Excellus BlueCross BlueShield Participating Provider Manual

Section 10: Government Programs

Revised August 2022

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10.1 Child Health Plus and Medicaid Managed Care

Excellus BlueCross BlueShield offers HMO programs, sponsored by New York state, that are intended to help ensure medical coverage for the uninsured. These programs are:

- Child Health Plus
- Medicaid Managed Care (HMOBlue Option/Blue Choice Option/Premier Option; Blue Option Plus/Premier Option Plus (HARP product)

Covered benefits vary by program and are primarily determined by New York state. Please refer to the benefit chart at the end of this section for additional details.

In addition to every provision of this manual, the following provisions apply with regard to the government programs Child Health Plus and Medicaid Managed Care (MMC).

Applying for Child Health Plus or Medicaid Managed Care

Prospective members may contact Excellus BlueCross BlueShield, for information about enrollment in any of these programs. The prospective members may schedule an appointment with an Excellus BlueCross BlueShield Marketplace Facilitated Enroller or Community IPA/ Navigators to provide in-person enrollment assistance. Prospective members may visit NY State of Health marketplace at info.nystateofhealth.ny.gov/IPANavigatorSiteLocations, for a list of navigators in their area or contact Excellus BlueCross BlueShield to schedule an appointment with a Marketplace Facilitated Enroller.

Prospective Child Health Plus members can apply online through the NY State of Health marketplace at https://nystateofhealth.ny.gov/ or by phone at 1-855-355-5777.

Applicants for each of the programs must meet certain income guidelines. Income guidelines vary by program and may change from year to year.

Restrictions

Members of HMO government programs must follow all the rules and guidelines of a typical HMO. This includes selecting a primary care physician (PCP) who coordinates all of their care, including obtaining referrals to specialists and obtaining preauthorization for specified services. Information regarding referral and preauthorization requirements is included in the *Benefits Management* section of this manual, and the guidelines for out-of-network referrals is also included below.

These requirements may vary from the requirements of Excellus BlueCross BlueShield's commercial HMO health benefit programs.

For services to be covered, members must use providers who participate in Excellus BlueCross BlueShield's government program network, or by approval to an out-of-network provider. Not all providers participate in all programs.

If Excellus BlueCross BlueShield's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. Excellus BlueCross BlueShield may grant a referral, pursuant to a treatment plan approved by Excellus BlueCross BlueShield's medical staff in consultation with the PCP, the non-participating provider, and the member.

In such event, Excellus BlueCross BlueShield will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within Excellus BlueCross BlueShield's provider network. In no event shall Excellus BlueCross BlueShield be required to permit a member to receive services from a non-participating specialist, except as approved above.

Excellus BlueCross BlueShield conducts utilization review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a member are medically necessary. For these programs, *medically necessary means that the health care and services 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. For children and youth, medically necessary means health care and services that are necessary to promote the normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability.*

Restricted Recipient Program

New York state mandates that individuals enrolled in the state Medicaid Restricted Recipient Program (RRP) join a managed care health plan. Restricted recipients are individuals who have been identified as abusers or misusers of the Medicaid program.

These individuals can be restricted to providers in one or more of the following categories:

- Physician, physician group
- Nurse practitioner
- Clinic
- Inpatient hospital
- Dental, dental clinic
- Pharmacy
- Ancillary service provider

As a result, Excellus BlueCross BlueShield can only make payment to the provider of record in these categories, or to a provider who has received a referral from the restricted member's PCP. The PCP of record for a restricted member is required to notify Excellus BlueCross BlueShield each time they refer a restricted patient for any service that will be rendered outside of their practice. This applies to all services, not only those in restricted categories.

It will be very important that the provider verify member eligibility for restricted recipients. Medicaid Managed Care restricted recipients will have **"RRP"** listed after the last name on their member identification card. A restricted recipient can also be verified by calling Customer Care.

How to Select or Change Primary Care Providers

Members may select or change their PCP by:

- Calling the customer care number on their ID card.
- Faxing a *PCP Selection Form* (available via our website) to Excellus BlueCross BlueShield. Providers may have the member complete it in the office and fax it to Excellus BlueCross BlueShield at the fax number listed on the form (The fax number is also included in the *Contact List* in this manual).

Family Planning

All claims for Medicaid Managed Care family care planning and reproductive services must be billed to Excellus BlueCross BlueShield and not Medicaid fee-for-service.

Medicaid Managed Care (HMOBlue Option, Blue Choice Option, and Premier Option) Blue Option Plus/Premier Option Plus

HMOBlue Option, Blue Choice Option, and Premier Option are HMO health benefit programs for New York state residents who are eligible for Medicaid and who live in the Excellus BlueCross BlueShield service area. HMOBlue Option is for members who reside in Excellus BlueCross BlueShield's Central New York, CNY Southern Tier or Utica regions. Blue Choice Option is for members who reside in Excellus BlueCross BlueShield's Rochester region, and Premier Option is for members residing in Orleans County. Blue Option Plus/Premier Option Plus eligible members reside in the counties in which we offer Medicaid Managed Care products.

The program maintains the benefit structure of Medicaid but requires members to follow all of the HMO rules and guidelines. (Medical management requirements may vary slightly from Excellus BlueCross BlueShield's commercial HMO health benefit programs.)

Some services are not part of the benefit package but rather are covered under the Medicaid fee-for-service program.

Emergency and non-emergency transportation services are carved out of the Medicaid Managed Care benefit. Non-emergency transportation is handled by Medical Answering Services (MAS). Each county has a specific MAS contact phone number. Please visit the MAS website at www.medanswering.com for county-specific contact phone numbers.

Members who participate in HMOBlue Option, Blue Choice Option, Premier Option, or Blue Option Plus/Premier Option Plus have no premiums, deductibles, copays or coinsurance. (Limited copays apply to the prescription drug benefit).

The pharmacy benefit is administered through Express Scripts, Inc., an independent company. Please contact Excellus BlueCross BlueShield for provider customer service and prior authorization related to the pharmacy benefit.

The dental benefit is managed through Healthplex, Inc., an independent company (Phone 1-800-468-9868).

A member's eligibility in HMOBlue Option, Blue Choice Option, Premier Option, or Blue Option Plus/Premier Option Plus is always month-to-month, from the first of the month through the last day of the month.

Please refer to the Excellus BlueCross BlueShield Blue Option Plus manual for information related to that product. Participating providers in Excellus BlueCross BlueShield's Medicaid Managed Care provider network can provide care to members who reside in a county that offers Excellus BlueCross BlueShield Medicaid Managed Care.

Child Health Plus

Child Health Plus is a New York state program designed to cover children under age 19, who are residents of New York, whose families have no comparable insurance coverage, and who are ineligible for Medicaid.

The amount of the monthly premium is based on income and family size. There are no deductibles, copayments or coinsurance.

Additional information is available by calling 1-800-698-4543, or by visiting the New York State Department of Health (NYSDOH) website, https://www.health.ny.gov/health_care/child_health_plus/.

Prospective Child Health Plus members may apply online through the NY State of Health marketplace at https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.

Excellus BlueCross BlueShield makes Child Health Plus available in all counties in its service area. Members may see providers in any county as long as the provider participates in Excellus BlueCross BlueShield's Child Health Plus provider network.

The pharmacy benefit is administered through Express Scripts, Inc., an independent company. Please contact Excellus BlueCross BlueShield for provider customer service and prior authorization related to the pharmacy benefit. See the *Pharmacy Management* section of this manual for additional information.

10.2 General Requirements

Minimum Office Hours

In keeping with requirements established by the NYSDOH, PCPs who serve HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus and Blue Option Plus/Premier Option Plus members must practice a minimum of 16 hours at each office location.

The NYSDOH will waive this requirement under certain circumstances:

- Excellus BlueCross BlueShield must submit a waiver regarding a specific physician to the Medical Director of the NYSDOH Office of Managed Care.
- The physician must be able to fulfill the responsibilities of a PCP, as defined in the *Benefits Management* section of this manual.
- The physician must be available at least eight hours a week.
- The physician must be practicing in a Health Provider Shortage Area (HPSA) or in a similarly determined shortage area.

The waiver request must demonstrate that there are systems in place to guarantee continuity of care and fulfillment of the appointment availability and 24-hour access standards defined in the *Quality Improvement* section of this manual or on our website (see below). The NYSDOH notifies Excellus BlueCross BlueShield when a waiver has been granted.

- Provider.ExcellusBCBS.com/resources/clinical/quality-improvement

Identifying Members

Members of HMOBlue Option, Blue Choice Option, Child Health Plus and Blue Option Plus have identification cards that include the BlueCross BlueShield "Cross and Shield" logos.

Premier Option and Premier Option Plus identification cards do not include the BlueCross BlueShield logo.

Providers can determine which government program the member is enrolled in by specific designations noted on the ID card.

Program	ID card designation	ID number
Child Health Plus	Group code "C"	Subscriber ID contains the prefix **VYB**
Medicaid Managed Care	Program name HMOBlue Option Blue Choice Option Premier Option	Subscriber ID contains the prefix **VYT** Note: For Premier products, no prefix displays on the member's card; only the ID number is displayed.
Restricted Recipient	The letters "RRP" entered into the "Title" field.	The letters "RRP' entered after the last name Example: JOHN A. DOE **RRP**
Health and Recovery Plan (HARP)	Blue Option Plus Premier Option Plus	Subscriber ID contains the prefix **VYT** Note: For Premier products, no prefix displays on the member's card; only the ID number is displayed.

Checking Eligibility

Providers may check eligibility for HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus and Blue Option Plus/Premier Option Plus members using the inquiry methods described in this manual. In addition, eligibility information for HMOBlue Option, Blue Choice Option, Premier Option, and Blue Option Plus/Premier Option Plus members is available via the Medicaid eligibility verification system, *ePACES,* www.emedny.org/epaces/. The code for HMOBlue Option and Blue Choice Option membership is "MR." and for Blue Option Plus/Premier Option Plus (HARP) is "EE."

Other options for checking eligibility are the Medicaid telephone system, or the PC Medicaid eligibility software. Providers should have the member's name, date of birth and CIN number available before calling.

> **Note:** Excellus BlueCross BlueShield recommends providers check eligibility at every visit as members may lose eligibility for government programs from month to month.
>
> **Also Note:** If the member's PCP is not listed correctly on the member ID card, the member may make a change by calling the Customer Care number on the ID card at the time of the appointment.

Another option is for the provider to have the member complete the *PCP Selection Form* and fax it to the number on the form, available online at:

- Provider.ExcellusBCBS.com/resources/forms

Speaking with Members

Note: A complete list of Member Rights and Responsibilities is included in Section 1 of this manual, or online at Provider.ExcellusBCBS.com/resources/member-rights.

Excellus BlueCross BlueShield expects participating providers to maintain certain standards when speaking with members. Participating providers must:

- Provide complete and current information concerning diagnosis, treatment and prognosis in terms a member can understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.
- Prior to initiating a service, inform a member if the service is not covered and specify the cost of the service. Providers must notify the member in writing prior to providing a service that is not covered, informing the member that they will be liable for payment.
- Prior to initiating a procedure or treatment, provide the information a member needs to give informed consent. Tell the member to contact Customer care for information about accessing services not covered by Excellus BlueCross BlueShield. (For contact information, see the *Contact List* in Section 2 of this manual.)
- Disclosure of affiliation to patients. According to the Medicaid contract, participating providers must advise patients of their affiliation with all Managed Care plans. Participating providers may display Excellus BlueCross BlueShield's marketing materials, provided that appropriate notice is clearly posted for all health plans with which they have a contract.

Interpretation Services

Excellus BlueCross BlueShield reimburses outpatient providers for interpretation services for Medicaid Managed Care members.

- Available for eligible Medicaid Managed Care members with limited English proficiency and communication services for members who are deaf and hard of hearing.
- Services may be facilitated face-to-face or by telephone.
- Services are coordinated by the provider and are not the responsibility of the member.
- The need for interpretation services must be documented in the member's medical record.
- The interpretation service must be provided during the medical visit by a third-party interpreter, who is either employed by or contracted with the Medicaid provider.

False Claims Act Reminder

Excellus BlueCross BlueShield expects participating providers to understand the state and federal requirements regarding false claims recovery. We have policies and procedures for the detection and prevention of fraud and abuse – including detailed information about the False Claims Act.

Our policy is posted to our website, ExcellusBCBS.com. Providers participating with Medicaid Managed Care and Child Health Plus are also obligated to report and return overpayments to the plan within 60 days of the time when the overpayments are identified. To view our overpayment self-disclosure policy, visit our website.

Disclosure of Ownership and Control Information

Excellus BlueCross BlueShield contracts with Medicaid, and section 18.6(b) of Federal Regulation 42 CFR 455.104 requires that we obtain ownership and control disclosures from providers who participate in Medicaid Managed Care.

We are required to collect a disclosure from any individual or corporation with an ownership or control interest in a provider who contracts with us to provide Medicaid services. This requirement does not apply to individual or group practitioners. We are required to collect a disclosure from any individual or corporation with an ownership or control interest of 5 percent or more in a provider who contracts with us to provide Medicaid services.

Applies to: Medicaid Managed Care providers (other than an individual practitioner or group of practitioners). Affected providers include, facilities/institutions, ancillary and suppliers. not-for-profit organizations are not excluded from this regulation.

Examples include but are not limited to: hospital, skilled nursing, free standing, home health, independent reference laboratory, ambulance and durable medical equipment providers.

Excluded Providers: Individual practitioner or group of practitioners, any state or federal government provider is excluded from this regulation.

Collection of Provider Disclosure

Disclosure of ownership and control information will be collected at any of the following times:

(1) Upon the provider submitting the provider application

(2) Upon the provider executing the provider agreement

(3) Upon a change in ownership which must be reported within 35 days of the change

Changes in Ownership and Control

Providers must notify us of any changes to their ownership and control within 35 days by completing the Disclosure of Ownership & Controlling Interest Statement with FAQs. This form can be downloaded from our website, Provider.ExcellusBCBS.com/resources/forms, in the Administration section.

Provider Enrollment in the New York State Medicaid Program

As a reminder, effective January 1, 2018, per Section 5005 of the 21st Century Cures Act, federal law requires that all Medicaid Managed Care, Health and Recovery Plan and Children´s Health Insurance Program network providers must be enrolled with New York State 's Medicaid program. The Medicaid provider enrollment process is for the State to ensure appropriate and consistent screening of providers and improve program integrity. Providers in the Excellus BCBS provider network must enroll in Medicaid or will be removed from our provider network. Enrollment as a Medicaid provider does not require the provider to see Medicaid fee for service patients. For any questions, please refer to:

- https://www.emedny.org/info/ProviderEnrollment/index.aspx

10.3 Prenatal, Postpartum and Newborn Care (for Medicaid Managed Care and HARP members)

New York State Requirements

Excellus BlueCross BlueShield is obligated by the NYSDOH to have participating providers follow the standards defined by Public Health Law with appropriate detail as defined by the Medicaid Prenatal Care Standards, which can be reviewed on the NYSDOH website:

- https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

The DOH recommends that any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day.

The standards incorporate evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetrics (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low income, high-risk pregnant women.

The standards provide a comprehensive model of care that integrates the psychosocial and medical needs and reflects the special needs of Medicaid population. The following topics are covered:

A. Requirements
B. Access to Care
C. Prenatal Risk Assessment, Screening and Referral for Care
D. Psychosocial Risk Assessment, Screening, Counseling and Referral for Care
E. Nutritional Screening, Counseling and Referral for Care
F. Health Education
G. Development of a Care Plan and Care Coordination
H. Prenatal Care Services
I. Postpartum Services

The NYSDOH has provided the following contact information to request further information:

- Prenatal Care Standards Development: Office of Health Insurance Programs, 518-486-6865 or fcg01@health.state.ny.us
- Prenatal Care and Managed Care: Division of Managed Care, Office of Health Insurance Programs, 1-518-473-1134 or omcmail@health.state.ny.us
- Presumptive Eligibility: Medicaid Coverage and Enrollment, Office of Health Insurance Programs, 1-518-474-8887

Clinical Guideline for Prenatal and Postpartum Care

Excellus BlueCross BlueShield has adopted the American College of Obstetrics (ACOG) and NYS DOH guidelines for prenatal and postpartum care which are meant to serve as a reference for physicians and health professionals who provide services to pregnant members of Excellus BlueCross BlueShield's programs.

These standards can be found on the NYS DOH website:

- https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

Excellus BlueCross BlueShield's prenatal and postpartum guidelines address the following, as well as other care specific to obstetrics:

- Comprehensive risk assessment, including but not limited to genetic, nutritional, psychosocial and historical and emerging obstetrical/fetal and medical/surgical risk factors.
- Nutrition assessment and referral.
- Prenatal diagnostic treatment services and postpartum services, including recommendations for HIV testing and counseling and post-HIV-test counseling.
- Coordination of care between providers of prenatal care and the PCP, pediatrician and other related providers.
- Management and coordination of care for high-risk pregnancies.
- After-hours emergency consultations.
- Postpartum services that include referral to and coordination with a neonatal care provider for pediatric care services.

Medicaid Managed Care Enrollees:

Women's Services do not require a referral if the member needs or presents with any of the following:

- pregnancy
- OB/GYN services
- family planning services
- midwife services
- breast or pelvic exam

Family Planning Services do not require a referral for the following:

- advice for birth control
- birth control prescriptions
- male or female condoms
- pregnancy tests
- sterilization
- abortion

Medicaid Managed Care members may also choose to see a non-participating provider for family planning services. These services can be billed to Medicaid fee-for-service. Member may contact the NYS Growing Up Healthy Hotline at 1-800-522-5006 for the names of available family planning providers.

Medicaid Prenatal Care Medical Record Review

The Medicaid Prenatal Care Medical Record Review process is designed to assess the practitioner's compliance with the NYS Prenatal Standards. A sample of medical records is assessed on an annual basis. To assess the quality of medical record keeping practices, an 80 percent performance goal has been established by Excellus BlueCross BlueShield.

- The Prenatal Standards are based on current medical practice guidelines and reflect requirements put forth by regulatory and accrediting bodies. Standards are assigned points for the purpose of scoring provider compliance.
- A random sample of records is reviewed annually for Medicaid members who had a delivery in the twelve months prior to the review period.
- Comprehensive obstetrical medical records are requested from practitioners and reviewed at Excellus BlueCross BlueShield.
- Annually, aggregate reports of compliance with standards are presented to the Health Care Quality Monitoring Committee (HCQMC) to identify opportunities for improvement. Actions, interventions and follow-up are implemented based on the results of the annual review.

See the *Quality Improvement* section of this manual for additional details.

Newborn Coverage

The newborn child of a Child Health Plus member does not automatically receive health coverage. To enroll the newborn of a Child Health Plus member, the parent or guardian must complete an application. For information about insurance options for the newborn, the parent or guardian may call the Customer Care number on their ID card (For contact information, see the *Contact List* in this manual), or they may contact the NY State of Health Marketplace through its website (see below) or by phone at 1-855-355-5777.

- https://nystateofhealth.ny.gov/

The newborn child of an Excellus BlueCross BlueShield Medicaid Managed Care member is entitled to coverage for one year. Providers may encourage pregnant women to contact their Medicaid Case Worker at the local Department of Social Services or the NY State of Health Marketplace to enroll the unborn child prior to birth.

10.4 Early and Periodic Screening, Diagnostic and Treatment

Overview

The federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). It requires that any medically necessary health care service listed at Section 1905(a) of the Social Security Act be provided to an EPSTD recipient, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan.

The EPSTD manual is available for reference on the NYSDOH website at emedny.org under *Provider Manuals*.

New York's Child Teen Health Program

New York state follows EPSTD guidelines through its Child Teen Health Program (C/THP). Care and services are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. They generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics. The guidelines also emphasize recommendations such as those described in Bright Futures in order to guide health care providers and improve health outcomes for members. C/THP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or behavioral health and substance use problems identified during these exams.

Clinical Guidelines

Excellus BlueCross BlueShield has established clinical guidelines for preventive care as a reference for physicians and other health professionals who provide services to pediatric and adolescent members of its programs. They are available on our website at:

- Provider.ExcellusBCBS.com/policies/guidelines/clinical-practice

The clinical guidelines recommend care for infants, children and adolescents in accordance with EPSDT guidelines.

Health Plan and Provider Requirements

Excellus BlueCross BlueShield and its providers must comply with the C/THP program standards and do at least the following for eligible members:

- Educate pregnant women and families with under age 21 enrollees about the program and its importance to a child's or adolescent's health.
- Educate network providers about the program and their responsibilities.
- Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure that children are kept current with respect to their periodicity schedules.

- Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments.
- Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.
- Achieve and maintain an acceptable compliance rate for screening schedules.

The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.

10.5 Vaccines for Children (VFC)

All providers administering vaccines to children under age 19 covered by HMOBlue Option, Blue Choice Option, Premier Option or Child Health Plus must participate in the New York Vaccine for Children (NYVFC) program. NYVFC provides the vaccines free of charge. For more information about VFC and how to obtain vaccines, providers should call VFC directly. The eligible vaccines are listed on the Centers for Disease Control and Prevention website. (The telephone number for NYVFC and the website for the CDC VFC program are included on the *Contact List* in this manual.) See the *Billing and Remittance* section of this manual for information about submitting claims.

10.6 Vision Care

Because members of government programs do not need a referral or preauthorization to access vision care services, it is very important for practitioners who provide vision care services to check eligibility and benefits by calling Customer Care. Benefit limitations and other requirements vary among the government programs. Member eligibility for covered services will be based on the information the provider supplies to Customer Care at the time of the call and on the member's current benefit history.

Covered Services

Routine Eye Exams

Medicaid Managed Care (Blue Choice Option, HMOBlue Option, Premier Option, and Blue Option Plus/Premier Option Plus) members are eligible for one routine eye examination every 24 months. Child Health Plus members may have one routine eye exam every 12 months. These limitations apply only to routine eye exams such as routine visual acuity or refraction tests. They do not apply to non-routine tests for individual with conditions such as diabetes that can affect the vision.

Lenses and Frames

The benefit for government program members is limited to medically necessary basic lenses and frames. This includes bifocal or trifocal lenses when medically necessary. It does not include contact lenses (see *Exclusions*, below).

Medicaid Managed Care (Blue Choice Option, HMOBlue Option, Premier Option and Blue Option Plus/Premier Option Plus members are eligible to receive one set of basic lenses and frames every 24 months. Child Health Plus members are eligible to receive one set of basic lenses and frames every 12 months. **Participating providers must have a selection of frames available that are within the allowed amount.**

If medically necessary, Medicaid Managed Care (Blue Choice Option, HMOBlue Option, Premier Option, Blue Option Plus/Premier Option Plus and Child Health Plus members may be eligible to receive an additional pair of glasses within the benefit time frames.

Exclusions

Excellus BlueCross BlueShield does not cover:

- Routine exams and lenses/frames that are beyond the limitations stated above.
- Lenses/frames from practitioners who have not agreed to accept Excellus BlueCross BlueShield's allowance (in other words, do not participate in the government program network).
- Safety glasses.
- Added features such as progressive lenses, anti-reflective coatings, photosensitive, tints, transition lenses or other specialty lenses, unless determined medically necessary.
- Contact lenses, unless determined medically necessary (See the Medical Policy *Contact Lenses for Medicaid, Child Health Plus Contracts* available on Excellus BlueCross BlueShield's website or from Customer Care.) The prescribing vision care provider must obtain prior approval and submit a letter of medical necessity to Excellus BlueCross BlueShield. The letter must include a diagnosis and the member's medical history.

Upgrades

Medicaid Managed Care

Excellus BlueCross BlueShield does not permit vision allowance upgrades for members of Medicaid Managed Care (HMOBlue Option/Blue Choice Option, Premier Option, Blue Option Plus/Premier Option Plus). Excellus BlueCross BlueShield will reimburse a vision care provider only if they dispense basic frames and/or basic lenses to a HMOBlue Option/Blue Choice Option or Blue Option Plus/Premier Option Plus member.

The practitioner must inform the member that the benefit is only for basic frames and lenses. If the member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the full cost of those items directly from the member.

However, if the upgrade is for only the lenses or only the frames, Excellus BlueCross BlueShield will reimburse the provider for whichever component is basic (lenses or frames). The member is responsible for the full cost of the upgraded component.

Child Health Plus

Child Health Plus members may choose to upgrade at their own expense and Excellus BlueCross BlueShield will reimburse the practitioner at the allowance for basic frames and/or lenses. **This does not mean that the member may choose contact lenses instead of eyeglasses.** (See *Exclusions*, above.) If the

member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the balance directly from the member.

Replacement and Repair of Lenses and Frames

Excellus BlueCross BlueShield's coverage for Medicaid Managed Care and Child Health Plus members includes the replacement of lost or destroyed eyeglasses, if appropriately documented. The replacement of eyeglasses must duplicate the original prescription and frame.

10.7 MMC Long-Term Care (Residential Health Care Facility Services – Nursing Home)

Rehabilitation:
HMOBlue Option, Blue Choice Option, Premier Option, and Blue Option Plus/Premier Option Plus (Health and Recovery Plan, or HARP) cover short-term rehabilitation stays in a skilled nursing home facility.

Long-Term Placement:
Blue Option Plus and Premier Option Plus cover long-term placement in a nursing home facility for members 21 years of age and older. Individuals already in nursing homes for permanent long-term care are not eligible for enrollment in Blue Option Plus or Premier Option Plus.

Covered nursing home services include:

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

To receive the nursing home services previously listed, the services must be ordered by a physician and authorized by HMOBlue Option, Blue Choice Option, Premier Option or Blue Option Plus/Premier Option Plus.

Members must also be found financially eligible for long-term nursing home care by their County Department of Social Services before state Medicaid and/or Excellus BlueCross BlueShield will pay for the services.

When a member is eligible for long-term placement, they must select a nursing home that participates with the Excellus BlueCross BlueShield network.

Members who wish to live in a nursing home that does not participate with Excellus BlueCross BlueShield may transfer to another health plan that works with the nursing home where they prefer to receive care.

To view our tip sheet for institutional long-term care placement of MMC members, visit:

- Provider.ExcellusBCBS.com/resources/management/tip-sheets.

10.8 HIV Care

Excellus BlueCross BlueShield recommends that providers follow the HIV guidelines established by the NYSDOH AIDS Institute. These guidelines pertain to prevention and medical management of adults, children, and adolescents with HIV infection. These guidelines are available at the NYSDOH AIDS Institute website, hivguidelines.org. Providers may also refer to the discussion of NYSDOH requirements for HIV Counseling, Testing and Care of HIV Positive Individuals in the *Quality Improvement* section of this manual.

Individuals may obtain HIV information and referrals by calling the NYSDOH's Anonymous HIV Counseling and Testing Program at 1-800-541-AIDS.

10.9 Personal Care Services

Personal care services are a benefit for MMC members only. Services are defined as some or total assistance with personal hygiene, dressing, feeding, nutritional and environmental support functions. Services must be essential to the maintenance of the patient's health and safety in their own home, as determined by an assessment performed by Excellus BlueCross BlueShield or the New York Independent Assessor (NYIA) in accordance with the regulations of the New York State Department of Health (NYSDOH). All agencies providing personal care services must be licensed or certified to operate as a home care agency by the NYSDOH and must participate in the Excellus BlueCross BlueShield provider network. Services must be prior authorized. See: "Personal Care Aide (PCA) and Consumer Directed Personal Assistant (CDPA) Services for Medicaid Managed Care Contracts" medical policy for medical criteria. Tentatively, effective October 1, 2022, the NYIA will begin conducting assessments for adults (18+) who are requesting Personal Care Services for the first time. All other assessments will be performed by Excellus BlueCross BlueShield until NYSDOH directs the NYIA to take over (this is yet to be determined).

10.10 Health Home

The Medicaid Health Home program provides reimbursement for care management to approved Health Home providers for the services listed below:

- care coordination and health promotion
- comprehensive care management
- transitional care from inpatient to other settings, including follow-up care
- individual and family support, which includes authorized representatives
- referrals to community and social support services
- use of health information technology to link services

These services are provided to enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services.

Excellus BlueCross BlueShield has assigned a single point of contact for each Health Home and that point of contact will communicate protocols with each Health Home's single point of contact.

Excellus BlueCross BlueShield collaborates with Health Homes and network PCPs to establish consistent BH screening for all members, with particular focus on those with high-risk medical conditions including,

but not limited to, tobacco use disorder, stroke, myocardial infarction, cancer, HIV, and chronic pain. Excellus BlueCross BlueShield screening activities will especially screen for depression, anxiety, and substance use disorders.

10.11 HARP Care Recovery Model

HARP is a product designed to address the severely and persistently mental ill through a care recovery model that emphasizes and supports a member's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals.

Blue Option Plus and Premier Option Plus are HARP managed care products that manage physical health, mental health and substance use services in an integrated way for adults with significant behavioral health needs (Mental Health and Substance Use Disorders). Providers of HARP services must be qualified by New York state and must have specialized expertise, tools and protocols.

For additional information, visit the New York State's Office of Mental Health's website at http://www.omh.ny.gov/omhweb/bho/, or review the Health and Recovery Plan Manual on our website, Provider.ExcellusBCBS.com.

10.12 Personal Emergency Response System (PERS)

The Medicaid Uniform Assessment System (UAS) assessment is completed simultaneously with the nursing and social assessment for personal care. Services that are deemed medically necessary will be reimbursed monthly. All PERS services must be provided by an Excellus BlueCross BlueShield-designated agency.

Preauthorization Requirements

All personal care services and PERS requests must receive preauthorization to be eligible for reimbursement. Call Customer Care at 1-800-920-8889.

Claim Submission

Attn: Claims
PO Box 21146
Eagan, MN 55121

10.13 Sterilization Procedures

Important: Sterilization procedures, whether incidental to maternity or not, require completion of a patient consent form in accordance with Medicaid guidelines covering informed consent procedures for hysterectomy and sterilization specified in 42 CFR, Part 441, sub-part (F), and 18NYCRR Section 505.13.

Informed Consent for Sterilization

Patients must be at least 21 years of age at the time of informed consent and mentally competent, and they must complete and sign LDSS-3134, *Sterilization Consent Form*,* at least 30 days, but not more than 180 days prior to a bilateral tubal ligation or vasectomy procedure, or any other medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of having a child.

"Informed consent" means that:

- The patient gave consent voluntarily after the provider planning to perform the procedure has:
  - Offered to answer any questions;
  - Told the patient that they are free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting their right to future care or treatment and without loss or withdrawal of any of their federally funded benefits.
  - Told the patient that there are alternative methods of family planning and birth control.
  - Told the patient that the sterilization procedure is considered to be irreversible.
  - Explained the exact procedure to be performed on the patient.
  - Described the risks and discomforts the patient may experience including effects of any anesthesia.
  - Described the benefits and advantages of sterilization; and
  - Advised the patient that the sterilization will not be performed for at least 30 days following the informed consent, and
- The provider planning to perform the procedure:
  - Made arrangements to ensure that the above information was effectively communicated to a blind, deaf or otherwise disabled person.
  - Provided an interpreter if the patient did not understand the language on the consent form or the person who obtained informed consent; and
  - Permitted the patient to have a witness present when consent was given.

*NYSDOH has determined that the Sterilization Consent Form (LDSS-3134) is **not required** where sterilization is an ancillary result of a procedure, such as gender reassignment surgery.

Hysterectomy

Hysterectomy is covered only in cases of medical necessity and not solely for the purpose of sterilization. Patients must be informed that the procedure will render them permanently incapable of reproducing. A patient must complete LDSS-3113, *Acknowledgement of Receipt of Hysterectomy Information*, at least 30 days prior to the procedure. Prior acknowledgment may be waived when a woman is sterile prior to the hysterectomy or in life-threatening emergencies where prior consent is impossible.

Retention of Forms Required for Payment

The performing provider must retain a copy of the completed *Sterilization Consent Form* or *Acknowledgement of Receipt of Hysterectomy Information* form. **New York state requires the retention of this record type for 10 years after the date of service pursuant to Section 19.4(a) of the MMC Model Contract**. As a participating provider with Excellus BlueCross BlueShield, it must be maintained on our behalf. The Plan will conduct post payment audits against any filed claims for

sterilization or hysterectomy services. Providers will be expected to produce a copy of the form at that time. Failure to produce the form will result in a retraction of payment **per New York state requirements.**

Where to Get Forms

Providers must request blank forms, *Sterilization Consent Form* or *Acknowledgment of Receipt of Hysterectomy Information*, from the NYSDOH by completing a *Request for Forms or Publications* form and faxing or mailing it to the NYSDOH. For contact information, see *Sterilization and Hysterectomy Consent Forms* on the *Contact List* in this manual.

10.14 Submitting Claims to Excellus BlueCross BlueShield

Submit claims for government programs to Excellus BlueCross BlueShield using the same method as claims for other health benefit programs — electronically or on paper. Information about billing and reimbursement is included in the *Billing and Remittance* section of this manual. The address for paper claim submittal is on the *Contact List* in this manual.

10.15 Member Payments – Medicaid

The following sections are a direct reprint from the April 2006 NYSDOH *Medicaid Update*. The update is a reminder to all hospitals, freestanding clinics and individual practitioners about requirements of the Medicaid program related to requesting compensation from Medicaid recipients, including Medicaid recipients who are enrolled in a Medicaid Managed Care plan. Providers may collect applicable copayments but may not deny treatment if the member does not have the copayment at the time.

Acceptance and Agreement

When a provider accepts a Medicaid recipient as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid Managed Care enrollee, agrees to bill the recipient's managed care plan for services covered by the MMC/Family Health Plus/HIV SNP Model Contract.

- The provider is prohibited from requesting any monetary compensation from the recipient, or their responsible relative, except for any applicable copayments.
- A provider may charge a Medicaid recipient, including a Medicaid Managed Care recipient enrolled in a managed care plan, **only** when both parties have agreed **prior to the rendering of the service** that the recipient is being seen as a private pay patient.
- This agreement must be mutual and voluntary.

It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A *provider who participates in Medicaid fee-for-service* may not bill Medicaid fee-for-service for any services included in a recipient's managed care plan, with the exception of family planning services, *when the provider does not provide such services under a contract with the recipient's health plan.*

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve Medicaid Managed Care members **may not bill Medicaid fee-for-service** for any services. Nor may any Excellus BlueCross BlueShield non-participating provider bill a recipient for services that are covered by the recipient's Medicaid Managed Care contract, unless there is prior agreement with the recipient that they are being seen as a private patient as described above. *The provider must inform the recipient that the services may be obtained at no cost to the recipient from a provider that participates in the recipient's managed care plan.*

Claim Submission

The prohibition on charging a Medicaid recipient applies:

- when a participating Medicaid provider or a Medicaid Managed Care participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required time frame; or
- when a claim is submitted to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid on the date of service.

Collections

A Medicaid recipient, including an MMC enrollee, **must not be referred to a collection agency** for collection of unpaid medical bills or otherwise billed, *except for applicable copayments*, **when the provider has accepted the recipient as a Medicaid patient.** Providers, however, may use any legal means to collect applicable unpaid copayments.

Emergency Medical Care

A hospital that accepts a Medicaid recipient as a patient, including a Medicaid recipient enrolled in a managed care plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established copayments, a Medicaid recipient **should never be required to bear any out-of-pocket expenses** for:

- medically necessary inpatient services; or,
- medically necessary services provided in a hospital-based emergency room (ER).

This policy applies regardless of whether the individual practitioner treating the recipient in the facility is enrolled in the Medicaid program.

When reimbursing for ER services provided to Medicaid Managed Care enrollees, health plans must apply:

- The Prudent Layperson Standard
- Provisions of the Medicaid Managed Care Model Contract; and,
- NYSDOH directives

Claim Problems

If a problem arises with a claim submission for services covered by Medicaid fee-for-service, the provider must first contact CSC. If the claim is for a service included in the Medicaid Managed Care benefit package, the enrollee's managed care plan must be contacted. If CSC or the managed care plan is unable to resolve an issue because some action must be taken by the recipient's local department of social services (e.g., investigation of recipient eligibility issues), the provider must contact the local department of social services for resolution.

For questions regarding Medicaid Managed Care, please call the Office of Managed Care at 518-473-0122. For questions regarding Medicaid fee-for-service, please call the Office of Medicaid Management at 518-473-2160.

10.16 Member Complaints and Action Appeal Policy and Procedure

> **Note:** The following guidelines apply to members with coverage under HMOBlue Option, Blue Choice Option, Premier Option, and Blue Option Plus/Premier Option Plus products. They do not, however, apply to members in the Child Health Plus health benefit program. (See the *Benefits Management* section of this manual for procedures for Child Health Plus members.)

Excellus BlueCross BlueShield encourages all members to voice both positive and negative comments regarding care and services they have received. All member concerns are documented at the member's request, and Excellus BlueCross BlueShield responds in a timely manner. If a member has a concern that cannot be resolved immediately on the telephone, Excellus BlueCross BlueShield informs the member of the right to file a formal complaint or to designate a representative to file a complaint on the member's behalf. Excellus BlueCross BlueShield describes these rights in the member handbook.

Assistance is available from Excellus BlueCross BlueShield to file member complaints; complaint appeals and action appeals. Members should call the number listed on their Excellus BlueCross BlueShield identification card to request assistance.

In no event will Excellus BlueCross BlueShield retaliate or take any discriminatory action against a member because the member has filed a complaint.

Excellus BlueCross BlueShield is required to make the complaint procedures accessible to members who do not speak English as a primary language. Upon request, Excellus BlueCross BlueShield will provide a written copy of the complaint procedure, readable at a fourth-grade level.

The following subsection addresses:

- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental/investigational determination (complaints & complaint appeals).
- The review of issues that involve a contractual benefit, not associated with medical necessity or experimental/investigational determination (action appeal).
- The review of issues that involve a medical necessity or experimental/investigational determinations (utilization review action appeals).

Medicaid Complaint Procedure

A. Complaints

1. A member or a member's representative may call Customer Care or come in person to register a complaint. (See Member Complaints on the *Contact List* in this manual.) Alternatively, a member or a member's representative may submit a complaint in writing to the Customer Care department at Excellus BlueCross BlueShield address listed on the *Contact List*. Complaints must be filed within 60 business days of the initial determination.

   If the complaint was filed orally, an Advocacy Associate will document a summary of the complaint form and submit the form to the member for signature, with the exception of expedited cases. Investigation of the complaint will continue during this process.

2. Customer Care representatives are available to document the member's complaint during regular business hours. After regular business hours and on weekends, the member may leave a message at 1-800-650-4359. If a member leaves a message or submits a complaint in writing, a Customer Care representative will telephone the member to verify receipt of the complaint. The representative will contact the member on the next business day after receipt of the oral or written complaint. An acknowledgement is sent within 15 days upon receipt of a written complaint.

3. An Advocacy Associate records the member's complaint and initiates a thorough review.

4. Time frames for response to a complaint:

   a) Within 15 calendar days of receipt of the complaint, an Excellus BlueCross BlueShield representative will send the member a written acknowledgment, including the name, address and telephone number of the individual or department handling the complaint. This acknowledgment will inform the member of the status of the complaint and advise whether any additional information is required for Excellus BlueCross BlueShield to process the complaint.

   b) Additional required information may include but is not limited to such items as medical records, a chronology of events, or legal documents related to the complaint.

   c) Once Excellus BlueCross BlueShield has received all necessary information, it will resolve the complaint on the following schedule:

      (1) **Within 48 hours after receipt of all necessary information, but no more than seven days from receipt of the complaint** when a delay would significantly increase the risk to the member's health **(Expedited Complaint)**. Excellus BlueCross BlueShield will notify the member of its decision by telephone within two business days, with a written notice to follow within 24 hours after the determination.

      (2) All other complaints shall be resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of the complaint. Excellus BlueCross BlueShield shall maintain reports of all complaints that are unresolved after 45 days.

B. Complaint appeals

Members have 60 business days after receipt of the complaint determination notice to file an appeal. An acknowledgement of the appeal must be sent within 15 days. Once Excellus BlueShield has received all of the necessary information it will resolve the complaint appeal on the following schedule:

a) Whenever a delay would significantly increase the risk to a member's health, complaints will be resolved, and the member will be notified no more than two business days after receipt of all of the necessary information.

b) All other complaints will be resolved, and the member notified within 30 days after the receipt of all of the necessary information.

C. Determinations

a) Appropriate administrative staff will decide the complaint or complaint appeal.

b) If the complaint relates to a clinical matter, the reviewer will be, or will consult with, a licensed, certified or registered health care professional.

c) Excellus BlueCross BlueShield will notify the member in writing of the determination. The notice will include detailed reasons for the determination, the clinical rationale, if applicable, the procedure for complaints, and the option to contact the Department of Health regarding the complaint, including the toll-free telephone number.

D. Investigation and Documentation of Complaints

1. **Research/Investigation**: All complaints are investigated thoroughly. The research/investigation phase includes but is not to the following interventions:
    a) Contact with appropriate provider and/or supervisor for intervention.
    b) Review written records to gather information.
    c) Obtain responses from appropriate staff as necessary.
    d) Contact with Medical Director(s) for all concerns regarding quality of care and treatment issues.
2. **Documentation**: All complaints are documented.
    a) All research/investigative activities and results are documented by the Advocacy Associate on the Grievance Tracking database.
    b) Documentation includes the names of the individuals who have been contacted for intervention or for informational purposes regarding the complaint.
    c) Any action taken and communication with a member is also documented on the database. The final resolution will include information received in the research phase and any additional explanatory information that will assist the member in their understanding of the process.

E. Records

The Advocacy Unit maintains a file on each complaint that includes the following:

a) The date that Excellus BlueCross BlueShield received the complaint.

b) Documentation compiled by the Advocacy Associate relating to the complaint.

c) The date of and a copy of the acknowledgment sent to the complainant.

d) A copy of the response to the complaint, including the date of determination and the titles and/or credentials of the personnel who reviewed the complaint.

F. Record/Information Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard complaints:

- Excellus BlueCross BlueShield will identify and request information **in writing** from the member and provider within 15 business days of receipt of the incomplete information, stating what information must be supplied.
- If additional information is not received, Excellus BlueCross BlueShield will send a statement in writing that the determination could not be made and the date the additional information time frame expires.

For expedited complaints:

- Excellus BlueCross BlueShield will expeditiously identify and request information via **phone or fax** to the member and provider followed by written notification to the member and provider.

Medicaid Action Appeal Procedure

A member may appeal adverse determinations. The Advocacy Unit is responsible for appeals related to adverse determinations. The member may make a verbal request for appeal of an adverse determination by calling the phone number listed on their identification card. Written appeal requests should be submitted to the Advocacy Department, P.O. Box 4717, Syracuse, NY 13221.

An Advocacy Associate will prepare and present all action appeals related to medical necessity or experimental or investigational to a Medical Director who was not involved in the initial determination. For action appeals involving contractual benefit denials, an Advocacy Associate who was not involved and who is not a subordinate to the person who worked on the initial decision will prepare and respond to the appeal. When necessary, the Advocacy Associate will obtain a Clinical Peer Review for the Medical Director's consideration. For information related to action appeal notification and determination time frames, visit our website (see below). Select the *Benefits Management* section for a chart titled *UM Initial Determination Time Frames - Medicaid & Safety Net Products*.

- Provider.ExcellusBCBS.com/resources/forms

For MMC (HMOBlue Option, Blue Choice Option, Premier Option, and HARP) products, the New York State Department of Health defines medically necessary as "healthcare and 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. For children and youth, medically necessary means health care and services that are necessary to promote the normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability."

In general, denials, complaints and action appeals must be peer-to-peer, which means that the credentials of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In

addition, the reviewer should have clinical experience relevant to the denial (e.g., denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).

In addition:

- A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.
- A physician certified in addiction treatment must review all inpatient level of care/continuing stay denial for SUD treatment.
- Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist.
- A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver.

A. Definition

For purposes of this policy, a Clinical Peer Reviewer means:

1. A physician who possesses a current and valid non-restricted license to practice medicine; or
2. A health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration, or where no provision for a license, certificate or registration exists, and is credentialed by the national accrediting body appropriate to the profession.
3. For behavioral health decisions, peer-to-peer reviews must include a physician who is board-certified in general psychiatry for review of all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment must review all inpatient level of care denials for substance use disorder (SUD) treatment.

B. Procedure

A member, the member's designee and, in connection with retrospective determinations, a member's health care provider, may appeal an Adverse Determination rendered by Excellus BlueCross BlueShield through the internal appeal process described below.

1. The member has the right to designate a representative to assist him/her in the action appeal process. The member must contact Customer Care either verbally or in writing to appoint a representative.
2. The member has 60 business days after receiving notice of an initial adverse determination to request an action appeal.
3. If the action appeal was filed orally, an Advocacy Associate will document a summary of the action appeal on a complaint form, with the exception of expedited cases and submit the form to the member for signature. Investigation of the action appeal will continue during this process.
4. The member has the right to present evidence (within a limited time stated by Excellus BlueCross BlueShield) and allegations of fact or law, in person as well as in writing.

5. The case file, including medical records and any other documents and records, is considered during the action appeal process. The plan is required to send the member or their designee a copy of the case file for examination before and during the action appeal process.

C. Time Frames

1. Fast-Track Action Appeals

a) In any case except one involving retrospective review, a fast-track appeal may be available if:

(i) The adverse determination involves continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, home health care services following discharge from an inpatient hospital admission, potential court-ordered mental health or substance use disorder services; or

(ii) The health care provider believes an immediate appeal is warranted.

(iii) If a fast-track appeal is requested but we determine that it does not meet the conditions described above, we will notify the member verbally and in writing within two days that the expedited appeal has been declined, however, we will immediately initiate a standard appeal.

b) A Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial adverse determination will review the appeal. Excellus BlueCross BlueShield will provide reasonable access to its Clinical Peer Reviewer within one business day of receiving notice of the taking of an expedited appeal.

c) Excellus BlueCross BlueShield will decide the fast-track appeal and notify the member and their health care provider of the determination as expeditiously as possible, but no later than **72 hours** after receipt of the appeal or **two business days** after receipt of all necessary information, whichever is less, with the exception of concurrent substance use review, which will be handled within 24 hours of receipt. If Excellus BlueCross BlueShield fails to make a determination within these time frames, the request will be deemed approved. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Excellus BlueCross BlueShield demonstrates (and notifies the member) that additional information is needed and that the delay is in the best interest of the member. If Excellus BlueCross BlueShield requires additional necessary information to conduct the appeal, we will notify the member or the member's designee and the member's health care provider immediately, by telephone or facsimile, to identify and request the necessary information, followed by written notification.

d) Excellus BlueCross BlueShield will make reasonable effort to provide oral notice of the determination to the enrollee and provider at the time the determination is made and will provide written confirmation of the decision within two business days of the determination. If Excellus BlueCross BlueShield upholds the initial adverse determination, written confirmation will be a final adverse determination.

2. Standard Appeals

When a fast-track appeal is not available, the member has the right to a standard appeal. Excellus BlueCross BlueShield will decide the standard appeal and notify the member or their designee as fast as the member's condition requires, and no later than **30 calendar days** from receipt of the appeal. Written notice of the determination will be provided to the member (and member's provider if they requested the review) within two business days after the determination is made. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Excellus BlueCross BlueShield demonstrates (and notifies the member) that additional information is needed and that the delay is in the best interest of the member.

a) Excellus BlueCross BlueShield will send the member an acknowledgment of their appeal within fifteen calendar days, indicating the address and telephone number of the person or department responsible for rendering a decision. If Excellus BlueCross BlueShield requires additional necessary information to conduct the appeal, we will notify the member or the member's designee and the Member's health care provider, in writing, within fifteen calendar days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of the necessary information is received, Excellus BlueCross BlueShield will request the missing information, in writing, within five business days of receipt of the partial information.

b) For action appeals involving clinical matters, a Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial Adverse Determination will review the appeal. Action appeals for non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original decision.

c) If Excellus BlueCross BlueShield fails to make a determination within 30 calendar days after receipt of all necessary information, the request will be deemed approved, unless an extension has been requested.

3. Action Appeal Notices

The action appeal notification will include:

a) the date that the action appeal was filed and a summary of the action appeal, along with the date that the action appeal was completed.

b) The result and the reasons for the determination, and if the initial Adverse Determination is upheld, including the clinical rationale, if any.

c) If the determination was not in favor of the member, a description of the member's fair hearing rights, if applicable.

d) The right of the member to contact the New York State Department of Health, including the toll-free telephone number.

e) For action appeals involving medical necessity or an experimental or investigational treatment, the notice must also include:

i. A clear statement that the notice constitutes a final adverse determination and that specifically uses the terms "medical necessity" or "experimental/investigational;"

ii. Excellus BlueCross BlueShield's contact person and their telephone number.

iii. The member's coverage type.

iv. The name and full address of the Excellus BlueCross BlueShield's utilization review agent.

v. The utilization review agent's contact person and their telephone number.

vi. A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service. Where the denial was for out-of-network services or a referral, the name of the provider with the training and experience to provide the requested service.

vii. A statement that the member is eligible for an external appeal and the time frames for filing, and if the action appeal was fast-tracked, a statement that the member may choose to file a standard action appeal with Excellus BlueCross BlueShield, or file an external appeal;

viii. A copy of "Standard Description and Instructions for Health Care Consumers to Request an External Appeal;"

ix. Right of the member to complain to the NYSDOH at any time, including toll-free phone number.

x. Description of member's fair hearing rights (see below); and

xi. A statement that the notice is available in other languages and formats for special needs and how to access these formats.

f) For action appeals regarding prescription medications that are classified as antipsychotics, immune-suppressants, anti-retroviral therapy, anticonvulsants or antidepressants, a clear statement to include:

i. that the requested medication must be provided when the prescriber demonstrates that, in their reasonable professional judgment, consistent with the FDA approved labeling or Official Compendia, the medication is medically necessary and warranted to treat the member.

ii. whether the appeal is upheld because the necessary information was not provided, and the time for review has expired, or the prescriber's reasonable professional judgment has not been adequately demonstrated and the time for review has expired.

g) For action appeals involving personal care services, long-term support services and/or a residential health care facility, the number of hours per day, number of hours per week and the personal care services function:

i. that was previously authorized.

ii. that was requested by the member or the member's representative.

iii. that was authorized in the new authorization period if any

iv. the original authorization period and the new authorization period.

4. Fair Hearing

MMC members may request a fair hearing if Excellus BlueCross BlueShield denies coverage and the member exhausts the internal appeal process. The member may request a fair hearing from the state and still file an external appeal, or vice versa. In some cases, the member may be able to continue to receive the terminated, suspended or reduced services until the fair hearing is decided. If the Member asks for both a fair hearing and an external appeal, the decision of the Fair Hearing Office will control. Refer to the *Fair Hearing* subsection below for additional information.

5. Waiving Internal Appeal Process

If the member and Excellus BlueCross BlueShield jointly agree to waive the internal appeal process, Excellus BlueCross BlueShield must provide a written letter agreeing to the waiver that includes information regarding the filing of an external appeal within 24 hours of the agreement to waive its internal appeal process.

D. Record Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard appeals: Excellus BlueCross BlueShield will identify and request information **in writing** from the member and provider within the applicable case time period but no later than 15 calendar days of receipt of the request.

For fast-track appeals: Excellus BlueCross BlueShield will expeditiously identify and request information via **phone or fax** to the member and provider followed by **written notification** to the member and provider.

E. External Appeal

A member, the member's designee and, a member's health care provider, may request in conjunction with a concurrent or retrospective appeal an adverse determination rendered by Excellus BlueCross BlueShield through the external appeal process. Only a member or the member's designee may file in conjunction with a pre-service determination. An external appeal must be submitted within 60 days (for a provider) or four months (for a member) of receipt of the final adverse determination of the first level appeal, which is the only level of appeal now offered.

An external appeal may be filed when:

1. the member has had coverage of a health care service, that would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the ground that such health care service is not medically necessary, **and**
2. Excellus BlueCross BlueShield has rendered a final adverse determination with respect to such health care service, **or**
3. both Excellus BlueCross BlueShield and the member have jointly agreed to waive any internal appeal.

An external appeal may also be filed when:

1. the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, **and**
2. the denial has been upheld on appeal **or** both Excellus BlueCross BlueShield and the member have jointly agreed to waive any internal appeal
3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health care services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Excellus BlueCross BlueShield or (c) for which there exists a clinical trial.
4. **and** the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. The physician certification mentioned above will include a statement of the evidence relied upon by the physician in certifying their recommendation,
5. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

An external appeal may also be filed:

1. if a health service is out-of-network and an alternate recommended treatment is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial,
2. **and** the insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network health service, and recommends a health service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment.

An external appeal may also be filed:

1. if the insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service, and the member's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health services sought, certifies that the in-network health care provider or providers recommended by the health plan do not have the training and experience necessary to meet the particular health care needs of the member and who is able to provide the requested service,

2. **or** an initial adverse determination on a formulary exception for a closed formulary product has been issued (please note that MMC, Health and Recovery Plan and Child Health Plus do not currently have a closed formulary).

A member or the member's designee may request a fair hearing and ask for an external appeal. If both a fair hearing and an external appeal are requested, the decision of the fair hearing officer will be the one that is followed.

An external appeal may be filed after an appeal determination has been upheld. However, if the member or member's designee wants an external appeal, they will lose their right to an external appeal if they do not file an external appeal application within the filing time frame.

Fair Hearing

In addition to the grievance and appeal guidelines outlined above, a member with coverage under Excellus BlueCross BlueShield's HMOBlue Option, Blue Choice Option or Blue Option Plus/Premier Option Plus products may request a fair hearing regarding adverse determinations concerning enrollment, disenrollment and eligibility; and regarding the denial, termination, suspension or reduction of a clinical treatment or other benefit package service. This hearing allows the member to present their case in person and ask the attendees questions regarding the member's case.

Fair hearing rights and the related form are included with member notices of final adverse determinations.

If the member believes that an action taken by Excellus BlueCross BlueShield is wrong, they can ask for a fair hearing by telephone or in writing. (See *Contact List* in this manual.)

The member must ask for a fair hearing within 120 days from the date of the appeal resolution. Once the fair hearing is requested, the State will send the member a notice with the time and place of the hearing. The member has the right to bring a person to help, such as a lawyer, a friend, a relative, or someone else. At the hearing, this person can give the hearing office something in writing or just orally state why the action should not be taken. This person can also ask questions of any other people at the hearing. The member also has the right to bring people to speak in their favor. If the member has any papers that will help their case (pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc.), they should bring them.

The member has the right to see their case file to help get ready for the hearing, and the case file will be provided directly to the member free of charge. The member may call or write to the NYS Office of Temporary and Disability Assistance, Fair Hearing Section, (as listed under fair hearings on the *Contact List* in Section 2 of this manual). The Office of Temporary and Disability Assistance will give the member— and the hearing officer— free copies of the documents from the member's file. The member should ask for these documents before the date of the hearing. The documents will be provided to the member within a reasonable time before the date of the hearing. Documents will be mailed only if the member requests that they be mailed.

The member has the right to request continuation of benefits while the fair hearing is pending. If Excellus BlueCross BlueShield's action is upheld at the hearing, the member may be liable for the cost of any continued benefits.

10.17 MMC Health and Behavioral Health for Children Under Age 21

The New York State Office of Addiction Services and Supports (OASAS), Office of Children and Family Services, (OCFS), Office of Mental Health (OMH), Office of People with Developmental Disabilities (OPWDD) and the Department of Health (DOH) released final Medicaid Managed Care Organization Children's System Transformation Requirements and Standards in October 2017.

These standards outline the key components of the Children's Medicaid Transformation, which is subject to policy and billing guidance issued by New York state. In addition, the time frames for the transformation are subject to approval by the Centers for Medicare & Medicaid Services (CMS).

Expanded Children Services into Medicaid Managed Care

New York Medicaid State Plan services formally covered under fee-for-service (FFS) are now included in the managed care benefit package to integrate children and youth's access more fully to physical health (PH) and behavioral health (BH) care.

Services include:

- Licensed Behavioral Health Practitioners, and
- Crisis Intervention
- Other Licensed Practitioner (OLP)
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Crisis Intervention
- Family Peer Support Services
- Youth Peer Support and Training

These services are available to any Medicaid enrollee under 21 years of age who meets medical necessity criteria (MNC).

A major goal of this transition and transformation is the elimination of care/service delivery silos to encourage and promote a care delivery system where Medicaid Managed Care organizations, service providers, care managers, family peers, youth peers, multiple child serving systems of care (e.g., education, child welfare, juvenile justice, developmental disabilities), and State and local government agencies work together to support the physical, social and emotional development of children and youth while increasing health and wellness outcomes during childhood and into adulthood.

Care for Medically Fragile Children

Excellus BlueCross BlueShield must contract with providers who have expertise in caring for medically fragile children, to ensure that medically fragile children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from Excellus BlueCross BlueShield for out-of-network providers when participating providers cannot meet the child's needs. Please refer to subsection 4.4 of this Participating Provider Manual for additional information regarding Excellus BlueCross BlueShield's referral requirements.

MMC Benefits

As of July 1, 2021, Foster Care Children in New York state moved from a fee-for-service model to Medicaid Managed Care. Excellus BlueCross BlueShield has a dedicated children's team to address the managed care implementation. Excellus BlueCross BlueShield works collaboratively with local departments of social services and 29-I Health Facilities or Voluntary Foster Care Agencies to ensure physical and behavioral health needs are met for this vulnerable population. If eligible, the foster care members participate in the newly carved in behavioral health benefits including Home and Community based services (HCBS) and Child and Family Treatment Support Services (CFTSS).

The following table represents the current delivery of benefits that are included in the Children's System Transformation for the MMC population under age 21.

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Fee-for-Service	July 1, 2019
Community First Choice Option (CFCO) State Plan Services for children meeting eligibility criteria	Fee-for-Service	July 1, 2019
Children's Crisis Intervention	Fee-for-Service/1915(c) Children's Waiver service	January 1, 2019 to December 31, 2019 Demonstration service for children eligible for aligned children's HCBS January 1, 2020 Children and Family Treatment and Support Services (CFTSS)
Children's Day Treatment	Fee-for-Service	TBD
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	Current MMC benefit for individuals age 21 and over	July 1, 2019
Continuing Day Treatment (minimum age is 18 for medical necessity for this adult oriented service)	Fee-for-Service	July 1, 2019
Community Psychiatric Support and Treatment (CPST)[9]	N/A (New SPA service)	January 1, 2019
Crisis Intervention Demonstration Service	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
Family Peer Support Services	Fee-for-Service/1915(c) children's waiver service	January 1, 2019 to June 30, 2019 Demonstration service for children eligible for aligned children's HCBS July 1, 2019 (as a new CFTSS service for children)
Inpatient Psychiatric Services	Current Medicaid Managed Care Benefit	Current benefit

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
OMH and OASAS Licensed Outpatient Clinic Services	Current MMC Benefit	Current Benefit
Medically Managed Detoxification (hospital-based)	Current MMC Benefit	Current Benefit
Medically Supervised Inpatient Detoxification	Current MMC Benefit	Current Benefit
Medically Supervised Outpatient Withdrawal	Current MMC Benefit	Current Benefit
OASAS Inpatient Rehabilitation Services	Current MMC Benefit	Current Benefit
OASAS Opioid Treatment Program (OTP) Services (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OASAS Outpatient and Residential Addiction Services	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
OASAS Outpatient Rehabilitation Programs (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OASAS Outpatient Services (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OMH State-Operated Inpatient	Fee-for-Service	TBD
Other Licensed Practitioner (OLP)	N/A (New CFTSS service)	January 1, 2019
Partial Hospitalization	Fee-for-Service	July 1, 2019
Personalized Recovery-Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)	Fee-for-Service	July 1, 2019
Psychosocial Rehabilitation (PSR)	N/A (New CFTSS service)	January 1, 2019
Rehabilitation Services for Individuals in Community Residences	Fee-for-Service	TBD
Residential Rehabilitation Services for Youth (RRSY)	Fee-for-Service	TBD
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	Office of Children and Family Services (OCFS) Foster Care	July 1, 2019
Residential Treatment Facility (RTF)	Fee-for-Service	TBD

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
Teaching Family Home	Fee-for-Service	TBD
Youth Peer Support and Training	Fee-for-Service/1915(c) Children's Waiver service	January 1, 2019 to December 31, 2019 Demonstration service for children eligible for aligned children's HCBS January 1, 2020 (as a new CFTSS service)

Excellus BlueCross BlueShield will authorize these services, if applicable, in accordance with established time frames as described in the MMC Model Contract, the Office of Health Insurance Programs Principles for Medically Fragile Children, under early and periodic screening, diagnostic and treatment (EPSDT), HCBS, and Community First Choice Option (CFCO) rules, and with consideration for extended discharge planning.

Appointment Availability Standards

Providers must adhere to the appointment availability standards established by the New York State Department of Health. Maintaining these minimum standards ensures patient access to care. Excellus BlueCross BlueShield will conduct an annual audit to ensure compliance with these standards. The appointment availability standards on the following pages apply to Medicaid Managed Care transition for children under the age of 21.

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Mental Health Outpatient Clinic		Within 24 hours of request	Within 1 week	Within 5 days of request	Within 5 days of request
Intensive Psychiatric Rehabilitation Treatment (IPRT)			2-4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation				

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Comprehensive Psychiatric Emergency Program (CPEP)	Upon presentation				
Inpatient Addiction Treatment Services (hospital or community based)	Upon presentation	Within 24 hours		Within 5 days of request	Within 5 days of request
Medically Managed Withdrawal Management	Upon presentation				
Medically supervised withdrawal (Inpatient/ Outpatient)	Upon presentation				
Residential Addiction Services Stabilization in Residential Setting		Within 24 hours of request	Two to four weeks	Within five days of request	Within five days of request
Residential Addiction Services Rehabilitation in Residential Setting		Within 24 hours of request	Two to four weeks	Within five days of request	Within five days of request
Outpatient Addiction Treatment Services Intensive Outpatient Treatment (IOP)				Within 24 hours	
Outpatient Rehabilitation Services		Within 24 hours of request	Within one week of request	Within five days of request	Within five days of request
Outpatient Withdrawal Management		Within 24 hours of request		Within five days of request	Within five days of request
Medication Assisted Treatment (MAT)		Within 24 hours of request		Within five days of request	Within five days of request
Opioid Treatment Program (OTP)		Within 24 hours of request	Within one week of request	Within five days of request	Within five days of request
Other Licensed Practitioner (Children)		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Crisis Intervention (Children)	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
Crisis Intervention (Adult)	Upon Presentation	Within 24 hours for short-term respite		Immediate	
Community Psychiatric Support and Treatment (Children)		Within 24 hours for intensive in-home & crisis response services under definition	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
Family Peer Support Services (Children)		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training (Children)			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Peer Supports		Within 24 hours for symptom management	Within one week	Within five days	
Psychosocial Rehabilitation (Children)		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite (Children)	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support (Children)			Within 5 business days of request		Within 5 business days of request
Habilitation (Children)			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	
CPST, Habilitation, Family Support and Training, and Psychosocial Rehabilitation (adult)			Within 2 weeks	Within five days of request	Within five days of request

Provider Training and Education

Excellus BlueCross BlueShield offers a comprehensive provider training and support program for providers serving children under the age of 21. The training program offers network providers an opportunity to gain appropriate knowledge, skills and expertise as well as receive technical assistance in complying with the requirements under managed care. The provider training plan is reviewed annually and coordinated

with the regional planning consortiums, to develop a uniform provider training curriculum that addresses clinical components necessary to meet the needs of children under the age of 21.

Initial orientation and training are provided for all providers new to Excellus BlueCross BlueShield's network. Additional training opportunities will be made available (at least annually) at a variety of times and modalities to ensure that providers have an opportunity to participate.

Materials and training schedules are available on our website (see below) and communicated in our provider newsletter.

- Provider.ExcellusBCBS.com/resources/management/staff-training

Training will include:

- Technical assistance on billing, coding, data interface, documentation requirements, provider profiling programs and utilization management requirements, credentialing and re-credentialing.
- Preauthorization expectations, utilization and documentation requirements, processes for assessments for HCBS eligibility (targeting criteria, risk factors and functional limitations), and plan of care development and review.

Additional training opportunities:

- Unique needs of special populations including serious emotional disability, substance use disorder, transitional aged youth, early intervention, medically fragile children and those involved in the child welfare system
- Cultural competency
- Family-driven, youth-guided, person-centered treatment planning and service provision.
- Recovery and resilience principles
- Multidisciplinary teams with member/family member/caregiver engagement and meaningful participation and member choice
- Discuss requirements of early and periodic screening, diagnostic and treatment, and completion of required foster care initial health assessments for developing a comprehensive plan of care
- Trauma-informed care
- Common medical conditions and medical challenges in the medically fragile population

Behavioral Health and Medical Integration

Excellus BlueCross BlueShield promotes behavioral health and medical integration for children, including at-risk populations defined by the state of New York.

Education and Training

The Plan provides education and training opportunities to in-network behavioral health/physical health providers and Health Homes to enhance care coordination.

- **Rapid Consultation:** Excellus BlueCross BlueShield offers consultation services from an in-network Board Certified Child and Adolescent Psychiatrist for PCPs to access by telephone or e-

mail to increase skill/knowledge and provide accurate diagnosis and effective evidence-based treatment including medication management.

- **Training:** Excellus BlueCross BlueShield offers training opportunities for behavioral health/physical health providers that focus on coordinated person-centered care and the roles/responsibilities of an integrated team, advantages of health care integration and highlight benefits to the member of community integration.

Care Coordination

Excellus BlueCross BlueShield's Care Management program will help meet the needs of children and adolescents with behavioral and physical health needs by providing linkages to an integrated continuum of supports and community-based services. Where applicable, Care Managers will contact physical health providers to suggest a behavioral health consult. The Case Manager will assist the member with making arrangements for the behavioral health consult and follow-up to ensure the consult was conducted. In addition, Excellus BlueCross BlueShield provides post discharge care coordination and support to the member, their identified family, and providers. Care Managers will work to engage members in outpatient services post discharge. Care Managers will also collaborate with Health Homes and HCBS providers to ensure appropriate assessments and referrals are made for HCBS services, where applicable.

Children's Home and Community-Based Services

Home and Community-Based Services (HCBS) are designed to provide Medicaid Managed Care members with specialized supports to remain in the community and avoid residential and inpatient care. Services previously delivered under agency-specific 1915(c) waivers have been aligned and carved into MMC.

HCBS benefits include:

- Health Home (if not otherwise eligible under the State Plan)
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Environmental Modifications
- Habilitation
- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Vehicle Modifications

Prior to rendering services, always check the member's identification card and visit our provider website, Provider.ExcellusBCBS.com, to verify eligibility and coverage, or contact Customer Care.

All HCBS under the 1115 MRT Waiver are available to any individual under the age of 21 who is determined to be eligible. Eligibility is based on target criteria, risk factors and functional limitations.

Individuals under the age of 21 who are eligible for HCBS may also enroll with a Health Home. Health Home is a care management service model for individuals enrolled in Medicaid with complex, chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated

physical health and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

Referral Process for HCBS and HCBS Eligibility Assessment

The eligibility assessment for Home and Community-Based Services will be conducted by the Health Home Care Manager (HHCM) or by the State's Independent Entity for children that have chosen not to enroll with a Health Home. HCBS eligibility will be determined using new target population, risk factor and functional eligibility criteria that has been applied to Child and Adolescent Needs and Strengths New York (CANS-NY) or by the Office for People with Developmental Disabilities (OPWDD) Level of Care/Medical Care Screen for children with developmental disabilities who may be medically frail or in foster care, which determines if the member is eligible for HCBS.

If eligibility is determined, the HHCM and/or the State's Independent Entity will develop a comprehensive plan of care that includes HCBS, as well as all the other services a member needs inclusive of the child and family's goals.

Upon contact from the Health Home/State Independent Entity, Excellus BlueCross BlueShield will call HCBS designated providers to confirm referral readiness. Once the member chooses providers, referral(s) should be made, as authorized by Excellus BlueCross BlueShield, if required. The HHCM/State Independent Entity should work to keep the member engaged and ensure linkage: reminders, phone calls, offering transportation, etc. The HCBS provider does an assessment, works with Excellus BlueCross BlueShield by submitting authorization request including scope, duration, and frequency, and communicates with HHCM/State Independent Entity. The Managed Care Plan will confirm that the plan of care is updated and implemented.

Sharing and Integration of HCBS and Health Home Information

Excellus BlueCross BlueShield's information systems will be inclusive of functionality for the children's population. All information and data transmitted by HCBS/Health Home providers related to a member receiving HCBS and/or Health Home services will be integrated into the member electronic record, including member assessments, care management notes, discharge plans, member requests at POC meetings, and care plans. Analysis of the POC and completion of the assessment/s serve multiple purposes. They are used to create authorizations for HCBS services when applicable; and also to track and provide data related to HCBS assurances and sub-assurances, assessment elements, level of care/level of need designation, plan of care elements, qualified provider, health and welfare, and fiscal accountability monitoring for children receiving HCBS, including amount, duration and scope of services authorized and reimbursed.

HCBS Review and Approval of the Plan of Care

The plan of care (POC) must be developed in a conflict-free manner, meaning that the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network; they must have a choice among available providers. Once the plan of care is completed, a health home care manager will work in collaboration with the individual to identify the Home and Community-Based Services to be included in the plan of care. At least one HCBS must be included in the POC for eligible individuals. If the individual does not meet the functional need for 1915i-like services through the eligibility tool, the POC cannot include 1915i-like services.

Reassessment for HCBS is conducted on an annual basis, or after a significant change in the member's condition, such as an inpatient admission or a loss of housing. Health Homes will provide care management and will have a role in the assessment of individuals for Home and Community-Based Services. Provider agencies will deliver the HCBS services as described in this manual. Provider agreements should include procedures for monitoring HCBS utilization for each enrollee. Excellus BlueCross BlueShield will use a data-driven approach to identify service utilization patterns that deviate from any approved POC and will also conduct outreach to review such deviations and will also require appropriate adjustments to either service delivery or the POC.

CMS requires state oversight to determine that 1) the assessment is comprehensive and compliant with federal regulations and state guidance, 2) the planning process is person-centered and addresses services and support needs in a manner that reflects individual preferences and goals, 3) the services were actually provided, and 4) the person is assessed at least annually or when there is a change in condition (e.g., loss of housing, inpatient admission) to appropriately reflect service needs.

CMS requires that state managed care plans and providers monitor and provide reporting for individuals enrolled in Home and Community-Based Service waivers to demonstrate that these individuals are receiving appropriate services. HCBS must be managed in compliance with the Centers for Medicare & Medicaid Services HCBS Final Rule, as well as any applicable New York state guidance.

Health Plan Acceptance of the Plan of Care

To help ensure a smooth transition of HCBS and long-term services and supports (LTSS) authorizations for individuals in receipt of HCBS, Excellus BlueCross BlueShield accepts POCs in accordance with CMS approval and timelines:

- 1) for its enrolled population or 2) for an individual under age 21 for whom the Health Home Care Manager or independent entity has obtained consent to share the POC with Excellus BlueCross BlueShield and the family has demonstrated the health plan selection process has been completed.

Excellus BlueCross BlueShield will continue to accept plans of care for individuals under the age of 21 who are in receipt of HCBS in advance of the effective date of enrollment when Excellus BlueCross BlueShield is notified by another health plan, a Health Home Care Manager, or the independent entity that there is consent to share the plan of care with Excellus BlueCross BlueShield and the family has demonstrated the health plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, health plan selection has been confirmed by the LDSS/VFCA.

Authorization of Covered HCBS and LTSS Services

Excellus BlueCross BlueShield will continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC will be developed.

During the initial 180 days of the transition, Excellus BlueCross BlueShield will authorize any children's specialty services newly carved into MMC that are added to the plan of care under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for fee-for-service individuals under the age of 21 who are in receipt of HCBS at the time of enrollment, Excellus BlueCross BlueShield will continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the individual, or the provider refuses to work with the health plan) for no less than 180 days, during which time, a new plan of care will be developed.

Quality Management Committee

The Behavioral Health Quality Management Committee (BHQM) is responsible for carrying out the planned activities of the BHQM Program. The BHQM will expand existing QM committee functions to meet the quality requirements and standards for the populations, benefits and services for individuals under the age of 21, as described in the Children's System Transformation Requirements and Standards.

The committee meets quarterly to review quality of care measures, accessibility to care and other issues of concern. Membership and attendance will be documented and include, at a minimum, Excellus BlueCross BlueShield's Behavioral Health Medical Director and Clinical Director, and Director of Quality Improvement. In addition, the BHQM will include advisory representation from members, family members, youth and family peer support specialists and child-serving providers.

Access and Continuity of Care

To ensure access and continuity of care for Medicaid Managed Care members, Excellus BlueCross BlueShield will allow children to continue with their care providers, including medical, behavioral health and HCBS providers, for a continuous episode of care. This requirement will be in place for the first 24 months of the Medicaid Managed Care transition. It applies only to episodes of care that were ongoing during the transition period from FFS to MMC.

To preserve continuity of care, enrollees will not be required to change Health Homes or Health Home Care Management Agencies at the time of the transition. Excellus BlueCross BlueShield will be required to pay on a single case basis for enrollees in a Health Home when the Health Home is not under contract with Excellus BlueCross BlueShield.

If an individual enrolled in foster care is placed in another county, and the Excellus BlueCross BlueShield product in which they are enrolled operates in the new county, Excellus BlueCross BlueShield must allow for the individual to transition to a new primary care provider and other health care providers without disrupting the care plan that is in place.

If an individual enrolled in foster care is placed outside of Excellus BlueCross BlueShield's service area, Excellus BlueCross BlueShield must allow that individual to access providers with expertise in treating individuals involved in the foster care system, as necessary, to ensure continuity of care and the provision of all medically necessary benefit package services.

Foster Care Initial Health Assessments

Excellus BlueCross BlueShield is committed to ensuring network adequacy to meet the time frames for completion of required foster care initial health assessments. A series of assessments (see the table below) provide a complete picture of the health needs of an individual in foster care and is the basis for developing a comprehensive plan of care.

The table on the next page outlines the time frames for initial health activities, to be completed within 60 days of placement.

An "X" in the Mandated Activity column indicates that the activity is required within the indicated time frame.

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Performed By
24 hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or child welfare caseworker or health staff
5 days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child welfare caseworker or designated staff
5 days	Initial HIV risk assessment for child without capacity to consent	X	X	Child welfare caseworker or designated staff
10 days	Request consent for release of medical records & treatment	X	X	Child welfare Caseworker or health staff
30 days	Initial medical assessment	X	X	Health practitioner
30 days	Initial dental assessment	X	X	Health practitioner
30 days	Initial mental health assessment	X		Mental health practitioner
30 days	Family planning education and counseling and follow-up health care for youth age 12 and older (or younger, as appropriate)	X	X	Health practitioner
30 days	HIV risk assessment for child with possible capacity to consent	X	X	Child welfare caseworker or designated staff

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Performed By
30 days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child welfare caseworker or health staff
45 days	Initial developmental assessment	X		Health practitioner
45 days	Initial substance abuse assessment			Health practitioner
60 days	Follow-up health evaluation			Health practitioner
60 days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent and assessed to be at risk for HIV infection	X	X	Child welfare caseworker or health staff
60 days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child welfare caseworker or health staff

Credentialing

Excellus BlueCross BlueShield will accept New York state designation for the credentialing process. When contracting with New York state designated HCBS and Children and Family Treatment and Support Services (CFTSS) providers, Excellus BlueCross BlueShield may not separately credential individual staff members in their capacity as employees of these facility programs. Excellus BlueCross BlueShield must still conduct program integrity reviews to ensure that provider staff is not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. Excellus BlueCross BlueShield will still collect and accept program integrity-related information from these providers, as required in the MMC Model Contract, and requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program, or on the CMS Preclusion List.

Please refer to section 3.3 this Participating Provider Manual for additional information related to Excellus BlueCross BlueShield's credentialing process and criteria.

Utilization Management

Note: Please refer to the benefit array included at the end of Section 10 for a list of services requiring preauthorization/concurrent review authorization.

Utilization management requirements help to ensure that a person-centered plan of care meets individual needs and that concurrent review protocols consider various factors.

The Plan's utilization management program aims to ensure that treatment is specific to the member's condition, effective, and most clinically appropriate level of care. It also ensures that

- member care meets medical necessity criteria.
- treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care.
- services provided comply with our quality improvement requirements; and, utilization management policies and procedures are systematically and consistently applied; and
- focus for members and their families' centers on promoting resiliency and hope.

To accomplish these objectives, participating providers must collaborate with us and adhere to program requirements and guidelines.

The utilization management team includes qualified behavioral health professionals with the appropriate level education, training and experience to conduct utilization management reviews. The team is under the direction of our licensed behavioral health medical directors, and staff meets regularly with the medical directors when there are any questions or concerns.

Our utilization review decisions are made in accordance with currently accepted behavioral health care practices, considering special circumstances of each case that may require deviation from the screening criteria. Our medical necessity criteria are used for the approval of medical necessity; plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer-to-peer discussion.

We conduct utilization management in a timely manner to minimize any disruption in the provision of behavioral health care services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. The decision-making process is based on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in under-utilization.

Coverage is not an entitlement, but rather is available when medical necessity is satisfied. Member benefit limits apply for a calendar year, regardless of the number of different behavioral health practitioners providing treatment for the member. Providers must work closely with our utilization management team to ensure judicious use of a member's benefit, and to carefully explain the treatment plan to the member in accordance with the member's benefit plan through Excellus BlueCross BlueShield.

The plan uses McKesson's InterQual Level of Care Criteria for both inpatient and outpatient mental health services, as well as New York state guidelines, and the LOCADTR 3.0 tool for substance use services. This multi-faceted approach to medical necessity criteria allows staff and the department to facilitate services and develop programs that can address most aspects of the member's behavioral health experience.

The New York State Medicaid Managed Care Model Contract requires that plans utilize the OASAS-provided LOCADTR 3.0 tool for making substance use disorder level of care decisions. The tool is accessible through the Health Commerce System (HCS). The LOCADTR is a web-based tool that utilizes a series of clinical questions to determine individual risk and resources. Following the several logic pathways, answers to the

questions lead to an initial LOCADTR recommended level of care. In most cases, this process will result in a level of care both recommended by the provider and approved by Excellus BlueCross BlueShield.

In addition, Excellus BlueCross BlueShield has established evidenced-based utilization management criteria, workflows and processes for rehabilitation and recovery services, including ACT, PROS, and BH HCBS. This will be achieved through collaboration across the service delivery system, including provider participation on utilization management and quality improvement committees, provider input on utilization management plan development and criteria, and enrollee feedback.

For LOCADTR 3.0 resources, visit https://oasas.ny.gov/locadtr.

InterQual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Both LOCADTR and InterQual criteria are reviewed annually. We are committed to the delivery of appropriate service and coverage, and offer no organizational incentives, including compensation, to any employed or contracted utilization management staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and utilization management staff is encouraged to bring inappropriate care or service decisions to the attention of the medical director.

Provider Reimbursement

Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide care management services that are being transitioned to Health Home, may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

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

Excellus BlueCross BlueShield must pay at least the Medicaid FFS fee schedule for 24 months or as long as New York state mandates, whichever is longer, for the following services/providers:

- CFTSS services, including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
- OASAS clinics (Article 32 certified programs)
- All OMH-licensed ambulatory programs (Article 31 licensed programs)
- Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

Excellus BlueCross BlueShield will ensure that all HCBS are paid according to the New York state fee schedule as long as Excellus BlueCross BlueShield is not at risk for the service costs (e.g., for at least two years, or until HCBS are included in the capitated rates).

Excellus BlueCross BlueShield will execute single case agreements with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan must pay at least the FFS fee schedule for 24 months for all single case agreements.

Appendix: Prepaid Benefit Package Grid

PREPAID BENEFIT PACKAGE

From **Appendix K** of the MEDICAID MANAGED CARE/
FAMILY HEALTH PLUS/
HIV SPECIAL NEEDS PLAN/
HEALTH AND RECOVERY PLAN
MODEL CONTRACT
as amended March 1, 2019

Note: If cell is blank, there is no coverage.

*	**Covered Services**	**MMC Non-SSI/Non-SSI Related**	**MMC SSI/SSI-Related**	**HARP**
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see §6.8 of this Agreement]
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered
3.	Physician Services	Covered	Covered	Covered
4.	Nurse Practitioner Services	Covered	Covered	Covered
5.	Midwifery Services	Covered	Covered	Covered
6.	Preventive Health Services	Covered	Covered	Covered
7.	Second Medical/Surgical Opinion	Covered	Covered	Covered
8.	Laboratory Services	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered, Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
9.	Radiology Services	Covered	Covered	Covered
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors.
11.	Smoking Cessation Products	Covered	Covered	Covered
12.	Rehabilitation Services (not including Psychosocial Rehabilitation, or PSR)	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees under age 21, enrollees who are developmentally disabled, and enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees under age 21, enrollees who are developmentally disabled, and enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees who are developmentally disabled, and enrollees with traumatic brain injury.
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered	
14.	Home Health Services	Covered	Covered	Covered
15.	Private Duty Nursing Services	Covered	Covered	Covered
16.	Hospice	Covered	Covered	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered	Covered Covered
18.	Foot Care Services	Covered	Covered	Covered
19.	Eye Care and Low Vision Services	Covered	Covered	Covered
20.	Durable Medical Equipment (DME)	Covered	Covered	Covered
21.	Audiology, Hearing Aids Services & Products	Covered	Covered	Covered
22.	Family Planning and Reproductive Health Services	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to phase-in schedule
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.
25.	Dental and Orthodontic Services	Covered	Covered	Covered

*	**Covered Services**	**MMC Non-SSI/Non-SSI Related**	**MMC SSI/SSI-Related**	**HARP**
26.	Court-Ordered Services	Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).
27.	LDSS Mandated SUD Services	Covered, pursuant to Welfare Reform / LDSS mandate (mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)
28.	Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered	Covered
29.	Mental Health Services	Covered	Covered on the effective date of the Behavioral Health Benefit Inclusion.	Covered
30.	SUD Inpatient Detox Services	Covered	Covered	Covered
31.	SUD Inpatient Rehabilitation and Treatment Services	Covered	Covered on the effective date of Behavioral Health Benefit Inclusion	Covered
32.	SUD Residential Addiction Treatment Services	Covered	Covered	Covered
33.	SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Covered	Covered	Covered
34.	SUD Medically Supervised Outpatient withdrawal	Covered	Covered	Covered
35.	Buprenorphine Prescribers	Covered	Covered	Covered
36.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis	Covered on a case by case basis

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
37.	Renal Dialysis	Covered	Covered	Covered
38.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	
39.	Personal Care Services	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.
40.	Personal Emergency Response System (PERS)	Covered	Covered	Covered
41.	Consumer-Directed Personal Assistance Services	Covered	Covered	Covered
42.	Observation Services	Covered	Covered	Covered
43.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP
44.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP
45.	Adult Day Health Care	Covered	Covered	Covered
46.	AIDS Adult Day Health Care	Covered	Covered	Covered
47.	Tuberculosis Directly Observed Therapy	Covered	Covered	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
48.	Crisis Intervention Services	Covered	Covered	Covered
49.	Psychosocial Rehabilitation (PSR)			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
50.	Community Psychiatric Support and Treatment (CPST)			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
51.	Habilitation Services			Covered on a non-risk basis as directed by the State (see Appendix T of this agreement).
52.	Family Support and Training			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
53.	Short-term Crisis Respite			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
54.	Intensive Crisis Respite			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
55.	Education Support Services			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
56.	Peer Supports			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
57.	Pre-vocational Services			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
58.	Transitional Employment			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
59.	Intensive Supported Employment (ISE)			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
60.	Ongoing Supported Employment			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
61.	Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program			Covered. (see § 10.41 of this Agreement.)