

## SECTION 3 - ELIGIBILITY AND MEMBERSHIP

### 3.1- Eligibility Verification

#### VNSNY CHOICE MLTC

While the member’s Care Manager orders most services, providers are encouraged to verify member eligibility before providing the service. Providers are prohibited from billing VNSNY CHOICE MLTC members for covered services. However, if a provider wishes to provide a non- covered service to a member, the provider must inform the member **in writing** prior to the initiation of the service, indicating the cost and the member’s responsibility for payment.

VNSNY CHOICE may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee’s capacity for normal activity, or threaten some significant handicap.

To verify eligibility for all of the covered services listed above, with the exception of dental services, please call our Provider Services Line 1-866-783-0222 or Member Services 1-888-867-6555. You may also check claims and eligibility status via the Internet at:

<https://vnsproviderportal.tmghealth.com>

VNSNY CHOICE will reimburse providers only for services rendered to currently eligible members. It is the responsibility of the provider to verify eligibility prior to providing services.

|  |   |
|--|---|
| <b>VNSNY CHOICE MLTC<br/>Managed Long Term Care Plan</b>   | <p>Use this card with your Medicaid and/or Medicare card (if you have Medicare). VNSNY CHOICE MLTC covers services to help you live safely at home. Medicaid and/or Medicare cover most medical services, including doctor visits, hospital care and prescription drugs.</p> <p>This member is covered by fee for service Medicaid.</p> |
| <p>Member ID: V12345678<br/>Member Name: <span style="background-color: #4a7ebb; color: white; padding: 2px 10px;">                    </span></p> <p><b>MLTC Member Services</b><br/><b>1-888-867-6555 (TTY: 711)</b><br/><b>9 am – 5 pm, Monday – Friday</b></p> <div style="display: flex; align-items: center; justify-content: center;"> </div> <p style="font-size: small; text-align: center;">VNSNY-E-38632-22</p> |   |

### VNSNY CHOICE Total

You may obtain information on VNSNY CHOICE member eligibility by calling the Member Services at 1-866-783-1444, Monday through Friday from 8 am to 8 pm.

You may also check claims and eligibility status via the Internet at:

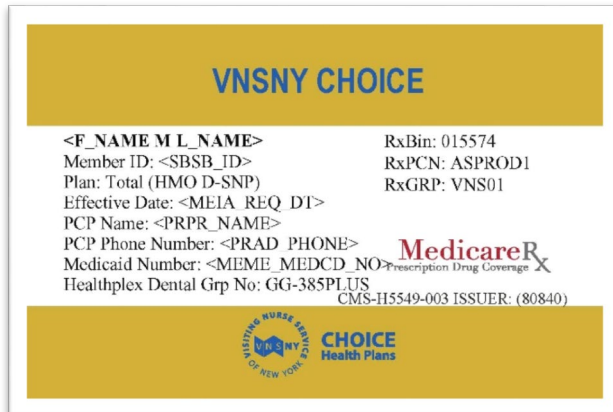
<https://vnsproviderportal.tmghealth.com>

Upon initial registration, you will be asked to complete a “Provider Portal Registration.” Upon proper completion, the registration is submitted and an assigned password will be sent to you within 2 business days.

The Provider Portal offers real-time access to member eligibility, claims status with details, and much more. In addition, the portal features self-service access (real-time registration, password reset capability, customizable quick links) and is easy to access and use, so that you can manage your patients’ information quickly and easily.

All CHOICE Total members are given an identification card (sample below). Members should present their ID cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.

06J



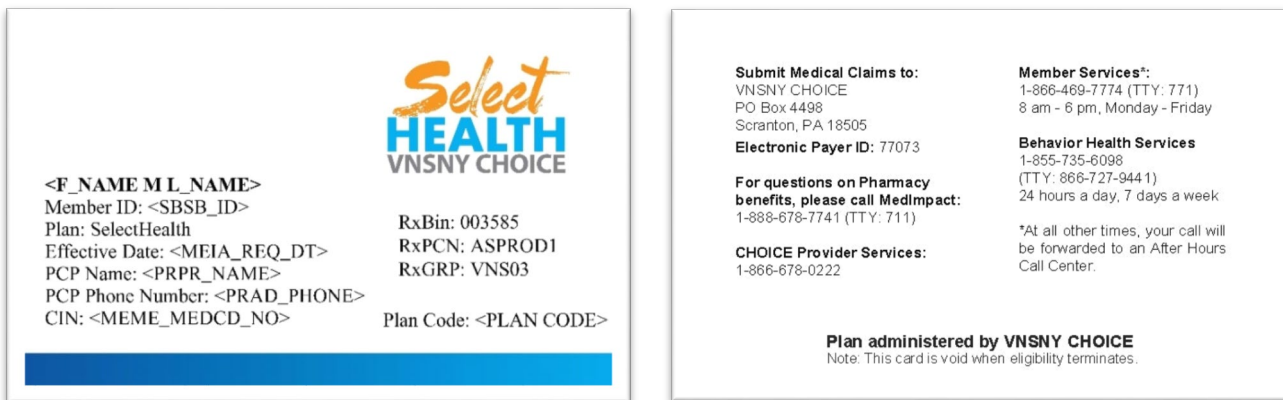
### SelectHealth from VNSNY CHOICE

The State is responsible for managing the enrollment process for HIV Special Needs Plans (SNP), which includes confirming eligibility criteria (valid Medicaid status and verbal confirmation from the client of HIV positive status). People who are transgender or gender non-conforming, people who are homeless, and children under 21 covered by an infected parent are also eligible to enroll with HIV SNP plans regardless of HIV status.

VNSNY CHOICE reimburses providers for services rendered to eligible members currently enrolled in the plan. If a provider wishes to provide a non-covered service to a member, the provider must inform the member in writing prior to the initiation of the service, indicating the cost and the member’s responsibility for payment.

VNSNY CHOICE may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee’s capacity for normal activity, or threaten some significant handicap.

**Identification Card:** VNSNY CHOICE generates an identification card to all actively enrolled members of the plan within 14 days of the member’s effective date of enrollment.



Information on the card includes member name, client identification number (CIN), primary care provider name and telephone number, the 24-hour VNSNY CHOICE toll-free number and the behavior health phone number. Plan code on the ID card identifies if a member is eligible for HCBS services (Home and Community Based Services).

Plan code “004” denotes a member who is not eligible for HCBS services and plan code “008” denotes a member who is eligible for HCBS services. At the time of the member’s visit providers should ask the member for his/her member identification card. Most providers make a copy of both sides of the card for their files.

**EMEVS (Electronic Medicaid Eligibility Verification System) or ePACES: Eligible** members are verified by the code “VS” on the EMEVS/EPACES. You can find additional information on the web through the following link - <https://www.emedny.org/index.aspx> .

**Member Roster:** Primary care providers receive a member roster from SelectHealth each month. The roster contains information regarding the members on the PCP’s panel, including name, CIN number, and enrollment effective date.

**Referral:** Although members do not need a referral to seek care from an in- network specialist, they should have a prescription from the primary care provider.

**Member Services:** If you have questions regarding member eligibility, call Member Services at 1-866-469-7774, Monday through Friday, 8 am to 6 pm.

## 3.2- Marketing, Advertising and Outreach

### Managed Long Term Care (MLTC)

In compliance with NYSDOH regulation of Medicaid managed long-term care (MLTC) plans, VNSNY CHOICE MLTC solicits the willing participation of healthcare providers and community influencers to develop its referral base. VNSNY CHOICE ensures, through its contracts with network providers and subcontractors, that these network providers and subcontractors comply with all Marketing Requirements.

VNSNY CHOICE does not pay network providers or subcontractors any commission, bonus, or similar compensation that uses numbers of Medicaid eligible persons enrolled in the VNSNY CHOICE MLTC plan as a factor in determining compensation.

### Communication with Patients

- Participating CHOICE MLTC Providers who wish to let their patients know of their affiliations with one or more managed care organizations (MCOs) must list each MCO with whom they have contracts.
- Participating Providers who are communicating with patients about managed care options

must direct patients to the State’s Enrollment Broker for education on all managed care plan options.

- Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type.
- Participating Providers are prohibited from displaying CHOICE MLTC outreach materials.
- Upon termination of a Provider Contract with CHOICE MLTC, a provider that has contracts with other MCOs that offer MLTC products may notify their patients of the change in status and the impact of such change on the patient.

### **VNSNY CHOICE Total (HMO D-SNP)**

As a Medicaid Advantage Plus plan with a Part D component, VNSNY CHOICE Total and the providers we contract with must conform with regulations from both the federal Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH).

CMS defines plan-initiated activities as those where either a Plan/Part D sponsor requests contracted providers to perform a task or the provider is acting on behalf of the Plan/Part D sponsor. For the purpose of plan-initiated activities, the Plan/Part D sponsor must ensure compliance with requirements applicable to communication and marketing.

CHOICE Total requests for providers to discuss benefits and cost sharing would fall under the definition of marketing and are hence prohibited from taking place where care is being delivered.

Additionally, CHOICE Total providers may not do any of the following:

- Accept/collect scope of appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Plans/Part D sponsors.

- Offer inducements to persuade their patients to enroll in a particular plan or organization.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials/applications in areas where care is being delivered.
- Offer anything of value to induce enrollees to select them as their provider.
- Accept compensation from the plan for any marketing or enrollment activities.

CHOICE Total providers may do either of the following:

- Make available, distribute, and display communication materials, including in areas where care is being delivered.
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).

### **SelectHealth from VNSNY CHOICE**

The SelectHealth from VNSNY CHOICE is contracted with the New York State Department of Health NYSDOH (NYSDOH) and is subject to contractual terms and conditions including comprehensive marketing guidelines. By NYSDOH definition, marketing encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

### **Written Marketing Materials**

Written marketing materials generated by providers must be approved by NYSDOH, Division of Health Care Access.

Written marketing materials must contain certain specified information to ensure that potential HIV SNP members receive basic information. The NYSDOH has developed a model letter for use by providers to communicate information about HIV SNPs to their patients. No further review is required if the model letter is used. Any modifications to this letter, however, must be approved by NYSDOH.

## Marketing Encounters

Marketing encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular HIV SNP. All marketing encounters must communicate at least the following information:

- A statement that participation in an HIV SNP is voluntary and that persons with HIV/AIDS may choose instead to join or remain in a mainstream Medicaid managed care plan.
- The potential member has a choice among several alternative HIV SNPs.
- Upon enrollment in a SNP, the member is required to use their HIV Specialist PCP and other plan providers exclusively for medical care, except in certain limited circumstances.
- Newborns of a mother enrolled in a SNP are automatically enrolled in the mother's HIV SNP. The infant may be disenrolled at any time at the mother's request.
- Providers may market to persons enrolled in the mainstream health plan operated by the same organization as the HIV SNP but must inform the member that the change is optional and the members who change from a mainstream health plan to an affiliated SNP must sign a new enrollment form.
- Providers who wish to let their patients know of their affiliation with one or more HIV SNPs must list each HIV SNP with whom they hold contracts.

## Marketing Conduct

- Marketing encounters are to be conducted in a manner that does not disclose nor breach the confidentiality of the potential member's HIV status.
- Providers may not give mailing lists of patients to HIV SNPs.
- Providers may not target mailings to HIV/AIDS patients or patients with a significant probability of having HIV/AIDS unless the patient has consented in writing to mail contact. This is to protect patient confidentiality. Some providers, such as facilities specializing in HIV/AIDS care, should consider handouts of literature rather than a mailing to avoid confidentiality problems.
- Providers should inquire as to whether the prospective member is currently enrolled in another HIV SNP. If so, providers may not market to persons who are enrolled in another HIV SNP.