if the Independent Review Organization needs to gather more information, it can take up to 14 additional calendar days. The Independent Review Organization shall issue a written decision that explains the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other requirements.

Administrative Law Judge or Attorney Adjudicator (Level 3 Appeal)

If the Independent Review Entity upholds the decision, you have the right to a Level 3 Appeal. However, in order to make an appeal at Level 3, there is a minimum amount requirement. If the dollar value of the coverage you are requesting is too low and doesn't meet a certain minimum, the decision at Level 2 is final.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

The Medicare Appeals Council (Level 4 Appeal)

The Medicare Appeals Council will review the appeal and give its decision; The Council is a part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.

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- If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Federal District Court (Level 5 Appeal)

A judge at the Federal District Court will review your appeals. This is the last step of the appeals process

Section 19: Grievance and Appeals

VillageCareMAX Medicare Health Advantage Plan (D-SNP) and Medicare Total Advantage Plan (MAP) Plan Part D Coverage Determinations, Appeals and Grievances

Coverage Determinations

Coverage determination is a decision by VillageCareMAX/ MedImpact to pay or cover a prescription drug. Coverage determinations include exception requests; such as request to cover a non-formulary drug. An exception request must be accompanied by a supporting statement from the prescribing provider.

VillageCareMAX strongly encourages and recommends that a prescribing provider review the current Plan formulary to identify the drugs that are covered for VillageCareMAX Members. The plan formulary can be found at www.villagecaremax.org. The formulary can help a provider identify the therapy or therapies that will be least expensive. In general, the lower the drug tier the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that are preferred by the Plan. The formulary was developed by a Pharmaceutical and Therapeutics (P&T) Committee comprised of a national panel of clinicians. The formulary can help providers understand the VillageCareMAX strategy for managing the pharmacy benefit. We recognize that sometimes this strategy may not align with a provider's treatment criteria.

The Plan requires a Member or his or her provider to request prior authorization for certain drugs. This means the Member must obtain prior approval for a prescription from the Plan before the prescription is filled. If approval is not obtained, VillageCareMAX may not cover the drug. For certain drugs, VillageCareMAX limits the amount of the drug that is covered. This is called Quantity Limit. In some cases, the VillageCareMAX Medicare Part D Plan requires a Member to first try certain drugs to a medical condition before we will cover another drug for that condition, this requirement is called Step Therapy.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact MedImpact.

CALL: MedImpact -1-888-807-6806
FAX: MedImpact – 1-858-790-6060

WRITE: MedImpact Healthcare Systems, Inc.
Attention: Prior Authorization Department
10181 Scripps Gateway Court
San Diego, CA 92131

Medicare Part D Appeals

Section 19: Grievance and Appeals

The Member's appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A Member may appeal an adverse coverage determination.

A Member has a right to appeal if he or she believes that VillageCareMAX / MedImpact decided not to cover a drug, vaccine, or other Part D benefit; decided not to reimburse a Member for a part D drug that he/she paid for; asked for payment or provided reimbursement with which a Member disagrees; denied the Member's exception request; made a coverage determination with which the Member disagrees.

Appeals for Part D Prescription Drugs

CALL: MedImpact at 1-800-807-6806

FAX: MedImpact at 1-858-790-6806

WRITE: MedImpact Healthcare Systems, Inc.
Attention: Appeals/Grievance Department
10181 Scripps Gateway Court
San Diego, CA 92131

If MedImpact fails to meet coverage determination or redetermination time frames, it must automatically forward the Member's request(s) to the Independent Review Entity (IRE) contracted by CMS. If the IRE upholds the Plan's adverse coverage determination, the IRE will notify the Member in writing and explain further appeal options that may be available to the Member.

Time Frames for Coverage Determinations and Appeals

VillageCareMAX is required to make coverage determinations and process appeals as expeditiously as the Member's health status requires but no later than is indicated in the following chart:

Medicare Prescription Drug (Part D) Time Frames		
Type of Appeal	STANDARD*	EXPEDITED*
Pharmacy Coverage Determinations (Initial Decision)	72-hour time limit	24-hour time limit
1 st Level - Part D Redetermination Appeal	7-day time limit	72-hour time limit
2 nd Level - IRE (Independent Review Entity) Review	7-day time limit	72-hour time limit

Section 19: Grievance and Appeals

3rd Level (Office of Medicare Hearings and Appeals) For amounts in controversy $\geq$ \$140	Administrative Law Judge Standard Decision 90-day time limit	Administrative Law Judge Expedited Decision 10-day time limit
4 th Level (Medicare Appeals Council – MAC)	Standard Decision 90-day time limit	Standard Decision 10-day time limit
5 th FINAL Level - Judicial Review (Federal District Court) For amounts in controversy $\geq$ \$1,400	Federal District Court	

Section 20: Dispute Resolution

Claim Issues

Discrepancies between a claim and VillageCareMAX authorization will be processed as follows:

- If the claim processing vendor denies a claim due to a discrepancy between VillageCareMAX authorization record and the claim, or for any other problem with the claim or authorization, the Participating Provider may submit a corrected claim within forty-five (45) days of the denial or follow the claim inquiry procedures outlined in this Participating Provider Manual.
- If the designated claim inquiry staff decides against the Participating Provider, the Participating Provider can appeal to the Provider Services at 1-855-769-2500.
- The Participating Provider will be notified in writing of the decision.
- If the Participating Provider wishes to pursue the discrepancy further, the discrepancy becomes a dispute and is adjudicated through the dispute resolution process.

If a dispute arises out of, or relates to, the Participating Provider's agreement with VillageCareMAX, and the dispute cannot be resolved by the parties within a reasonable time of either parties notice to the other party of the dispute, the dispute shall be resolved by arbitration, unless otherwise stipulated. Arbitration shall be conducted pursuant to the agreement between VillageCareMAX and the Participating Provider. Arbitration decisions shall be final and binding.

Section 21: Credentialing

Provider Credentialing

The VillageCareMAX Provider Relations Department maintains credentialing files for each Participating Provider and ensures timely credentialing. Organizational Providers and Individual Providers must submit information and documentation required by VillageCareMAX to validate the Provider's qualifications to provide services to VillageCareMAX Members.

Organizational Credentialing criteria include:

- Completed and signed Participating Provider application;
- All regulatory licenses, registrations and certifications;
- Evidence of insurances, as applicable, e.g. general liability, automobile insurance, etc.,
- NPI (National Provider Identifier Number);
- Medicaid and Medicare Provider numbers for all Medicaid and Medicare Providers;
- Valid Drug Enforcement Agency and/or Controlled Substance Certificate, (if applicable).
- A copy of an accreditation certificate or a copy of the most recent federal or state regulatory body site visit report (with a letter if appropriate of the acceptance of a plan of correction).

VillageCareMAX includes review of compliance with the American with Disabilities Act of 1990 (ADA) as part of its credentialing and recredentialing process. To be fully compliant with ADA requirements, participating providers must attest that the following standards are in place.

Provider sites at which Members receive services are required to be compliant with the ADA. A self-assessment questionnaire is included as part of the initial credentialing process. Compliance with ADA accessibility requirements includes, but is not limited to the following:

- Wheelchair accessible office, doorways, waiting rooms, examination rooms, lavatories, etc.
- Elevator controls (if applicable) and light switches for lavatories reachable by someone in a wheelchair
- Assistance available for those who may need sign language interpretation and other special needs

If an organization has not been accredited and has not had a recent, favorable regulatory site visit, then VillageCareMAX will conduct a quality assessment which may include a site visit.

Individual Credentialing (medical providers including MDs, DOs, DPMs, DCs, ODs, NPs, PTs and behavioral health care providers, including Psychiatrists, Psychologists, PhDs and Social Workers) Criteria includes, but is not limited to:

- An active license in New York State

Section 21: Credentialing

- An active Drug Enforcement Agency (“DEA”) certification if a prescribing practitioner)
- Controlled substance registration
- An acceptable 5-year work history for initial credentialing
- Acceptable malpractice claims history
- Current malpractice insurance coverage in accordance with contractual provisions (if applicable)
- Appropriate training and board certification
- Clinical privileges in good standing (as applicable)

Note: Providers who are sanctioned or excluded from participation with Medicare and/or New York State Medicaid Program will be excluded from participation. Medicare Opt Out providers cannot participate in MA-PD plans.

Practitioners who ***do not need*** to be credentialed:

1. Practitioners who practice exclusively within the inpatient setting and who provide care for organization Members only as a result of Members being directed to the hospital or another inpatient setting; and/or covering Primary Care Provider (PCP) who works less than 16 hours per week.
2. Practitioners who practice exclusively within free-standing facilities and who provide care for organization Members only as a result of Members being directed to the facility
3. Covering practitioners (e.g., locum tenens). Locum tenens who do not have an independent relationship with the organization are outside the scope of credentialing

Providers applying for Initial Credentialing are required to complete a credentialing application along with documents specified on the application. VillageCareMAX will inform the Provider of any deficiencies or missing documents. If the Provider cannot correct deficiencies or provide timely submission of documents, processing of the provider’s application will cease and the provider will be informed that participation with the plan will not proceed within no more than 90 days after the application is received. Providers being considered for Recredentialing will be afforded the same opportunities to correct deficiencies and/or submit documents. However, should a provider fail to comply with recredentialing activities, the provider will be terminated from participation with VillageCareMAX. Termination for non-compliance with recredentialing does not afford appeal rights, but does not preclude the provider from applying for Initial Credentialing once again.

VillageCareMAX may conduct a site survey of the Provider’s premises when services are to be rendered on site at the Provider’s facility. VillageCareMAX will consider the results of the site survey in determining whether to contract with a Provider, and in determining whether to renew an agreement with a Participating Provider.

Recredentialing Criteria

Section 21: Credentialing

VillageCareMAX requires all providers to undergo recredentialing at least every three (3) years. Providers must maintain the same minimum qualification requirements as applicable for the Initial Credentialing. In addition, the recredentialing process will factor in the following elements when evaluating each practitioner:

- Access/availability
- Under/over utilization data
- Quality of care
- Primary and secondary prevention
- Disease management
- Member satisfaction
- Site/medical record audit scores
- Member concerns
- Peer review
- Continuity of care

All of the credentialing and recredentialing decisions are made by the VillageCareMAX Credentialing Committee. The Credentialing Committee can approve, pend for additional information, or deny the applicant. The provider's effective date is the date the Credentialing Committee approved the provider's application. Providers will be notified of their status within 60 days of a Credentialing Committee's decision date, as per New York State Public Health Law (PHL 44). In some cases, credentialing has been delegated to a hospital system, Independent Practice Association (IPA) or other Credentials Verification Organization (CVO). On an annual basis, the Credentialing Policy shall be reviewed and approved by the VillageCareMAX Board of Directors or a designated Board committee.

Monitoring of Participating Providers

To insure that Participating Providers comply with the terms of provider contracts and provide the most cost effective, quality care for Members, VillageCareMAX audits and monitors Participating Providers on a regular and ongoing basis. Participating Providers who are found to have performance issues will be required to take corrective actions that will demonstrate improved performance. If corrective action is not taken or fails to produce improved results over an acceptable period of time, the Participating Provider will be evaluated for possible termination of their agreement.

Monitoring Process

- The Assistant Vice President of Quality Assurance or designee reviews Member satisfaction surveys and Member complaint logs.

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- The Quality Assurance and Provider Relations Departments meet as needed to review Member complaints.
- Repeated complaints regarding a particular Participating Provider are followed up by the Provider Relations Department and the Quality Assurance Department when applicable.
- The Provider Relations Department, or Quality Assurance staff where quality of care issues are involved, will contact the Participating Provider to discuss complaints and request a plan of action.
- If repeated issues that are identified through Member satisfaction surveys and complaint logs cannot be remedied, the Provider Relations Department will commence agreement termination procedures.

VillageCareMAX reviews governmental sanction databases and the Medicare Opt Out Provider list to ensure that participating providers are eligible to serve Members, including:

- New York State Education Department Office of the Professions—Enforcement Actions
- New York State Office of the Medicaid Inspector General—Terminations and Exclusions List
- U.S. Dept. of Health and Human Services Office of the Inspector General-- List of Excluded Individuals and Entities
- U.S. General Services Administration System for Award Management

Any disciplinary action taken against a Participating Provider will be reviewed by the Credentialing Committee and appropriate action will be taken.

Section 22: Participating Provider Audits

VillageCareMAX will annually review a sampling of Participating Provider records documenting evidence of service delivery to determine compliance with State and local laws, contract terms and verify claims accuracy and any patterns of error. Audits will be based upon a sampling of paid claims for a specific time frame. Participating Provider selection will be rotated based on utilization. A statistically significant number of claims will be reviewed.

Documents Collected During Provider Audit

The data to be collected will depend on the specific audit being performed. The following list includes an example of documents to be collected during audits:

- Medical record notes;
- Doctor's orders;
- Plan of care;
- RN Supervision notes and proof of visit;
- Attendance/ Duty sheets;
- Home health aide certification;
- Last annual physical examinations and health status assessment;
- Evidence of participation in 6 hours of in-service education per year;
- Annual assessment of performance of home health aide, including at least one in-home visit to observe performance;
- Results of NYS criminal history record check for required staff;
- Evidence of verification against government exclusion lists including date and proof of screening for each aide in the audit sample;
- Policy and procedure that describes how provider conducts Medicaid/Medicare exclusion/sanction list verifications for all new and existing employees and contractors;
- Activity records;
- Time slips, Sign in logs and attendance sheets;
- Durable Medical Equipment delivery tickets;
- Trip verification;
- Monitoring Reports from Participating Providers
- Documentation related to ADA compliance
- Payroll documentation to verify compliance with Wage Parity

Retrospective Claims Audit Process

- Upon ten (10) days' notice to a Participating Provider, VillageCareMAX will give the Participating Provider a list of claim numbers, Member names and service dates as applicable.

Section 22: Participating Provider Audits

- Participating Providers will provide documentation of service records for VillageCareMAX to review against paid claims.
- VillageCareMAX will compile data into a report indicating number of Participating Providers audited, number of claims, and number of errors, if any, found.
- Participating Providers showing a pattern of errors (in excess of five percent (5%) will be notified, and corrective action requested.
- Additional audits of these Participating Providers will be conducted quarterly.
- If no corrective action is taken to improve the results, VillageCareMAX Provider Relations will be notified and agreement termination procedures will be initiated.

VillageCareMAX reserves the right to audit participating providers as required by law and Participating Provider Agreement.

Section 23: Termination of Participating Providers

Participating Provider Termination

VillageCareMAX may terminate its agreement with a Participating Provider pursuant to the provisions of the VillageCareMAX Participating Provider Agreement. VillageCareMAX will comply with the requirements of Section 4406-d of the New York Public Health Law when terminating a health care professional's contract. Under this policy, the term "health care professional" shall be defined in accordance with Section 4406-d of Public Health Law, as a health care professional licensed, registered or certified pursuant to Title Eight of the New York Education Law. Organization providers do not have appeal rights.

In some cases, a health care professional whose contract is being terminated or who is being denied continuing network participation at the time of re-credentialing, may be eligible to appeal the termination. Appeals rights do not apply in cases of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health care professional's ability to practice or in cases of non-renewal of a health care provider's contract. Health care professional who are terminated for non-compliance with recredentialing will not be entitled to appeals rights but may re-apply for initial credentialing.

VillageCareMAX will provide health care professionals with the reason for terminations in writing and will include:

- Notice that the health care professional has the right to request a hearing or review, at the health care professional's discretion, before a panel appointed by the health plan
- Time limit of thirty (30) days from receipt of notice within which the health care professional may request the hearing
- Time limit for a hearing date which is required to be held within not less than 30 days after the date the hearing was requested

Reasons for termination include, but are not limited to:

- Rendering care to members in a harmful, potentially harmful, personally offensive, or unnecessary, or inefficient manner
- Failure to provide access to care to an extent that continuity of care to enrolled patients is inadequate
- Failure to comply with VillageCareMAX's policies and/or procedures, including those for utilization management, quality improvement, or billing
- Loss or restriction of hospital privileges
- Loss, suspension, revocation or limitations on license or DEA registration
- Censure, suspension, or disqualification from participation in Medicare or Medicaid
- Indictment or conviction of a felony
- Failure to comply with the recredentialing process or submitting false, incomplete or misleading information with respect to credentials
- Failure to maintain appropriate malpractice insurance coverage

Section 23: Termination of Participating Providers

- Physical or mental impairment, including chemical dependency, which affects the ability to provide care to patients

In order to appeal the termination of a provider contract, the provider must make the request in writing within thirty (30) days of receipt of notice. Appeals requests should be sent to the attention of: “Provider Relations/Credentialing (URGENT)” at:

VillageCareMAX
Attn: Provider Relations
112 Charles St
New York, NY 10014

Appeals/Hearing Panel

When an Appeal of a termination is received, the Credentialing Manager, in conjunction with the Medical Director, will determine that the Appeal is eligible for a Hearing.

Within fourteen (14) days of receipt of an eligible request for a Hearing, the Credentialing Committee Medical Director Chair will schedule the Hearing at a mutually agreeable time but no later than thirty (30) days from receipt of the request.

The Credentialing Committee Medical Director Chair will appoint an impartial Review Panel of three (3) clinicians, at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Committee.

The Hearing may be conducted telephonically or at VillageCareMAX offices during regular business hours.

The health care professional who is appealing may choose to have a representative represent him/her and may provide witnesses to support his/her appeal.

The hearing will include: Chairman's Statement of the Procedure, Presentation of Evidence by Credentialing Committee, Presentation of Evidence by the Health Care Professional, Credentialing Committee Rebuttal (as appropriate), and Summary Statements.

The health care professional will be notified in writing of the Review Panel's decision within thirty (30) days of the Hearing.

VillageCareMAX Duty to Report

VillageCareMAX is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

Section 23: Termination of Participating Providers

1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.
2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member's health

Continuation of Treatment

***Please refer to your contract to confirm specific language.**

The Provider agrees that in the event of plan's insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period.

Health Care Provider agrees that in no event, including, but not limited to nonpayment by the plan, insolvency of the plan or breach of the Participating Provider Agreement, shall Health Care Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against VillageCareMAX Members or persons (other than the plan) acting on a VillageCareMAX Member's behalf for Covered Services provided pursuant to the Participating Provider Agreement.

In the event of termination of the Participating Provider Agreement, the Provider agrees to: (i) continue to provide services to Members pursuant to the terms of the Participating Provider Agreement for one hundred eighty (180) days following notice of termination or until such time VillageCareMAX makes other arrangements for Members, whichever first occurs; (ii) continue to permit VillageCareMAX access to all records of Members who have or are receiving services; and (iii) provide VillageCareMAX with copies all records of services rendered to Members on or prior to the effective date of terminations.

Section 24: Policies and Procedures

Updates and Changes to Policies and Procedures

If VillageCareMAX updates or makes changes to policies and procedures related to Participating Providers, these changes will be posted on the plan's website. Please see <http://www.villagecaremax.org> for policy and procedure updates.

Participating Providers will be provided with in-service and orientation programs as required.

Section 25: Quality Management

The VillageCareMAX Quality Assurance and Performance Improvement (QAPI) Program provides a framework for monitoring and evaluating critical aspects of service delivery, including Eligibility and Enrollment, Disenrollment, Grievances & Appeals, and Care Coordination. Care Coordination includes the functions of Case Management and Utilization Management. Case Management is the coordination of care across time and across different care settings including acute care, and also engaging the individual Members and their informal supports in the development and execution of the care plan, to the extent desired by each individual. Utilization management maximizes quality of care, while providing services in the most efficient and cost effective manner.

Measures will be selected to track and trend the access, timeliness and quality of delivery of these services to Members; Member outcomes at they receive care; and Member satisfaction. The QAPI Program Description along with the QAPI Work Plan and a QAPI Program Evaluation are reviewed and approved annually by the Board of Directors.

In addition to ongoing QAPI activities and monitoring, VillageCareMAX identifies and investigates adverse events and potential quality of care issues including: Unusual Events, CMS Never Events and State reporting requirements. Appropriate actions are taken to resolve these issues and where possible to prevent and reduce future occurrences.

Incidents and Quality of Care (QOC) Concerns

1. Incidents can be:

- Sentinel events which are the unexpected occurrence that already has or has the potential to cause the Member mental or physical harm, loss of limb, death, or threatens life.
- The National Quality Forum's List of Serious Reportable Adverse Events (CMS adopted "Never Events")
- Incidents which providers are required to report via NYSPORT
- Serious incidents which providers are required to report to the New York State Office of Mental Health
- Critical Incidents which are any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Member.

Reportable Critical Incidents are defined as:

- Abuse
- Neglect or patient abandonment
- Exploitation
- Rights Violations
- Falls that require medical intervention
- Serious Injury
- Missing Person

Section 25: Quality Management

- Death
- Medical Emergency
- Restraints
- Medical Errors
- Law Enforcement Contact
- Suicide Attempt

2. A QOC Concern can be any clinical or medical event other than an incident about which a question has been raised as to the whether the appropriate medical protocol was followed or a generally accepted standard of care maintained. These include:

- Occurrences as listed on the NYSPORT reporting requirements for providers:
- Other New York State Office of Mental Health reporting requirements,
- Additionally, the Plan may identify other potential quality of care concerns for investigation, tracking and trending.

Identification of an Incident or Quality of Care Concern

A number of parties can identify an incident or QOC concern. Examples include:

- A Member, family member or caregiver may file verbally or in writing a grievance about an incident or QOC concern.
- A UR Nurse may learn of an incident during the service authorization process.
- A Care Manager may identify a concern during the care management or care planning process.
- As encouraged, a provider may proactively report an incident relative to their practice, or an incident or QOC concern regarding another practitioner to a Member's Care Manager.
- Quality Management (QM) staff may identify events through
 - Routine medical record review/quality measurement activity
 - Claim based reports designed to identify retrospectively potential incidents and quality of care concerns

Referrals

1. Incidents and Quality of Care Concerns can be reported at any point in time in proximity to the event.

2. Members and Providers may report them verbally or in writing. If a verbal report is being made, the provider should call 1-800-469-6292, and the member services staff who answers the call can provide assistance. Written notification can be sent by fax to: 212-337-5711.

3. At minimum, the referral should include:

- The name(s) of the Member(s) affected, their date of birth, Membership number and address.

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- A description of the incident or concern including the time of the event, location, and extent of injury or damage.
- The steps the facility/provider has taken to date to address the incident if any
- The next steps the facility intends to take to address the incident including timeframes for completion if any.

4. Timelines for Investigation

- a. If the case is a grievance about quality, the Grievance Policy timelines are followed.
- b. Incidents and serious QOC concerns that pose an ongoing or immediate risk to the Member, other Members, or the public are immediately reviewed with the Medical Director or a physician consultant if the Medical Director is not available.
 - i. The Medical Director will direct the plan to take the level of action needed to address the severity of the issue. This may include reporting it to the Department of Health or other government or regulatory bodies, immediately transferring a Member to another facility or provider, or suspending admissions to the facility, provider or practice until the investigation can be completed.
- c. All other incidents/QOC concerns are investigated as quickly as the situation warrants. The QM Department strives to complete the investigations within 30 days (or as indicated by contractor's regulatory requirements) of receiving all needed information.

Investigating an Incident or Quality of Care Concern

1. A QA Nurse conducts an initial investigation, which usually involves requesting and reviewing the Member's medical record.
2. Depending on the nature of the issue, he/she may also gather other information for analysis including claims, utilization, case management, inquiry and complaint, and provider performance profile data.
3. The purpose of the initial investigation is to review the care which was rendered and to ascertain whether the generally accepted standard of care was met. Case medical documentation is usually reviewed against regulatory and accreditation standards and/or industry accepted clinical practice guidelines.

Peer Review

1. Cases which do not meet the standard of care are referred to the Medical Director for determination of next steps.

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2. Medical record review by a professional from the appropriate subspecialty may be recommended by the Medical Director and facilitated by the QM Department.
3. The Medical Director may request that a vendor/facility investigate the incident or quality of care concern.
 - a. A letter summarizing the investigation is signed by the Medical Director and sent to the vendor/facility's Quality Assurance Liaison.
 - b. Medical opinions or conclusions about the quality of care rendered are not asserted in the letter.
 - c. The letter requests that the vendor/facility's Quality Assurance Liaison responds with a description of the incident or concern, the steps taken by the vendor/facility to investigate the incident or issue, and the corrective actions taken.
 - d. The Plan may ask the vendor/facility to report the findings of their investigation.
 - e. The QM Department tracks receipt of response to these requests.
4. When an incident or quality of care concern involves an individual practitioner:
 - a. Summaries of the investigation are forwarded to the Provider Relations (PR) Department for inclusion in the provider's file. At minimum, this documentation is reviewed during re-credentialing decisions.
 - b. The Medical Director may request Peer Review of the issue.
 - i. Depending on the severity of the issue this may require an adhoc meeting of the Committee.
 - ii. After review, the Quality Committee may elect to implement disciplinary actions for providers and/or reporting to professional disciplinary agencies.
 - iii. Alternatively, the Committee may request that the provider submit a corrective action plan.
 - iv. The PR Department facilitates the corrective action plan request and the QM Department tracks receipt of responses to these requests.

Oversight

1. A brief summary of incidents/concerns, the outcome of the investigations, and follow-up on facility requests for investigations and provider corrective action requests, is reported to the Quality Committee for discussion, clinical program follow-up and next steps to reduce future occurrences in the health care system if appropriate.
2. When related to a Member complaint, a summary of a particular incident/concern and the outcome of the investigation may be reported to the Quality Committee for discussion and programmatic follow-up relative to customer service and Member satisfaction.

Reporting

Section 25: Quality Management

The number and type of incidents and QOC concerns reported, and the outcome of the investigations, are aggregated and analyzed at minimum annually and presented to Quality Committee to aide in the identification of potential trends and to determine whether opportunities exist for system wide practice improvement.

Additional Quality Management Activities

VillageCareMAX quality management activities also include broader review and management of the Participating Provider network and key internal operations and processes. This includes periodic measurement and review of:

- Access and Availability
- Medical Records Documentation
- Utilization Review Processes and Appeals
- Service Utilization Rates
- Hospitalization and re-hospitalization rates
- Claims submission and audits
- Complaints (Grievances) and quality of care concerns
- Functional status and other clinical outcomes
- Satisfaction Surveys (rating of provider communication, provider customer service and perceived quality of care)

If deficiencies are identified, corrective measures or a performance improvement plan may be requested. VillageCareMAX will provide resources to assist (i.e., patient or provider education materials) where possible.

In addition, the QA Program will include:

- Seeking the input of Providers and medical professionals representing the composition of the Plan's Provider Network in developing functions and activities;
- Utilizing the Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS), and other measurement results in designing QI activities;
- Implementing a Medical Record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care.
- Measuring Participating Providers and Members, at least annually, regarding their satisfaction with the Plan.
- Measuring clinical reviewer consistency by applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;
- Including Members and their families in Quality Management activities, as evidenced by participation in Member Advisory Committee and Member Feedback Sessions; and

Section 25: Quality Management

- Collaborating with and as further directed by NYSDOH, develop a customized Medical Record review process to monitor the assessment for and provision of Community-based and Facility-based LTSS.

Clinical Practice Guidelines

Clinical practice guidelines are systematically developed standards that help practitioners and Members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives VillageCareMAX the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH and the local departments of health, participating providers are expected to comply with the guidelines adopted by VillageCareMAX.

VillageCareMAX has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two (2) years unless otherwise specified. Please see Appendix 6 for a copy of the Clinical Practice Guidelines. VillageCareMAX adopts guidelines upon the recommendation and approval of the Internal Quality Review Committee. They are communicated to providers, including performance indicators chosen by the clinical Members of the Council, through the Provider Manual, annual mailings, newsletters and the VillageCareMAX web site. Performance against chosen indicators is measured annually – preventive guidelines are measured utilizing HEDIS/QARR measurement tools and clinical guidelines are measured using focused studies methodologies.

Please note: VillageCareMAX disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our Members. These guidelines provide a tool for objective comparison of clinical practices among network providers and ensure appropriateness of care to our Members. These guidelines are readily available by virtue of their already broad publication and distribution and are available on our website at www.villagecaremax.org.

VillageCareMAX will also in the aggregate, without reference to individual Physicians or Member identifying information, report the following information to CMS and the New York State Department of Health on a quarterly basis or as requested by CMS and the New York State Department of Health:

- QI findings, conclusions, recommendations, actions taken, results or other documentation relative to QI

CMS and the New York State Department of Health, and in the case of Providers of Behavioral Health Services, OMH or OASAS as appropriate, shall be notified of any Participating Provider or First Tier, Downstream or Related Entity to the Medicare Advantage HMO Special Needs Plan who ceases to be a Participating Provider or First Tier, Downstream, or Related Entity to the Plan for a quality of care issue.

VillageCareMAX has mechanisms in place to:

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- Collect data for the measures specified in Appendix 5;
- Utilize results of the measures specified in Appendix 5 in designing QI initiatives.
- Conduct Member Experience Surveys.
- Meet Quality Improvement Project Requirements including implementing the Quality Improvement Project Requirements, in a Culturally Competent manner.
- Develop a chronic care improvement program (CCIP) and establish criteria for participation in the CCIP. The CCIP will be relevant to and target the Plan's population.

Provider Reporting and Quality Measures

VillageCareMAX is required to report encounter data to New York State, CMS and other regulatory agencies, which lists the types and number of healthcare services Members receive. Accurate claims data is essential for encounter data submission, utilization reporting and for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.

The claims information you submit to us usually provides the encounter and claims data submitted monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, and that all claims include complete information about the member's diagnosis and services. MEDS is the standard by which the performance of VillageCareMAX, its providers and other managed care organizations is measured. To meet the state mandate, VillageCareMAX requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section above for the specific requirements when submitting claims or encounter data to CMS.

Including all of the applicable member diagnoses in the claims submission is essential for the plan to continuously work on improving members' services and experience and other quality improvement activities but also for accurately reporting members' participating risk level. In addition to encounter data submission, VillageCareMAX expects its providers to comply with Core Quality Measures established by NCQA, NY SDOH, CMS for Medicare Advantage HMO Special Needs Plans. Measures for reporting includes measures included in Appendix 5.

Section 26: Fraud and Abuse

Fraud and Abuse Investigation

VillageCareMAX proactively investigates and resolves all complaints and other reports or findings that raise suspicion of fraud and/or abuse. Such cases and findings are reported to external regulatory and law enforcement agencies as required by law and contract. Members, Providers, employees or the public can report suspected fraudulent or abusive behavior by calling VillageCareMAX at 1-800-4MY-MAXCARE (1-800-469-6292) or writing to:

Compliance Officer
VillageCareMAX
120 Broadway, Suite 2840
New York, NY 10271

Following the receipt of an issue which may indicate potential fraud and/or abuse VillageCareMAX will conduct a preliminary investigation to assess the nature and scope of the issue. Based upon the findings of the preliminary investigation, a plan for further investigation and/or resolution of the matter is established.

As necessary and appropriate, cases are reported to regulatory agencies, enforcement agencies and/or professional disciplinary agencies including the New York State Department of Health, the New York City Department of Health and Mental Hygiene, the New York State Office of the Medicaid Inspector General, the New York State Insurance Fraud Bureau, MEDIC, and the New York State Medicaid Fraud Control Unit.

A fraud and abuse training module will be available on the VillageCareMAX website – www.villagecaremax.org.

First Tier, Downstream and related entities who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste and abuse.

Section 27: False Claims Act

Scope of the False Claims Act

The False Claims Act (the “FCA”) is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term “knowingly” means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include “treble damages” (damages equal to three times the amount of the false claims) and civil penalties of up to \$11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

Potential FCA Violations

Knowingly submitting claims to VillageCareMAX, for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Knowingly billing for services that were not furnished and/or supplies not provided, including billing VillageCareMAX for appointments that the Member failed to keep;
- Submitting a claim for authorized not actual hours of personal care provided;
- Submitting a claim for Durable Medical Equipment or Supplies when delivery was refused by the Member;
- Submitting a claim for two (2) man transportation, as authorized, but providing only one (1) man; or
- Submitting a claim for a service not provided.

The FCA’s Qui Tam Provisions

The FCA contains a qui tam, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

Section 27: False Claims Act

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation.

VillageCareMAX False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws which also apply to the submission of false claims and the making of false statements:

- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.
- Article 176 of the Penal Law makes it a misdemeanor to commit a “fraudulent insurance act,” which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds one thousand dollars (\$1,000) the crime is punishable as a felony.
- Article 177 of the Penal Law makes it a misdemeanor to engage in “health care fraud,” which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds three thousand dollars (\$3,000) the crime is punishable as a felony.

Section 28: Compliance Requirements

Annual Compliance Training Requirement

CMS requires that all employees who provide services on behalf of VillageCareMAX's Medicare or Medicaid plans, complete the Compliance and Fraud Waste & Abuse within 90 days of hire and annually thereafter. A record of all employees and contractors receipt of the policies, Standards of Conduct, and information must be maintained for a period of ten years and can be provided upon request.

***Note:** Medicare has developed training to meet the annual training requirements. This training can be found on the Medicare Learning Network Provider (MLN) Compliance page as follows:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

You can find additional information regarding this requirement on our website at:

<http://villagecaremax.org/provider-compliance/>

Home Care Worker Wage Parity Law

This law establishes a minimum wage requirement for home care aides who perform Medicaid reimbursed work (including partial payment for dual-eligible Medicaid and Medicare plans) for certified home health agencies (CHHAs), long-term home health care programs (LTHHCPs), licensed home care service agencies (LHCSAs), limited licensed home care service agencies (LLHCSAs) and other organizations that employ home care aides in New York City or in Nassau, Suffolk or Westchester County. This law is in effect in New York City for services provided on or after March 1, 2012, and in Nassau, Suffolk and Westchester counties for services provided on or after March 1, 2013.

If your organization is a contracted entity providing home care services for VillageCareMAX Medicaid or Managed Long Term Care (MLTC) members, you are required to provide VillageCareMAX with quarterly written certification of your organization's compliance with the minimum wage requirements of the Home Care Worker Wage Parity — Public Health Law of §3614-c. This certification must also be sent to the New York State Department of Health (NYSDOH) annually.

You can find additional information regarding this requirement at the following location:

https://www.health.ny.gov/health_care/medicaid/redesign/mrt_61.htm

Section 28: Compliance Requirements

Submitting Your Certifications to VillageCareMAX

Quarterly certifications are due to VillageCareMAX on March 1, June 1, September 1 and December 1 of each year. Annual certifications are due to the NYSDOH by March 1 of each year.

Please email the certification to VillageCareMAX's Provider Relations department at providerrelations@villagecare.org

Additional Wage Parity Information

For additional information about the Home Care Worker Wage Parity provision and its implementation, please send an email to homecare@health.state.ny.us with "Home Care Worker Parity" in the subject line.

Maintenance of Records Requirement

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (<https://www.gpo.gov/fdsys/pkg/CFR-2006-title42-vol3/pdf/CFR-2006-title42-vol3-sec422-504.pdf>) on the Internet.

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly. Documentation of Care Management activities is performed primarily in our online computer systems, using specific software designed to facilitate clinical management and decision making. These online records reflect all review findings and actions taken during prior approval and concurrent management processes.

All providers must maintain records of compliance for at least 10 years. These records must be made available to the CMS/NYSDOH/OMIG upon request. If you have any questions about complying with this request, please contact your VillageCareMAX provider representative.

[Appendix](#)

Appendix

The following appendix documents are included in the Provider Manual:

[Appendix 1: VillageCareMAX MLTC Referral Form](#)

[Appendix 2: Sample Authorization Letter](#)

[Appendix 3: Electronic Funds Transfer Form for Providers](#)

[Appendix 4: Service Authorization Request Form](#)

[Appendix 5: Quality Improvement Program](#)

[Appendix 6: Clinical Practice Guidelines](#)

[Appendix 7: LCSHA Operational Guidelines](#)

[Appendix 8: Provider Information Change Form](#)

[Appendix 9: Important Information: CMS -10611 Form - Medicare Outpatient Observation Notice \(MOON\)](#)

[Appendix 10: DME Services requiring Prior Authorization](#)

[Appendix 11: NYS DOH universal billing codes for home care and adult day health care services](#)

[Appendix 12: 2019 Medicare Part D Opioid Policies](#)

[Appendix 13: Update: NYS Medicaid Program Dental Policy and Procedure Code Manual](#)

[Appendix 14: Member Correspondence Grid](#)

[Appendix 1](#)

Appendix 1: VillageCareMAX MLTC Referral Form



Potential Member Contact Form

<u>MEMBER INFORMATION</u>		<u>DATE:</u>
Last Name:		Middle Initial: First Name:
Address		Apt City State NY Zip Code
Primary Language		Primary Phone # Add'l Phone #
Gender	Male ☐ Female ☐	Date of Birth Social Security #
Medicaid #		Medicare # Other Insurance
If no Medicaid, does client want to apply? ☐ Yes ☐ No ☐		
Has client expressed interest in learning more information about Medicare programs? Yes ☐ No ☐		
Is this part of a mutual case? Yes ☐ No ☐		Mutual Case Name
CDPAP Yes ☐ No ☐	(If Yes) Name & Tel Number of primary caregiver	
Additional Contact		Relationship Phone #
PCP:		Contact Number:

<u>Provider Information:</u>	
Organization	Name & Title
Tel #	Fax # Email
Address	City State Zip Code

<u>Notes:</u>

Please E-MAIL form to: yccmaxrefer@villagecare.org

*VillageCareMAX is part of VillageCare's network of community based not-for-profit organizations.

9/25/2014

[Appendix 2](#)

Appendix 2: Sample Authorization Letter

Medicaid #:
VCM Member #:
DOB:
Member Phone #:

BROOKLYN, NY 11235

Dear

This letter is to confirm authorization of your request for services to the provider listed below:

Provider:
Authorization Number:
Preliminary Diagnosis:
Place of Service:
Type of Service:
Procedure Code:
Quantity:
Authorization Valid From:
Additional Information:

If you have any questions regarding this authorization, please call VillageCareMAX at 1-800-4MY-MAXCARE (1-800-469-6292), 7 days a week, 8:00 am to 8:00 pm, and reference the authorization number indicated above. If you have a hearing or speech impairment, please call us at TTY/TDD 1-800-662-1220.

Please be advised that any additional services beyond those authorized above are subject to review and re-authorization by VillageCareMAX. Authorizations may be obtained by contacting your VillageCareMAX Care Manager at 1-800-4MY-MAXCARE (1-800-469-6292).

This authorization is only valid for health plan Members who are Members of VillageCareMAX on the day services are rendered. This letter is not a guarantee of payment. Payment for this service is subject to all terms, conditions, limitations, copayments/coinsurance and exclusions as outlined in your Member Handbook and in our Provider Contracts.

Sincerely,
VillageCareMAX

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Appendix 3: Electronic Funds Transfer Form for Providers Electronic Claims & Payment Process

Electronic Funds Transfer (EFT)

1. EFT Request Process:

To request a new EFT Enrollment, the requestor must use the Change Health Care Enrollment form. Check the EFT box and fax the completed form to 631-963-4935 or email to EFT@ILSHEALTH.com.

2. EFT inquiry/Status Update:

Please contact 855-769-2500 or email EFT@ILSHEALTH.com

3. EFT Confirmation Process:

A confirmation to the email address on EFT request form is sent to the requestor once EFT setup is complete, within 30 days of receipt of the form.

Electronic Remittance Advice (ERA/835)

4. ERA Request Process:

To request a new ERA Enrollment, the requestor must use the Change Health Care Enrollment forms. Check the ERA box, fax the completed form to 615-885-3713 or email to BatchEnrollment@ChangeHealthCare.com.

5. ERA Inquiry/Status Update:

Please contact 866-924-4634 or email BatchEnrollment@ChangeHealthCare.com

6. ERA Confirmation Process:

Change Health Care will send a confirmation email to the requestor within 7 business days, once ERA/835 setup is complete.

Link to EFT/ERA Form:

https://www.changehealthcare.com/docs/default-source/enrollment-services/26545erap3.pdf?sfvrsn=3fa5c1c8_2

If you have any questions, please contact the phone numbers listed above for ERA/EFT.

Appendix 4

Appendix 4: Service Authorization Request Form



112 Charles Street
New York, New York 10014
(800) 4MY-MAXCARE
(800) 469-6292
www.villagecaremax.com

LIVE THE LIFE YOU WANT

Member Information:

Member ID:	Medicaid ID:	Medicare ID:	SSN:
Preferred Language:	Location:	Phone Number:	DOB:
PCP Name:			PCP Phone Number:
PCP Address:			

Provider Information:

Name:	Provider Number:
Address:	Phone Number:

Auth #:	Service Type:
Start Date:	End Date:
Days of the Week:	
Frequency:	
DX Code:	
CPT Code:	Decision:
Modifier1:	Modifier2:
Units:	
Actions:	
Special Instructions:	

Authorization Disclaimer

If you have any questions regarding this authorization, please call VillageCareMAX at 1-800-4MY-MAXCARE (1-800- 469-6292), 8:00 am to 8:00 pm, 7 days a week and reference the authorization number indicated above.

Please be advised that any additional services beyond those authorized above are subject to review and re-authorization by VillageCareMAX. Authorization may be obtained by contacting your VillageCareMAX Care Manager at 1-800-4MY-MAXCARE (1-800-469-6292).

This authorization is only valid for health plan members who are members of VillageCareMAX on the day services are rendered. This letter is not a guarantee of payment. Payment for this service is subject to all terms, conditions, limitations, copayment s/ coinsurance and exclusions as outlined in the Member's Handbook and in our Provider Contracts.

Sincerely,

Customer Service Department
VillageCare MAX

Please call our Customer Service Department at 1-800-469-6292 if you need help reading this letter in other languages.

Por favor llame a nuestro Departamento de Servicio al Cliente al 1-800-469-6292 si necesita ayuda para leer esta carta en español.

Если Вам нужна помощь, чтобы прочитать это письмо на русском языке, пожалуйста, позвоните в наш Отдел обслуживания клиентов по телефону 1-800-469-6292.

如您需要中文翻譯這封信,請致電我們的客戶服務部 1-800-469-6292.

CARA TEST
100000102

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VillageCareMAX

Appendix 5: Quality Improvement Program

PURPOSE

The VillageCareMAX Quality Improvement (QI) Program includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery to members. The program consists of designated structures, processes, and measures, used to assess, assure, and improve access to services and quality of care for all members. Its purpose is to continuously improve the quality, safety, and cost-effectiveness of care and service provided to members.

The QI program provides a framework for monitoring and evaluating critical aspects of care management, service delivery, and customer service. Measures for evaluating the effectiveness of care management, appropriateness of services, customer service and satisfaction, and operational efficiency will be implemented to assist VillageCareMAX in ensuring ongoing quality and continuous performance improvement.

This document describes the QI program. Quality Improvement is the responsibility of all VillageCareMAX staff, and it is an essential component of all the plan's activities. The Quality Improvement program is reviewed annually, and revised as appropriate. In addition, an annual quality improvement workplan, outlining specific projects and workstreams for the coming year is developed and approved by the VillageCareMAX Board of Directors, and monitored throughout the year.

The QI program and all material changes will be submitted to the New York State Department of Health for review and approval.

TARGET POPULATION:

VillageCareMAX is a not for profit health plan offering several plan options to residents of New York City. The plans offered by VillageCareMAX include:

- Medicaid Managed Long Term Care (MLTC) plan. The MLTC is a partially-capitated product for individuals with Medicaid, who

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are nursing home eligible, and those with Medicare and Medicaid who wish to remain living in their homes and community and require long-term services and supports (LTSS). The MLTC offers members a benefit package that consists primarily of long term care services traditionally paid for by Medicaid Fee-For- Service. To enroll in the plan, individuals must be eligible for Medicaid and/or Medicare and Medicaid and be:

- Age 18 or older;
 - A resident of Bronx, Brooklyn, Queens, Manhattan;
 - If Medicaid-only eligible for nursing home level of care (as of the time of enrollment) according to the Uniform Assessment System (UAS); and
 - Expected to need care management and long-term care services for more than 120 days from the date of enrollment.
- Medicare Advantage Dual Eligible Special Needs Plans. VillageCareMAX offers two Medicare Advantage Prescription Drug plans for dual eligible individuals. The plans are:
 - VillageCareMAX Medicare Health Advantage, for dual eligible individuals who reside in the service area of Bronx, Brooklyn, Queens, and Manhattan. This plan covers all Medicare Part A, Part B, and Part D services.
 - VillageCareMAX Medicare Total Advantage, for dual eligible individuals who are also nursing home eligible (based on the UAS assessment) and require LTSS for more than 120 days from the date of enrollment. This plan covers all Medicare Part A, Part B, and Part D services, as well as a range of Medicaid covered services including home and community-based long term care services and supports.

GOVERNANCE AND ACCOUNTABILITY

The Board:

VillageCareMAX's Board of Directors (Board), maintains ultimate accountability for oversight of the QI Program. The Board will review and approve the QI Program at least annually. The Board will receive reports on QI activities directly from VillageCareMAX's Medical Director on a regular basis, but no less than quarterly.

Medical Director:

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The VillageCareMAX Medical Director will be responsible for overall supervision of the QI program and its implementation, and for ensuring that the QI program is evaluated, updated, and approved annually.

Assistant Vice President of Quality and Performance Improvement:

The Assistant Vice President will manage the QI Program and its implementation on a day-to-day basis, including ensuring that recommendations of the Quality Assurance Committee (described below) are implemented.

The Assistant Vice President will supervise the staff that conducts quality audits and studies, and will oversee Quality Improvement Projects (QIPs). In addition, the Assistant Vice President will be responsible for:

- Communicating the decisions of the QA Committee to the appropriate personnel in the VillageCareMAX organization;
- Overseeing the implementation of the performance improvement activities approved by the QA Committee;
- Collection and analysis of data necessary to determine the effectiveness of the performance improvement activity;
- Providing the QA Committee with information and analyses to assess the effectiveness of the implemented performance improvement activity;
- Reviewing performance and quality indicators, and the results of studies and audits, with the Medical Director;
- Ensuring that all quality subcommittees meet on a regular basis and accomplish their assigned tasks; and
- Overseeing the Quality Improvement Committee described later in this document.

The Quality Management and Improvement Committee (QMIC):

The Board will appoint a Quality Management and Improvement Committee (Committee) that is responsible for developing the QI Program. The Committee will be made up of the Medical Director, key plan management staff, Compliance Officer, staff from the Quality Assurance (QA) department and key operations areas, and provider representatives. The Committee is led by the Medical Director, in coordination with the Assistant Vice President for Quality and Performance Improvement. Meetings will be held quarterly, and minutes of these meeting will be documented and shared with the Board. Attendance sheets for each Committee meeting will also be maintained.

The Committee will develop and oversee the implementation of the QI program. It will approve the quality goals for the year, and will determine which studies and audits will be conducted. The Committee will review quality and performance indicators, oversee clinical policy and procedure

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development, review the results of quality studies and audits, and make recommendations to improve quality of services and operations based on the information it reviews. This may include revisions to policy or procedures, changes in service delivery, or the formulation of workgroups to look at issues in more depth.

The results of studies and audits, and quality/performance indicators, will be presented to the Committee by the Assistant Vice President or his/her designee, including leaders of operations departments of the health plan. Other VillageCareMAX staff, including Case Management and Provider Relations, will make reports to the Committee on quality related issues identified as the result of day-to-day operations. Workgroups will be assigned to study quality related issues and will also make reports to the Committee, as will representatives of member focus groups which will be formulated to address improved services to members.

In addition to the above, the Committee will review the reports from quality subcommittees (outlined below), and will report a summary of all meetings to the Board of Directors.

Other Quality Improvement Sub-Committees Internal Quality Review Committee (IQRC):

Led by the Assistant Vice President, the Internal Quality Review Committee is a working committee responsible for collecting, analyzing, and integrating data reported to the QMIC. The membership will include but is not limited to Quality Assurance department staff and other VillageCareMAX staff, as needed. The IQRC Committee meets a minimum of eight times per year and ad hoc as needed. Meeting minutes are taken and maintained.

The IQRC Committee:

- Identifies areas of needed quality improvement through analysis of quality indicators, results of quality studies and audits;
- Develops, analyzes, trends, and monitors quality indicators;
- Analyzes the results of Member Satisfaction Surveys and clinical quality improvement programs/ studies/ audits, disenrollment trends, and quality indicators;
- Monitors and evaluates service utilization and appropriateness of care.
- Targets interventions, monitors process improvements, and establishes tracking mechanisms;
- Evaluates the effectiveness of communication to providers and Members;
- Evaluates complaints and appeal data;
- Provides in-depth analysis together with plans of action to affect improvement; and

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- Reports findings of all activities to the QMIC.

Utilization Management Committee:

The Utilization Management Committee is chaired by the Medical Director and includes leadership staff from clinical and business operations, pharmacist, claims staff, data analysts, finance staff, and others as needed. The Utilization Management Committee reviews claims and other data related to service utilization in order to understand patterns of service use, and ensure that appropriate care is provided to the enrolled members. The Committee develops strategies to address over-utilization, under-utilization, high cost members and providers, and other opportunities to better manage care.

Credentialing Committee:

The Credentialing Committee reviews the qualifications of all providers (individuals and companies) that have applied to be included in the VillageCareMAX provider network. In addition to new providers, the committee reviews credentials of all current providers every three years, and it reviews providers that have identified issues or sanctions for potential removal from the provider network. The Committee is led by the Credentialing Manager, and includes the Medical Director, Director of Provider Relations, and other department leaders in VillageCareMAX.

Model of Care Committee:

The Model of Care Committee meets quarterly to review outcomes and care management processes for the VillageCareMAX Medicare Advantage plan. As a special needs plan, VillageCareMAX is required to submit its model of care to CMS for approval, and this committee monitors the implementation and results of the approved model of care. The Committee is chaired by the Assistant Vice President for Quality and Performance Improvement, and includes the Medical Director, Assistant Vice President of Clinical Operations, and other department leaders in VillageCareMAX.

Member Experience Workgroup:

The Member Experience Workgroup is charged with analyzing and improving the ability of members to have high quality interactions with VillageCareMAX. This Committee is chaired by the Vice President for Member Experience and Support Services, and includes Board member and a range of staff from all departments and all levels of the organization, including staff who interact directly with

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members on a daily basis in their jobs at VillageCareMAX. The Committee monitors member level data, conducts surveys, and implements strategies to improve members' experiences with the health plan and member retention.

Member Advisory Committees:

VillageCareMAX will implement one or more Member Advisory Committees, to ensure that enrolled members have input into the policies and practices of VillageCareMAX. The Committees are led by the Manager of Member Services and are comprised of VillageCareMAX members and key VillageCareMAX staff, including the Assistant Vice President of QA and other QA staff. The Member Advisory Committee(s) will provide information on matters of concern to members, including those related to quality of care, access to services, and customer service. The Assistant Vice President will report to the QMIC Committee on activities and feedback from the Member Advisory Committee, and reports from this Committee will also be presented to the Board of Directors. Issues identified will be incorporated into the quality improvement activities of the Plan.

Policy Committee:

The purpose of the VillageCareMAX Policy Committee (VPC) is to guide good practices in policy governance and ensure collaboration and consistency in VillageCareMAX policy development. The VPC will be the collaborative body with the authority to review, and recommend new and significant changes to existing VillageCareMAX policy to the Policy and Procedures Committee and Compliance Officer for final adoption. The Committee is chaired by the Project Coordinator, and includes the AVP of Government Affairs/Compliance Officer and other department leaders in VillageCareMAX.

COMPONENTS OF THE QUALITY ASSURANCE PROGRAM Quality Improvement Activities

To ensure ongoing quality improvement of services, care, and operations, VillageCareMAX will have ongoing quality improvement activities in place. Below, is a description of the planned quality improvement activities:

Health Outcomes and Quality Measures

QA staff will collect and monitor quality indicators that are objective and measurable and that are related to the entire range of services provided by the plan. QA staff will analyze evidence based health outcome measures and will analyze functional status outcome measures at a member specific level, using information derived from claims and data maintained in the Case Management System.

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QA staff will review all grievances and evaluate the impact on the member. QA staff will work with Care Management staff to develop and implement the appropriate intervention for the member, and they will monitor the implementation and outcome, modifying interventions as necessary based on patterns and trends that are observed. QA staff will similarly focus on identifying patterns, trends, and opportunities for improvement based on data collected on reported falls, hospitalizations, and other quality of care issues. Interventions are designed to continuously improve health outcomes.

On a monthly basis, QA staff will compile a Health Outcomes and Quality Measures dashboard which is presented to the IQRC for review. The dashboard will include a range of measures that are reported externally, measures that are monitored in the conduct of quality improvement projects, member services metrics, and the results of clinical audits which focus on implementation of the care plan, care coordination, and quality and appropriateness of care. The QMIC and IQRC (as well as other quality subcommittees) will analyze the reported data, discuss individual interventions, and work with VillageCareMAX staff and providers to implement immediate systemic measures to ensure that member health outcomes and quality of care is maximized.

Access to Care and Services

The adequacy of the provider network will be evaluated on an ongoing basis to ensure that members have access to the care they need. To evaluate adequacy of the provider network, QA staff will conduct a quarterly analysis of complaints filed by members and/or their representatives to identify deficiencies in the provider network. In addition, QA staff will assess compliance with access standards including the length of time to respond to requests for service placement from the plan and the timeliness of receipt of covered services.

The aforementioned information will be reviewed by the QMIC and Credentialing Committee. If the analysis indicates issues with accessing specific providers or services, QA staff will work with the Director of Provider Relations to develop and implement a corrective action plan. This may include adding providers to the network, or working with individual providers to improve their performance. Performance data reported to Provider Relations will be considered during the re-credentialing process.

Member Satisfaction

The QA department will conduct an annual member satisfaction survey. The purpose of the survey will be to measure satisfaction with the health plan and to identify opportunities for improvement. The topics covered by the survey will include satisfaction with Plan Services, Utilization Management, Customer Service, Care Managers, and Provider Relations.

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Quality Improvement Projects

VillageCareMAX is committed to improving the quality of the services delivered to both internal and external customers. To this end, the organization will develop and implement projects designed to increase the plan's ability to improve clinical outcomes, and have productive and satisfying interactions with members and providers. Each year the plan will select one or more clinical area as its focus for improvement project(s). The QMIC Committee will identify these activities through analysis of complaints and appeals, Member satisfaction surveys, provider satisfaction surveys and key business indicators. As required by State and Federal regulation, Quality Improvement Projects may be approved in advance and may include period reporting to regulatory authorities.

Complaints

All complaints, including quality of care complaints, will be recorded in the Care Management System, monitored, tracked and analyzed. A summary by complaint type will be reported to the QMIC Committee. Where issues are identified, the QMIC Committee and other quality sub-committees will develop strategies to improve performance in the area(s) with a high

complaint rate. This may include the formulation of workgroups to look at specific issues, modifications to the provider network, and changes to business practices.

Ensuring Appropriateness of Care

VillageCareMAX will perform various quality improvement activities to evaluate the quality and appropriateness of care. The QA department will conduct audits of the clinical information maintained in the HMA System to ensure that Care Managers implement the plan of care and document, provide and/ or arrange for the appropriate interventions to address identified health risks. The results of these audits will be shared with Care Management staff. Where deficiencies are noted, QA staff will develop strategies to improve performance. This may include re-educating/training staff.

Patient Safety

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Patient safety activities will be conducted by the QA Department and will be reported at the QA Committee meeting. Some of these activities will include identifying, addressing, then tracking and trending of clinical and service complaints to determine rates of patient safety complaints.

Delegation Oversight of Vendors

VillageCareMAX will conduct annual reviews of delegated vendors to evaluate and monitor care provided to members by delegated vendors. Reviews will include, as applicable, customer service, utilization, quality of care, timeliness and appropriateness of notices to members, and compliance with access standards. Delegation oversight of vendors will be conducted by the Delegated Oversight Manager.

REPORTING TO THE STATE

VillageCareMAX will submit periodic reports to the New York State Department of Health in a data format and according to a time schedule required by the Department of Health.

Reports may include but are not limited to information on: availability; accessibility and acceptability of services; enrollment; member demographics; disenrollment; member health and functional status including the Uniform Assessment System (UAS) data set; service utilization; encounter data; member satisfaction; marketing; grievance and appeals; and other data determined by the Department of Health.

IMPLEMENTATION AND ANNUAL REVIEW OF THE QI PROGRAM

The QI Program will be evaluated on an annual basis. Using data maintained in the Care Management System, as well as from other sources, QA staff will prepare the monthly Health Outcomes and Quality Measures dashboard. This data will be reviewed and analyzed by the QMIC and IQRC, which identifies trends, issues, and areas for improvement. Based on the information presented, the QMIC and IQRC Committees will develop strategies to improve performance. These strategies will be implemented by Case Management and operations staff as required, with QA staff providing oversight.

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On an annual basis, the QA Committee will review quality performance for the year, will recommend changes to the QI Program based on performance indicators and other studies, and will set QI priorities for the year. The Assistant Vice President for Quality and Performance Improvement, working with the plan's Medical Director, will revise the QI Program accordingly. The annual plan will be submitted to the Board for approval.

On an annual basis, the Medical Director will provide the Board with a formal evaluation of the QI Program and associated activities. The report will provide the Board with detailed information on studies and internal quality improvement activities.

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	Quality Assurance and Performance Improvement Work Plan Calendar Year 2018
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Reviewed/Approved					
Date:	_____	By:	_____	Title:	_____
Date:	_____	By:	_____	Title:	_____
Date:	_____	By:	_____	Title:	_____

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Quality Related Committees						
#	Plan	Committee Name	Description	Responsible Party	Meeting Frequency	Comments
1	MLTC, MEDICARE	Quality Management and Improvement Committee (QMIC)	Develop and oversee the quarterly progress of the Quality Improvement program. It will approve the quality goals for the year, and will determine which studies and audits will be conducted. The Committee will review quality and performance indicators, including HEDIS, HOS and CAHPS data as required, including any data related to behavioral health, care coordination transitions, LTSS and/or utilization data, oversee clinical policy and procedure development, review the results of quality studies and audits, and makes recommendations to improve quality of services and operations based on the information it reviews. QMIC reviews minutes from all quality subcommittees, and provides reports to Board of Directors.	Senior Medical Director and AVP, Quality Management and Performance Improvement	Quarterly	
2	MEDICARE	Model of Care Oversight Committee	The Model of Care Committee meets quarterly to review outcomes and care management processes for the VillageCareMAX Medicare Advantage plan. As a special needs plan, VillageCareMAX is required to submit its model of care to CMS for approval, and this committee monitors the implementation and results of the approved model of care. The Committee is chaired by the Assistant Vice President of Quality Management and Performance Improvement, and includes the Senior Medical Director, Assistant Vice President of Clinical	AVP, Quality Management and Performance Improvement	Quarterly	

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Quality Related Committees						
#	Plan	Committee Name	Description	Responsible Party	Meeting Frequency	Comments
			Operations, and other department leaders in VillageCareMAX.			
3	MLTC, MEDICARE	Utilization Management Committee	The Utilization Management Committee is chaired by the Senior Medical Director and includes leadership staff from clinical and business operations, pharmacist, claims staff, data analysts, finance staff, and others as needed. The Utilization Management Committee reviews claims and other data related to service utilization in order to understand patterns of service use, and ensure that appropriate care is provided to the enrolled members. The Committee develops strategies to address over-utilization, under-utilization, high cost members and providers, and other opportunities to better manage care.	Senior Medical Director and AVP, Clinical Operations and Utilization Management	Quarterly	
4	MLTC, MEDICARE	Credentialing Committee	The Credentialing Committee reviews the qualifications of all providers (individuals and companies) that have applied to be included in the VillageCareMAX provider network. In addition to new providers, the committee reviews credentials of all current providers every three years, and it reviews providers that have identified issues or sanctions for potential removal from the provider network. The Committee is led by the Credentialing Manager, and includes the Senior Medical Director, Director of Provider Relations, and other department leaders in VillageCareMAX.	Credentialing Manager and Senior Medical Director	Monthly	

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Quality Related Committees						
#	Plan	Committee Name	Description	Responsible Party	Meeting Frequency	Comments
5	MLTC, MEDICARE	Member Advisory/Experience Committee	VillageCareMAX will implement one or more Member Advisory/Experience Committees, to ensure that enrolled members have input into the policies and practices of VillageCareMAX. The Committees are chaired by the Vice President for Member Experience and Support Services, and includes a Board member and a range of staff from all departments and all levels of the organization, including staff who interact directly with members on a daily basis in their jobs at VillageCareMAX. The Member Advisory/Experience Committee(s) will provide information on matters of concern to members, including those related to quality of care, access to services, and customer service. The Vice President of Member Experience & Support Services will report to the QMIC on activities and feedback from the Member Advisory Committee, and reports from this Committee will also be presented to the Board of Directors. Issues identified will be incorporated into the quality improvement activities of the Plan.	Vice President of Member Experience & Support Services	Quarterly (MLTC, Medicare)	

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Key Performance Indicators for QM Board Scorecard												
#	Plan	MLTC		MEDICARE	Domain	Metric/Indicator	Description	Methodology		Measurement Frequency	2018 Target	Source
		CONSUMER STAR RATING	QUALITY INCENTIVE	STAR RATING				Numerator	Denominator			
1	MLTC	☐	☐	☐	Prevention	Influenza Vaccination	Percentage of members who received an influenza vaccination in the last year	Members who received an influenza vaccine in the last year	All members	Monthly	84%	UAS
2	MLTC	☐			Prevention	Pneumococcal Vaccination	Percentage of members age 65 or older, who received a pneumococcal vaccination in the last five years or after age 65	Members age 65 or older who received a pneumococcal vaccine in the last 5 years or after age 65	All members age 65 and over	Monthly	80%	UAS

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3	MLTC	☐			Prevention	Dental Exam	Percentage of members who received a dental exam in the last year	Members who received a dental exam in the last year	All members	Monthly	65%	UAS
4	MLTC	☐			Prevention	Eye Exam	Percentage of members who received an eye exam in the last year	Members who received an eye exam in the last year	All members	Monthly	85%	UAS
5	MLTC	☐			Prevention	Hearing Exam	Percentage of members who received a hearing exam in the last two years	Members who received a hearing exam in the last two years	All members	Monthly	51%	UAS
6	MLTC	☐			Prevention	Mammogram	Percentage of female members ages 50-74, who received a mammogram or breast exam in the last two years	Female members ages 50-74 who received a mammogram or breast exam in the last 2 years	All female members ages 50-74	Monthly	80%	UAS
7	MLTC	☐	☐	☐	Patient Safety	No Falls Resulting in	Risk-adjusted	Members who did not have falls that	All members	Monthly	96%	UAS

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						Medical Intervention	percentage of members who did not have falls that required medical intervention in the last 90 days	required medical intervention in the last 90 days				
8	MLTC	☐	☐	☐	Patient Safety	No Emergency Room Visits	Risk-adjusted percentage of members who did not have an emergency room visit in the last 90 days	Members who did not have an emergency room visit in the last 90 days (or since last assessment if less than 90 days)	All members	Monthly	95%	UAS
9	MLTC	☐	☐	☐	Quality of Life	Not Lonely and Distressed	Risk-adjusted percentage of members who were not lonely or were not distressed	Members who were not lonely or did not experience any of the following: decline in social activities, eight or more hours alone during the day, major life stressors, self-reported depression, or	All members	Monthly	95%	UAS

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								withdrawal from activities				
10	MLTC	☐	☐	☐	Uncontrolled Pain	Pain Controlled	Risk-adjusted percentage of members who did not experience uncontrolled pain	Members who did not experience uncontrolled pain	All members	Monthly	95%	UAS
11	MLTC	☐	☐	☐	ADL Stable or Improved	ADL Stable or Improved	Risk-adjusted percentage of members who remained stable or demonstrated improvement in ADL function	Members who remained stable or demonstrated improvement in ADL function	All members	Monthly	91%	UAS
12	MLTC	☐	☐	☐	Pain Intensity Stable/Improved	Pain Intensity Stable or Improved	Risk-adjusted percentage of members who remained stable or demonstrated	Members who remained stable or demonstrated improvement in pain intensity	All members	Monthly	92%	UAS

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							improvement in pain intensity					
13	MLTC	☐	☐	☐	Urinary Continence	Urinary Continence Stable or Improved	Risk-adjusted percentage of members who remained stable or demonstrated improvement in urinary continence	Members who remained stable or demonstrated improvement in urinary continence	All members	Monthly	80%	UAS
14	MLTC	☐	☐	☐	Shortness of Breath	Shortness of Breath Stable or Improved	Risk-adjusted percentage of members who remained stable or demonstrated improvement in shortness of breath	Members who remained stable or demonstrated improvement in shortness of breath	All members	Monthly	94%	UAS
15	MLTC		☐	☐	Quality	NFLOC score stable or Improved	Risk-adjusted percentage of members who	Members who remained stable or demonstrated improvement in NFLOC score	All members	Monthly	90%	UAS

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							remained stable or demonstrated improvement in NFLOC score					
16	MLTC	☐	☐	☐	Satisfaction	Plan of care	Percentage of members who responded that they were usually or always involved in making decisions about their plan of care	Members who responded that they were usually or always involved in making decisions about their plan of care	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	83%	Internal Satisfaction Survey
17	MLTC	☐	☐	☐	Satisfaction	Advance Directive Planning	Percentage of members who responded that a health plan representative talked to them about appointing someone to make decisions	Members who responded that a health plan representative talked to them about appointing someone to make decisions about their health if they are unable to do so	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	86%	Internal Satisfaction Survey

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							about their health if they are unable to do so					
18	MLTC		☐	☐	Satisfaction	Management of Illnesses	Percentage of members who rated their MLTC plan in assisting with the management of their illnesses as good or excellent	Members who rated their MLTC plan in assisting with the management of their illnesses as good or excellent	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	88%	Internal Satisfaction Survey
19	MLTC	☐	☐	☐	Satisfaction	Timeliness of HHA/PCA	Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time	Members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	98%	Internal Satisfaction Survey

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20	MLTC	☐	☐	☐	Satisfaction	Quality of Aide	Percentage of members who rated their aide as good or excellent	Members who rated their aide as good or excellent	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	98%	Internal Satisfaction Survey
21	MLTC	☐	☐	☐	Satisfaction	Quality of Care manager	Percentage of members who rated the care manager within the last 6 months as good or excellent	Members who rated the care manager within the last 6 months as good or excellent	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	92%	Internal Satisfaction Survey
22	MLTC	☐	☐	☐	Satisfaction	Quality of Visiting Nurse	Percentage of members who rated the visiting nurse within the last 6 months as good or excellent	Members who rated the visiting nurse within the last 6 months as good or excellent	Sample of members continuously enrolled in a MLTC plan for a minimum of 6 months	Quarterly, begin survey in 2018 Q2	91%	Internal Satisfaction Survey
23	MLTC	☐	☐	☐	Satisfaction	Quality of Health Plan	Percentage of members who rated their MLTC plan as	Members who rated their MLTC plan as good or excellent	Sample of members continuously enrolled in a MLTC plan for a	Quarterly, begin survey in 2018 Q2	89%	Internal Satisfaction Survey

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							good or excellent		minimum of 6 months			
24	MEDICARE			☐	Care Management	HRA's completed within 90 days in compliance with CMS standards and requirements, timely and accurate.	HRA's completed within 90 days in compliance with CMS standards and requirements, timely and accurate.	Members whose HRA completed within 90 days of enrollment (<90) or members with reassessment done 90 days before or after enrollment	All members in numerator and members who were continuously enrolled for at least 90 days	Monthly	$\geq 74.2\%$	eCare IRAD (Internal Reporting Tool)
25	MEDICARE			☐	Care Management	Medication Adherence for Diabetes Medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking	18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT) inhibitors. This	Number of member-years of enrolled beneficiaries 18 years and older with at least two fills of medication(s) across any of the drug classes during the measurement period (denominator)	Monthly (results are cumulative)	$\geq 79\%$	Prescription Drug Event (PDE) data

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							the medication.	percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period (numerator)				
26	MEDICARE			☐	Care Management	Medication Adherence for Hypertension (RAS antagonists)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time	Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct	Number of member-years of enrolled beneficiaries 18 years and older with at least two fills of either the same medication or medications in the drug class during the measurement period	Monthly (results are cumulative)	≥ 79%	Prescription Drug Event (PDE) data

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							they are supposed to be taking the medication.	renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period (numerator)				
27	MEDICARE			☐	Care Management	Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to	Number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement	The number of member-years of enrolled beneficiaries 18 years and older with at least two fills of either the same medication or medication in the drug class during the	Monthly (results are cumulative)	≥ 77%	Prescription Drug Event (PDE) data

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							cover 80% or more of the time they are supposed to be taking the medication.	period (numerator)	measurement period (denominator)			
28	MEDICARE			☐	Care Management	Plan All-Cause Readmissions (Lower is better)	Percent of senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 65 years of age and older using the following formula to control for differences in the case mix of patients across different contracts	All members ages 18 and older discharged from hospital	Monthly	≤ 10%	Claims

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
1	MLTC /MEDICARE	Satisfaction	Grievances/Quality of Care	· Number of grievances per month · Number of grievances per thousand · Number of same day & standard grievances · % of same-day grievances & of standard grievances · % of standard grievances substantiated · % of grievances processed timely · Grievances by reason, category, provider type, and provider · LHCSA Rate = (substantiated grievances/members served) per LHCSA · % of closed grievances · Timely notification sent · Average Days for Notification	Quarterly	VCMAX Grievance Data via Ecare

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
2	MLTC /MEDICARE	Member Services	Call Center Productivity	Member services measures include: · # of calls received per month · % of calls answered within 30 seconds · Abandonment Rate · Average speed of answer	Quarterly	VCMAX Data From ACD
3	MLTC /MEDICARE	Member services	Call Handling Audit	Member services measures include: · Introduction, · Confirm Demographics · HIPPA · Accuracy of Information · Tone, · Time Placing Called on Hold · Notes Entered in E-CARE · Offering to Take Message · Call Resolution · Closing	Quarterly	Review of Recorded Calls from MSRs

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
4	MLTC /MEDICARE	Disenrollment	Disenrollment Rates	Overall disenrollment rate	Quarterly	VCMAX administrative data
5	MLTC /MEDICARE	Effective Care Management	Rate of timely outreach to new members	Percent of members who received an introductory call from the care manager within 5 business days of enrollment	Quarterly	Sample of care management records
6	MLTC /MEDICARE	Effective Care Management	Rate of Plan ensures that the members plans of care reflects member needs and individualized for member needs	Percent of members where the assessment and plan of care are aligned	Quarterly	Sample of care management records

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
7	MLTC /MEDICARE	Effective Care Management	Rate of timely and high quality care manager visits and contacts	Percent of members who received monthly contacts, consistent with care management standards. Care management contacts include: · evidence that the care manager reviews PCA services and/or other items from the care plan with the member · evidence that the care manager reviews medications with the member · evidence that any issues identified are promptly addressed · evidence that service requests are processed timely, with appropriate notice to members	Quarterly	Sample of care management records
8	MLTC /MEDICARE	Effective Care Management	Completion of ICT meetings	Percent of members with a care planning meeting completed on schedule with the appropriate participants	Quarterly	Sample of care management records
9	MLTC /MEDICARE	Care Transitions	Rate of Participation in Discharge Planning	Percent with evidence of participation in discharge planning after a member has been admitted for care	Quarterly	Sample of care management records

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
10	MLTC /MEDICARE	Care Transitions	Care transition record transmitted to health care professional	Percent of members with records that show discharge planning documentation has been shared with the member's provider(s)	Quarterly	Sample of care management records
11	MLTC /MEDICARE	Effective Care Management	Completion of re-assessment on schedule	Percentage of members whose reassessment completed timely	Quarterly	UAS
12	MEDICARE	Care Management	HRA's completed within 90 days in compliance with CMS standards and requirements, timely and accurate	Members whose HRA completed within 90 days of enrollment (<90) or members with reassessment done 90 days before or after enrollment	Quarterly	Compliance Dashboard
13	MEDICARE	Care Management	Number of Care Plans documented within 90 days of initial HRA date	Members whose Care Plan was documented within 90 days of initial HRA date or UAS date	Quarterly	eCare IRAD
14	MEDICARE	Care Management	Service requests processed timely, including notice to Member	Auths processed within 14 calendar days from receipt date (72 hours for expedited)	Quarterly	Compliance Dashboard

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
15	MEDICARE	Care Management	Completed Medication Reconciliation Review at ICT meetings	All members (age 66 years old and older and were continuously enrolled for one year with enrollment gap of no more than 45 days) who had at least one medication review in a year by doctor or pharmacist	Quarterly	eCare (Note Type)
16	MEDICARE	Care Management	Medication Adherence for Diabetes Medications	18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT) inhibitors. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period.	Quarterly	Prescription Drug Event (PDE) data

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
24	MEDICARE	Care Management	Medication Adherence for Hypertension (RAS antagonists)	Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications. This percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for RAS antagonist medications during the measurement period.	Quarterly	Prescription Drug Event (PDE) data
25	MEDICARE	Care Management	Medication Adherence for Cholesterol (Statins)	Number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period (numerator)	Quarterly	Prescription Drug Event (PDE) data
26	MEDICARE	Grievances & Appeals	Complaints about the Health Plan (Part C and D) Per 1000 members	Rate of complaints about the health plan per 1,000 members.	Quarterly	Complaints Tracking Module

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
27	MEDICARE	Grievances & Appeals	Members Choosing to Leave the Plan (Part C and D)	The number of members who chose to leave the plan based on disenrollment reason codes in Medicare's enrollment system.	Quarterly	Medicare Beneficiary Database Suite of Systems (MBDSS)
28	MEDICARE	Grievances & Appeals	Beneficiary Access and Performance Problems (BAPP)	Based on CMS' sanctions, civil money penalties (CMP) as well as Compliance Activity Module (CAM) data. This includes: notices of non-compliance, warning letters {with or without business plan}, and ad-hoc corrective action plans (CAP) and the CAP severity.	Quarterly	Compliance Activity Module (CAM) in HPMS (Monitoring-Compliance Activity)
29	MEDICARE	Grievances & Appeals	Total Received Appeals	Total # of Appeals	Quarterly	Appeals Tracker
30	MEDICARE	Grievances & Appeals	Timely Resolution of Appeals within 14 days. (Internal tracking)	Appeals closed within 14 calendar days of receipt date	Quarterly	Appeals Tracker

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
31	MEDICARE	Grievances & Appeals	IRE - Appeals Timely Decisions (external report)	Numerator = Number of timely appeals Denominator = ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) * 100	Quarterly	MAXIMUS Website
32	MEDICARE	Grievances & Appeals	Appeals Auto-forwarded to IRE - Appeals auto-forward (external quarterly report) Part D	[Total number of cases auto-forwarded to the IRE/average medicare part d enrollment]*10000	Quarterly	Independent Review Entity(IRE)/Appeals Tracker
33	MEDICARE	Grievances & Appeals	Appeals Auto-forwarded to IRE - Appeals Upheld (external quarterly report) Part D	[Number of cases upheld/Total number of cases reviewed]*100	Quarterly	Independent Review Entity(IRE)/Appeals Tracker
34	MEDICARE	Disenrollment Rate	Rapid Disenrollment Rate (90 Days)	All member dis-enrolled within 90 days of enrollment for given month	Quarterly	Disenrollment Data

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Key Performance Indicators for Internal Scorecard

#	Plan	Domain	Metric/Indicator	Description	Reporting Frequency	Source
35	MEDICARE	Other	Plan All-Cause Readmissions (Lower is better)	Senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	Quarterly	HEDIS
36	MEDICARE	Other	Call Center – Foreign Language Interpreter and TTY Availability	The number of successful contacts with the interpreter and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part C benefit	Quarterly	HPMS Performance Page- Call Center reports

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Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
1	MLTC	Senior Medical Director AVP, Quality Management and Performance Improvement AVP, Clinical Operations and Utilization Management Vice President of Member Experience & Support Services	Externally Reported Measures (Quality Incentive and Star Measures)	Continue to evaluate the plan's results on externally reported measures and to test the rapid deployment of strategies aimed at specific measures, based on identified opportunities. Examples include but are not limited to: • Continued focus on urinary incontinence • Continued focus on effective pain management • Continued focus on members who experience shortness of breath • Continued focus on members who are lonely and distressed • Continued focus on advance directives • Continued administration of member incentive program, focused on completion of preventive services • New focus on members who did not remain stable or demonstrated improvement in activities of daily living (ADL) • New focus, based on results of state-administered member satisfaction survey	Ongoing, to be reported quarterly	Projects may be updated during the year, based on observed VCMAX results and/or the introduction of new state measures.

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Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
2	MEDI CARE	Senior Medical Director AVP, Quality Management and Performance Improvement AVP, Clinical Operations and Utilization Management Vice President of Member Experience & Support Services VP, Operations Director, Medicare	Externally Reported Measures (Medicare STARS)	• Develop strategy for addressing and improving gaps in care for Medicare members. • Identify and work with a consultant to provide guidance in developing this strategy.	Ongoing, to be reported quarterly	
3	MEDI CARE	AVP, Quality Management and Performance Improvement Director, Medicare	Healthcare Effectiveness Data and Information Set (HEDIS)	• Manage all aspects of Healthcare Effectiveness Data and Information Set (HEDIS) reporting to CMS • Identify areas for improvement in HEDIS data submission process, and modify process for subsequent year's reporting.	Ongoing, to be reported by June 15th 2018	Regulatory Requirement
4	MEDI CARE	AVP, Clinical Operations and Utilization Management AVP, Quality Management and Performance	Risk Score Integrity	• Develop strategy for monitoring diagnoses data for Medicare members (HCC scores), and ensure that VCMAX has collects and reports data on all member health conditions. • Identify and work with a consultant to provide guidance in developing this strategy.	Ongoing, to be reported quarterly	

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Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
		Improvement Director, Medicare Senior Medical Director				
5	MLTC	Senior Medical Director AVP, Quality Management and Performance Improvement AVP, Clinical Operations and Utilization Management VP, Operations	Risk Score Integrity	Focused on improving risk score via accurate Uniform Assessment System (UAS) completion. Continue to focus on interventions included but not limited to; • Mandatory Usage of Analyzer for all internal staff and vendors • Conduct Risk Score training (Annual, quarterly refresh, new hire training) • Continue to collaborate to ensure consistent practices across the board and ensuring that "best practices" are adopted between Care Management and Enrollment. • Care Management Oversight of Assessments. Review all Analyzer suggestions and outreach each individual Nurse Assessor to ensure the assessments are completed and accurate. • Decrease the number of vendors we use for assessment to improve oversight.	Ongoing, to be reported quarterly	

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Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
6	MLTC	Director, Provider Relations Director, Provider Network Contracting AVP, Quality Management and Performance Improvement Chief Information Officer, IT	Value Based Model/Providers Performance Monitoring and Improvement	• Build a common platform that will provide a single data source to enable analytics for all core functions, as well as inform member and provider engagement, could help to drive greater efficiencies between functional teams. • Implement new Value Base Model (VBP) scorecard for Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Care Agencies (CHHAs), and Nursing Homes. • Include Gaps in Care Report with the provider report cards. • Design improvement strategies for specific providers or provider types, if trends are identified in performance. • Increase provider outreach and education (FAQ, workshops and Webinars) around the changes for VBP and quality improvement.	Ongoing, to be reported quarterly	Regulatory Requirement

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Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
7	MLTC , MEDI CARE	Chief Information Officer, IT Vice President of Member Experience & Support Services AVP, Clinical Operations and Utilization Management	Collect Clinical Regional Health Information Organization (RHIO) Data	• Collect clinical Regional Health Information Organization (RHIO) data for the purpose of improving member health and coordination of care. This requires securing member consent for VCMAX to access their data from multiple data sources and encounters. • Set up infrastructure to receive real-time notifications to care team about clinical events (e.g. hospital discharges, ER visits, etc.), and facilitate the management of patients, especially those with chronic diseases. • Develop internal care management processes to respond to notifications, in order to ensure smooth transitions between sites of care and use the data in care planning.	Ongoing, to be reported quarterly	Healthix is the largest RHIO in New York State.
8	MLTC , MEDI CARE	Vice President of Member Experience & Support Services Director, Grievance & Appeals	Grievances/Quality of Care	• Integrate grievance investigation and resolution into member services, and identify ways to streamline processes to improve member experience. • Investigate and review all potential clinical quality issues specific to individual providers to ensure member safety and identify areas for improvement.	Ongoing, to be reported quarterly	

[Appendix 5](#)



Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
9	MLTC	Senior Medical Director AVP, Quality Management and Performance Improvement	Performance Improvement Project (PIP) Advance Directives	Focused on increasing the rate of advance directive planning discussions and improving the rate of completion and procurement of advance directive documents.	Annual	Report due to IPRO by January 31, 2018. Regulatory Requirement
10	MEDI CARE	Senior Medical Director AVP, Quality Management and Performance Improvement Director, Medicare	Quality Improvement Project (QIP) Depression	- Improving the Identification, Diagnosis and Treatment of Depression Through Effective Communication and Coordination of Care. Planned Interventions are; - Medication Adherence - Care Coordination - Enrollee Outreach - Enrollee/Caregiver Engagement - Plan Outreach to Providers - Disease Management (promotion of compliance with treatment plan)	Annual	Regulatory Requirement

[Appendix 5](#)



Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
13	MEDI CARE	Senior Medical Director AVP, Quality Management Director, Medicare	Chronice Care Improvement Project (CCIP) Congestive Heart Failure	• Focused on reduction in Hospitalization for Congestive Heart Failure Planned Interventions are; 1) Education of Care Managers on disease management/lifestyle changes 2) Enrollee Education and Outreach 3) Care Coordination 4) Enrollee Engagement 5) Medication compliance initiative	Annual	Regulatory Requirement
14	MLTC	AVP, Quality Management and Performance Improvement Vice President of Member Experience & Support Services	VCMAX Internal Member Satisfaction Survey	• Review results from State DOH 2017 MLTC Member Satisfaction Survey; identify opportunities for improvement. • Conduct internal survey through vendor in addition to the biannual survey conducted by the SDOH, to gauge areas of improvement. • Implement interventions aimed at improving satisfaction.	Quarterly, begin survey in 2018 Q2	

[Appendix 5](#)



Quality Improvement Projects, Activities and Surveys

#	Plan	Responsible Discipline	Project/Activity Type	Description	Reporting Frequency	Comments
15	MEDI CARE	AVP, Quality Management and Performance Improvement Vice President of Member Experience & Support Services Director, Medicare	VCMAX Internal Satisfaction Survey	Conduct internal survey through vendor to gauge areas of improvement. Implement interventions aimed at improving satisfaction.	Annual, begin survey in September 2018	
16	MEDI CARE	AVP, Quality Management and Performance Improvement VP, Business Operations Director, Medicare	CMS Health Outcomes Survey (HOS)	Conduct internal survey through vendor to gather valid and reliable clinically meaningful data. Implement interventions aimed at improving Medicare members Health Outcomes.	Annual	Regulatory Requirement

[Appendix 6](#)

Appendix 6: Clinical Practice Guidelines

Clinical Practice Guidelines



Clinical Practice Guidelines

Conditions	Clinical Practice Guidelines	Source
Respiratory		
Asthma	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma: August 28, 2007	National Heart, Lung and Blood Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/guidelines/01_front.pdf
Chronic Obstructive Pulmonary	*COPD Essentials for Health Professionals	National Heart, Lung and Blood Institute/National Institutes of Health

[Appendix 6](#)

Conditions	Clinical Practice Guidelines	Source
Disease (COPD)	NIH Publication No. 07-5845 Reprinted October 2011	http://www.healthywomen.org/condition/chronic-obstructive-pulmonary-disease-copd
Treating Tobacco Use & Dependence	Treating Tobacco Use and Dependence 2008 Update	Treating Tobacco Use and Dependence: 2008 Update http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf
Cardiovascular		
Chronic Stable Coronary Artery Disease	American College of Cardiology Foundation (ACCF) American Heart Association (AHA) Physician Consortium for Performance Improvement® (PCPI™) ACCF, AHA, PCPI Approved January 2011	American Medical Association http://www.circ.ahajournals.org/content/125/19/2382.full.pdf

Appendix 6

Conditions	Clinical Practice Guidelines	Source
Congestive Heart Failure (CHF)	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adult	American College of Cardiology http://circ.ahajournals.org/content/119/14/e391.full.pdf
Coronary Heart Disease (CHD)	AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update: Endorsed by the National Heart, Lung, and Blood Institute	American Heart Association http://circ.ahajournals.org/content/113/19/2363.full.pdf+html
Hyperlipidemia	Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection,	National Heart, Lung and Blood Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/resources/heart/atp3full.pdf

[Appendix 6](#)

Conditions	Clinical Practice Guidelines	Source
	Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) – 2004	
Hypertension	National High Blood Pressure Education Program – The Seventh Report of the Joint National Committee on Prevention Detection, Evaluation, and Treatment of High Blood Pressure – 2004	National Heart, Lung and Blood Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf
Endocrine		
Diabetes	Standards of Medical Care in Diabetes - 2011	American Diabetes Association http://care.diabetesjournals.org/content/34/Supplement_1/S11.long
Mental Health		

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Conditions	Clinical Practice Guidelines	Source
Depression	Treatment of Patients with Major Depressive Disorder, Third - Edition May 2010	American Psychiatric Association http://psychiatryonline.org/data/Books/prac/PG_Depression3rdEd.pdf
Psychiatric Disorders	American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders	American Psychiatric Association Practice Guidelines http://www.psychiatry.org/practice/clinical-practice-guidelines
Preventive and Screening Guidelines		
Preventive Screening Guidelines	Guide to Clinical Preventive Services, 2014, Recommendations of the U.S. Preventive Services Task Force	http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/cpsguide.pdf
Eye Examinations	Recommended Eye Examination Frequency for Adult Patients and	American Optometric Association http://www.aoa.org/documents/CPG-1.pdf

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Conditions	Clinical Practice Guidelines	Source
	Comprehensive Adult Eye and Vision Examination: Revised April 2005 (2nd edition)	
Sexually Transmitted Diseases		
STD	Guidelines for Treatment of Sexually Transmitted Diseases: December 2010 *New York City STD Treatment Guidelines Table for Adults and Adolescents; updated 2011	Centers For Disease Control and Prevention http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf New York City Department of Health & Mental Hygiene http://www.nyc.gov/html/doh/downloads/pdf/std/treat-gl-table.pdf
HIV	Primary Care Approach To The HIV-Infected Patient;	New York State Department of Health AIDS Institute

Appendix 6

Conditions	Clinical Practice Guidelines	Source
	updated April 2011 *New York City STD Treatment Guidelines Table for Adults & Adolescents, updated 2011	http://www.hivguidelines.org/wp-content/uploads/2014/01/primary-care-approach-to-the-hiv-infected-patient.pdf New York City Department of Health & Mental Hygiene http://www.nyc.gov/html/doh/downloads/pdf/std/treat-gl-table.pdf
Low Back Pain		
Low Back Pain	Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society; October 2007	American College of Physicians http://www.aafp.org/afp/2008/0601/p1607.html
Osteoporosis		

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Conditions	Clinical Practice Guidelines	Source
Osteoporosis	Osteoporosis, diagnosis and treatment of: July 2013, 8th Edition	Institute for Clinical System Improvement Diagnosis and Treatment of Osteoporosis
Urinary Incontinence		
Urinary Incontinence	Diagnosis and Treatment of Overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline. 2014 by the American Urological Association	American Urological Association American Urological Association – Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline Agency for Health Care Policy and Research - Urinary Incontinence in Adults: Clinical Practice Guideline Update
Obesity & Weight Management		
Obesity	2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American	American Heart Association http://jaccjacc.cardiosource.com/acc_documents/2013_FULL_Guideline_Obesity.pdf

[Appendix 6](#)

Conditions	Clinical Practice Guidelines	Source
	College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society	

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Appendix 7: LHCSA Operational Guidelines



VillageCareMAX

LHCSA OPERATIONAL GUIDELINES

Introduction:

At VillageCareMAX, we want to work collaboratively with our LHCSA partners to be sure our Members get the best care at all times. As the MLTC plan responsible for coordinating each Member's care, we realize this requires consistent ongoing communication. We sometimes deal with challenging situations; by working together, we can meet our Member's needs and keep them satisfied with the program, safe in the community. The goal of this booklet is to outline a framework for how we will work together to ensure that our Members receive the highest quality care. In general:

- All services based on the LHCSA's plan of care. The types of services provided is based on a comprehensive assessment, which includes an evaluation of personal care tasks that the Member needs assistance with. It is important to keep the plan of care updated so it matches the Member's health care needs.
- The LHCSA will receive an authorization from VillageCareMAX, outlining the days of coverage and number of hours to be covered.
- Each LHCSA is expected to maintain all required documentation, consistent with its regulations and best practices. This includes for each Member, but is not limited to:

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- Assessment
- Plan of care
- Physician orders
- Evidence of PCA/HHA supervision
- Duty sheets outlining the work that is performed. (Note: for split shift cases, each PCA/HHA must keep a duty sheet.)
- Human resources records, consistent with DOH regulation.
- All communication with the Case Manager, Care Coordinator, Member, family Members, aides, and anyone else involved in providing care for the VillageCareMAX Members must be carefully documented -- who did you speak to, at what time and date, what was communicated, what are the follow-up tasks, etc. Each person creating the documentation must sign, initial, date the entry.
- If you have questions at any time, please feel free to call us. Our staff are in the office from 8:30 to 6:00 p.m. Monday through Friday, and staff are on call at all times when the office is closed. Please contact us:
 - By Phone: 800-469-6292
 - By Fax: 212-337-5711
 - By EMAIL: faxgroup@villagecare.org
- Effective March 1, 2019, authorizations will no longer be required for the following:
 - Schedule changes of one of two days. **Adjustment requests (i.e. change in days (Mon to Tues/Wed to Thurs) and change in Aide are no longer required.**
 - Notification of no service to the member
 - Notification of vacations
 - If the member is hospitalized, the current LTSS authorization will **NOT** be end-dated
 - VillageCareMAX will no longer send cancellation of services for disenrolled members. We encourage providers to verify eligibility via ePaces to ensure continuity of care or disenrollment status

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Provider Requirements:

- As a reminder, providers are required to notify VillageCareMAX with no expectation to receive a corrected authorization when:
- Member is hospitalized
- There is identification of a clinical issue of serious concern
- Change in member status
- Member is out of service area
- Refusal of service
- Inability to access members home
- Inability to provide service for **any** reason

Providers are also required to:

- Communicate verbally and in writing regarding the nature and extent of services provided to the member and the member's progress and status.
- Submit incident reports to VillageCareMAX within 10 working days of request
- Communicate to VillageCareMAX any complaint made by or on behalf of the member

For any questions related to authorization inquiries and claims issues, please contact Provider Services at (855) 769-2500.

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	Topic	LHCSA Guidelines	Contact
1.	Member Information Changes	Licensed agency should contact Member Services for each of the following related changes. We will update our records. • Permanent change in the Member's address • Change in the Member's telephone number	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org
2.	Schedule Changes	Temporary changes in time of day of service or temporary changes in scheduled service days: • Licensed agency should notify the Member of the change at least one day in advance, by 3:00 p.m. • Licensed agency to notify Member Services of all temporary changes one day in advance. • Licensed agency should update their system as appropriate. Permanent changes in time of day of service or permanent changes in scheduled service days: • If a Member requests a permanent change in service (either a change in time of day or a change in scheduled days), the licensed agency must notify the Member at least one day in advance of when the change will be implemented. • Licensed agency to notify Member Services of all temporary changes one day in advance. • Licensed agency should update their system as appropriate.	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
		If the Member requests an increase of decrease in services: • Licensed agency should inform the Member that requests need to be approved by VillageCareMAX. • Licensed agency should contact Member Services to inform us of the request, but VillageCareMAX must also receive the request from the Member. The Care Manager will be contacted and will follow up.	
3.	Changes in Clinical Condition and Plan of Care	General: • The paraprofessional should report any changes in the Member's clinical condition or issues/problems in following the Plan of Care directly to his/her agency that will, in turn, report to VillageCareMAX Member Services immediately. Examples of situations that should be reported include but are not limited to: ○ changes in skin integrity, such as blisters, skin tears, bruising or development of decubitus ulcers ○ falls ○ changes in mental status ○ changes in Member's intake, such as Member refusing food or liquids ○ any emergency situations (see below) In an emergency:	By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
		• In emergent situations observed by a home health aide or other paraprofessional in the home, in which no professional staff, family Member/significant other is available, the home health aide should immediately call the Supervisor at their employing agency who will either direct the person in the home to call 911 or will call 911 for them, based upon an evaluation of the situation. • The HHA or paraprofessional in the home will be instructed to remain with the Member, provide appropriate care during that time which he/she is trained and competent to provide, protect the Member from harm and report back to the agency. • When a Member is hospitalized before or during the paraprofessional's shift, the paraprofessional or the licensed agency coordinator must notify Member Services of this change in clinical status as soon as they are aware of the admission. In addition, the licensed agency coordinator must also report the hospitalization to discharge the service. (See Section 4 below for more information.)	By PHONE 800-469-6292
4.	Member Hospitalized, Relocated Out Of Service Area or Died	• Paraprofessional will notify licensed agency immediately. • Licensed agency will notify Member Services immediately. Agency should provide as much information as is available (e.g., the name of the hospital, time of transport to the hospital, if the Member was accompanied by someone, if the Member was admitted or in the Emergency Room, etc.)	By PHONE 800-469-6292

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[illegible]

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	Topic	LHCSA Guidelines	Contact
		provided with the name of the new aide and when he/she will start work in the home.	
6.	No Shows and Coverage Problems	As soon as the licensed agency becomes aware that an aide has not reported to a Member's home at the scheduled time: • The licensed agency must immediately contact the Member to discuss whether or not a replacement aide is needed. • If a replacement aide is needed, the licensed agency should send a replacement aide and notify the Member of the aide's name and approximate arrival time. • Licensed agency should notify the Member Services immediately of the decision and what time the aide should arrive at the Member's home if the Member is requesting a replacement aide. If VillageCareMAX care manager or Member Services is notified by the Member that an aide has not reported to a Member's home at the scheduled time, Member Services will follow up with the licensed agency immediately. The licensed agency should reach out to the Member (as outlined above) and report back to VillageCareMAX regarding the status of the aide coverage.	By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
7.	Member Request for No Service	The licensed agency will notify Member Services immediately of all requests for no coverage for one or more days. • They should discuss any concerns for the Member's health or safety if there is no personal care coverage. • If the licensed agency is concerned that honoring the request for no coverage may be inappropriate or dangerous to the Member, Member Services will discuss the concerns with the Member's care manager. • VillageCareMAX will then review the situation and contact the licensed agency with instructions about the Member's services. • If the licensed agency does not receive a response from VillageCareMAX by 3 p.m. the same day, we ask that you contact Member Services again for an update. • <i>NOTE: If the Member is requesting a permanent stop in service, please follow the guidelines in Section 8 below.</i>	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org
8.	Member Refusing Service	A Member refusing service can be a serious concern, particularly if the Member is new/unknown to us or is potentially not stable. • Timely and appropriate follow-up on these situations is very critical. The Licensed Agency coordinate should contact Member Services and provide as much information as possible, regarding the reason the Member is refusing aide service. • VillageCareMAX will contact the Member to discuss his/her services, review the situation, and contact the licensed agency with instructions about the Member's services.	By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
		If the licensed agency does not receive a response from VillageCareMAX by 3 p.m. the same day, we ask that you contact Member Services again for an update.	
9.	Service On Hold	Cases are never placed on hold. Please identify the reason for suspending services in the Member's home and follow the appropriate guidelines, as outlined in this booklet.	
10.	Unable to Locate Member	If the HHA is unable to locate the Member on the first day of service: - The licensed agency should contact Member Services to verify the address. - Member Services and/or the Member's Care Manager will attempt to determine the correct address and/or Member's location (e.g. Still in the hospital, staying elsewhere temporarily, etc.) - VillageCareMAX staff and the licensed agency will collaborate on whether service can be provided that day at another location and/or at a different time.	By PHONE 800-469-6292
11.	Member Not Answering Door or Phone	Paraprofessional will notify his/her agency immediately to report that the Member is not answering the door or phone. - The licensed agency should ensure that the following factors were considered and checked: - Was the Member telephoned? - Did the aide knock on Member's door or ring buzzer?	By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
		○ Is the Member hard of hearing? ○ Is it unusual for the Member not to be home; do they have a history of not being home when the aide arrives? ○ Did the aide check with the building's super or neighbor? ○ How long has the aide been trying to gain entry? ○ When was the Member last visited by aide? ● After making all reasonable efforts to reach the Member and the aide is still not getting a response, the licensed agency should release the aide and immediately notify Member Services of the situation. VillageCareMAX staff will attempt to locate the Member. ● If possible, the licensed agency should also try calling the Member's home throughout the course of the day to see if someone is home who knows the Member's whereabouts. Any new information should be relayed to Member Services as soon as it is received. ● Member Services will update licensed agency with next day instructions by 3pm. Unless it is confirmed that the Member is not going to be home, the licensed agency should send the aide again the next day.	
12.	Hospital Pick-up Delay	Hospital pick-ups are arranged and authorized on a case-by-case basis. ● In most cases, this is the responsibility of the family/ caregiver. ● If authorized, and then discharge is delayed, the aide informs agency of hospital pick-up delay.	By FAX or EMAIL, in most circumstances 212-337-5711

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	Topic	LHCSA Guidelines	Contact
		- Licensed agency either approves overtime or travel time if necessary and or adjusts the aide's schedule as needed. - Up to four hours of overtime can be approved by the licensed agency; any additional overtime must be approved by VillageCareMAX. - NOTE: LHCSA must inform VillageCareMAX about each overtime occurrence, so that the service authorization can be updated. The claims for overtime services cannot be paid without an up-to-date authorization.	faxgroup@villagecare.org By PHONE, if more than four hours of overtime is requested 800-469-6292
13.	Escorting Member	<u>Escorting/Accompanying the Member (General):</u> - The Licensed agency coordinator will determine whether or not escorting is permissible on a case-by-case basis, based on the authorization received from VillageCareMAX. - If not already authorized and escorting is requested by the Member, the licensed agency must contact Member Services to discuss and obtain authorization. - If escorting is indicated on the authorization for services, the licensed agency may authorize the paraprofessional to accompany the Member, up to four hours per appointment. Member Services must be notified when this occurs, so that an updated authorization can be issued. - Any overtime in excess of four hours must be approved in advance by VillageCareMAX; the licensed agency must call Member Services to request authorization.	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By PHONE

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	Topic	LHCSA Guidelines	Contact
		• VillageCareMAX monitors overtime. We will encourage Members to make appointments at times when the aide will be present, so overtime can be kept at a minimum. <u>Escorting/Accompanying the Member to the Emergency Room</u> • VillageCareMAX does not routinely authorize service for the aide to accompany a Member who is being transported by ambulance to the emergency room. If requested, the licensed agency must contact Member Services immediately to discuss and obtain authorization. • The aide must stay with the Member until EMS has arrived and transported the Member from the home. The aide should provide all available information to the EMS workers, including the Member's health status and the Member's emergency contact(s). • The aide must immediately report a change in the Member's clinical status directly to the licensed agency. The licensed agency must contact: (1) the Member's family/caregiver, and (2) Member Services. • If the Member is admitted, VillageCareMAX will contact the licensed agency to suspend services for the time that the Member is hospitalized. • Upon discharge, VillageCareMAX will contact the licensed agency at least one day in advance, in order to	800-469-6292

Appendix 7

	Topic	LHCSA Guidelines	Contact
		resume services. Any changes to service authorizations will be forwarded to the licensed agency at this time.	
14.	Incidents and Unsafe Situations including: • Verbal or physical abuse of the paraprofessional or Member • Threats to the aide/Member's safety in the home • Unsanitary conditions in the home • Illegal activity in the home • Alleged altercation between the aide and Member/family • Allegations of coercion by the aide, Member, or family • Motor Vehicle Accidents (while being transported by	Paraprofessional should report occurrence of any incident or unsafe situation to his/her licensed agency immediately. • Licensed Agency will ensure that a manager is informed and involved immediately. VillageCareMAX Member Services should be notified as soon as the agency becomes aware of the incident. • Depending on the situation, the licensed agency manager will: ○ Call 911 if necessary, depending on circumstances. ○ Immediately notify Member Services ○ Make a decision on whether the aide should be released. • Licensed agency and VillageCareMAX staff will collaborate to ensure that a plan is established by the end of the day to ensure the staff's safety while attempting to resolve the situation. Follow-up in these circumstances will be closely coordinated and handled on a case-by-case basis.	By PHONE 800-469-6292

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	Topic	LHCSA Guidelines	Contact
	VillageCareMAX transportation services)		
15.	Allegations of Theft	The Member or family/caregiver may report allegations of theft to the licensed agency or directly to VillageCareMAX. • If the report is made to the licensed agency, the agency must ensure that a manager is informed and involved immediately. VillageCareMAX Member Services should be notified as soon as the agency becomes aware. (If the report is made to VillageCareMAX, our staff will notify the licensed agency as soon as we become aware.) • The Member or family /caregiver should be encouraged to follow up with the police. • Whenever allegations of theft are made, the agency must investigate and provide VillageCareMAX with a report of the outcome of its review. • Follow-up in these circumstances will be closely coordinated and handled on a case-by-case basis. If a request is made for a change in aide, this request will be approved.	By PHONE 800-469-6292
16.	Requests for Overtime and Travel Time	• Requests for overtime are approved if necessary to accompany the Member to an appointment, or if the Member has an issue that requires overtime by the aide in order to maintain the Member's health or safety. • The licensed agency should follow the guidelines outlined in Section 13 above.	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711

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	Topic	LHCSA Guidelines	Contact
			faxgroup@villagecare.org
17.	HHA Access to Member's Phone (Call-In System)	Every aide must have access to the Member's telephone on a daily basis, in order to report his/her time of arrival and departure at the Member's home. • If the Member or the Member's family refuses to allow an aide access to the phone, the aide must immediately contact their respective licensed agency. • The licensed agency coordinator will instruct aide to stay with Member and provide coverage as usual. • The licensed agency coordinator will contact Member Services, and VillageCareMAX staff will follow-up with Member or family/ caregiver about allowing the aide access to the phone and inform the CM that a resolution will be needed before the end of the aide's shift. • Until the issue is resolved, the coordinator should register the aide's presence through the Call-In System, or by following the licensed agency's alternative policies and procedures for verifying staff attendance. Manual/paper duty sheets should be used to document the services. • If the Member ultimately refuses to allow the aide to use the phone, services will <u>not</u> be suspended. The licensed agency should follow the licensed agency's alternative policies and procedures for verifying staff attendance. Manual/paper duty sheets should be used to document the services.	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org

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Performance Improvement Process:

If VillageCareMAX is notified of a serious performance issue or of a pattern of performance issues, our Quality Management and/or Provider Relations staff will contact the licensed agency or contracted vendor and request that the matter be investigated and that a verbal or written response be submitted to VillageCareMAX immediately. The response should be reviewed and approved by the Contract Manager and/or Administrator at the licensed agency before being submitted to VillageCareMAX.

Performance related issues include gaps or interruptions in any of the following areas:

- Service delivery
- Communication protocol
- Administrative follow up
- Customer satisfaction.

VillageCareMAX will also review the LHCSA's performance indicators and reports of complaints/grievances to insure that agencies are achieving expected performance thresholds for each indicator. VillageCareMAX will monitor performance in the identified area(s) of concern on an ongoing basis. If the pattern continues, or an issue occurs that requires immediate intervention, VCMAX may request that the licensed agency submit a written performance improvement plan of correction. The Licensed agency must ensure that the plan of correction is comprehensive and approved by its Contract Manager and/or Administrator before it is submitted.

VillageCareMAX will continue to monitor performance after the plan of correction has been submitted to insure that the action plan is implemented and achieving improvement objectives. Failure to achieve the targeted improvement may result in a reduction in the volume of cases served by the LHCSA, or additional actions up to the termination of the LHCSA's contract.

Performance improvement plans should be submitted to the VillageCareMAX Quality Management (or designee), depending upon the type of issue and within the time frames requested. Below, please see a sample format for the Plan of Correction document. Please use this format when submitting your plan to VillageCareMAX.

PLEASE NOTE: VillageCareMAX Compliance staff also conduct targeted provider audits, which may also result in requests for a plan of correction, to address findings of fraud, abuse and/or non-compliance with regulatory requirements.

[Appendix 7](#)

AGENCY' S NAME

SUBJECT OR AREA OF DEFICIENCY

PLANS FOR IMPROVEMENT

Issue	Detailed Plan for Performance Improvement	Person Responsible	Date to be Completed

Plan Completed by: _____

Title: _____

Date Submitted: _____

Appendix 8

Appendix 8: Provider Information Change Form



Provider Information Change Form

*1. INDICATE CHANGE(S) BEING SUBMITTED: (Check all that apply — please include effective date for each item checked.) *Section required.			
☐ Practice information (Complete sections 2, 3, 6)	Effective date _____	☐ Panel status (Complete sections 2, 4, 6)	Effective date _____
☐ Billing information (Complete sections 2, 3, 6)	_____	☐ Termination (Complete sections 2, 5, 6)	_____
☐ Provider name (Complete sections 2, 6)	_____		
Indicate documents included: ☐ W9 ☐ Provider Roster ☐ Other _____			

PLEASE COMPLETE THE APPLICABLE SECTIONS BELOW TO UPDATE YOUR INFORMATION.

*2. PROVIDER INFORMATION: *Section required.		
Provider Last Name:	First Name:	MI:
Provider Former Name (if applicable):		
NPI#:	TAXID#:	
Provider Type: ☐ PCP ☐ Specialist ☐ Both ☐ Ancillary ☐ Other		
Practice/Business name:		
Street:		
City:	State:	Zip:
Phone:	Fax:	
Provider Email Address:		

IF APPLICABLE, PLEASE ATTACH A SEPARATE LIST WITH THE NAMES AND NPI NUMBERS OF ALL OF THE PROVIDERS IN THIS GROUP FOR WHOM THE ADDRESS CHANGE IS APPLICABLE.

3. ADDRESS INFORMATION:			
ENTER NEW OR ADDITIONAL ADDRESSES BELOW		ENTER OLD ADDRESSES TO BE TERMINATED BELOW	
Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing		Address type: ☐ Primary ☐ Secondary ☐ Billing ☐ Mailing	
Address line 1:		Address line 1:	
Address line 2:		Address line 2:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Contact person completing form: _____ Phone: _____			

Appendix 8

VillageCareMAX PROVIDER INFORMATION CHANGE FORM (continued)

Provider Name: _____

4. PRIMARY CARE PANEL STATUS: <i>May be impacted by contract terms and follow-up may be required.</i>	
☐ Open panel	☐ Home Visits
☐ Close panel	☐ Nursing home only
☐ Accepting existing patients only	☐ Other (please specify) _____
5. TERMINATION: <i>Effective date may be impacted by contract terms and follow-up may be required.</i>	
Reason for termination, please check only one box:	
☐ Resigned	☐ Practice closed
☐ Retired	☐ Provider sanctioned*
☐ Deceased	☐ Sabbatical*
☐ Leave of absence*	☐ Provider transferred to (group name) _____
☐ Moved out-of-state	☐ Other _____
*Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/sabbatical or sanction specifics).	
*6. CONTACT PERSON SUBMITTING INFORMATION: *Section required.	
Name:	Title:
Phone:	Fax:
Email:	
Date of submission:	

Submit this form to the following:

Via Email to:

ProviderRelations@villagecare.org

Or Via U.S. Mail to:

VillageCareMAX
Attn: Provider Relations
112 Charles Street, 2nd Floor
New York, NY 10014

[Appendix 9](#)

Appendix 9: Important Information: CMS -10611 Form - Medicare Outpatient Observation Notice (MOON)

As of March 8, 2017, hospitals and critical access hospitals (CAHs) are required to provide a Medicare Outpatient Observation Notice to all Medicare beneficiaries who are receiving outpatient observation services and are not an inpatient of a hospital or a CAH. The notice must include the reasons why the individual is an outpatient receiving services and the implication of receiving services.

All hospital and CAHs are required to provide written and oral notification to individuals who receive observation services as outpatients for more than 24 hours.

The notice must be delivered no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted

[Appendix 10](#)

Appendix 10: DME Services requiring Prior Authorization

Effective December 1, 2018, only the below DME services will require prior authorization.

All other DME services not listed below will not require prior authorization; however, all services will continue to require a physician order.

To request DME services for your patient, please call 212-337-5880.

CODE	DESCRIPTION
B4152	ENTERAL FORMULA, NUTRITIONALLY COMPLETE,
B4150	ENTERAL FORMULA, NUTRITIONALLY COMPLETE
B4100	FOOD THICKENER, ADMINISTERED ORALLY, PER
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITI
B4158	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITI
B4159	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITI
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE,
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZE
B4083	STOMACH TUBE-LEVINE TYPE
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLET
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLY
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE,
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED,
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED,
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE,
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PE
B4082	NASOGASTRIC TUBING WITHOUT STYLET
B4081	NASOGASTRIC TUBING WITH STYLET
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD,
A9282	WIG, ANY TYPE, EACH
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFIL
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY POR
E0482	COUGH STIMULATING DEVICE, ALTERNATING PO
A5501	FOR DIABETICS ONLY, FITTING, CUSTOM PREPARATIO
L5656	ADDITION TO LOWER EXTREMITY, SOCKET INS
L5658	ADDITION TO LOWER EXTREMITY, SOCKET INS
L2530	ADDITION TO LOWER EXTREMITY, THIGH-WEIG

[Appendix 10](#)

CODE	DESCRIPTION
L2624	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L5630	ADDITION TO LOWER EXTREMITY, SYMES TYPE,
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KN
L5810	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM,
L5920	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNE
L1980	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT FREE
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUN
L6625	UPPER EXTREMITY ADDITION, ROTATION WRIS
L6677	UPPER EXTREMITY ADDITION, HARNESS, TRIPL
L3760	ELBOW ORTHOSIS, WITH ADJUSTABLE POSITION
E2631	SEO, ADDITION TO MOBILE ARM SUPPORT, ELE
L5785	ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WIT
L2340	ADDITION TO LOWER EXTREMITY, PRE-TIBIAL
L2630	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS T
L3984	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST
L6642	UPPER EXTREMITY ADDITION, EXCURSION AMP
K0554	RECEIVER(MONITOR),DEDICATED,FOR USE W/CGM
A9278	RECEIVER(MONITOR),EXTERNALUSED W/INTERSTITIAL CGM,NON
L3000	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIG
L5622	ADDITION TO LOWER EXTREMITY, TEST SOCKET
L5624	ADDITION TO LOWER EXTREMITY, TEST SOCKET
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INN
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, E
L6623	UPPER EXTREMITY ADDITION, SPRING ASSIST
L5812	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM,
L5676	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE
L5982	ALL EXOSKELETAL LOWER EXTREMITY PROSTHES
L5986	ALL LOWER EXTREMITY PROSTHESES, MULTI-AX
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SY
L7367	LITHIUM ION BATTERY, RECHARGEABLE REPLACEMENT
L6895	ADDITION TO UPPER EXTREMITY PROSTHESIS,
L6915	HAND RESTORATION (SHADING, AND MEASUREME
L5626	ADDITION TO LOWER EXTREMITY, TEST SOCKET
L5716	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM,

Appendix 10

CODE	DESCRIPTION
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR
K0001	STANDARD WHEELCHAIR
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WID
L0642	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
L5680	ADDITION TO LOWER EXTREMITY, BELOW KNEE
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIG
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYP
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L1904	AFO, MOLDED ANKLE GAUNTLET, CUSTOM-FABRI
E0600	RESPIRATORY SUCTION PUMP, HOME MODEL, PO
L6645	UPPER EXTREMITY ADDITION, SHOULDER FLEX
L3980	UPPER EXTREMITY FRACTURE ORTHOSIS, HUMER
L5712	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM,
L6805	ADDITION TO TERMINAL DEVICE, MODIFIER WR
L1990	ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT FREE
L2050	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L0472	TLSO, TRIPLANAR CONTROL, HYPEREXTENSION,
L2550	ADDITION TO LOWER EXTREMITY, THIGH/WEIG
E1399	Positioning bath chair, small/medium
L5653	ADDITION TO LOWER EXTREMITY, KNEE DISAR
L5629	ADDITION TO LOWER EXTREMITY, BELOW KNEE,
L5000	PARTIAL FOOT, SHOE INSERT WITH LONGITUDI
L6650	UPPER EXTREMITY ADDITION, SHOULDER UNIV
L6640	UPPER EXTREMITY ADDITIONS, SHOULDER ABDU
L2620	ADDITION TO LOWER EXTREMITY, PELVIC CONT
E2624	SKIN PROTECTION AND POSITIONING WHEELCHA
L0469	TLSO, SAGITTAL-CORONAL CONTROL, RIGID PO
L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION
L5410	IMMEDIATE POST SURGICAL OR EARLY FITTING
L5430	IMMEDIATE POST SURGICAL OR EARLY FITTING
L6386	IMMEDIATE POST SURGICAL OR EARLY FITTING
L5636	ADDITION TO LOWER EXTREMITY, SYMES TYPE
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYS
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR
L2060	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L3808	WRIST HAND FINGER ORTHOSIS, RIGID WITHOU

[Appendix 10](#)

CODE	DESCRIPTION
L0190	CERVICAL, MULTIPLE POST COLLAR, OCCIPITA
E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE
E2608	SKIN PROTECTION AND POSITIONING WHEELCHA
E1399	Positioning bath chair, large
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POS
L0200	CERVICAL, MULTIPLE POST COLLAR, OCCIPITA
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
L5811	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM,
E2201	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD
L5711	ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM,
L6684	UPPER EXTREMITY ADDITION, TEST SOCKET,
L0452	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT,
L1971	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MA
L5637	ADDITION TO LOWER EXTREMITY, BELOW KNEE,
L3916	WRIST HAND ORTHOSIS, INCLUDES ONE OR MOR
L3230	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID PO
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS,
L3806	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE
L5665	ADDITION TO LOWER EXTREMITY, SOCKET INS
L2580	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L5634	ADDITION TO LOWER EXTREMITY, SYMES TYPE,
L2112	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS,
E2291	BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCH
E2292	SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCH
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME M
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR
L0170	CERVICAL, COLLAR, MOLDED TO PATIENT MODE
L7368	LITHIUM 10N BATTERY CHARGER
L1230	ADDITION TO TLSO, (LOW PROFILE), MILWAUK
L3250	ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE,
E1014	RECLINING BACK, ADDITION TO PEDIATRIC SI
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POS
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STAND
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY
L3960	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDU

[Appendix 10](#)

CODE	DESCRIPTION
L5628	ADDITION TO LOWER EXTREMITY, TEST SOCKET
L5790	ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE
L2114	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS,
E2340	POWER WHEELCHAIR ACCESSORY, NONSTANDARD
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPME
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHAR
L2640	ADDITION TO LOWER EXTREMITY, PELVIC CONT
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WID
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WID
E2625	SKIN PROTECTION AND POSITIONING WHEELCHA
L7364	TWELVE VOLT BATTERY, EACH
E2500	SPEECH GENERATING DEVICE, DIGITIZED SPEE
L6388	IMMEDIATE POST SURGICAL OR EARLY FITTING
L1848	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUS
L1907	AFO, SUPRAMALLEOLAR WITH STRAPS, WITH OR
L5679	ADDITION TO LOWER EXTREMITY, BELOW KNEE/
L3330	LIFT, ELEVATION, METAL EXTENSION (SKATE)
L0458	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENT
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENT
L0462	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENT
L0464	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENT
L0470	TLSO, TRIPLANAR CONTROL, RIGID POSTERIOR
E2369	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MOR
L4040	REPLACE MOLDED THIGH LACER, FOR CUSTOM F
L5450	IMMEDIATE POST SURGICAL OR EARLY FITTING
L1932	AFO, RIGID ANTERIOR TIBIAL SECTION, TOTA
L1940	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MA
L1945	ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTE
L5975	ALL LOWER EXTREMITY PROSTHESIS, COMBINAT
L3982	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIU
L5673	ADDITION TO LOWER EXTREMITY, BELOW KNEE/
E2202	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD
E2203	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE
L6687	UPPER EXTREMITY ADDITION, FRAME TYPE SOC

[Appendix 10](#)

CODE	DESCRIPTION
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICA
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICA
L2106	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS,
L2116	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS,
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEI
E0575	NEBULIZER; ULTRASONIC
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE C
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLA
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDE
L5671	ADDITION TO LOWER EXTREMITY, BELOW KNEE
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUS
L5661	ADDITION TO LOWER EXTREMITY, SOCKET INS
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIG
L5631	ADDITION TO LOWER EXTREMITY, ABOVE KNEE
L6694	ADDITION TO UPPER EXTREMITY PROSTHESIS,
L6695	ADDITION TO UPPER EXTREMITY PROSTHESIS,
L5962	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNE
E2630	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPP
L6692	UPPER EXTREMITY ADDITION, SILICONE GEL I
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WI
L4030	REPLACE QUADRILATERAL SOCKET BRIM, CUSTO
L1640	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L5984	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHE
L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE
K0002	STANDARD HEMI/LOW SEAT WHEELCH
E2368	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL
L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KN
L5976	ALL LOWER EXTREMITY PROSTHESES, ENERGY S
L5704	CUSTOM SHAPED PROTECTIVE COVER, BELOW KN
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN
E2370	POWER WHEELCHAIR COMPONENT, INTEGRATED DR
E1226	WHEELCHAIR ACCESSORY, MANUAL FULLY RECLI
L6688	UPPER EXTREMITY ADDITION, FRAME TYPE SOC
L5460	IMMEDIATE POST SURGICAL OR EARLY FITTING
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POS
L5646	ADDITION TO LOWER EXTREMITY, BELOW KNEE,

[Appendix 10](#)

CODE	DESCRIPTION
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE
L3962	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDU
L4010	REPLACE TRILATERAL SOCKET BRIM

[Appendix 11](#)

Appendix 11: NYS DOH universal billing codes for home care and adult day health care services

Beginning April 1, 2018, the New York State Public Health law requires plans and providers to use consistent standards for the coding of payments for home and community based long term care services claims. Claims under contracts or agreements between any long term care providers and managed long term care plans or managed care plans are required to be processed using the universal standards of coding for payments.

Adult Day Health Care and Long Term Care Services

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
ADHC	Adult Day Health Care - Basic Level	Per Diem	S5102	U1	Adult Day Health Care Services
CDPAS	CDPA Basic 15 Minutes	Per 15 Minutes	T1019	U6	Personal Assistant
CDPAS	CDPA Two Consumer	Per 15 Minutes	T1019	U7	Personal Assistant mutual
CDPAS	CDPA Live In	Per Diem (13 Hours)	T1020	U6	Personal Assistant live-in
CDPAS	CDPA Live In Two Consumer	Per DIEM (13 Hours)	T1020	U7	Personal Assistant mutual live-in
LHCSA	HHA - 15 Minutes	Per 15 Minutes	S5125	None	Home Health Aide
LHCSA	HHA Two Client	Per 15 Minutes	S5125	U2	Home Health Aide Mutual
LHCSA	HHA - Live In	Per Diem (13 Hours)	S5126	None	HHA Live-In
LHCSA	HHA Live In Two Client	Per Diem (13 Hours)	S5126	U2	HHA Mutual Live-In

[Appendix 11](#)

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
LHCSA	PCS Level II - 15 Minutes	Per 15 Minutes	T1019	U1	Personal Care Aide
LHCSA	PCS Level II Basic Two Client	Per 15 Minutes	T1019	U2	Personal Care Aide Mutual
LHCSA	PCS Level II Weekend/Holiday	Per 15 Minutes	T1019	TV	Personal Care Aide Weekend/Holiday
LHCSA	PCS Level II Live In	Per Diem (13 Hours)	T1020	None	PCA live-in
LHCSA	PCS Level II Live In Two Client	Per Diem (13 Hours)	T1020	U2	PCA Mutual Live-In
LHCSA	PCS Level II Live in Weekend/Holiday	Per DIEM (13 Hours)	T1020	TV	PCA live-in Weekend/Holiday
LHCSA	Nursing Care in Home (RN)	Per Diem (13 Hours)	T1030	None	Skilled Nursing /RN services
LHCSA	LPN	Per Hour	S9124	None	LPN Private Duty Nursing
CHHA	HHA - 15 Minutes	Per 15 Minutes	S5125	None	Home Health Aide
CHHA	Nursing Assessment/Evaluation	Per Visit	T1001	None	Initial Visit
CHHA	Nursing Care in Home (RN)	Per Diem (13 Hours)	T1030	None	Skilled Nursing Subsequent Visit/Revisit

[Appendix 11](#)

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
CHHA	Occupational Therapy	Per Visit	S9129	None	Occupational Therapy
CHHA	Physical Therapy	Per Visit	S9131	None	Physical Therapy
CHHA	Speech Therapy	Per Visit	S9128	None	Speech Therapy
CHHA	Nutritional Counseling	Per Visit	S9470	None	Nutrition
CHHA	Medical Social Services	Per Visit	S9127	None	Medical Social Services
CHHA	Respiratory Therapy	Per 15 Minutes	G0237	None	Respiratory Therapy
CHHA	Respiratory Therapy	Per 15 Minutes	G0238	None	Respiratory Therapy
CHHA	Installation	Per Service	S9110	None	Telehealth (for installation)
CHHA	Monitoring	Monthly	S9110	U1	Telehealth (a day)
PERS Medication	Installation	One Time	T1505	None	Delivery, Removal Nurse Training & User Orientation
PERS Medication	Monitoring	Monthly	S5185	None	Medication Dispensing Monitoring Service & Reporting or System Rental (with Event Reporting)
UAS	UAS Assessment	Per Visit	T2024	None	

[Appendix 11](#)

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
UAS	UAS Reassessment	Per Visit	T2024	None	
Sign Language	Sign Language/Oral interpreter	Per 15 Minutes	T1013	None	
Soc & Env Supports	Social and Environmental Supports- Home Modification	Per Service	S5165	None	
Soc & Env Supports	Social and Environmental Supports - Assessment	Per Service	T1028	None	

[Appendix 12](#)

Appendix 12: 2019 Medicare Part D Opioid Policies



2019 Medicare Part D Opioid Policies: Information for Prescribers

The Centers for Medicare and Medicaid Services (CMS) [finalized new opioid policies](#) for Medicare drug plans starting on January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The new policies include improved **safety alerts** when opioid prescriptions are dispensed at the pharmacy and **drug management programs** for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions. These policies should not impact patients' access to medication-assisted treatment (MAT), such as buprenorphine.

Opioid Safety Alerts

Part D plans are expected to implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. CMS encourages prescribers to respond to pharmacists' outreach in a timely manner and give the appropriate training to on-call prescribers when necessary to resolve opioid safety edits expeditiously and avoid disruption of therapy.

Opioid Safety Alert	Prescriber's Role
Seven-day supply limit for opioid naïve patients ("hard edit") Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days) will be limited to a supply of 7 days or less. Limiting the amount dispensed with the first opioid prescription may reduce the risk of a future dependency or overuse of these drugs. <u>Important Note:</u> <i>This alert should not impact patients who already take opioids.</i>	Patient may receive up to a 7 days supply or request a coverage determination for full days supply as written. The physician or other prescriber has the right to request a coverage determination on patient's behalf, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid. Prescriber only needs to attest to plan that the days supply is the intended and medically necessary amount. Subsequent prescriptions written by prescribers are not subject to the 7 days supply limit, as the patient will no longer be considered opioid naïve.

Appendix 12

Opioid care coordination alert at 90 morphine milligram equivalent (MME) This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative MME per day across all of their opioid prescription(s) reaches or exceeds 90 MME. <i>Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.</i> The prescriber will be contacted to resolve the alerts and to be informed of other opioid prescribers or increasing level (MME) of opioids.	Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. The prescriber who writes the prescription will trigger the alert and will be contacted even if that prescription itself is below the 90 MME threshold. Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions.
<u>Important Note:</u> <i>This is not a prescribing limit.</i> Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.	On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.
Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy ("soft edits") The alerts will trigger when opioids and benzodiazepines are taken concurrently or if on multiple duplicate long-acting opioids.	The pharmacist will conduct additional safety reviews to determine if the patient's opioid use is safe and clinically appropriate. The prescriber may be contacted.
Optional Safety Alert at 200 MME or more ("hard edit") Some plans may implement a hard safety alert when a patient's cumulative opioid daily dosage reaches 200 MME or more. <i>Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.</i> <u>Important Note:</u> <i>This is not a prescribing limit.</i> Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.	This alert stops the pharmacy from processing the prescription until an override is entered or authorized by the plan. On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid. In the absence of other approved utilization management requirements, once the prescriber(s) attests that the identified cumulative MME level is the intended and medically necessary amount, the medication will be dispensed to the patient.

[Appendix 14](#)

Drug Management Programs (DMPs)

Medicare Part D plans may have a DMP that limits access to opioids and benzodiazepines for patients who are considered to be at-risk by the plan for prescription drug abuse.

The goal of a DMP is better care coordination for safer use. Coverage limitations under a DMP can include requiring the patient to obtain these medications from a specified prescriber and/or pharmacy, or implementing an individualized POS edit that limits the amount of these medications that will be covered for the patient. The coverage limitation tools may be put in place for 12 months and extended for an additional 12 months (total of 24 months).

Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies. After the plan conducts case management with prescribers, and before implementing a coverage limitation tool, the plan will notify the patient in writing. Plans are required to make reasonable efforts to send the prescriber a copy of the letter. After this 30 day time period, if the plan determines based on its review that the patient is at-risk and implements a limitation, it must send the patient a second written notice confirming the specific limitation and its duration.

If the plan decides to limit coverage under a DMP, the patient and their prescriber have the right to appeal the plan's decision. The patient or prescriber should contact the plan for additional information on how to appeal.

[Appendix 14](#)

Appendix 13: Update: NYS Medicaid Program Dental Policy and Procedure Code Manual

The Department of Health has updated section VIII of the Dental Policy and Procedure Code Manual. This update is effective **November 12, 2018** and provides procedure codes and general guidelines for dental implants.

Prior approval for implant services will apply to dental practitioners and Article 28 dental clinics.

The updates will be published in the Dental Policy and Procedure Code Manual found online at https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf

[Appendix 14](#)

Member Correspondence Grid

Our goal at VillageCareMAX is to streamline and facilitate the exchange of information between our organizations and make everyone's day to day operation a bit easier. Effective January 1, 2020, we have established guidelines for select activities where communication is no longer required, required only via phone, or required via fax.

Correspondence	Notification Not Required	Verbal Notification	Fax Notification
All Scripts: All Scripts Referral and Discharge Information			x
CDPAP Documentation (M11Q, Form, CDPAP Agreement)			x
Complaint: Member/Family Complaint		x	
Complaint: Provider Complaint			x
HCP: Health Care Proxy			x
AOR: Appointment of Representative			x
Hospital Discharge Summary			x
LHCSA 1 hour travel time	x		
LHCSA Replacement Aide	x		
LHCSA Holding Services – Hospitalization		x	
LHCSA Holding Services – Other		x	
LHCSA Holding Services – Vacation		x	
LHCSA Incident Report			x
LHCSA No services for less than 3 consecutive days	x		
LHCSA No services for more than 3 consecutive days			x
LHCSA Nursing Revisit Note, Medication Profile, and Progress Notes			x
LHCSA One day schedule change	x		
LHCSA Overtime			x
LHCSA Permanent schedule change			x
LHCSA Request for increase PCA hours			x
LHCSA Resume services		x	
LHCSA RN Initial Assessment / Reassessment, Medication Profile			x
MCA: Mutual Care Agreement			x
MD Letter			x
SNF/Rehab: PT, OT, and/or ST Progress Notes			x
PERS Incident Report			x
POA: Power of Attorney			x
Prescriptions / Request for Services			x
PRI: Patient Review Instrument			x
Quality Attestation Review			x
RX/DME Request: Other Equipment (Cane, Walker, Wheelchair, etc)			x
RX/DME Requests: Incontinence Supplies			x
RX: Prescriptions for DME Incontinence Supplies			x
RX: Prescriptions for DME Supplies			x
SNF/Rehab Discharge Summary			x
Vendor: Quality/Adverse Event			x