SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

5.1 Plan Requirements

The Offeror must provide a copy of their current DOH Certificate of Authority to operate an HMO.

A copy of MVP's **Health Maintenance Organization Certificate of Authority** has been included in **Technical Proposal Supporting Documents - A**.

In addition, the Offeror must:

1. **Submit a copy of the draft NYSHIP Dependent Eligibility Rider that the organization will file with the DFS. A draft *2020 NYSHIP Dependent Eligibility Rider* (Attachment 19) provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.**

   A copy of the draft **NYSHIP Dependent Eligibility Rider** has been included in **Technical Proposal Supporting Documents - B**.

2. **Indicate whether or not the HMO will be proposing a Medicare Advantage offering.**

   Yes—MVP plans to offer a NYSHIP Medicare Advantage Plan in addition to the Commercial Plan.

   The service area for the NYSHIP Medicare Advantage Plan includes the same counties as in the NYSHIP Commercial Plan service area.

   The Medicare Advantage Plan counties have been approved by the Centers for Medicare & Medicaid Services (CMS).

3. **Provide a list of Counties and associated rating region configuration for the HMO's proposed 2021 NYSHIP Service Area. Counties must be contiguous and listed for both Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP. The Medicare Advantage Plan Service Area must be identical to the Commercial Plan and all counties must be CMS approved. However, additional participation in underserved counties is permissible during the term of the Contract. As of January 1, 2020, the Department, in consultation with the JLMC, considers Chemung, Schuyler, Rockland, Bronx, New York, Richmond, Queens, Kings, Nassau, and Suffolk counties in New York State to be underserved. The Department, in consultation with the JLMC currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) NYSHIP HMO is offered. The definition of an "underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.**

   Please see **Technical Proposal Supporting Documents – C** for a List of Counties and associated rating regions.

4. Provide a copy of your organization's most recent annual filing of Schedule M (Complaints).

Please see **Technical Proposal Supporting Documents - D**. Schedule M (Complaints).

5. Describe the method that the Offeror uses to determine that all Members have reasonable access to Network Providers. For example, access to primary care physicians (PCP) should be within a 5-mile radius in an urban setting and 15 miles in a rural area. Provide the minimum standards that the Offeror uses to measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2020.

MVP evaluates whether there is sufficient provider access in particular geographic regions through several sources. This is done every year using data obtained during MVP's site visits to provider offices, through member satisfaction surveys, by analysis of member comments about access to services, and by reviewing MVP's Customer Care Center's telephone performance statistics.

The table below shows the general access standards used by MVP to measure member accessibility to providers.

Access Standard	Primary Care Physician	Specialist	Hospitals
Urban	100% within 10 miles	100% within 15 miles	100% within 15 miles
Suburban	100% within 15 miles	100% within 20 miles	100% within 25 miles
Rural	100% within 20 miles	100% within 30 miles	100% within 50 miles

Access Standards

Refer to the Access Report found in **Technical Requirements Supporting Documents - E** for a snapshot of the network access based on MVP's HMO provider network in the first quarter of 2020. The table below provides a general break down of provider and hospital totals in the NYSHIP HMO service area.

2020	HMO		
	PCPs	Specialists	Hospitals
March 31, 2020	8,122	27,080	114

6. Describe how the Offeror monitors if Network Providers are accepting new patients into their practices. Indicate whether the Offeror's proposed access standards take into account Provider availability. If yes, describe how.

MVP keeps track of those providers accepting new patients in the following ways:

Providers complete the "Provider Change of Demographic Information" on MVP's website and fax it to the Professional Relations (PR) Department or email. PR will confirm the information is correct with the provider's office. The information is then processed and updated in MVP's system. The information is also reflected online.

In addition, if a PR representative is in the field, or talking to the provider on the phone, and is informed that the provider no longer accepting patients, they will follow the process to get the information updated in MVP's systems.

The Professional Relations (PR) Department actively reaches out to PCP offices and large group practices twice annually to communicate changes and provide updates on policies, procedures, programs, and products. During these scheduled visits, the PR representatives routinely ask the provider's office if there are any changes to their office practice status. In addition to direct contact

with MVP staff, providers have easy access to update their practice status using the Online Demographic Change Form located on the Provider Portal at www.mvphealthcare.com. Change to provider status can be entered and sent directly to MVP. Usually the doctor's office directly reaches out to MVP's PR team that they are no longer accepting new patients so that the status change can be immediately reflected in MVP's online Provider Directory.

Yes—providers accepting new patients are tracked on MVP's provider database as "Open," therefore the provider's status can be flagged and used to determine access when running accessibility reports.

7. Describe the Offeror's approach for credentialing Network Providers; specify if the Offeror utilizes an external credentialing verification organization. When was this process last completed? What is the Offeror's process for confirming continuing compliance with credentialing standards? How often does the Offeror conduct a complete review? Include a description of how the Offeror monitors disciplinary actions by licensing agencies.

MVP performs Credentialing and re-credentialing directly or through delegated arrangements with health care entities and a credentialing verification organization. If performed through a delegated arrangement, MVP conducts a pre-delegation assessment to ensure that the delegate meets all required State and Federal regulatory requirements, NCQA requirements and MVP requirements. An annual site visit which includes a full policy and file review against all applicable requirements is also conducted. All assessments conducted are presented to the MVP Delegation Oversight Committee and Quality Improvement Committee. Additionally, our stringent ongoing monitoring process ensures that all providers are monitored to ensure that they maintain active licenses and are not subject to disciplinary actions or sanctions from such agencies as the New York State Department of Education, Office of Professional Medical Conduct, Office of Inspector General or Office of Medicaid Inspector General.

All our traditional providers and ancillary providers (physical therapists, podiatrists, and mental health providers, including CSWs and PhDs) must satisfy stringent credentialing criteria to qualify for inclusion in MVP's network.

We implement an efficient and streamlined credentialing process to ensure provider competency. Quality of care is at the forefront of MVP's corporate philosophy, and we enforce strict measures to retain qualified health care providers.

Site Visits

MVP performs site visits on all new office locations of primary care physicians and OB/GYNs within six months of the Credentials Committee decision. *Please note that site visits are not used as a factor to initially credential a provider.*

Federal and State Compliance

We query the National Practitioner Data Bank for malpractice history and adverse actions, state health departments for disciplinary actions, and the HCFA Office of Inspector General for Medicare/Medicaid sanctions.

Application

The credentialing and re-credentialing application contains a current and signed attestation regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of current illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- The correctness and completeness of the application

Review

MVP's Credentialing Committee conducts a thorough review of all provider credentialing applications. Evaluation criteria include the applicant's ability to perform the essential functions of the position and the applicant's record concerning current illegal drug use. Applicants with a history of license limitations, sanctions, felony convictions, loss or limitations of privileges, or disciplinary actions will be requested to submit, in writing, clarifying information prior to review by MVP's Credentialing Committee.

Applicants are obliged to provide MVP with information sufficiently detailed to render an opinion regarding any adverse action taken by a state or federal agency, another institution such as the New York State Education Department (NYSED), New York State Office of Professional Medical Conduct (OPMC), U.S. Office of Personnel Management (OPM), or any other applicable regulatory or professional body, or any other items on the application as requested by MVP.

Verification

MVP will obtain at least five years of work history from each applicant. Work history must include the starting and ending month and year for each position in the applicant's employment history. Gaps in the applicant's employment history exceeding six months require explanation. Gaps of from six months to one year in duration can be explained verbally. Gaps greater than one year require a written and signed explanation from the applicant.

Credentialing staff will conduct verifications 180 days prior to MVP's Credentialing Committee's decision, including but not limited to:

- License status and registration.
- License sanctions.
- Sanctions activity.
- Board certification status.
- DEA Certificate for each state where the practitioner is treating MVP members.
- Participation in Medicare.
- Education and completion of residency and/or specialty training.
- Proof of malpractice insurance coverage in the minimum coverage amounts of $1 million per incident and $3 million per aggregate.
- Information relating to malpractice settlements or actions.
- Unrestricted, active clinical privileges at an MVP participating hospital, if applicable.

- Federal National Practitioner Identification (NPI) number.

Frequency of Review

In accordance with NCQA guidelines, MVP re-credentials providers every three years.

Monitoring Disciplinary Actions

At the time of credentialing, MVP primary source verifies the practitioner licenses including any disciplinary actions that have been taken. This information is reviewed by MVP's Credentialing Committee in the decision-making process.

Additionally, on an ongoing basis, MVP will review disciplinary actions by licensing agencies between re-credentialing cycles to monitor information about the practitioner that could impact the quality of care delivered to MVP members or to determine if there is evidence suggesting that the practitioner no longer meets MVP's criteria and standards.

All disciplinary actions by licensing agencies are reviewed within 30 calendar days of the release date. MVP receives these actions through direct email distribution lists from the licensing agencies, direct queries to the licensing agencies, and the CAQH Sanctions module. All information is promptly reviewed by the CMO or physician designee.

If the adverse action includes imminent harm to MVP patients, a determination of fraud, a final disciplinary action by a state licensing board, or other governmental agency that impairs the health care professional's ability to practice, the information will be presented to the CMO or physician designee to terminate or suspend the practitioner's participation with MVP.

8. Explain the Offeror's approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements that the Offeror has with each type of Provider (e.g., per diems, case rates, hourly rates, all-inclusive per diems covering Facility and Practitioner fees, etc.).

MVP contracts with physicians through individual practice associations (IPAs), directly with physicians or physician groups, and through physician-hospital organizations (PHOs). Physicians are required to bill for services rendered individually on a fee-for-service basis, regardless of how they are contracted. Physician reimbursement may be based on the Medicare resource-based relative value scale (RBRVS), capitation, or flat/case rates.

Providers bill MVP for services rendered using current procedural terminology (CPT) codes and/or HCPCS coding. CPT/HCPCS codes are reimbursed based on the providers' contracted reimbursement levels, which are mostly derived from the Medicare resource-based relative value scale. Most provider contracts call for a percentage factor to be applied to the Medicare fee schedule. This percentage may vary by region.

Reimbursement for anesthesia services is often based on the American Society of Anesthesiologists relative value guide.

MVP maintains fee tables based on each provider's contracting region. The fee table lists the reimbursements allowed for all valid CPT codes. The entire fee table is reviewed annually, and changes are made when appropriate or upon renegotiation of the provider contract.

Hospitals in New York (excluding NYC) are reimbursed by DRG, per diem, case rates, or any combination of the three, for inpatient services. For outpatient services, such as ambulatory surgery, the hospitals are reimbursed through case rates and/or discount off charges. Referred ambulatory is

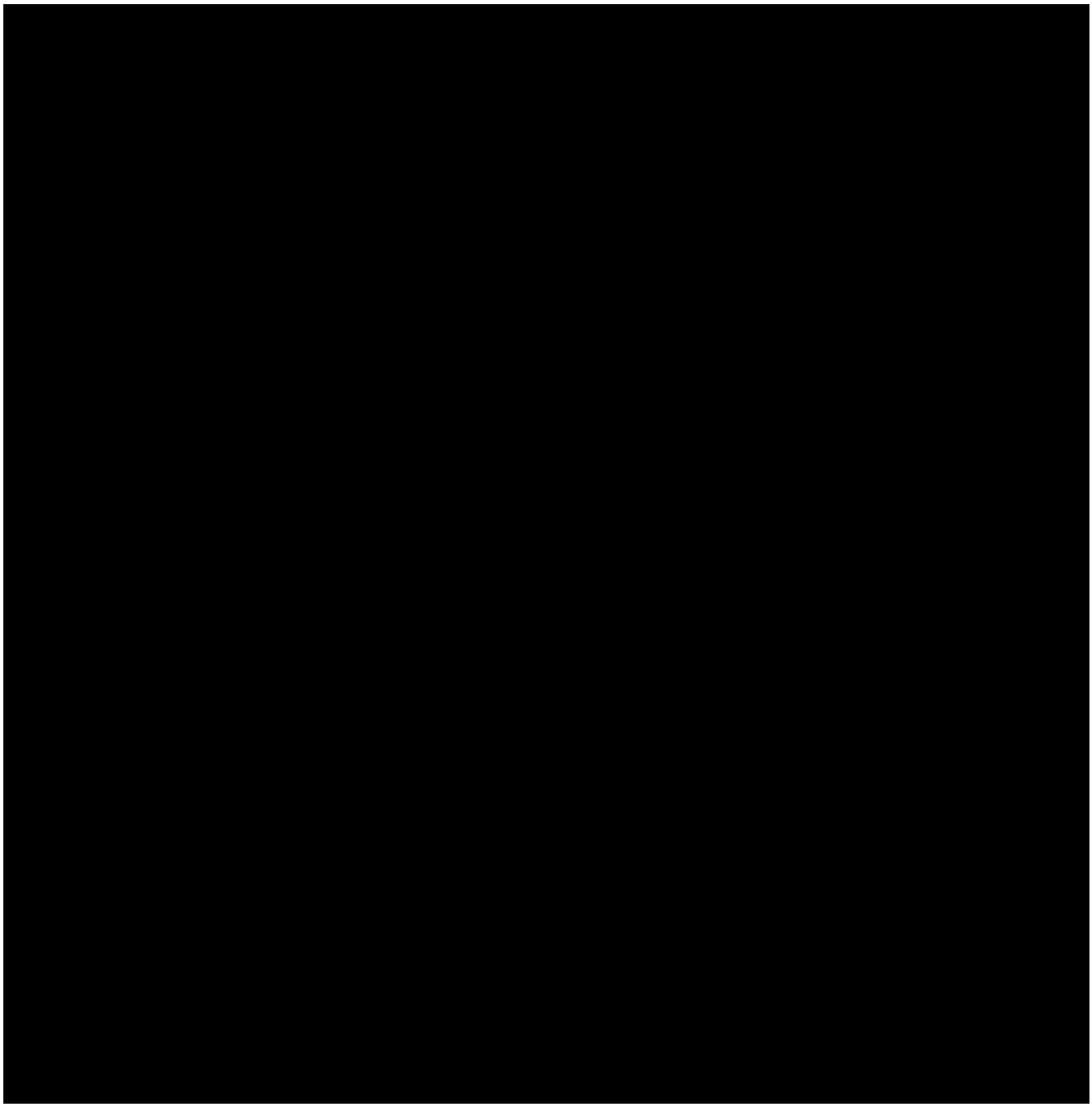
reimbursed through discount off charges, capitation, and resource-based relative value scale (RBRVS) methodologies.

9. Indicate whether the Offeror ever incorporates pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers. If yes, describe.

THIS INFORMATION IS CONSIDERED PROPRIETARY AND CONFIDENTIAL

10. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

THIS INFORMATION IS CONSIDERED PROPRIETARY AND CONFIDENTIAL



11. Provide an electronic copy of the most recent Health Plan Network (HPN) report submitted to the DOH indicating the HMO provider network in place at the time of submission. This electronic report must be provided for both the Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP.

Electronic copies of the most recent Health Plan Network (HPN) reports submitted to the DOH have been included in the **Technical Proposal Supporting Documents – F** *(Only an electronic copy has been included due to file size).*

12. Describe the utilization review procedures used when determining if care is medically necessary.

MVP's Utilization Management staff uses member certificates, clinical case data, assessments, and medical information in conjunction with clinical review criteria, utilization review guidelines, and consultations with MVP's medical directors to determine coverage of these procedures and/or services. Individual clinical case assessments, data, and practice guidelines for the specific clinical conditions are given equal or greater weight than the utilization review guidelines in deciding to approve or deny coverage. Proposed treatment or utilization management of services is not influenced by member race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

In addition, MVP uses the InterQual criteria and MVP proprietary medical policies for pre-certification of selected inpatient and outpatient hospital procedures and appropriateness of inpatient stays. MVP shares the annual changes to the criteria with our provider panel and requests comments or concerns from our panel. The comments or concerns are provided to MVP's medical director, who discusses these with the submitting physician and presents the feedback to the Medical Management Committee (MMC). The MMC forwards their proposal to the QIC for final approval.

MVP's medical necessity criteria for mental health consists of InterQual. For substance use services, MVP uses the most current version of the New York State Office of Addiction Services and Supports (OASAS) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) for all levels of care when treatment is provided within New York state. For Medicare and when treatment is provided outside of New York state, InterQual is utilized for substance use reviews. MVP utilizes criteria which have been deemed appropriate and approved for use in determining health care coverage for the treatment of mental health conditions by the Commissioner of the NYS Office of Mental Health (OMH), in consultation with the Commissioner of Health and the Superintendent of Financial Services. MVP uses criteria designated by OASAS that are appropriate to the age of the patient. 'MVP's behavioral health clinical practice guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex behavioral health conditions. These guidelines represent standards of best practice for treating complex conditions and are references for clinicians and Physician Advisors during clinical reviews to ensure effective care delivery. MVP develops, revises, and/or adopts clinical guidelines from recognized sources and scientific bodies including professional organizations (e.g., American Psychiatric Association), published scientific evidence, best practice standards, input from board-certified physicians from appropriate specialties, internal experts in particular subject areas, national experts, practitioners, members, and community agencies.

MVP developed the behavioral health clinical practice guidelines by adopting national evidence-based practice guidelines from recognized sources such as the American Psychiatric Association Manual for Peer Review, the Diagnostic and Statistical Manual V, American Accreditation HealthCare Commission/URAC Standards, ASAM Standards, and Health Management Strategies International, to name a few.

MVP follows all State and Federal requirements applicable to both medical and mental health services.

Hospital Admissions Precertification

Elective Hospitalization

When a member requires an elective hospital admission, the participating physician is required to contact MVP to secure an inpatient authorization prior to the admission. The participating physician also agrees to cooperate and participate in a coordinated discharge planning program.

Prior authorization for elective surgery may also be required and includes preadmission testing. Admission for preoperative days is subject to review by the utilization management nurse for medical necessity, and by a medical director as needed.

For behavioral health admissions, MVP requires notifications for all inpatient and residential mental health and substance use treatment admissions. Providers are expected to notify MVP within two business days of the admission.

Emergency Hospitalization

In the case of an emergency hospitalization, prior authorization is not necessary. To ensure that services are being delivered at the appropriate level of care, the hospital is required to notify MVP within 24 hours of the emergency. MVP utilization management nurses work with the facility Utilization Review department (and/or attending physician) acquiring medical records for review of appropriate level of care utilizing nationally recognized criteria (InterQual). Admission review will be performed within 24 hours or 1 business day after receipt of medical records. Discharge planning needs are continually assessed throughout the review process. MVP will refer to the MVP Case Management Department for assistance, as needed. Any changes in level of care are reviewed and approved by an MVP medical director.

For behavioral health admissions, MVP requires notifications for all inpatient and residential mental health and substance use treatment admissions. Providers are expected to notify MVP within two business days of the admission.

Medical Criteria for Hospitalization

After the health plan is notified of an elective or emergency admission to the hospital, the utilization management nurse reviews the need for admission, within 24 hours or one business day after receipt of medical records, using nationally recognized guidelines, the InterQual ISD-AC review criteria. The nurse also utilizes the inpatient surgery guidelines and the physician office procedure guidelines adopted by the plan, to determine if a procedure should be accomplished as an inpatient, outpatient, or office procedure.

If a physician requests an inpatient admission for a procedure that would otherwise be performed as an ambulatory surgery procedure, or an office procedure, medical documentation must be submitted to the medical director for prior authorization.

Medical Service and Procedures

MVP's Quality Improvement Committee has identified selected procedures as those procedures requiring focused review for appropriateness of services.

Guidelines and criteria are reviewed and approved by the Quality Improvement Committee, which consists of physicians from all IPA regions. Copies of criteria and guidelines are available to MVP providers upon request. If the indicators for the procedure are not met, the member and physician are notified by phone and in writing of the health plan's determination and the process to appeal any decision denying reimbursement for services.

Outpatient Services Precertification

Prospective review of selected outpatient services is conducted prior to services being rendered. The focus of the reviews is on medical necessity and appropriateness, member eligibility and contract limitations. Review of outpatient services often includes a discussion with the ordering practitioner about any alternatives that may be available to a member that would achieve the same or better outcome in a less costly setting while maintaining the quality of care. Durable medical equipment and

select ambulatory surgical procedures are examples of services that are prior authorized as part of the outpatient medical services processes. Inpatient surgery guidelines and physician office guidelines adopted by the plan are utilized to determine whether the procedure should be accomplished in an outpatient setting or within a physician's office. These selected procedures are identified by and approved through MVP's Quality Program. MVP utilizes nationally recognized guidelines (InterQual) and MVP proprietary written criteria (MVP's Benefit Interpretation Manual) as well as CMS (Centers for Medicare and Medicaid) to conduct prospective review. The guidelines, MVP UM Program and criteria are reviewed and approved through MVP's Quality Program. Copies of criteria and guidelines are available to MVP providers and members upon request.

For each type of review, the staff obtains clinical information regarding the service requested. When necessary, the clinical reviewer will solicit additional information from the practitioner. The medical director may involve an appropriate specialty physician, chosen for their clinical qualification and experience, for consultation.

For behavioral health, coverage for partial hospitalization intensive outpatient, routine outpatient (therapy, medication management) outpatient rehabilitation, and opioid treatment are not subject to authorization requirements if services are rendered by a participating provider. Transcranial Magnetic Stimulation (TMS) and Applied Behavioral Analysis (ABA) do require authorizations.

Inpatient Concurrent Management

After the health plan is notified of an elective or emergency admission to the hospital, the utilization management nurse reviews the need for admission, within 24 hours or one business day after receipt of medical records, using nationally recognized guidelines, the InterQual ISD-AC review criteria. The medical directors also utilize the Inpatient Level of Care Policy to determine if the inpatient admission is the most appropriate and least restrictive level of care. Utilization management is performed via telephone, fax or EMR (electronic medical record). UM utilizes certificate of coverage benefits, individual clinical case data, assessments, and medical information in conjunction with MVP's clinical review criteria, utilization review guidelines and consultations with MVP's medical directors to determine appropriateness of continued inpatient services. Individual clinical case assessments, data and practice guidelines for the specific clinical conditions are given equal or greater weight than MVP's utilization review guidelines in making decisions to approve or deny coverage, with the former taking precedence over the latter when there is a conflict between the two. Proposed treatment or utilization management of services is not influenced by member race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. The nurse reviewer takes into consideration the capacity of MVP's practitioner and facility delivery system when making recommendations to members, attending providers and medical directors for services such as care in alternative settings.

MVP does not conduct concurrent reviews on all behavioral health admissions. Concurrent reviews are completed based upon member need and high-risk quality indicators. MVP clinicians contacts facilities at the time of the member's admission for periodic consultations and/or utilization review. These conversations are collaborative for the purposes of care coordination, to ensure the member is progressing, addressing barriers to care, and the discharge plan is adequate to meet the ongoing recovery needs of the member.

Inpatient Case Management

Concurrent review clinical reviewers work collaboratively with MVP case managers while a patient is in a facility when appropriate. MVP case management activities with a facility are managed via phone.

Discharge Planning

Concurrent review clinical reviewers work collaboratively with hospital/facility discharge planners for the most medically appropriately level of care utilizing the patient's available benefits for each individual patient.

13. If the Offeror previously participated in NYSHIP, provide the total appeals filed by, or on behalf of NYSHIP Members for the previous plan year. Please provide the number of upheld, denied, and modified internal and external appeals. For internal appeals, HMOs must provide a breakdown of appeals by administrative and clinical categories.

2019 Appeals	Total	Overturned	Upheld
NYSHIP First Level Appeals			
Administrative	11	2	9
Clinical categories	29	11	18
NYSHIP Second Level Appeals	3	1	2
NYSHIP External Review	1	0	1

14. State if the Offeror requires referrals to network specialists. If referrals are required, describe the procedure enrollees must follow for referrals to network specialists. This information should be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

No—MVP does not require referrals to network specialists for Commercial or Medicare Advantage Plans.

MVP does not require a referral from the member's primary care physician (PCP) to obtain benefits for covered services received from an MVP participating professional provider (specialist).

Members are required to take certain actions before obtaining the following covered services:

- Non-Emergency Inpatient Hospital Services – MVP will only provide benefits for non-emergency inpatient hospital services when a member has been admitted to the participating hospital by a participating physician. The member's participating admitting physician is responsible for obtaining prior authorization from MVP for the hospital admission.
- Non-Emergency Outpatient Mental Health or Alcoholism/Substance Abuse Rehabilitation Services – Members or their designees should contact MVP's Behavioral Health Access Center at 1-800-568-0458 before obtaining non-emergency outpatient mental health or alcoholism/substance abuse rehabilitation services. Mental Health and Substance Abuse Services are managed by Beacon Health Options.
- Physical Therapy or Speech Therapy Services – Members are required to obtain a prescription from either a participating PCP or participating specialist before obtaining physical, occupational or speech therapy services.
- Non-Emergency Care Services from a Non-Participating Provider – Requires prior authorization if the member does not have out of network benefits (see response to next question below).

15. Describe the procedure Enrollees must follow for referrals to non-network providers. This information must be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

For the commercial HMO product and Medicare Advantage members, in the rare instance that a member needs to see a non-participating provider as in-network, the member's PCP must submit a written request to MVP's Utilization Management (UM) Department using the prior authorization request form, and the member must receive prior written approval from MVP's UM Department**.** The out-of-plan referral will be approved only if MVP does not have a participating physician with the appropriate training or experience needed to treat the member.

In addition, Medicare Advantage members have the option of the Point of Service (POS) (out-of-network) benefit, which covers some medically necessary services from non-plan providers. MVP will pay 70 percent, up to $5000 per year, and the member is responsible for 30 percent. There are no deductibles. Once the limit is reached, members are responsible for 100 percent of the cost of out-of-network services. Point of Service coverage is available for the following benefits:

- Office visits
- Chiropractic services
- Podiatry services
- Hospitalization (MVP approval required)
- Outpatient surgery (MVP approval required)
- X-ray, lab, and blood services
- Diagnostic and therapeutic radiology services
- Mammograms
- Durable medical equipment
- Prosthetics and medical supplies
- Physical, speech and occupational therapies
- Cardiac and pulmonary therapies

Emergency and urgent care will continue to be covered worldwide. Renal dialysis will continue to be covered anywhere in the United States when provided at Medicare-certified centers, and not subject to the Point of Service (POS) cost sharing or limit.

The POS benefit does not extend to covered services such as:

- Skilled Nursing Facility
- Home health care
- Mental health
- Routine hearing exams
- Substance abuse services
- Diabetic supplies
- Routine dental services
- Medicare Covered Part B Drugs

16. For HMOs proposing to offer both a Commercial Plan and a Medicare Advantage Plan (MAP) through NYSHIP, state if the provider networks for both plans are identical. If there are differences in the networks, describe any differences among the networks relative to provider type. For example, 95% of the primary care physicians in the Commercial Plan also participate

in the Medicare Advantage Plan and 40% of the Specialty providers (HMO must define "Specialty providers") in the Commercial Plan also participate in the Medicare Advantage Plan.

While similar, the provider networks for the Commercial HMO and the Medicare Advantage (MA) plan are not the same. 96.4 percent of the primary care providers in our commercial HMO also participate in the MA plan and 95.7 percent of the specialty providers in our commercial HMO also participate in the MA plan.

17. **For HMOs proposing to offer a Medicare Advantage Plan through NYSHIP, provide the last three (3) years of CMS Star Ratings for the Medicare Advantage Plan that will be offered through NYSHIP. Indicate whether CMS has frozen enrollment any time during the last three (3) years.**

The table below shows the CMS Star Ratings for MVP for the last three years.

Year	Part C Summary Rating	Part D Summary Rating	Overall Rating
2020	4.0	4.5	4.0
2019	4.5	5.0	4.5
2018	4.0	4.0	4.5

Medicare HMO-POS Star Rating by Reporting Year

No—CMS has not frozen enrollment during the past three years.

18. **Describe the Offeror's Medicare Enrollment reporting process. This description must include how changes to Medicare eligibility and enrollment/ disenrollment is identified and the proposed frequency and method these enrollment changes will be provided to the Department. Additionally, an Offeror is encouraged to suggest/identify a methodology of preference that will facilitate the most accurate and frequent sharing of information.**

MVP currently audits the full NYSHIP membership monthly including Medicare members and reports any discrepancies back to NYS for review and resolution. CMS initiated transactions such as disenrollment transactions are captured by this reporting. MVP will continue to follow this process.

19. **Describe the Offeror's process for Enrolling Members into their Medicare Advantage that conforms to the requirements set forth in Chapter 2 of the MMCM.**

MVP follows all enrollment and disenrollment guidance as outlined in Chapter 2 – Medicare Advantage Enrollment and Disenrollment in the Medicare Managed Care Manual. Checks for entitlement and eligibility of all Medicare applicants is performed through the Batch Eligibility Query (BEQ) process on an hourly basis and enrollment/disenrollment transactions are submitted to CMS via the MARx Batch Input Transaction Data File daily. Daily Transaction Reply Reports (DTRR) are received and processed timely each morning after receipt from CMS. Member notifications are mailed in accordance within the turnaround times required by Chapter 2 of the MMCM.

20. **Provide current status of the NCQA or URAC rating. Please provide the 5-point NCQA rating scale or the applicable URAC rating. The JLMC encourages an HMO to seek accreditation by**

nationally recognized organizations such as NCQA or URAC. If not currently accredited by NCQA or URAC, provide a detailed explanation why accreditation was not obtained.

MVP has a NCQA "Commendable" accreditation status for Commercial HMO/POS products. Our most recent accreditation survey was 2017 for this product, and we earned 100% of the available points for compliance with standards. MVP is currently engaged in an NCQA renewal survey for its Commercial HMO/POS products. The survey is scheduled to end in October with results being available in November.

For 2019 MVP's HEDIS score for Commercial HMO/POS was 86.07.

MVP's NCQA Health Plan Accreditation Certificate for its Commercial HMO/POS product can be found in **Technical Requirements Supporting Documents - G**.

21. **HMOs (charitable organizations) that are not for profit entities must provide a statement that the organization is exempt pursuant to one of the categories indicated on the Office of Attorney General's Request for Registration Exemption (Schedule E). The statement must identify the specific category under which the charitable organization is exempt.**

MVP Health Plan, Inc. is not exempt from registration with the NYS AG's Charities Bureau, so MVP Health Plan, Inc. cannot provide a statement that the organization is exempt as question #21 asks. MVP Health Plan, Inc. files its registration every year pursuant to the applicable NYS AG's Charities Bureau rules.

22. **Outline what, if any, coverage is available to both Commercial and Medicare Members travelling outside of the United States. Please provide an overview for both Commercial and Medicare coverage as well as emergent, non-emergent and prescription drug services.**

Commercial coverage per the COC

MVP does not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services, and ambulance services to treat the Emergency Condition.

Coverage of Emergency Services for treatment of the Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Emergency Conditions worldwide. However, MVP will cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize the Emergency Condition in a Hospital.

In addition to Pre-Hospital Emergency Medical Services, MVP will also cover emergency ambulance transportation [worldwide] by a licensed ambulance service (either ground, water, or air ambulance) to the nearest hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a hospital when the originating facility does not have the ability to treat the Emergency Condition.

Medicare coverage per the EOC

Emergency and urgent care is covered worldwide.

Emergency medical care is covered whenever a member needs it, anywhere in the United States or its territories or world-wide. MVP covers ambulance services in situations where getting to the emergency room in any other way could endanger the member's health.

After the emergency is over members are entitled to follow-up care to be sure that the condition continues to be stable. Follow-up care will be covered by the plan., MVP will try to arrange for network providers to take over the care as soon as medical conditions and the circumstances allow.

Prescription Drug Services

On MVP's behalf, CVS Caremark processes foreign claims. Eligible members who self-pay the full cost of a prescription from an out of the country pharmacy may submit a reimbursement request on an approved Foreign Claim Form with the relevant information and documentation. Where a Foreign Claim Form is not available to the member, CVS Health will accept a Standard Claim Form if the member clearly marks the claim form as a Foreign Claim and provides the required information and documentation.

The information required to accurately process a foreign claim includes:

- The country in which the prescription was filled.
- A receipt for payment.
- The amount paid in the currency of the country (reimbursement will be in U.S. dollars).
- Drug names must be legible and are researched to ensure that they match a U.S. equivalent.
- Dollar amounts must be legible and are converted to the exchange rate in the country of origin, based on the exchange rate for the date of fill on the prescription.
- If information is not legible or cannot be translated, the claim is returned to the member for assistance.
- Copays are applied to foreign/international claims based on the benefit the client chooses.

The prescription is subject to any applicable utilization management edits that MVP has in place for that line of business.

23. Provide an overview of the current telemedicine/telehealth program available to NYSHIP Members in the HMO. Explain if there is an out-of-pocket cost to Members for these services and what the cost would be. Indicate if the program is administered in house or if the HMO uses a subcontractor. Describe when Members have access to telemedicine/telehealth services.

Telemedicine

MVP offers a direct to consumer Telemedicine benefit to HMO enrollees. MVP will cover 24/7 online doctor visits through two partners: American Well and UCM Digital Health. This telemedicine benefit allows covered employees to access care via video and/or phone visits, when and where it's most convenient for them—from a phone, mobile device, tablet, or computer with a webcam. **myVisitNow** and **myERnow** offers access to convenient and affordable care, saving employees time and money.

What does the service offer?

With this benefit, MVP members will be able to access health care professionals—including MDs, mid-level providers, behavioral health specialists, psychiatrists, dieticians, and lactation consultants—through a phone, mobile device or computer and web cam from their home, or anywhere in the United States. There are three primary types of visits: ER avoidance, urgent care, and behavioral health, in addition to wellness services such as nutrition and lactation consultations. Members can access ER avoidance and urgent care visits 24/7/365, and may make appointments with behavioral health specialists, Psychiatrists, dieticians, and lactation consultants with convenient self-scheduling.

What would a member use the service for?

MVP members can use the benefit for non-emergency care, keeping in mind it's not intended to replace their Primary Care Physician (PCP) or other in-person provider visits. Most common urgent care and behavioral health diagnoses include sinusitis, upper respiratory infections/flu, pharyngitis, skin disorders, UTI, bronchitis, conjunctivitis, earache, back pain, stress, mood disorders, insomnia, and eating disorders. UCM Digital Health can also provide referrals to in person follow up care, when needed, such as laboratory and radiology referrals or follow up with the member's PCP or specialist.

What does it cost for a visit?

There is $0 copay.

When would a member use the service?

The benefit should be used for non-emergency situations only and is especially beneficial for busy families, for those with limited mobility, who live in remote or rural areas, and for patients who may be incapacitated for any number of reasons. UCM Digital Health also provides the option for members to use this service first to help direct the member where to seek future care, as a way to give them guidance on where to seek in person care. Direct to consumer telemedicine will enable them all to access health care from the comfort of their home. In addition, members might consider using the benefit in situations such as these:

- When their doctor's office is closed.
- If they feel too sick to drive.
- If it's difficult to get to a doctor's office.
- If they are on business travel and stuck in a hotel room.

Telehealth

MVP offers a Telehealth benefit to HMO enrollees. The member is only responsible for the copayment associated with the physician visit at the originating site. This service is administered by MVP.

Telehealth is defined as:

> The use of electronic information and telecommunications to provide health care services to a member from an Originating Site to a Distant Site as a substitution for an in-person visit. The member must be at an Originating Site unless they are being treated for a condition that requires Remote Patient Monitoring.

For a service to be considered eligible for Telehealth coverage, the interactive audio and video telecommunications must be real-time communication with electronic transmission of the member's health information, or pre-recorded videos known as store and forward technology. The purpose of the electronic information and communication is to collect the member's health information and medical data for use in treatment and management of conditions that require frequent monitoring.

Services or communication by audio-only (telephone, fax, skype, etc.) do not qualify as a Telehealth service.

An Originating Site is the location of the member at the time the Telehealth services are provided. Examples of an Originating Site include the office of the physician or practitioner, Emergency Room or Hospital, Urgent Care Center, or Skilled Nursing Facilities.

A Distant Site is where the provider is located who would be receiving payment for eligible Telehealth Services. Telehealth providers may include Physicians, Physician Assistants, Clinical Psychologists, Nurse Practitioners, Nurse Midwives, Registered Dieticians. These services must be rendered by an in-plan provider.

24. **Provide confirmation that the HMO will cover the diagnosis and treatment of Gender Dysphoria. Please also provide any Member cost-sharing or prior authorizations that may apply.**

    Confirmed—MVP covers treatment for Gender Dysphoria. In addition, coverage of medically necessary services is allowed for binary and non-binary gender identifies.

    There are medical necessity requirements around the diagnosis of gender dysphoria and certain services are reviewed on a case by case basis. For example:

    - Conversion therapy
    - cryopreservation, storage, and thawing of reproductive tissue
    - reversal of genital and/or breast surgery
    - reversal of surgery to revise secondary sex characteristics
    - reversal of any procedure resulting in sterilization
    - Surgery and/or additional treatments solely for the purpose of improving or altering appearance or self-esteem related to one's appearance characteristics or self-esteem are cosmetic in nature

    Gender identity is not limited to binary gender identity (exclusively masculine or feminine) but may include non-binary gender identity (a combination of masculine or feminine or neither).

    Please refer to **Technical Proposal Supporting Document – H** for Gender Dysphoria medical criteria and prior authorization requirements.

    Inpatient, outpatient, and ambulatory visits do not have a physician cost share; in office procedures have a $25 physician copay. Outpatient and ambulatory procedures have a $0 copay at a preferred provider network location or a $25 copay in network.

25. **Complete the charts and answer the narrative questions as they appear on the Prescription Drug Benefit Form (Attachment 14).**

    Please refer to the Prescription Drug Benefit Form response found in the **Technical Requirements Supporting Documents – I.**

26. **Certificate of Coverage (for Commercial Plan) and coverage riders. The proposed standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Certificate of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Certificate and separate out the prescription drug coverage provisions.**

    Please refer to the Certificate of Coverage (Commercial) and coverage riders in the **Technical Requirements Supporting Documents – J.**

The Certificate of Coverage (COC) is the same except for the prescription drug coverage section. The Prescription drug coverage section is bracketed and appears in pages 66-79 of the COC (please note that the COC is currently pending approval and the page numbering may change). The Prescription Drug Section is bracketed allowing for this section to be variable i.e. MVP files one COC and uses the bracketed, variable section to offer a plan that includes the Prescription Drug and one plan that does not include Prescription Drug.

A separate Drug Rider has been included that will be addended to the COC if prescription drug coverage is not included with the COC. This rider is required per NYS mandate to be included with any plan that carves out Rx.

27. **Evidence of Coverage (for Medicare Advantage Plans) and coverage riders, if offering a Medicare Advantage Plan. The proposed Medicare standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Evidence of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Evidence of Coverage and separate out the prescription drug coverage provisions.**

    Please refer to the evidence of coverage for Medicare Advantage Plans and coverage riders found in the **Technical Requirements Supporting Documents – K.**

    Evidence of Coverage (Medicare Advantage Plan) and Coverage Riders

    i. Evidence of Coverage – East Region
    ii. Evidence of Coverage – West Region
    iii. Prescription Drug Rider
    iv. Eyewear Rider
    v. Hearing Services Rider

28. **A completed Commercial Benefits Chart (Attachment 35) and Medicare Benefits Chart (Attachment 36) for both Commercial and Medicare Advantage Plans, as applicable, citing where each of the named benefits proposed for 2021 can be found in Contract or rider language. All Contracts and/or riders relating to the 2021 benefit offering must be listed. If there is no additional cost, indicate N/C in Projected Monthly Premium column. List the cost of the standard contract and riders for each rating region once, reference the citation in all other appropriate areas.**

    Please refer to the Benefits Charts for 2021 for Commercial and Medicare Advantage Plans found in the **Technical Requirements Supporting Documents – L**

    i. Commercial Benefits Chart
    ii. Medicare Advantage Benefits Chart