# MEDICAID MANAGED CARE/

# FAMILY HEALTH PLUS/

# HIV SPECIAL NEEDS PLAN/

# HEALTH AND RECOVERY PLAN

# MODEL CONTRACT

March 1, 2019

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# MISCELLANEOUS/CONSULTANT SERVICES
**(Award Without Formal Request For Proposal)**

STATE AGENCY (Name and Address):

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
One Commerce Plaza
Room 1609
Albany, NY 12260

NYS Comptroller's Number:

Originating Agency GLBU: DOH01
Department ID: 3450000 (Use Unit ID)

CONTRACTOR (Name and Address):

TYPE OF PROGRAM(S):

Medicaid Managed Care and/or
Family Health Plus and/or HIV Special Needs Plan

CHARITIES REGISTRATION NUMBER:

Contractor has ( ) has not ( ) timely filed with the Attorney General's Charities Bureau all required period or annual written reports.

FEDERAL TAX IDENTIFICATION NUMBER:

NYS VENDOR IDENTIFICATION NUMBER:

MUNICIPALITY NUMBER (if applicable):

CONTRACT TERM:

FROM: March 1, 201~~4~~9
TO: February 2~~8~~9, 20~~19~~24

FUNDING AMOUNT FOR CONTRACT TERM:
~~Based on approved capitation rates~~

STATUS:

CONTRACTOR IS [ ] IS NOT [ ]
A SECTARIAN ENTITY

CONTRACTOR IS [ ] IS NOT [ ]
A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS [ ] IS NOT [ ]
A NY STATE BUSINESS ENTERPRISE

( ) IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ____ ADDITIONAL ONE-YEAR PERIOD(S) AT THE SOLE OPTION OF THE STATE AND SUBJECT TO THE APPROVAL OF THE NEW YORK STATE DEPARTMENT OF HEALTH, THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE OFFICE OF THE STATE COMPTROLLER.

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**APPENDICES TO THIS AGREEMENT AND INCORPORATED BY REFERENCE INTO THE AGREEMENT**

-X- **Appendix A.** Standard Clauses for New York State Contracts

-X- **Appendix B.** Certification Regarding Lobbying

-X- **Appendix B-1**. Certification Regarding MacBride Fair Employment Principles

-X- **Appendix C.** New York State Department of Health Requirements for the Provision of Family Planning and Reproductive Health Services

-X- **Appendix D.** New York State Department of Health MCO Outreach/Advertising Activities

-X- **Appendix E.** New York State Department of Health Member Handbook Guidelines

-X- **Appendix F.** New York State Department of Health Action and Grievance and Appeal System Requirements for the MMC and FHPlus Programs

-X- **Appendix G.** New York State Department of Health Requirements for the Provision of Emergency Care and Services

-X- **Appendix H.** New York State Department of Health Requirements for the Processing of Enrollments and Disenrollments in the MMC and FHPlus Programs

-X- **Appendix I.** New York State Department of Health Guidelines for Use of Medical Residents and Fellows

-X- **Appendix J.** New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act

-X- **Appendix K.** Prepaid Benefit Package Definitions of Covered and Non-Covered Services

-X- **Appendix L.** Approved Capitation Payment Rates

-X- **Appendix M.** Service Area and Benefit Package Options

-X- **Appendix N.** RESERVED

-X- **Appendix O.** Requirements for Proof of Workers' Compensation and Disability Benefits Coverage

-X- **Appendix P.** Facilitated Enrollment and Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreements

-X- **Appendix Q.** New York State Department of Health Recipient Restriction Program Requirements for MMC and FHPlus Programs

-X- **Appendix R.** Additional Specifications for the MMC and FHPlus Agreement

-X- **Appendix S.** New York State Department of Health Requirements for Long Term Services and Supports for MMC and FHPlus Programs

-X- **Appendix T.** Additional Requirements for the HARP and HIV SNP Programs

-X- **Appendix U.** Intellectual/Developmental Disabilities (I/DD) Specialized I/DD Plan (SIP)

-X- **Appendix X.** Modification Agreement Form

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IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE

By: _____

_____
Printed Name

Title: _____

Date: _____

STATE AGENCY SIGNATURE

By: _____

_____
Printed Name

Title: _____

Date: _____

State Agency Certification:
In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK )
) SS.:
County of _____ )

On the _____ day of _____in the year_____, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Notary)

ATTORNEY GENERAL

_____

Title: _____

Date: _____

Thomas P. DiNapoli
STATE COMPTROLLER

_____

Title: _____

Date: _____

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**B-1**. Certification Regarding MacBride Fair Employment Principles

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**L**. Approved Capitation Payment Rates

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**R**. Additional Specifications for the MMC and FHPlus Agreement

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**T.** Additional Requirements for the HARP and HIV SNP Programs

**U.** Intellectual/Developmental Disabilities (I/DD) Specialized I/DD Plan (SIP)

**X.** Modification Agreement Form

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# STATE OF NEW YORK
# MEDICAID AND FAMILY HEALTH PLUS
# PARTICIPATING MANAGED CARE PLAN AGREEMENT

This AGREEMENT is hereby made by and between the New York State Department of Health (SDOH) and _____(Contractor) as identified on the face page of this Agreement.

RECITALS

WHEREAS, pursuant to Title XIX of the Federal Social Security Act, codified as 42 U.S.C. Section 1396 et seq. (the Social Security Act), and Title 11 of Article 5 of the New York State Social Services Law (SSL), a comprehensive program of medical assistance for needy persons exists in the State of New York (Medicaid); and

WHEREAS, pursuant to Title 11 of Article 5 of the SSL, the Commissioner of Health has established a managed care program under the medical assistance program, known as the Medicaid Managed Care (MMC) Program; and

WHEREAS, pursuant to Article 44 of the Public Health Law (PHL), the New York State Department of Health (SDOH) is authorized to issue Certificates of Authority to establish Health Maintenance Organizations (HMOs), PHL Section 4400 et seq., Prepaid Health Services Plans, (PHSPs), PHL Section 4403-a, and HIV Special Needs Plans (HIV SNPs), PHL Section 4403-c, and, jointly with the Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), for Health and Recovery Plans (HARPs), PHL Section 4403-d and

WHEREAS, pursuant to Title 11-D of Article 5 of the SSL, a health insurance program known as Family Health Plus (FHPlus) was created effective January 1, 2001 for eligible persons who do not qualify for Medicaid , and such Law was repealed effective January 1, 2015; and

WHEREAS, organizations certified under Article 44 of the New York State Public Health Law (PHL) are eligible to provide comprehensive health services through comprehensive health services plans to Eligible Persons as defined in Titles 11 and 11-D of the SSL, MMC, HIV SNPs, HARP and FHPlus Programs, respectively; and

WHEREAS, the Contractor is organized under the laws of New York State and is certified under Article 44 of the PHL and has offered to provide covered health services to Eligible Persons residing in the geographic area specified in Appendix M of this Agreement (Service Area and Benefit Package Options); and

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WHEREAS, the SDOH has determined that the Contractor meets the qualifications established for participation in the MMC Program, the HIV SNP Program, the FHPlus, and/or the HARP Program to provide the applicable health care coverage to Eligible Persons in the geographic area specified in Appendix M of this Agreement.

**NOW THEREFORE**, the parties agree as follows:

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## 1. DEFINITIONS

**"834 Electronic Data Interchange Transmission File (834 File)"** means a HIPAA 5010 compliant transaction enacted as part of the Affordable Care Act (P.L. 111-148 and 111-152). The 834 is an electronic Benefit Enrollment and Maintenance document generated by the New York State of Health. The 834 File contains new enrollments, changes in enrollments, reinstatement of enrollments and disenrollments.

"**Abuse"** means practices that are inconsistent with sound fiscal, business, medical or professional practices, and which result in unnecessary costs to the Medicaid program, payments for services that were not medically necessary, or payments for services which fail to meet recognized standards for health care. It also includes enrollee practices that result in unnecessary costs to the Medicaid program.

**"Advance Directive"** means a written instruction recognized under State law, whether statutory or as recognized by the courts of the State, relating to the provision of health care when the individual is incapacitated.

**"Aliessa"** means a non-citizen under 65 years of age who entered the United States on or after August 22, 1996 and is lawfully residing in New York State, who would otherwise be ineligible for Medicaid solely due to his or her immigration status.

**"Auto-assignment"** means a process by which an MMC Eligible Person, as this term is defined in this Agreement, who is mandated to enroll in the MMC Program, but who has not selected and enrolled in an MCO within sixty (60) days of receipt of the mandatory notice sent by the LDSS, is assigned to an MCO offering a MMC product in the MMC Eligible Person's county of fiscal responsibility in accordance with the auto-assignment algorithm determined by the SDOH.

**"Behavioral Health"** means mental health and/or substance use disorders.

**"Behavioral Health Benefit Inclusion"** means the date, as determined by the State, the Contractor is responsible for the provision of the expanded behavioral health Benefit Package services, pursuant to the New York State Section 1115 Behavioral Health Partnership Plan Waiver Amendment, for Enrollees 21 years of age and older residing in a specified county within the Contractor's Service Area or the date the State determines the Contractor may begin accepting Enrollees in their HARP line of business.

**"Behavioral Health Home and Community-Based Services (BHHCBS)"** means services as set forth in Appendix T of this Agreement that are provided to individuals enrolled in a HARP or HIV SNP who have been determined to be eligible for such services pursuant to this Agreement.

**"Behavioral Health Provider"** means a provider of mental health services licensed under Article 31 of the Mental Hygiene Law, a provider of substance use services certified under Article 32 of the Mental Hygiene Law and a New York State-designated

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provider of Behavioral Health Home and Community Based Services. For the purposes of this Agreement, individual practitioners are not considered Behavioral Health Providers except where specifically indicated.

**"Behavioral Health Services"** means services to address mental health disorders and/or substance use disorders, including Behavioral Health Home and Community Based Services.

**"Benefit Package"** means the covered services for the MMC and/or FHPlus Programs, described in Appendix K of this Agreement, to be provided to the Enrollee, as Enrollee is defined in this Agreement, by or through the Contractor, including optional Benefit Package services, if any, as specified in Appendix M of this Agreement.

**"Capitation Rate"** means the fixed monthly amount that the Contractor receives for an Enrollee to provide that Enrollee with the Benefit Package.

**"Chemical Dependence Services"** means examination, diagnosis, level of care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence, and includes the provision of alcohol and/or substance abuse services.

**"Child/Teen Health Program" or "C/THP"** means the program of early and periodic screening, including inter-periodic, diagnostic and treatment services (EPSDT) that New York State offers all Eligible Persons under twenty-one (21) years of age. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The services include administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative case management and transportation assistance, to the extent that transportation is included in the Benefit Package.

**"Clinical Advisory Groups (CAGs)"** means groups that are composed of individuals with clinical or industry experience and knowledge of specific care or conditions. The CAGs review clinical and episodic bundles, subpopulations and outcome measures that are relevant to the New York State Medicaid Program and make recommendations to SDOH for inclusion in the CAG Playbooks.

**"Clinical Advisory Groups (CAGs) Playbooks"** means a document that is produced by SDOH in consultation with the CAGs. The Playbooks contain outcome measures for VBP arrangements, data and other support required for the Contractor and its network providers to be successful and other implementation details. The SDOH approved CAG Playbooks are published on the SDOH website, www.health.ny.gov.

**"Clubhouse"** means a program that supports individuals living with mental illness and has been designated by the State to provide Behavioral Health Home and Community Based Services including peer support, supported employment, supported education, and

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psychosocial rehabilitation. Clubhouses are an evidence-based practice and operate using the work-ordered day model where staff and clubhouse members work side-by-side to maintain the clubhouse.

**"Comprehensive HIV Special Needs Plan" or "HIV SNP"** means an MCO certified pursuant to Section forty-four hundred three-c (4403-c) of Article 44 of the PHL which, in addition to providing or arranging for the provision of comprehensive health services on a capitated basis, including those for which Medical Assistance payment is authorized pursuant to Section three hundred sixty-five-a (365-a) of the SSL, also provides or arranges for the provision of specialized HIV care to HIV positive persons eligible to receive benefits under Title XIX of the federal Social Security Act or other public programs.

**"Comprehensive Third Party Health Insurance (TPHI)"** means comprehensive health care coverage or insurance (including Medicare and/or private MCO coverage) that does not fall under one of the following categories:

a) accident-only coverage or disability income insurance;
b) coverage issued as a supplement to liability insurance;
c) liability insurance, including auto insurance;
d) workers compensation or similar insurance;
e) automobile medical payment insurance;
f) credit-only insurance;
g) coverage for on-site medical clinics;
h) dental-only, vision-only, or long-term care insurance;
i) specified disease coverage;
j) hospital indemnity or other fixed dollar indemnity coverage;
k) prescription-only coverage.

**"Continuous Behavioral Health Episode of Care"** means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the Behavioral Health Benefit Inclusion in each geographic service area in which services had been provided at least twice during the six months preceding the Behavioral Health Benefit Inclusion Date by the same provider to an Enrollee for the treatment of the same or related behavioral health condition.

**"Conversion Therapy"** means any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

**"Co-payment"** means an amount an Enrollee pays for a covered service included in the Benefit Package.

**"Court-Ordered Services"** means those services that the Contractor is required to provide to Enrollees pursuant to orders of courts of competent jurisdiction, provided

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however, that such ordered services are within the Contractor's Benefit Package and reimbursable under Title XIX of the Federal Social Security Act (SSA), SSL 364-j(4)(r).

**"Days"** means calendar days except as otherwise stated.

**"Designated Third Party Contractor"** means a MCO with which the SDOH has contracted to provide Family Planning and Reproductive Health Services for FHPlus Enrollees of a MCO that does not include such services in its Benefit Package or, for the purpose of this Agreement, the New York State Medicaid fee-for-service program and its participating providers and subcontractors.

**"Detoxification Services"** means Medically Managed Detoxification Services and Medically Supervised Inpatient and Outpatient Withdrawal Services as defined in Appendix K of this Agreement.

**"Disenrollment"** means the process by which an Enrollee's membership in the Contractor's MMC or FHPlus product terminates.

**"Effective Date of Disenrollment"** means the date on which an Enrollee may no longer receive services from the Contractor, pursuant to Section 8.5 and Appendix H of this Agreement.

**"Effective Date of Enrollment"** means the date on which an Enrollee may begin to receive services from the Contractor, pursuant to Section 6.8(e) and Appendix H of this Agreement.

**"Eligible Person"** means an MMC Eligible Person, FHPlus Eligible Person, HIV SNP Eligible Person, or a HARP Eligible Person as these terms are defined in this Agreement.

**"eMedNY"** means the electronic Medicaid system of New York State for eligibility verification and Medicaid provider claim submission and payments.

**"Emergency Medical Condition"** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

**"Emergency Services"** means health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

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**"Enrollee"** means either an MMC Enrollee or FHPlus Enrollee as these terms are defined in this Agreement.

**"Enrollment"** means the process by which an Enrollee's membership in the Contractor's MMC or FHPlus product begins.

**"Enrollment Broker"** means the state and/or county-contracted entity that provides Enrollment, education, and outreach services to Eligible Persons; effectuates Enrollments and Disenrollments in MMC and FHPlus; and provides other contracted services on behalf of the SDOH and the LDSS.

**"Enrollment Facilitator"** means an entity under contract with SDOH, and its agents, that assists children and adults to complete the Medicaid, Family Health Plus, Child Health Plus and Special Supplemental Food Program for WIC application and the enrollment and recertification processes, to the extent permitted by federal and state law and regulation. This includes assisting individuals in completing the required application form, conducting the face-to-face interview, assisting in the collection of required documentation, assisting in the MCO selection process, and referring individuals to WIC or other appropriate sites.

**"Essential Community Behavioral Health Providers"** means State-operated providers of ambulatory mental health services, State-operated providers of Behavioral Health Home and Community Based Services and Opioid Treatment Programs.

**"Facilitated Enrollment"** means the enrollment infrastructure established by SDOH to assist children and adults in applying for Medicaid, Family Health Plus, Child Health Plus or WIC using a joint application, and recertifying for these programs, as allowed by federal and state law and regulation.

**"Family Health Plus" or "FHPlus"** means the health insurance program established under Title 11-D of Article 5 of the SSL that was repealed effective January 1, 2015.

**"FHPlus Eligible Person"** means a person whom the LDSS, state or federal government determines to have met the qualifications established in state or federal law necessary to receive FHPlus benefits under Title 11-D of the SSL and who meets all the other conditions for enrollment in the FHPlus Program.

**"FHPlus Enrollee"** means a FHPlus Eligible Person who either personally or through an authorized representative, has enrolled in the Contractor's FHPlus product.

**"Fiscal Agent"** means the entity that processes or pays vendor claims on behalf of the Medicaid state agency pursuant to an agreement between the entity and such agency.

**"Fraud"** means an intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the provider, Contractor, Subcontractor, or another person and includes the acts prohibited by section 366-b of the

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Social Services Law. It also includes any other act that constitutes fraud under applicable Federal or State law.

**"Guaranteed Eligibility"** means the period beginning on the Enrollee's Effective Date of Enrollment with the Contractor and ending six (6) months thereafter, during which the Enrollee may be entitled to continued Enrollment in the Contractor's MMC or FHPlus product, as applicable, despite the loss of eligibility as set forth in Section 9 of this Agreement.

**"HARP Eligible Person"** means a person age 21 or older, whom the LDSS, state or federal government determined to have met the qualifications established in state or federal law necessary to receive Medical Assistance under Title II of the SSL and who meets all of the other conditions for enrollment in the HARP Program.

**"HARP Enrollee"** means an MMC Eligible Person who, either personally or through an authorized representative, has enrolled in the Contractor's HARP.

**"Health and Recovery Plan (HARP)"** means an MCO certified pursuant to Section forty-four hundred three-d (4403-d) of Article 44 of the PHL which, in addition to providing or arranging for the provision of comprehensive health services on a capitated basis, including those for which Medical Assistance payment is authorized pursuant to Section three hundred sixty-five-a (365-a) of the SSL, also provides or arranges for specialized and integrated physical and behavioral health services for adults with serious mental illness (SMI) and Substance Use Disorders (SUD) who are eligible to receive benefits under Title XIX of the federal Social Security Act or other public programs.

**"Health Commerce System" or "HCS"** means a closed communication network dedicated to secure data exchange and distribution of health related information between various health facility providers and the SDOH. HCS functions include: collection of Complaint and Disenrollment information; collection of financial reports; collection and reporting of managed care provider networks systems (PNS); and the reporting of encounter data systems (MEDS III) or its successor system.

**"Health Home"** means an entity designated by the New York State Department of Health pursuant to Social Services law § 365-L to provide care management services to Health Home eligible Medicaid recipients.

**"HIV SNP Eligible Person"** means a person whom the LDSS, state or federal government determines to have met the qualifications established in state or federal law necessary to receive medical assistance under Title II of the SSL and who meets all of the other conditions for enrollment in the HIV SNP Program.

**"HIV SNP Enrollee"** means an MMC Eligible Person who either personally or through an authorized representative, has enrolled in the Contractor's HIV SNP.

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**"HIV Specialist PCP" (for HIV SNPs only)** means an HIV experienced Primary Care Provider who has met the criteria of one of the following recognized bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, or
- HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM), or
- Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

**"Indian Health Care Provider"** means a health care provider as defined in 42 USC 1326u-2(h)(4)(A)

**"Inpatient Stay Pending Alternate Level of Medical Care"** means continued care in a hospital pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85.

**"Institution for Mental Disease" or "IMD"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an Institution for Mental Disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for people with developmental disabilities is not an Institution for Mental Diseases.

**"LOCADTR"** means a patient placement criteria system designed to assure that a client in need of substance use disorder services is placed in the least restrictive, but most clinically appropriate level of care available that is to be used in making all initial and ongoing level of care decisions in New York State. LOCADTR is developed and updated, as appropriate, by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and is the clinical level of care tool that assesses the intensity and need of services for an individual with a Substance Use Disorder (SUD).

**"Local Public Health Agency" or "LPHA"** means the city or county government agency responsible for monitoring the population's health, promoting the health and safety of the public, delivering public health services and intervening when necessary to protect the health and safety of the public.

**"Local Department of Social Services" or "LDSS"** means a city or county social services district as constituted by Section 61 of the SSL.

**"Lock-In Period"** means the period of time during which an Enrollee may not change MCOs, unless the Enrollee can demonstrate Good Cause as established in state law and specified in Appendix H of this Agreement.

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**"Long Term Placement (Permanent Placement) Status"** means the status of an individual in a Residential Health Care Facility (RHCF) when the Contractor or the LDSS determines that the individual is not expected to return home or to a community setting based on medical evidence affirming the individual's need for RHCF level of care on an ongoing basis. An Enrollee may be in Long Term Placement Status while the LDSS determination of the Enrollee's eligibility for chronic care Medicaid is pending, pursuant to Section 10.40 and Appendix K of this Agreement.

**"Long Term Services and Supports" or (LTSS)** means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, AIDS Adult Day Health Care Program, Personal Care Services, and institutional services including long term placement in Residential Health Care Facilities.

**"Managed Care Organization" or "MCO"** means a health maintenance organization ("HMO") or prepaid health service plan ("PHSP") certified under Article 44 of the PHL.

**"Medicaid Managed Care Quality Incentive"** means a monetary incentive in the form of a percentage of the managed care capitation payment rates that is awarded to MCOs with superior performance in relation to a predetermined set of measures which may include quality of care, consumer satisfaction and compliance measures.

**"Medical Record"** means a complete record of care rendered by a provider documenting the care rendered to the Enrollee, including inpatient, outpatient, and emergency care, in accordance with all applicable federal, state and local laws, rules and regulations. Such record shall be signed by the medical professional rendering the services.

**"Medically Necessary"** means health care 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 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.

**"Member Handbook"** means the publication prepared by the Contractor and issued to Enrollees to inform them of their benefits and services, how to access health care services and to explain their rights and responsibilities as a MMC Enrollee or FHPlus Enrollee.

**"MMC (Medicaid Managed Care)",** unless otherwise specified, includes HIV SNP and HARPs.

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**"MMC Eligible Person"** means a person whom the LDSS, state or federal government determines to have met the qualifications established in state or federal law necessary to receive medical assistance under Title 11 of the SSL and who meets all the other conditions for enrollment in the MMC Program.

**"MMC Enrollee"** means an MMC Eligible Person who either personally or through an authorized representative, has enrolled in, or has been auto-assigned to, the Contractor's MMC product.

**"Native American"** means, for purposes of this Agreement, a person identified in the Medicaid eligibility system as a Native American, American Indian or Alaskan Native.

**"New York State of Health (NYSoH)"** means an office located within the New York State Department of Health that functions as the state's official health insurance marketplace. The NYSoH was established in accordance with the Patient Protection and Affordable Care Act of 2010. NYSoH provides a web portal through which individuals may apply for and enroll in Medicaid and other government sponsored health insurance, or purchase standardized health insurance that is eligible for federal subsidies.

**"New York State Office of the Attorney General (OAG)"** means the New York State Office of the Attorney General, including but not limited to, the Medicaid Fraud Control Unit. The Medicaid Fraud Control Unit is the entity designated to (i) conduct a statewide program for investigating and prosecuting alleged violations of all applicable State laws pertaining to any and all aspects of fraud in connection with the administration of the Medicaid Program, the provision of medical assistance and the activities of Providers of medical assistance under the Program, (ii) review complaints alleging abuse or neglect of patients in health care facilities receiving Medicaid payments; and (iii) when warranted, make statutory or programmatic recommendations regarding program integrity issues to NYSDOH and OMIG and; (iv) receives federally and state mandated referrals of suspected fraud and criminality from OMIG or other referrals as required or contemplated by federal law pursuant to PHL §32(7) and reviews such referrals pursuant to 42 C.F.R. §455.15(a), §455.21(a) and §455.23 and (v) receives and reviews referrals of potential fraud from the Contractor and its subcontractors and others.

**"New York State Office of the Medicaid Inspector General (OMIG)"** means the independent program integrity office within SDOH, the single state agency responsible for the administration of the Medicaid Program, responsible for SDOH's duties as the single state agency with respect to the (a) prevention, detection and investigation of fraud, waste and abuse within the medical assistance program; (b) referral of appropriate cases for criminal prosecution; and (c) recovery of improperly expended medical assistance funds (see Public Health Law §§ 30, 31, 32).

**"Nonconsensual Enrollment"** means Enrollment of an Eligible Person, other than through Auto-assignment, newborn Enrollment or case addition, in a MCO's MMC or FHPlus product without the consent of the Eligible Person or consent of a person with the legal authority to act on behalf of the Eligible Person at the time of Enrollment.

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**"Non-Participating Provider"** means a provider of medical care and/or services with which the Contractor has no Provider Agreement, as this term is defined in this Agreement.

**"NYS Value Based Payment (VBP) Roadmap"** means a document that is updated annually by SDOH and approved by CMS to ensure that best practices and lessons learned throughout implementation of Value Based Payment into Medicaid Managed Care are leveraged and incorporated into the State's overall vision. The NYS VBP Roadmap is published on the SDOH website, www.health.ny.gov**"Participating Provider"** means a provider of health or behavioral health care and/or services that has a Provider Agreement with the Contractor.

**"Overpayment"** means any payment made to a Participating Provider or Non-Participating Provider by the Contractor or subcontractor, or by the Contractor to a subcontractor, to which the Participating Provider, Non-Participating Provider or subcontractor is not entitled to under Title XIX of the Social Security Act, or any payment to the Contractor to which the Contractor is not entitled to under the Medicaid program. It includes any payment which would constitute an overpayment under State or Federal law.

**"Participating Provider"** means a provider of health or behavioral health care and/or services that has a Provider Agreement with the Contractor.

**"Personal Care Agency (PCA)"** means an entity that provides some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district, or its designee, in accordance with the regulations of the SDOH.

**"Physician Incentive Plan" or "PIP"** means any compensation arrangement between the Contractor or one of its contracting entities and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to the Contractor's Enrollees .

**"Post-stabilization Care Services"** means covered services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition.

**"Potential Enrollee"** means a MMC Eligible Person who is not yet enrolled in a MCO that is participating in the MMC Program.

**"Prepaid Capitation Plan Roster" or "Roster"** means the Enrollment list generated on a monthly basis by SDOH by which LDSS and Contractor are informed of specifically which Eligible Persons the Contractor will be serving for the coming month, subject to

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any revisions communicated in writing or electronically by SDOH, LDSS, or the Enrollment Broker.

**"Presumptive Eligibility Provider"** means a provider designated by the SDOH as qualified to determine the presumptive eligibility for pregnant women to allow them to receive prenatal services immediately. These providers assist such women with the completion of the full application for Medicaid and they may be comprehensive Prenatal Care Programs, Local Public Health Agencies, Certified Home Health Agencies, Public Health Nursing Services, Article 28 facilities, and individually licensed physicians and certified nurse practitioners.

**"Preventive Care"** means the care or services rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than treatment programs.

**"Primary Care Provider" or "PCP"** means a qualified physician, or certified nurse practitioner or team of no more than four (4) qualified physicians/certified nurse practitioners which provides all required primary care services contained in the Benefit Package to Enrollees.

**"Prospective Enrollee"** means any individual residing in the Contractor's Service Area that has not yet enrolled in a MCO's MMC or FHPlus product.

**"Provider Agreement"** means any written contract between the Contractor and Participating Providers to provide medical care and/or services to Contractor's Enrollees.

**"Quality Steering Committee (QSC)"** means a committee comprised of representatives from New York State Department of Health (DOH), Office of New York State Mental Health (OMH), New York State Office of Alcoholism and Substance Abuse Services (OASAS), and the New York City Department of Health and Mental Hygiene (DOHMH), to coordinate the monitoring and oversight of the quality of Behavioral Health in Medicaid Managed Care Plans serving residents of New York City.

**"Regional Planning Consortium (RPC)"** means a Regional Behavioral Health planning Consortium, which is comprised of the Local Government Unit(s) in each region, representatives of mental health and Substance Use Disorder service providers, child welfare system, peers, families, Health Homes, and MCOs. The RPC works closely with State agencies to guide behavioral health policy as it relates to Medicaid Managed Care in the region, problem solve regional service delivery challenges, and recommend provider training topics.

**"School Based Health Centers" or "SBHC"** means SDOH approved centers which provide comprehensive primary and mental health services including health assessments,

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diagnosis and treatment of acute illnesses, screenings and immunizations, routine management of chronic diseases, health education, mental health counseling and treatment on-site in schools. Services are offered by multi-disciplinary staff from sponsoring Article 28 licensed hospitals and community health centers.

**"Seriously Emotionally Disturbed" or "SED"** means, an individual through twenty-one (21) years of age who meets the criteria established by the Commissioner of Mental Health, including children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (1) whose severity and duration of mental illness results in substantial functional disability or (2) who require mental health services on more than an incidental basis. SED also means an individual up to twenty-two (22) years of age who meets these criteria and began receiving treatment in an OMH designated clinic serving SED children prior to the individual's 21st birthday, only for the duration of the treatment episode.

**"Seriously and Persistently Mentally Ill" or "SPMI"** means an individual eighteen (18) years or older who meets the criteria established by the Commissioner of Mental Health, including persons who have a designated diagnosis of mental illness under the most recent edition of the diagnostic and statistical manual of mental disorders, and (1) whose severity and duration of mental illness results in substantial functional disability or (2) who require mental health services on more than an incidental basis.

"**Short Term Placement (Temporary Placement) Status**" means the status of an individual in a Residential Health Care Facility who has not been determined by the Contractor or the LDSS to be in Long Term Placement (Permanent Placement) Status.

**"Subcontractor"** shall mean an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this Agreement.

**"Substance Use Disorder (SUD)"** means the misuse of, dependence on, or addiction to alcohol and/or legal or illegal drugs leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others and shall include alcoholism, alcohol abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence. "Substance Use Disorder" means "Chemical Dependence" or "Substance Abuse."

**"Substance Use Disorder Services"** shall mean and include examination, evaluation, diagnosis, care, treatment, or rehabilitation of persons with substance use disorders and their families or significant others, and, includes services otherwise referred to a: chemical dependences; alcohol; drug treatment; and/ or substance abuse services.

**"Supplemental Maternity Capitation Payment"** means the fixed amount paid to the Contractor for the prenatal and postpartum physician care and hospital or birthing center delivery costs, limited to those cases in which the Contractor has paid the hospital or birthing center for the maternity stay, and can produce evidence of such payment.

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**"Supplemental Newborn Capitation Payment"** means the fixed amount paid to the Contractor for the inpatient birthing costs for a newborn enrolled in the Contractor's MMC product, limited to those cases in which the Contractor has paid the hospital or birthing center for the newborn stay, and can produce evidence of such payment.

**"Supportive Housing"** means housing licensed, certified, or funded by OMH or OASAS.

**"Tuberculosis Directly Observed Therapy" or "TB/DOT"** means the direct observation of ingestion of oral TB medications to assure patient compliance with the physician's prescribed medication regimen.

**"Urgently Needed Services"** means covered services that are not Emergency Services as defined in this Section, provided when an Enrollee is temporarily absent from the Contractor's service area, when the services are medically necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the services through the Contractor's MMC or FHPlus Participating Provider.

**"Value-Based Payment (VBP)"** means a strategy that is used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to both quality and cost outcomes.

**"VBP Innovator Program"** means a program that is for qualifying providers that are supporting the total cost of care for both VBP subpopulations and the general population of their attributed members under an advanced VBP Level 2 or a VBP Level 3 arrangement. SDOH is responsible for identifying providers that qualify to participate in this program.

**"Waste"** means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by intentional action but rather the misuse or misappropriation of resources.

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## 2. AGREEMENT TERM, AMENDMENTS, EXTENSIONS, AND GENERAL CONTRACT ADMINISTRATION PROVISIONS

### 2.1 Term

a) This Agreement is effective March 1, ~~2014~~ 2019 and shall remain in effect until February 2~~8~~9, ~~2019~~2024; or until the execution of an extension, renewal or successor Agreement approved by the SDOH, the Office of the New York State Attorney General (OAG), the New York State Office of the State Comptroller (OSC), the US Department of Health and Human Services (DHHS), and any other entities as required by law or regulation, whichever occurs first. The SDOH shall consult with the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS), as applicable, prior to the execution of an extension, renewal or successor Agreement.

b) This Agreement shall not be automatically renewed at its expiration.

c) The maximum duration of this Agreement is five (5) years. An extension to this Agreement beyond the five year maximum may be granted for reasons including, but not limited to, the following;

   i) Negotiations for a successor agreement will not be completed by the expiration date of the current Agreement; or

   ii) The Contractor has submitted a termination notice and transition of Enrollees will not be completed by the expiration date of the current Agreement.

d) Notwithstanding the foregoing, this Agreement will automatically terminate, in its entirety, or in relevant part, should federal financial participation for the MMC and/or FHPlus Program expire.

### 2.2 Amendments

a) This Agreement may be modified only in writing. Unless otherwise specified in this Agreement, modifications must be signed by the parties and approved by the OAG, OSC and any other entities as required by law or regulation, and approved by the DHHS prior to the end of the quarter in which the amendment is to be effective. The SDOH shall consult with OMH and OASAS, as applicable, prior to issuing a modification of this Agreement to the Contractor for signature.

b) SDOH will make reasonable efforts to provide the Contractor with notice and opportunity to comment with regard to proposed amendment of this

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Agreement except when provision of advance notice would result in the SDOH being out of compliance with state or federal law.

c) The Contractor will return the signed amendment or notify SDOH that it does not agree within ten (10) business days of the date of the Contractor's receipt of the proposed amendment.

2.3 Approvals

This Agreement and any amendments to this Agreement shall not be effective or binding unless and until approved, in writing, by the OAG, OSC, DHHS, and any other entity as required in law and regulation. SDOH will provide a notice of such approval to the Contractor.

2.4 Entire Agreement

a) This Agreement, including those attachments, schedules, appendices, exhibits, and addenda that have been specifically incorporated herein and written plans submitted by the Contractor and maintained on file by SDOH and/or LDSS pursuant to this Agreement, contains all the terms and conditions agreed upon by the parties, and no other Agreement, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties or vary any of the terms contained in this Agreement. In the event of any inconsistency or conflict among the document elements of this Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

i) Appendix A, Standard Clauses for New York State Contracts;

ii) The body of this Agreement;

iii) The appendices attached to the body of this Agreement, other than Appendix A

iv) The Contractor's approved

A) Outreach/Advertising Procedures and Materials on file with SDOH and LDSS

B) Action and Grievance System Procedures on file with SDOH

C) Quality Assurance Plan on file with SDOH

D) ADA Compliance Plan on file with SDOH

E) Fraud and Abuse Prevention Plan on file with SDOH.



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2.5 Renegotiation

The parties to this Agreement shall have the right to renegotiate the terms and conditions of this Agreement in the event applicable local, state or federal law, regulations or policy are altered from those existing at the time of this Agreement in order to be in continuous compliance therewith. This Section shall not limit the right of the parties to this Agreement from renegotiating or amending other terms and conditions of this agreement. Such changes shall only be made with the consent of the parties and the prior approval of the OAG, OSC, and DHHS.

2.6 Assignment and Subcontracting

a) The Contractor shall not, without SDOH's prior written consent, assign, transfer, convey, sublet, or otherwise dispose of this Agreement; of the Contractor's right, title, interest, obligations, or duties under the Agreement; of the Contractor's power to execute the Agreement; or, by power of attorney or otherwise, of any of the Contractor's rights to receive monies due or to become due under this Agreement. SDOH agrees that it will not unreasonably withhold consent of the Contractor's assignment of this Agreement, in whole or in part, to a parent, affiliate or subsidiary corporation, or to a transferee of all or substantially all of its assets. The SDOH shall consult with OMH and OASAS, as applicable, prior to consenting to any assignment, transfer, conveyance, sublease, or other disposition. Any assignment, transfer, conveyance, sublease, or other disposition without SDOH's consent shall be void.

b) Contractor may not enter into any subcontracts related to the delivery of services to Enrollees, except by a written agreement, as set forth in Section 22 of this Agreement. The Contractor may subcontract for provider services and management services. If such written agreement would be between Contractor and a provider of health care or ancillary health services or between Contractor and an independent practice association, the agreement must be in a form previously approved by SDOH. If such subcontract is for management services under 10 NYCRR Part 98, it must be approved by SDOH prior to its becoming effective. Any subcontract entered into by Contractor shall fulfill the requirements of 42 CFR Parts 434 and 438 to the extent such regulations are or become effective that are appropriate to the service or activity delegated under such subcontract. Contractor agrees that it shall remain legally responsible to SDOH for carrying out all activities under this Agreement and that no subcontract shall limit or terminate Contractor's responsibility.

2.7 Termination

a) SDOH Initiated Termination



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i) SDOH shall have the right to terminate this Agreement, in whole or in part; for the Contractor's MMC or FHPlus product; or for any or all products in specified counties of Contractor's service area, if the Contractor:

A) takes any action that threatens the health, safety, or welfare of its Enrollees;

B) has engaged in an unacceptable practice under 18 NYCRR Part 515, that affects the fiscal integrity of the MMC or FHPlus Program or engaged in an unacceptable practice pursuant to Section 27.2 of this Agreement;

C) has its Certificate of Authority suspended, limited or revoked by SDOH;

D) materially breaches the Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) days, or to such longer period as the parties may agree, of SDOH's written request for compliance;

E) becomes insolvent;

F) brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under Title 11 of the U.S. Code (the Bankruptcy Code);

G) knowingly has a director, officer, partner or person owning or controlling more than five percent (5%) of the Contractor's equity, or has an employment, consulting, or other agreement with such a person for the provision of items and/or services that are significant to the Contractor's contractual obligation who has been debarred or suspended by the federal, state or local government, or otherwise excluded from participating in procurement activities; or

H) [Not applicable to HIV SNP Plans] failed to qualify for any incentive based on SDOH's Medicaid Managed Care Quality Incentive calculation in each of three consecutive years; after two consecutive years of failing to qualify for any such incentive, the Contractor will be notified by SDOH that the Contractor has one year remaining to raise its scores to the requisite level or be subject to SDOH-initiated termination or non-renewal of this Agreement. By December 1 of each calendar year, SDOH will issue the general parameters of the Quality Incentive measures to be implemented for the subsequent year which form the basis for awarding the Quality Incentive in the year following the measurement. In no instance will quality data scores for years prior to measurement year 2007 be utilized for contract termination.



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I) fails to meet applicable requirements of Sections 1903(m), 1905(t) and 1932 of the Social Security Act.

J) is located outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

ii) The SDOH will notify the Contractor of its intent to terminate this Agreement for the Contractor's failure to meet the requirements of this Agreement and provide Contractor with a hearing prior to the termination.

iii) If SDOH suspends, limits or revokes Contractor's Certificate of Authority under PHL § 4404, and:

A) if such action results in the Contractor ceasing to have authority to serve the entire contracted service area, as defined by Appendix M of this Agreement, this Agreement shall terminate on the date the Contractor ceases to have such authority; or

B) if such action results in the Contractor retaining authority to serve some portion of the contracted service area, the Contractor shall continue to offer its MMC and/or FHPlus products under this Agreement in any designated geographic areas not affected by such action, and shall terminate its MMC and/or FHPlus products in the geographic areas where the Contractor ceases to have authority to serve.

iv) No hearing will be required if this Agreement terminates due to SDOH suspension, limitation or revocation of the Contractor's Certificate of Authority.

v) Prior to the effective date of the termination the SDOH shall notify Enrollees of the termination, or delegate responsibility for such notification to the Contractor, and such notice shall include a statement that Enrollees may disenroll immediately without cause.

b) Contractor and SDOH Initiated Termination

The Contractor and the SDOH each shall have the right to terminate this Agreement in its entirety, for the Contractor's MMC or FHPlus product, or for any or all products in specified counties of the Contractor's service area, in the event that SDOH and the Contractor fail to reach agreement on the monthly Capitation Rates. In such event, the party exercising its right shall give the other party written notice specifying the reason for and the effective date of

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termination, which shall not be less time than will permit an orderly transition of Enrollees, but no more than ninety (90) days.

c) Contractor Initiated Termination

i) The Contractor shall have the right to terminate this Agreement in its entirety, for the Contractor's MMC or FHPlus product, or for any or all products in specified counties of the Contractor's service area, in the event that SDOH materially breaches the Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) days, or within such longer period as the parties may agree, of the Contractor's written request for compliance. The Contractor shall give SDOH written notice specifying the reason for and the effective date of the termination, which shall not be less time than will permit an orderly transition of Enrollees, but no more than ninety (90) days.

ii) The Contractor shall have the right to terminate this Agreement, in its entirety, for the Contractor's MMC or FHPlus product, or for any or all products in specified counties of the Contractor's service area in the event that its obligations are materially changed by modifications to this Agreement and its Appendices by SDOH. In such event, Contractor shall give SDOH written notice within thirty (30) days of notification of changes to the Agreement or Appendices specifying the reason and the effective date of termination, which shall not be less time than will permit an orderly transition of Enrollees, but no more than ninety (90) days.

iii) The Contractor shall have the right to terminate this Agreement in its entirety, for either the Contractor's MMC or FHPlus product, or for either or both products in specified counties of the Contractor's service area, if the Contractor is unable to provide services pursuant to this Agreement because of a natural disaster and/or an act of God to such a degree that Enrollees cannot obtain reasonable access to services within the Contractor's organization, and, after diligent efforts, the Contractor cannot make other provisions for the delivery of such services. The Contractor shall give SDOH written notice of any such termination that specifies:

A) the reason for the termination, with appropriate documentation of the circumstances arising from a natural disaster and/or an act of God that preclude reasonable access to services;

B) the Contractor's attempts to make other provision for the delivery of services; and

C) the effective date of the termination, which shall not be less time than will permit an orderly transition of Enrollees, but no more than ninety (90) days.



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d) Termination Due To Loss of Funding

In the event that State and/or Federal funding used to pay for services under this Agreement is reduced so that payments cannot be made in full, this Agreement shall automatically terminate, unless both parties agree to a modification of the obligations under this Agreement. The effective date of such termination shall be ninety (90) days after the Contractor receives written notice of the reduction in payment, unless available funds are insufficient to continue payments in full during the ninety (90) day period, in which case SDOH shall give the Contractor written notice of the earlier date upon which the Agreement shall terminate. A reduction in State and/or Federal funding cannot reduce monies due and owing to the Contractor on or before the effective date of the termination of the Agreement.

2.8 Close-Out Procedures

a) Upon termination or expiration of this Agreement in its entirety, for the Contractor's MMC or FHPlus product, or for any or all products in specified counties of the Contractor's service area, and in the event that it is not scheduled for renewal, the Contractor shall comply with close-out procedures that the Contractor develops in conjunction with LDSS and that the LDSS, and the SDOH have approved. The close-out procedures shall include the following:

i) The Contractor shall promptly account for and repay funds advanced by SDOH for coverage of Enrollees for periods subsequent to the effective date of termination;

ii) The Contractor shall give SDOH, and other authorized federal, state or local agencies access to all books, records, and other documents and upon request, portions of such books, records, or documents that may be required by such agencies pursuant to the terms of this Agreement;

iii) If this Agreement is terminated in its entirety, the Contractor shall submit to SDOH, and authorized federal, state or local agencies, within ninety (90) days of termination, a final financial statement, made by a certified public accountant or a licensed public accountant, unless the Contractor requests of SDOH and receives written approval from SDOH and all other governmental agencies from which approval is required, for an extension of time for this submission;

iv) The Contractor shall establish an appropriate plan acceptable to and prior approved by the SDOH for the orderly transition of Enrollees. This plan shall include the provision of pertinent information to identified Enrollees who are: pregnant; currently receiving treatment for a chronic or life



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threatening condition; prior approved for services or surgery; or whose care is being monitored by a case manager to assist them in making decisions which will promote continuity of care; and

v) SDOH shall promptly pay all claims and amounts owed to the Contractor.

b) Any termination of this Agreement by either the Contractor or SDOH shall be done by amendment to this Agreement, unless the Agreement is terminated by the SDOH due to conditions in Section 2.7 (a)(i) or Appendix A of this Agreement.

2.9 Rights and Remedies

The rights and remedies of SDOH and the Contractor provided expressly in this Section shall not be exclusive and are in addition to all other rights and remedies provided by law or under this Agreement.

2.10 Notices

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

(a) via certified or registered United States mail, return receipt requested;

(b) by facsimile transmission;

(c) by personal delivery;

(d) by expedited delivery service; or

(e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

**State of New York Department of Health**

| | |
|---|---|
| Name: | Jonathan Bick |
| Title: | Director, Division of Health Plan Contracting and Oversight |
| Address: | Division of Health Plan Contracting and Oversight<br>Office of Health Insurance Programs<br>One Commerce Plaza<br>Room 1609<br>Albany, NY 12260 |
| Telephone Number: | 518-474-5737 |
| Facsimile Number: | 518-474-5738 |



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E-Mail Address: Jonathan.Bick@health.ny.gov

**New York State Office of Mental Health**
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

**New York State Office of Alcoholism and Substance Abuse Services**
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

**Contractor Name**
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or e-mail, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

2.11 Severability

If this Agreement contains any unlawful provision that is not an essential part of this Agreement and that was not a controlling or material inducement to enter into this Agreement, the provision shall have no effect and, upon notice by either

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party, shall be deemed stricken from this Agreement without affecting the binding force of the remainder of this Agreement.

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## 3. COMPENSATION

### 3.1 Capitation Payments

a) Compensation to the Contractor shall consist of a monthly capitation payment for each Enrollee and the Supplemental Capitation Payments as described in Section 3.1 (d), 3.9 (b) and (e), and 3.10 (b) where applicable.

b) The monthly Capitation Rates are attached hereto as Appendix L and shall be deemed incorporated into this Agreement without further action by the parties.

c) The monthly capitation payments, the Supplemental Newborn Capitation Payment, the Low Birth Weight Kick Payment and the Supplemental Maternity Capitation Payment, when applicable, to the Contractor shall constitute full and complete payments to the Contractor for all services that the Contractor provides, except for payments due the Contractor as set forth in Sections 3.12, 3.13, and 3.14 of this Agreement for MMC Enrollees.

d) Capitation Rates shall be effective for the entire contract period, except as described in Section 3.2.

e) In accordance with Section 6.9 of this Agreement, the Contractor shall receive the Aliessa capitation payment for Enrollees listed in the monthly Roster generated by SDOH, or the 834 File generated by the NYSoH, that match Aliessa logic criteria detailed in supplemental guidance issued by SDOH.

### 3.2 Modification of Rates During Contract Period

a) Any technical modification to Capitation Rates during the term of the Agreement as agreed to by the Contractor, including but not limited to, changes in premium groups, reinsurance or Benefit Package, shall be deemed incorporated into this Agreement without further action by the parties upon approval of such modifications by the SDOH and the US Department of Health and Human Services (DHHS).

b) Any other modification to Capitation Rates, as agreed to by the Department and the Contractor during the term of the Agreement shall be deemed incorporated into this Agreement without further action by the parties upon approval of such modifications by the SDOH, the State Division of the Budget and DHHS as of the effective date of the modified Capitation Rates as established by the SDOH and approved by the State Division of the Budget and DHHS.

c) In the event that the SDOH and the Contractor fail to reach agreement on modifications to the monthly Capitation Rates, the SDOH will provide formal written notice to the Contractor of the amount and effective date of the

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modified capitation rates approved by the State Division of the Budget and DHHS. The Contractor shall have the option of terminating this Agreement, in its entirety, for the Contractor's MMC or FHP product, or for any or all products in specified counties of the Contractor's service area, if such approved modified Capitation Rates are not acceptable. In such case, the Contractor shall give written notice to the SDOH and the LDSS within thirty (30) days from the date of the formal written notice of the modified Capitation Rates from the SDOH specifying the reasons for and effective date of termination. The effective date of termination shall be ninety (90) days from the date of the Contractor's written notice, unless the SDOH determines that an orderly transfer of Enrollees to another MCO or disenrollment to Medicaid fee-for-service can be accomplished in fewer days. The terms and conditions of the Contractor's approved phase-out plan must be accomplished prior to termination.

d) Effective April 1, 2014, it will be incumbent on Contractors to negotiate payment agreements with personal care agencies (PCAs) sufficient to cover expenditures related to the Central Insurance Program (CIP) previously administered by the New York City Human Resources Administration (HRA). This expense covers the Workers' Compensation, disability and general liability insurance for applicable PCAs in New York City. As an alternative to negotiating payment arrangements with the PCAs, Contractors may pay the adjusted HRA rates and postpone negotiating payment agreements until the new provider contract term.

e) Effective April 1, 2015, and consistent with Sections 11 and 12 of Part B of Chapter 57 of the Laws of 2015, Contractors must reimburse qualifying hospitals at rates published by the SDOH on the Managed Care Publication Schedule for Hospital Quality Pool and Sole Community Hospital Programs.

f) Pursuant to Section 22 of this Agreement, the Contractor shall include VBP arrangements in subcontracts with Participating Providers. At the sole discretion of the State, the Contractor's Capitation Rate shall be reduced for failure to meet VBP arrangement goals, in accordance with the methodology and timeline as set forth in the NYS VBP Roadmap approved by CMS.

3.3 Rate Setting Methodology

a) Capitation rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual Medicaid fee-for-service data or Contractor experience for the time period covered by the rates. Capitated rates shall be certified to be actuarially sound in accordance with 42 CFR § 438.6(c).

b) Notwithstanding the provisions set forth in Section 3.3(a) above, the SDOH reserves the right to terminate this Agreement, in its entirety for the

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Contractor's MMC or FHPlus product, or for any or all products in specified counties of the Contractor's service area, pursuant to Section 2.7 of this Agreement, upon determination by SDOH that the aggregate monthly Capitation Rates are not cost effective.

3.4 Payment of Capitation

a) The monthly capitation payments for each Enrollee are due to the Contractor from the Effective Date of Enrollment until the Effective Date of Disenrollment of the Enrollee or termination of this Agreement, whichever occurs first. The Contractor shall receive a full month's capitation payment for the month in which Disenrollment occurs. The Roster generated by SDOH with any modification communicated electronically or in writing by the LDSS or the Enrollment Broker prior to the end of the month in which the Roster is generated, shall be the Enrollment list for purposes of eMedNY premium billing and payment, as discussed in Section 6.9 and Appendix H of this Agreement.

b) Upon receipt by the Fiscal Agent of a properly completed claim for monthly capitation payments submitted by the Contractor pursuant to this Agreement, the Fiscal Agent will promptly process such claim for payment and use its best efforts to complete such processing within thirty (30) business days from date of receipt of the claim by the Fiscal Agent. Processing of Contractor claims shall be in compliance with the requirements of 42 CFR § 447.45. The Fiscal Agent will also use its best efforts to resolve any billing problem relating to the Contractor's claims as soon as possible. In accordance with Section 41 of the New York State Finance Law (SFL), the State and LDSS shall have no liability under this Agreement to the Contractor or anyone else beyond funds appropriated and available for this Agreement.

3.5 Denial of Capitation Payments

If the US Centers for Medicare and Medicaid Services (CMS) denies payment for new Enrollees, as authorized by SSA § 1903(m)(5) and 42 CFR § 438.730 (e), or such other applicable federal statutes or regulations, based upon a determination that Contractor failed substantially to provide medically necessary items and services, imposed premium amounts or charges in excess of permitted payments, engaged in discriminatory practices as described in SSA § 1932(e)(1)(A)(iii), misrepresented or falsified information submitted to CMS, SDOH, LDSS, the Enrollment Broker, or an Enrollee, Prospective Enrollee, or health care provider, or failed to comply with federal requirements (i.e. 42 CFR § 422.208 and 42 CFR § 438.6 (h) relating to the Physician Incentive Plans), SDOH and LDSS will deny capitation payments to the Contractor for the same Enrollees for the period of time for which CMS denies such payment.

3.6 SDOH Right to Recover Premiums



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a) MMC Recovery Scenarios

SDOH shall have the right to recover capitation payments made to the Contractor for an MMC Enrollee when, for the entire applicable payment month(s), SDOH determines that the MMC Enrollee was or is:

i) deceased;

ii) incarcerated;

iii) non-consensually enrolled;

iv) no longer residing in the Contractor's service area or New York State;

v) in Long Term Placement (Permanent Placement) Status in a residential institution or an institutional care facility prior to:

A) February 1, 2015, for MMC Enrollees in Bronx, Kings, New York, Queens or Richmond Counties;

B) April 1, 2015, for MMC Enrollees in Westchester, Nassau or Suffolk Counties; or

C) July 1, 2015, for MMC Enrollees in remaining counties

vi) in an Institution for Mental Diseases, unless the capitation payment is allowed pursuant to 42 C.F.R. § 438.6(e);

vii) a child in receipt of foster care services whose status or placement in foster care renders the child ineligible to be enrolled in the MMC program;

viii) simultaneously enrolled or in receipt of ~~c~~Comprehensive Third Party ~~h~~Health ~~care~~Insurance coverage~~ through another product offered by Contractor (or a parent, subsidiary, or sister entity)~~;

ix) simultaneously enrolled or in receipt of comprehensive health care coverage through any government health insurance program;

x) simultaneously enrolled or in receipt of comprehensive health care coverage through a third party commercial insurer, where the insurer has covered or agrees to cover the Enrollee, who is an infant or the mother of an infant if both will be covered, from the infant's date of birth; or

xi) otherwise ineligible to be enrolled in the MMC program pursuant to this Agreement or State or federal law.

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b) FHPlus Recovery Scenarios

SDOH shall have the right to recover capitation payments made to the Contractor for an FHPlus Enrollee when, for the entire applicable payment month(s), SDOH determines that the FHPlus Enrollee was or is:

i) deceased;

ii) incarcerated;

iii) non-consensually enrolled; or

iv) no longer resides in Contractor's service area or New York State.

c) Concurrent Fee-for-service (FFS) Payments

SDOH shall have the right to withhold or recover capitation payments made to the Contractor for an Enrollee when FFS claims were paid for benefit package services rendered on behalf of the Enrollee during the applicable payment month(s), and where:

i) the payment month(s) correspond with a period for which the Enrollee was retroactively enrolled into Contractor's MMC or FHPlus product;

ii) the Enrollee had been assigned multiple CINs; or

iii) the Enrollee was no longer eligible for MMC.

d) Duplicate Payments

SDOH shall have the right to recover any duplicate MMC or FHPlus capitation payments made to the Contractor for an MMC or FHPlus Enrollee, respectively. SDOH shall not allow, under any circumstance, duplicate Medicaid payments for an Enrollee, and shall have the right to recover such payments if made.

e) Reimbursement for Encounters and Recovery Rules

i) For withholds and recoveries made pursuant to Section 3.6(a)(iv)-(vii), (a)(ix)-(xi), (b)(iv), and (c), SDOH shall reimburse the Contractor the cost of benefits provided for any encounter(s) that occurred during the applicable payment month(s) and for which the Contractor has not already received reimbursement from any source.

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ii) For withholds and recoveries made pursuant to Section 3.6(a)(viii) of this Agreement, SDOH shall reimburse the Contractor the cost of the benefits provided for any encounter(s) that occurred during the applicable payment month(s), except for instances when:

A) the Contractor has already received reimbursement from any source; or

B) such Comprehensive Third Party Health Insurance coverage is provided through another product offered by Contractor (or a parent, subsidiary, or sister entity).

iii) SDOH reimbursements provided to the Contractor under Section 3.6(e) of this Agreement shall be limited to verifiable expenses.

~~i~~iv) All withholds and recoveries, and the submission of costs for reimbursement, shall be made pursuant to Appendix H of this Agreement and Guidelines developed by SDOH.

~~iii~~v) Notwithstanding any provision of this Section, no withholds or recoveries shall be made for a period prior to the effective disenrollment dates specified in Section 7 of Appendix H.

3.7 Third Party Health Insurance Determination

a) Point of Service (POS)

The Contractor will make diligent efforts to determine whether Enrollees have third party health insurance (TPHI). The LDSS is also responsible for making diligent efforts to determine if Enrollees have TPHI and to maintain third party information on the WMS/eMedNY Third Party Resource System. If TPHI coverage is known at the POS, the Plan shall use the TPHI information to coordinate benefits (e.g., alert the provider and ask them to bill the TPHI that should be primary to the Plan).

The Contractor shall make good faith efforts to coordinate benefits and must inform the LDSS of any known changes in status of TPHI insurance eligibility within five (5) business days of learning of a change in TPHI. The Contractor may use the Roster as one method to determine TPHI information.

b) Post Payment and Retroactive Recovery – Non Pharmacy

The State, and/or its designee, will also be vested with the responsibility to collect any reimbursement for Benefit Package services obtained from TPHI. In no instances may an Enrollee be held responsible for disputes over these recoveries. A recovery shall not exceed the encounter data paid claim amount.

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The State will continue to identify available TPHI and post this information to the eMedNY System. The TPHI information will appear on the Contractor's next roster and TPHI file. The Contractor will have six months from the later of the date the TPHI has been posted (eMedNY transaction date) or the Contractor's claim payment date to pursue any recoveries for medical services. All recoveries outside this period will be pursued by the State.

For Federal or State-initiated and Federal or State-identified recoveries, the Federal or State Government will direct providers to refund the State directly. In those instances where the provider adjusted the recovery to the Contractor in error, the Contractor will refund the adjusted recovery to the State.

c) Post Payment and Retroactive Recovery – Pharmacy

The Federal or State, and or their designee, will be vested with the sole responsibility to collect any reimbursement for Benefit Package services obtained from TPHI.

d) TPHI Reporting

The Contractor shall report TPHI activities through the Medicaid Encounter Data System (MEDS III) or its successor system and Medicaid Managed Care Operating Report (MMCOR) in accordance with instructions provided by SDOH. To prevent duplicative efforts, the Contractor shall, on a quarterly basis, share claim specific TPHI disposition (paid, denied, or recovered) information with the State. If no information is received from the Contractor, the State will assume there are no retroactive recoveries being pursued by the Contractor and will initiate recovery processing.

3.8 Other Insurance and Settlements

The Contractor is not allowed to pursue cost recovery against personal injury awards the Enrollee has received. Any recovery against these resources is to be pursued by the Medicaid program and the Contractor cannot take actions to collect these funds. Pursuit of Worker's Compensation benefits and No-fault Insurance by the Contractor is authorized, to the extent that they cover expenses incurred by the Contractor.

3.9 Payment For Newborns

a) The Contractor shall be responsible for all costs and services included in the Benefit Package associated with an Enrollee's newborn, unless the child is Excluded from Medicaid Managed Care pursuant to Appendix H of this Agreement, or the Contractor does not offer a MMC product in the mother's county of fiscal responsibility.



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b) The Contractor shall receive a capitation payment from the first day of the newborn's month of birth and, in instances where the Contractor pays the hospital or birthing center for the newborn stay, a Supplemental Newborn Capitation Payment.

   i) The Contractor shall receive a Low Birth Weight Kick Payment in lieu of the Supplemental Newborn Capitation Payment if the newborn infant weighed less than 1,200 grams at birth.

c) The Capitation Rate and Supplemental Newborn Capitation Payment or Low Birth Weight Kick Payment for a newborn will begin the month following certification of the newborn's eligibility and enrollment, retroactive to the first day of the month in which the child was born.

d) The Contractor cannot bill for a Supplemental Newborn Capitation Payment or Low Birth Weight Kick Payment unless the newborn hospital or birthing center payment has been paid by the Contractor. The Contractor must submit encounter data evidence for the newborn stay. Failure to have supporting records may, upon an audit, result in recoupment of the Supplemental Newborn Capitation Payment by SDOH.

e) The following provisions apply to the HIV SNP Program Only:

   i) For the newborn's first six months of life, the monthly capitation rate paid to the Contractor for newborns of infected Enrollees enrolled in the Contractor's SNP will be the HIV children's rate. In order for payment to continue at the HIV children's rate beyond the sixth month of the child's life, the Contractor will be required to provide, in a format as determined by the AIDS Institute and with appropriate consent for any necessary testing, clinical documentation of HIV infection in the child.

   ii) Except as described in (e), above, for newborns of infected mothers enrolled in the SNP, the monthly capitation rates paid to the Contractor for uninfected children enrolled in the SNP shall be as follows:

      A) If Contractor also participates in the Partnership Plan as a mainstream Medicaid managed care plan, the children's capitation rates established for the mainstream plan will be paid.

      B) If Contractor does not participate as a mainstream Medicaid managed care plan, the average capitation rate paid for that premium group in the plan's region will be paid.

   iii) If the Contractor participates as a mainstream Medicaid managed care plan, Contractor will receive the supplemental newborn capitation

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payment established for the mainstream plan. If Contractor does not participate as a mainstream Medicaid managed care plan, Contractor will receive the average newborn capitation payment in the plan's region.

3.10 Supplemental Maternity Capitation Payment

a) The Contractor shall be responsible for all costs and services included in the Benefit Package associated with the maternity care of an Enrollee.

b) In instances where the Enrollee is enrolled in the Contractor's MMC or FHPlus product on the date of the delivery of a child, the Contractor shall be entitled to receive a Supplemental Maternity Capitation Payment. The Supplemental Maternity Capitation Payment reimburses the Contractor for the inpatient and outpatient costs of services normally provided as part of maternity care, including antepartum care, delivery and post-partum care. The Supplemental Maternity Capitation Payment is in addition to the monthly Capitation Rate paid by the SDOH to the Contractor for the Enrollee.

c) In instances where the Enrollee was enrolled in the Contractor's MMC or FHPlus product for only part of the pregnancy, but was enrolled on the date of the delivery of the child, the Contractor shall be entitled to receive the entire Supplemental Maternity Capitation Payment. The Supplemental Capitation payment shall not be pro-rated to reflect that the Enrollee was not enrolled in the Contractor's MMC or FHPlus product for the entire duration of the pregnancy.

d) In instances where the Enrollee was enrolled in the Contractor's MMC or FHPlus product for part of the pregnancy, but was not enrolled on the date of the delivery of the child, the Contractor shall not be entitled to receive the Supplemental Maternity Capitation Payment, or any portion thereof.

e) Costs of inpatient and outpatient care associated with maternity cases that end in termination or miscarriage shall be reimbursed to the Contractor through the monthly Capitation Rate for the Enrollee and the Contractor shall not receive the Supplemental Maternity Capitation Payment.

f) The Contractor may not bill a Supplemental Maternity Capitation Payment until the hospital inpatient or birthing center delivery is paid by the Contractor, and the Contractor must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the Enrollee to be eligible to receive a Supplemental Maternity Capitation Payment. Failure to have supporting records may, upon audit, result in recoupment of the Supplemental Maternity Capitation Payment by the SDOH.

3.11 Contractor Financial Liability

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Contractor shall not be financially liable for any services rendered to an Enrollee prior to his or her Effective Date of Enrollment.

3.12 Inpatient Hospital Stop-Loss Insurance for Medicaid Managed Care (MMC) Enrollees

a) The Contractor must obtain stop-loss coverage for inpatient hospital services for MMC Enrollees. A Contractor may elect to purchase stop-loss coverage from New York State. In such cases, the Capitation Rates paid to the Contractor shall be adjusted to reflect the cost of such stop-loss coverage. The cost of such coverage shall be determined by SDOH.

b) Under NYS stop-loss coverage, if the hospital inpatient expenses incurred by the Contractor for an individual MMC Enrollee during any calendar year reaches $100,000, the Contractor shall be compensated for eighty percent (80%) of the cost of hospital inpatient services in excess of this amount up to a maximum of $250,000. Above that amount, the Contractor will be compensated for one hundred percent (100%) of cost. All compensation shall be based on the lower of the Contractor's negotiated hospital rate or Medicaid rates of payment. Effective January 1, 2016, hospital inpatient expenses shall also include expenses for detoxification services provided in inpatient hospital facilities certified pursuant to 14 NYCRR Part 816 and expenses for services delivered in OASAS certified 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation and Treatment programs for all Enrollees.

☐ The Contractor has elected to have NYS provide stop-loss reinsurance for MMC Enrollees.

**OR**

☐ The Contractor has not elected to have NYS provide stop-loss reinsurance for MMC Enrollees.

c) For HIV SNPs only, if the hospital inpatient expenses incurred by the Contractor for an individual Enrollee during any calendar year reaches $100,000, the Contractor shall be compensated for eighty-five percent (85%) of the cost of hospital inpatient services between $100,000 and $300,000 incurred by the HIV SNP during that period. Above that amount the Contractor will be compensated for one hundred percent (100%) of costs. All compensation shall be based on the lower of the Contractor's negotiated hospital rate or Medicaid rates of payment. Effective January 1, 2016, hospital inpatient expenses shall also include expenses for detoxification services provided in inpatient hospital facilities certified pursuant to 14 NYCRR Part 816 and expenses for services delivered in OASAS certified 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation and Treatment programs for all Enrollees.

3.13 Mental Health Stop-Loss for MMC Enrollees

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a) The Contractor will be compensated for medically necessary and clinically appropriate inpatient mental health services provided to MMC Enrollees, in a psychiatric inpatient program licensed by the Office of Mental Health according to the following schedule:

i) For Episodes of Inpatient Psychiatric Care provided to Enrollees beginning before January 1, 2016, the State will reimburse the Contractor 100% of payments for days in excess of a combined total of thirty (30) days;

ii) For Episodes of Inpatient Psychiatric Care commencing on or after January 1, 2016, the State will reimburse the Contractor for 50% of payments made for the 46th through the 60th day of the episode and 100% of payments made for the days in the episode beyond the 60th day;

iii) For Episodes of Inpatient Psychiatric Care commencing on or after January 1, 2017, the State will reimburse the Contractor for 50% of payments made for the 61st through the 100th day of the episode and 100% of payments made for the days in the episode beyond the 100th day; and

iv) For Episodes of Inpatient Psychiatric Care commencing on or after January 1, 2018, the State will reimburse Contractor for 100% of the payments made for days in the episode or care beyond the 100th day.

v) The Contractor shall be reimbursed for such Episodes of Inpatient Psychiatric Care at the lower of the Contractor's negotiated inpatient rate or Medicaid rate of payment.

vi) For the purposes of this Section, Episode of Inpatient Psychiatric Care means, for the purpose of determining stop-loss coverage, all continuous inpatient days beginning on and including the date of admission through the date of discharge from the licensed psychiatric unit. Such episode shall not include days related to a transfer within a hospital from the psychiatric unit to another unit of the hospital for treatment of a non-psychiatric condition. A transfer back to the psychiatric unit of the hospital shall commence a new episode of inpatient psychiatric care. A transfer to any other hospital for psychiatric inpatient care shall not commence a new episode of inpatient psychiatric care.

3.14 Residential Health Care Facility (Nursing Home) Stop-Loss for MMC Enrollees

The Contractor will be compensated for medically necessary and clinically appropriate Medicaid reimbursable non-permanent nursing home inpatient rehabilitation services, as defined in Appendix K of this Agreement, provided to MMC Enrollees in excess of sixty (60) days during a calendar year at the lower of

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the Contractor's negotiated rates or Medicaid rate of payment.

3.15 Stop-Loss Documentation and Procedures for the MMC Program

The Contractor must follow procedures and documentation requirements in accordance with the New York State Department of Health stop-loss policy and procedure manual. The State has the right to recover from the Contractor any stop-loss payments that are later found not to conform to these SDOH requirements.

3.16 Family Health Plus (FHPlus) Reinsurance

The Contractor shall purchase reinsurance coverage unless it can demonstrate to SDOH's satisfaction the ability to self insure.

3.17 Tracking Visits Provided by Indian Health Clinics – Applies to MMC Program Only

The SDOH shall monitor all visits provided by tribal or Indian health clinics or urban Indian health facilities or centers to enrolled Native Americans, so that the SDOH can reconcile payment made for those services, should it be deemed necessary to do so.

3.18 Payment for Patient Centered Medical Home and Adirondack Health Care Home Multipayor Demonstration Program

a) Patient Centered Medical Home (PCMH)

i) SDOH will provide payments to the Contractor for the sole purpose of the Contractor making enhanced payments to contracted office based physicians/practices and Article 28 clinics that meet New York's medical home standards and provide primary care services to persons enrolled in Medicaid Managed Care and Family Health Plus.

A) Effective April 1, 2015, enhanced PCMH payments will not be included in the Capitation Rate. PCMH payments will be made by SDOH twice per year to the Contractor based on PCMH expenses detailed in the Contractor's Annual and 2nd Quarter financial reports that are submitted to comply with the requirements set forth in Section 18.5 (a) of this Agreement.

B) For the period of April 1, 2010 – March 31, 2015, SDOH will complete a one-time reconciliation of the Contractor's PCMH expenses.

I) If this reconciliation results in the Contractor owing money to



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SDOH, the SDOH will reduce the next available PCMH payment by the amount owed to SDOH.

II) If this reconciliation results in SDOH owing money to the Contractor, the SDOH will remit payment to the Contractor for the amount owed as a supplemental payment.

ii) To be eligible for the medical home payment, contracted office based physicians/practices, nurse practitioners and Article 28 clinics, both freestanding and hospital outpatient facilities, must meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home Program standards and be designated as the Enrollee's primary care provider.

iii) SDOH will provide the Contractor with a "master list" of providers eligible to receive an enhanced payment in accordance with this Section that will be updated monthly.

iv) The Contractor will make payments to those providers on the master list that are the PCP of record for identified Enrollees.

b) Payment for Adirondack Health Care Home Multipayor Demonstration Program (AHCHMDP).

i) SDOH will provide payments to the Contractor for the sole purpose of the Contractor making enhanced payments to contracted office based physicians/practices and Article 28 clinics that operate in the upper northeastern region (Clinton, Essex, Franklin, Hamilton, Saratoga and Warren Counties) of New York and are participants in the Adirondack Health Care Home Multipayor Demonstration Program authorized pursuant to Article 29-A of the Public Health Law.

A) Effective April 1, 2015, enhanced AHCHMDP payments will not be included in the Capitation Rate. AHCHMDP payments will be made by SDOH twice per year to the Contractor based on AHCHMDP expenses detailed in the Contractor's Annual and 2nd Quarter financial reports that are submitted to comply with the requirements set forth in Section 18.5 (a) of this Agreement.

B) For the period of April 1, 2010 – March 31, 2015, SDOH will complete a one-time reconciliation of the Contractor's AHCHMDP expenses.

I) If this reconciliation results in the Contractor owing money to SDOH, the SDOH will reduce the next available AHCHMDP payment by the amount owed to SDOH.



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II) If this reconciliation results in SDOH owing money to the Contractor, the SDOH will remit payment to the Contractor for the amount owed as a supplemental payment.

ii) The Contractor will make payments to contracted office based physicians/practices and Article 28 clinics that provide primary care services to persons enrolled in Medicaid Managed Care and Family Health Plus and participate in the Adirondack Health Care Home Multipayor Demonstration Program.

iii) Providers that participate in the Adirondack Health Care Home Multipayor Demonstration Program are not eligible for enhanced payments under the Statewide Patient Centered Medical Home program as described in Section 3.18 a) of this Agreement.

c) Enhanced payments received by the Contractor in accordance with this Section may not be retained or used for any other purpose. The Contractor cannot use the payments received from SDOH to reduce or augment reductions in reimbursement to its contracted primary care providers.

d) SDOH will make periodic reconciliations of prior years' payments based on data reported by the Contractor in the Annual Financial Statement filed with SDOH and will make adjustments if necessary to the Contractor's payment rates on a prospective basis. Such periodic reconciliations will end March 31, 2015, at which time SDOH shall remove PCMH and AHCHMDP payments from the Capitation Rate.

e) Payment under the Statewide Patient Centered Medical Home initiative and the Adirondack Health Care Home Multipayor Demonstration Program is subject to the availability of funding and federal financial participation.

3.19 Prohibition on Payments to Institutions or Entities Located Outside of the United States

The Contractor is prohibited under Section 6505 of the federal Affordable Care Act, which amends Section 1902(a) of the Social Security Act, from making payments for Medicaid covered items or services to any financial institution or entity, such as provider bank accounts or business agents, located outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

3.20 Primary Care Rate Increase

a) Effective January 1, 2013, and until the effective date of the termination of the program, the SDOH will provide payments to the Contractor for the sole

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purpose of the Contractor making enhanced payments to eligible providers (including network providers and out of network providers providing services as authorized by the Contractor) who provide certain primary care services.

b) All such revenues received by the Contractor pursuant to the Primary Care Rate Increase (PCRI) must be paid to qualifying providers to enhance payments up to 100% of the Medicare fee schedule pursuant to any guidelines issued by the SDOH. For the purposes of this section, Medicare fee schedule means the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the calendar year 2009 Medicare physician fee schedule conversion factor. If no applicable rate is established by Medicare, the Contractor shall use the rate specified in a fee schedule established by CMS. At the discretion of SDOH and in accordance with procedures and time schedules to be determined by SDOH, any such funding may be reconciled to determine the aggregate level of any overpayments or underpayments to providers made by the Contractor relative to the funding level provided to the Contractor by SDOH.

c) The Contractor shall be responsible for reporting aggregate PCRI revenue received and aggregate payments made to qualifying providers in a manner to be established by SDOH. The Contractor will report aggregate PCRI payments separate and apart from other provider and capitation payments reported to SDOH pursuant to Section 18.5 a) of this Agreement.

3.21 Payment for Long Term Placement in Residential Health Care Facilities (Nursing Homes)

a) The Contractor shall receive the premium associated with Long Term Placement from the SDOH after the LDSS has determined eligibility for Long Term Placement in a nursing home.

b) The Contractor must include the appropriate Restriction Exception code (R/E) or bed type with the authorization to the provider.

c) The associated premium will be paid for Enrollees, retroactive to the month of determination of eligibility for Long Term Placement in a nursing home.

d) Effective April 1, 2016, the Contractor may qualify for an incentive payment from the State when the Contractor develops a safe discharge back to the community for an Enrollee in Long Term Placement in a nursing home. The following must occur in order for the Contractor to receive the incentive payment:

i) The Contractor must develop an appropriate Patient Centered Services Plan and coordinate the LTSS to maintain the Enrollee in the community.

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ii) Upon the Enrollee's discharge to the community, the Contractor or nursing home must notify the LDSS in a format determined by SDOH. The LDSS shall change the R/E code for the Enrollee and reflect the Enrollee's transition back into the community.

iii) On an annual basis as prescribed by SDOH, the Contractor shall notify the SDOH of all Enrollees who were in Long Term Placement in nursing homes who have transitioned back into the community.

iv) Once the transition has been verified and maintained for a minimum of three (3) months, SDOH will pay the Contractor a lump sum equivalent to the rate differential between the nursing home premium and the non-nursing home premium over a three (3) month period. This differential will be multiplied by the number of Enrollees transitioned back into the community and meeting the requirements of this Section.

3.22 Minimum Medical Expense Targets and Limits on Profit and Loss

a) The Contractor shall be subject to a Minimum Medical Expense Target as set forth below and in this Section, and in SDOH Guidelines, "Behavioral Health Transition," which is hereby made a part of this Agreement as if set forth fully herein.

b) [Not Applicable to the HARP Program] The Contractor shall track payments to Behavioral Health Providers against Contractor-specific Per Member Per Month (PMPM) aid category specific premium targets established by the State on a calendar year basis. The Contractor-specific PMPM shall be fully accounted for in premiums and shall be separately identified by the State. Such payments shall be exclusive of reimbursement for administrative services. The Contractor shall document such spending in compliance with State-defined reporting requirements, which shall be provided to Contractor prior to the effective date of spending documentation requirements.

i) The State reserves the right to recover the difference between 96% of the total annual Behavioral Health Expenditure Target, based on the premium targets for each aid category and actual plan membership in each aid category in a calendar year, and actual total Behavioral Health expenditures in the calendar year, if less than 96% of the Minimum Expense Target.

ii) Notwithstanding the provisions of paragraph a of this section, the State shall not calculate an annual Minimum Expense Target until such time as all advances to Behavioral Health Providers have been fully reconciled against actual claims made. In the event that such calculation is more than 12 months following the end of a calendar reporting period, the State shall be precluded from recovering any difference.

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iii) In determining whether to exercise its right to recover pursuant to paragraph i above, the State shall consider:

A) whether the premiums and the Contractor Specific PMPM were established in advance of the start of the rate year;

B) the overall adequacy of the Medicaid managed care premium as measured by actual financial results; and

C) the financial condition of a particular health plan.

iv) The parties shall work in good faith to define those payments that are included in the Behavioral Health Target.

c) [Applicable to the HARP Program Only]

i) From the date the Contractor begins operating a HARP until December 31, 2017, the Contractor shall spend for medical services at least 89% of the total premium. The Contractor shall refund any unexpended premium below the 89% level to SDOH. The maximum profit will be 1.5% of the premium. The Contractor shall refund any profit in excess of 1.5% to SDOH. The maximum loss will be 1.5% of the premium. That portion of any loss in excess of 1.5% will be refunded to the Contractor by SDOH. The calculation of profit and loss will be subject to a cap on administrative expenses. For the period ending December 31, 2016, the cap on administrative expenses will be 9.5% of the premium. For the calendar year ending December 31, 2017, the cap on administrative expenses will be 8.5% of the premium. For the calendar year ending December 31, 2018, the cap on administrative expenses will be 7.5% of the premium.

ii) For the calendar year ending December 31, 2017, the State will withhold and pay 1.0% of the premium as a behavioral health quality incentive payment to qualified Contractors as determined by the State.

iii) For all calendar year periods thereafter, the State will withhold and pay 2.0% of the premium as an annual behavioral health quality incentive payment to qualified Contractors as determined by the State.

3.23 Conditions on Incentive Arrangements

a) Pursuant to 42 CFR § 438.6, all incentive arrangements identified in Section 3.23(b) shall:

i) be for a fixed period of time, as specified in this Agreement or as otherwise provided by the Department;



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ii) be measured in the rate year under the contract for which the incentive payment is applied;

iii) not be renewed automatically;

iv) be available to Contractor under the same terms of performance SDOH establishes for other contractors, regardless of its public or private status;

v) not be conditioned on intergovernmental transfer agreements; and

vi) be necessary for the specified activities, targets, performance measure, or quality-based outcomes that support program initiatives specified in the state's quality strategy, including the VBP Roadmap.

b) Incentive arrangements, including but not limited to the Medicaid Managed Care Quality Incentive or as otherwise identified in this Agreement, between Contractor and SDOH may result in a payment to Contractor in excess of the amount permitted under 42 CFR § 438.6

c) Upon identification of any such excess amount, the Contractor must promptly notify SDOH and return said amount. If not returned, and upon notice to Contractor, SDOH may withhold any such amounts it identifies from other payment to Contractor to recover the funds.

3.24 Medical Loss Ratio

Pursuant to 42 CFR 438.8, the Contractor's MMC products shall be subject to a Medical Loss Ratio (MLR) determined by SDOH and noticed to the Contractor prior to the reporting year. Where the Contractor reports an MLR in reports filed pursuant to Section 18.5(a)(xx) that does not equal at least the minimum MLR established by SDOH, the Contractor shall be subject to a remittance and shall provide such remittance to the State in accordance with supplemental guidance issued by SDOH.

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# 4. SERVICE AREA

## 4.1 Service Area

The Contractor's service area for Medicaid Managed Care, FHPlus, HARP and/or HIV SNP shall consist of the county(ies) described in Appendix M of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein. Such service area is the specific geographic area within which Eligible Persons must reside to enroll in either the Contractor's Medicaid Managed Care or FHPlus product. For HIV SNPs and HARPs, Eligible Persons must reside in the specific counties listed in Appendix M, except that in New York City, Eligible Persons may reside in any of the five boroughs of New York City.

## 4.2 Modification of Service Area and Optional Benefit Package Covered Services During Contract Period

The Contractor must request written SDOH approval to reduce or expand its service area or modify its Optional Benefit Package Covered Services for purposes of providing Medicaid Managed Care, FHPlus, HARP, and/or HIV SNP services. In no event, however, shall the Contractor modify its service area or Optional Benefit Package Covered Services until it receives such approval. Any modifications made to the Contractor's service area as a result of an approved request to reduce or expand the service area shall become effective fifteen (15) days from the date of the written SDOH approval without the need for further action on the part of the parties to this Agreement, and modifications to the Optional Benefit Package Covered Services shall become effective on the effective date specified in the written SDOH approval.

## 4.3 Modification of Benefit Package Services

The parties acknowledge and accept that the SDOH has the right to make modifications to the Benefit Package, with advance written notice to the Contractor of at least (60) days. Such modifications include expansions of and restrictions to covered benefits listed in Appendix K of this Agreement, the addition of new benefits to the Benefit Package, and/or the elimination of covered benefits from the Benefit Package. Such modifications will be made only as necessary to implement statewide Medicaid program initiatives, including Medicaid Redesign initiatives.

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# 5. RESERVED

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# 6. ENROLLMENT

## 6.1 Populations Eligible for Enrollment

a) Medicaid Managed Care Populations

All Eligible Persons who meet the criteria in Section 364-j of the SSL and/or New York State's Operational Protocol for the Partnership Plan and who reside in the Contractor's service area, as specified in Appendix M of this Agreement, shall be eligible for Enrollment in the Contractor's Medicaid Managed Care product.

b) Family Health Plus Populations

All Eligible Persons who meet the criteria listed in Section 369-ee of the SSL and/or New York State's Operational Protocol for the Partnership Plan and who reside in the Contractor's service area, as specified in Appendix M of this Agreement, shall be eligible for Enrollment in the Contractor's Family Health Plus product.

c) HIV SNP Populations

All Eligible Persons with HIV infection, and who meet the criteria in Section 364-j of the SSL and/or New York State's Operational Protocol for the Partnership Plan and who reside in New York City or any other County in the Contractor's service area, as specified in Appendix M of this Agreement, shall be eligible for Enrollment in the Contractor's HIV SNP. Additionally, in New York City, Eligible Persons may reside in any of the five boroughs. Related children of such Eligible Persons enrolled in the Contractor's HIV SNP shall be eligible for enrollment in the Contractor's HIV SNP regardless of such children's HIV status. Individuals who are homeless or who are members of other high need populations as determined by the Commissioner of Health shall also be eligible for enrollment in the Contractor's HIV SNP regardless of HIV status.

d) HARP Populations

All Eligible Persons who meet the criteria in Section 365-m of the SSL, who are identified by the State as being appropriate for HARP enrollment, and who reside in the Contractor's service area, as specified in Appendix M of this Agreement or in New York City, reside in any of the five boroughs, shall be eligible for Enrollment in the Contractor's HARP.

## 6.2 Enrollment Requirements

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The Contractor agrees to conduct Enrollment of Eligible Persons in accordance with the policies and procedures set forth in Appendix H of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein.

6.3 Equality of Access to Enrollment

The Contractor shall accept Enrollments of Eligible Persons in the order in which the Enrollment applications are received without restriction and without regard to the Eligible Person's age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services or to the Capitation Rate that the Contractor will receive for such Eligible Person.

6.4 Enrollment Decisions

An Eligible Person's decision to enroll in the Contractor's MMC or FHPlus product shall be voluntary except as otherwise provided in Section 6.5 of this Agreement.

6.5 Auto Assignment – For MMC Program Only [Not Applicable to HIV SNP and HARP Programs]

a) An MMC Eligible Person whose Enrollment is mandatory under the Medicaid Managed Care Program and who fails to select and enroll in a MCO upon initial eligibility determination or within thirty (30) days of receipt of notice of mandatory Enrollment may be assigned by the SDOH, the NYSoH or the LDSS-Enrollment Broker to the Contractor's MMC product pursuant to SSL § 364-j and in accordance with Appendix H of this Agreement.

b) An individual who has been determined to be eligible for Long Term Placement in a nursing home is allowed sixty (60) days to select a MCO for enrollment. Individuals who do not enroll in a MCO within the allotted time shall be auto-assigned to a MCO which contracts with the nursing home where the individual is currently placed.

6.6 Prohibition Against Conditions on Enrollment

Unless otherwise required by law or this Agreement, neither the Contractor, the NYSoH, nor the LDSS shall condition any Eligible Person's Enrollment into the Contractor's MMC or FHPlus product upon the performance of any act. Neither the Contractor, the NYSoH, nor the LDSS shall suggest in any way that failure to enroll in the Contractor's MMC or FHPlus product may result in a loss of

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benefits, except in the case of the FHPlus Program when the Contractor is the sole MCO offering a FHPlus product in the Enrollee's county of fiscal responsibility.

6.7 Newborn Enrollment

a) All newborn children not Excluded from Enrollment in the MMC Program pursuant to Appendix H of this Agreement, shall be enrolled in the MCO in which the newborn's mother is an Enrollee, effective from the first day of the child's month of birth, unless the MCO in which the mother is enrolled does not offer a MMC product in the mother's county of fiscal responsibility.

b) In addition to the responsibilities set forth in Appendix H of this Agreement, the Contractor is responsible for coordinating with the LDSS the efforts to ensure that all newborns are enrolled in the Contractor's MMC product, if applicable.

c) The SDOH, NYSoH and LDSS shall be responsible for ensuring that timely Medicaid eligibility determination and Enrollment of the newborns is effected consistent with state laws, regulations, and policy and with the newborn Enrollment requirements set forth in Appendix H of this Agreement.

d) Applicable to HIV SNP Program Only:

In addition to the responsibilities set forth above and in Appendix H, the Contractor is responsible for:

i) Issuing a letter informing parent(s) about newborn child's enrollment or a member identification card within two (2) business days of the date on which the Contractor becomes aware of the birth. The child may be disenrolled at any time at the mother's request.

ii) Assuring that enrolled pregnant women select a PCP for an infant prior to birth and the mother to make an appointment with the PCP immediately upon birth; and

iii) Linking the newborn with a PCP within two (2) days of the HIV SNP's notification of the birth.

6.8 Effective Date of Enrollment

a) For MMC Enrollees, the Contractor, NYSoH and the LDSS are responsible for notifying the MMC Enrollee of the expected Effective Date of Enrollment.

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b) For FHPlus Enrollees, the Contractor must notify the FHPlus Enrollee of the Effective Date of Enrollment.

c) Notification may be accomplished through a "Welcome Letter." To the extent practicable, such notification must precede the Effective Date of Enrollment.

d) In the event that the actual Effective Date of Enrollment changes, the Contractor, and for MMC Enrollees the LDSS or NYSoH, must notify the Enrollee of the change.

e) As of the Effective Date of Enrollment, and until the Effective Date of Disenrollment, the Contractor shall be responsible for the provision and cost of all care and services covered by the Benefit Package and provided to Enrollees whose names appear on the Prepaid Capitation Plan Roster, except as hereinafter provided.

   i) Contractor shall not be liable for the cost of any services rendered to an Enrollee prior to his or her Effective Date of Enrollment.

   ii) Contractor shall not be liable for any part of the cost of a hospital stay for a MMC Enrollee who is admitted to the hospital prior to the Effective Date of Enrollment in the Contractor's MMC product and who remains hospitalized on the Effective Date of Enrollment; except when the MMC Enrollee, on or after the Effective Date of Enrollment, 1) is transferred from one hospital to another; or 2) is discharged from one unit in the hospital to another unit in the same facility and under Medicaid fee-for-service payment rules, the method of payment changes from: a) Diagnostic Related Group (DRG) case-based rate of payment per discharge to a per diem rate of payment exempt from DRG case-based payment rates, or b) from a per diem payment rate exempt from DRG case-based payment rates either to another per diem rate, or a DRG case-based payment rate. In such instances, the Contractor shall be liable for the cost of the consecutive stay.

   iii) Contractor shall not be liable for any part of the cost of a hospital stay for a FHPlus Enrollee who is admitted to the hospital prior to the Effective Date of Enrollment in the Contractor's FHPlus product and who has not been discharged as of the Effective Date of Enrollment, up to the date the FHPlus Enrollee is discharged.

   iv) Except for newborns, an Enrollee's Effective Date of Enrollment shall be the first day of the month on which the Enrollee's name appears on the Roster for that month or the Effective Date of Enrollment on the NYSoH 834 enrollment file.

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6.9 Roster/834 File

a) The first and second monthly Rosters generated by SDOH in combination shall serve as the official Contractor Enrollment list for the WMS Medicaid population for purposes of eMedNY premium billing and payment, subject to ongoing eligibility of the Enrollees as of the first (1st) day of the Enrollment month. Modifications to the Roster may be made electronically or in writing by the LDSS or the Enrollment Broker. If the LDSS or Enrollment Broker notifies the Contractor in writing or electronically of changes in the Roster and provides supporting information as necessary prior to the effective date of the Roster, the Contractor will accept that notification in the same manner as the Roster.

b) The 834 File generated by NYSoH shall serve as the official Contractor Enrollment notification for the NYSoH Medicaid population for purposes of eMedNY premium billing and payment, subject to ongoing eligibility of the Enrollees as of the first (1st) day of the enrollment month. The NYSoH will also advise the Contractor of any changes to a NYSoH Medicaid enrollment electronically via an 834 File.

c) The NYSoH or LDSS is responsible for making data on eligibility determinations available to the Contractor and SDOH to resolve discrepancies that may arise between the Roster or the 834 enrollment file and the Contractor's Enrollment files in accordance with the provisions in Appendix H of this Agreement.

d) All Contractors must have the ability to receive Rosters and the 834 enrollment files.

6.10 Re-Enrollment

a) An Enrollee who loses Medicaid or FHPlus eligibility and who regains eligibility for either Medicaid or FHPlus within a three (3) month period, will in most cases be automatically prospectively re-enrolled in the Contractor's MMC or FHPlus product unless:

i) the Contractor does not offer such product in the Enrollee's county of fiscal responsibility; or

ii) the Enrollee selects another MCO or, if permitted, receives coverage under Medicaid fee-for-service;

iii) the FHPlus program is no longer available for enrollment; o



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iv) the Contractor is precluded from enrollments by State regulatory action or has withdrawn from the county of fiscal responsibility.

b) An Enrollee whose Medicaid benefits are suspended and later reinstated by the LDSS shall be prospectively re-enrolled in the same MMC product that the Enrollee was previously enrolled in before the suspension of Medicaid eligibility unless:

i) the Contractor does not offer the same product in the Enrollee's county of fiscal responsibility; or

ii) the Enrollee elects to enroll in another MMC product; or

iii) the Contractor is precluded from enrollments by State regulatory action or has withdrawn from the county of fiscal responsibility; or

c) Notwithstanding the provisions in Section 6.10 b) of this Agreement, an Enrollee whose Medicaid benefits are suspended and later reinstated and who elects to re-establish eligibility through the NYSoH may choose to enroll in any MMC product operating in such Enrollee's county of fiscal responsibility.

6.11 Verification of HIV SNP Enrollment Eligibility [Applicable to HIV SNP Program Only]

a) The Contractor shall confirm that Enrollee applicants have HIV infection and are eligible to enroll in an HIV SNP, except that such confirmation is not required for the Enrollee applicant's related children. New Enrollees who are homeless must have their HIV status verified or the homeless uninfected Capitation Rate applies until the Enrollee's HIV infected status is verified.

b) The Contractor must obtain verification of HIV infection as defined in (d) within ninety (90) days of the effective date of Enrollment prior to billing an HIV Capitation rate.

c) The Contractor must obtain verification of HIV infection in related children prior to billing an HIV capitation rate.

d) For purposes of HIV SNP Enrollment eligibility, acceptable verification of HIV infection shall include:

i) One of the following laboratory test results or other diagnostic tests approved by the AIDS Institute:

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A) HIV antigen and/or antibody immunoassay;

B) Viral Identification Assays (e.g., p24 antigen assay, viral culture, nucleic acid (RNA or DNA) detection assay);

C) CD4 Level Measurement of less than 200; or

ii) For patients currently under treatment without diagnosis confirming laboratory results and with undetectable viral load, a physician's statement verifying HIV status will be accepted when other verifying tests are not available. The physician's statement must conform to AIDS Institute requirements; or,

iii) For Enrollees not currently engaged in care, other documentation approved by the AIDS Institute.

e) Sharing of medical information for purposes of HIV verification must comply with the confidentiality requirements set forth in Section 20 of this Agreement.

f) All testing for HIV verification must be conducted in compliance with State regulations.

g) The Contractor shall be solely responsible for maintaining and providing documentation necessary to support its determination of HIV infection for enrollment eligibility. Failure by the Contractor to have required supporting records may upon an audit result in recoupment of payment. The Contractor shall not delegate to its participating providers responsibility for maintaining supporting records verifying HIV status.

h) The Contractor must submit to SDOH verification of HIV infection with demographic and additional Enrollee information as required, in a manner and format prescribed by the AIDS Institute.

i) Homeless Enrollees who are not HIV infected will have their eligibility verified by their inclusion on the New York City Department of Homeless Services Shelter List or other documentation determined acceptable by SDOH.

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## 7. LOCK-IN PROVISIONS

### 7.1 Lock-In Provisions in MMC Mandatory Counties and for Family Health Plus

All MMC Enrollees residing in local social service districts where Enrollment in the MMC Program is mandatory and all FHPlus Enrollees are subject to a twelve (12) month Lock-In Period following the Effective Date of Enrollment, with an initial ninety (90) day grace period in which to disenroll without cause and enroll in another MCO's MMC or FHPlus product, if available. An Enrollee with HIV infection or AIDS may request transfer from an MMC plan to an HIV SNP, or from an HIV SNP to another HIV SNP at any time. An Enrollee identified as HARP Eligible may request transfer from an MCO's MMC product to a HARP at any time

### 7.2 Disenrollment During a Lock-In Period

An Enrollee subject to Lock-In may disenroll from the Contractor's MMC or FHPlus product during the Lock-In Period for Good Cause as defined in Appendix H of this Agreement. Persons with HIV infection or AIDS whose local district of residence qualifies them for enrollment in an HIV Special Needs Plan (HIV SNP) may request transfer from an MCO to an HIV SNP, or from an HIV SNP to another HIV SNP at any time.

### 7.3 Notification Regarding Lock-In and End of Lock-In Period

The LDSS, either directly or through the Enrollment Broker, is responsible for notifying Enrollees of their right to change MCOs in the Enrollment confirmation notice sent to individuals after they have selected an MCO or been auto-assigned (the latter being applicable to areas where the mandatory MMC Program is in effect). The SDOH or its designee will be responsible for providing a notice of end of Lock-In and the right to change MCOs at least sixty (60) days prior to the first Enrollment anniversary date as outlined in Appendix H of this Agreement.

### 7.4 Lock-In and Change in Eligibility Status

Enrollees whose Medicaid benefits are suspended and reinstated within a three (3) month period or who lose Medicaid or FHPlus eligibility and regain eligibility for either Medicaid or FHPlus within a three (3) month period, will not be subject to a new Lock-in Period unless they opt to change MCOs pursuant to Section 6.10 of this Agreement.

### 7.5 Lock-In Provisions for Children in Foster Care

Children entering or being discharged from foster care may change plans during intake, foster care placement, and discharge planning period regardless of the Lock-In Period.

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## 7.6 Lock-In Provisions for Individuals in Long Term Placement in Nursing Homes

Individuals in Long Term Placement in nursing homes may change plans at any time regardless of the Lock-In Period.

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# 8. DISENROLLMENT

## 8.1 Disenrollment Requirements

a) The Contractor agrees to conduct Disenrollment of an Enrollee in accordance with the policies and procedures for Disenrollment set forth in Appendix H of this Agreement.

b) SDOH, NYSoH or LDSSs are responsible for making the final determination concerning Disenrollment requests.

c) For enrollees in the HIV SNP Program, regardless of reason for disenrollment, upon notice of or request for disenrollment the Contractor must prepare a written discharge plan for an Enrollee for whom a treatment plan has been established to assure continuity of care at the time of disenrollment.

   i) With the Enrollee's consent, information will also be provided on and referrals provided to case management resources and primary care providers.

   ii) The discharge plan should be provided to the Enrollee and, with the Enrollee's consent, his/her designated care provider, within fifteen (15) days of the notice of or request for disenrollment.

   iii) For HIV infected individuals who lose Medicaid eligibility, the discharge plan will include information regarding services offered by the HIV Uninsured Care Program.

d) For Enrollees who are in foster care, are in receipt of LTSS, or who are individuals included in a SDOH-identified special population, upon notice of or request for disenrollment, the Contractor must prepare a written discharge plan for an Enrollee for whom a treatment plan has been established to assure continuity of care at the time of disenrollment. Information will also be provided on and referrals provided to case management resources and primary care providers. The discharge plan should be provided to the Enrollee or his/her legal guardian, his/her designated care provider, and the LDSS within fifteen (15) days of notice or request for disenrollment.

## 8.2 Disenrollment Prohibitions

Enrollees shall not be disenrolled from the Contractor's MMC or FHPlus product based on any of the factors listed in Section 34 (Non-Discrimination) of this Agreement.

## 8.3 Disenrollment Requests

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a) Routine Disenrollment Requests

The SDOH, NYSoH or LDSS is responsible for processing Routine Disenrollment requests to take effect as specified in Appendix H of this Agreement. In no event shall the Effective Date of Disenrollment be later than the first (1st) day of the second (2nd) month after the month in which an Enrollee requests a Disenrollment.

b) Non-Routine Disenrollment Requests

i) Enrollees with a complaint of Nonconsensual Enrollment may request an expedited Disenrollment by the LDSS, SDOH or NYSoH.

ii) Retroactive Disenrollments may be warranted in rare instances and may be requested of the LDSS, SDOH or NYSoH as described in Appendix H of this Agreement.

iii) Substantiation of non-routine Disenrollment requests by the LDSS, SDOH or NYSoH will result in Disenrollment in accordance with the timeframes as set forth in Appendix H of this Agreement.

8.4 Contractor Notification of Disenrollments

a) Notwithstanding anything herein to the contrary, the Roster or 834 File, along with any changes sent by the LDSS, SDOH or NYSoH to the Contractor in writing or electronically, shall serve as official notice to the Contractor of Disenrollment of an Enrollee. In cases of expedited and retroactive Disenrollment, the Contractor shall be notified of the Enrollee's Effective Date of Disenrollment by the LDSS, SDOH or NYSoH.

b) In the event that the LDSS, SDOH or NYSoH intends to retroactively disenroll an Enrollee on a date prior to the first day of the month of the Disenrollment request, the LDSS, SDOH or NYSoH is responsible for consulting with the Contractor prior to Disenrollment.

c) In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the LDSS, SDOH or NYSoH is responsible for noticing the Contractor at the time of Disenrollment of the Contractor's responsibility to submit to the SDOH's Fiscal Agent voided premium claims for any months of retroactive Disenrollment where the Contractor was not at risk for the provision of Benefit Package services during the month.

8.5 Contractor's Liability

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a) The Contractor is not responsible for providing the Benefit Package under this Agreement on or after the Effective Date of Disenrollment except as hereinafter provided:

i) The Contractor shall be liable for any part of the cost of a hospital stay for a MMC Enrollee who is admitted to the hospital prior to the Effective Date of Disenrollment from the Contractor's MMC product and who remains hospitalized on the Effective Date of Disenrollment; except when the MMC Enrollee, on or after the Effective Date of Disenrollment, 1) is transferred from one hospital to another; or 2) is discharged from one unit in the hospital to another unit in the same facility and under Medicaid fee-for-service payment rules, the method of payment changes from: a) DRG case-based rate of payment per discharge to a per diem rate of payment exempt from DRG case-based payment rates, or b) from a per diem payment rate exempt from DRG case-based payment rates to either another per diem rate, or a DRG case-based payment rate. In such instances, the Contractor shall not be liable for the cost of the consecutive stay. For the purposes of this paragraph, "hospital stay" does not include a stay in a hospital that is a) certified by Medicare as a long-term care hospital and b) has an average length of stay for all patients greater than ninety-five (95) days as reported in the Statewide Planning and Research Cooperative System (SPARCS) Annual Report 2002; in such instances, Contractor liability will cease on the Effective Date of Disenrollment.

ii) The Contractor shall be liable for any part of the cost of a hospital stay for a FHPlus Enrollee who is admitted to the hospital prior to the Effective Date of Disenrollment from the Contractor's FHPlus product and who has not been discharged as of the Effective Date of Disenrollment, up to the date the FHPlus Enrollee is discharged.

b) The Contractor shall notify the LDSS, SDOH or NYSoH that the Enrollee remains in the hospital and provide the LDSS with information regarding his or her medical status. The Contractor is required to cooperate with the Enrollee and the new MCO (if applicable) on a timely basis to ensure a smooth transition and continuity of care.

8.6 Enrollee Initiated Disenrollment

a) An Enrollee subject to Lock-In as described in Section 7 of this Agreement may initiate Disenrollment from the Contractor's MMC or FHPlus product for Good Cause as defined in Appendix H of this Agreement at any time during the Lock-In period by filing an oral or written request with the LDSS, SDOH or NYSoH.

b) Once the Lock-In Period has expired, the Enrollee may disenroll from the Contractor's MMC or FHPlus product at any time, for any reason.

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c) An Enrollee with HIV infection or AIDS may request transfer from an MMC plan to an HIV SNP, or from an HIV SNP to another HIV SNP at any time.

d) An Enrollee may disenroll from the Contractor's MMC product at any time, without cause, if the Contractor has repeatedly failed, as determined by SDOH in accordance with 42 CFR 438.706, to meet substantive requirements of Sections 1903(m) or 1932 of the Social Security Act, or 42 CFR 438. The SDOH shall notify Enrollees of such determination.

8.7 Contractor Initiated Disenrollment

a) The Contractor may initiate an involuntary Disenrollment if an Enrollee engages in conduct or behavior that seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees, provided that the Contractor has made and documented reasonable efforts to resolve the problems presented by the Enrollee. These efforts will include Contractor initiated restriction where the Enrollee's actions meet the criteria for such restriction as specified in Appendix Q of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein. The Contractor shall submit the request for disenrollment in writing to the LDSS, Enrollment Broker, SDOH or NYSoH and shall include the documentation of reasonable efforts.

b) Consistent with 42 CFR § 438.56 (b), the Contractor may not request Disenrollment because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs (except where continued Enrollment in the Contractor's MMC or FHPlus product seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees).

c) Contractor initiated Disenrollments must be carried out in accordance with the requirements and timeframes described in Appendix H of this Agreement.

d) Once an Enrollee has been disenrolled at the Contractor's request, he/she will not be re-enrolled with the Contractor's MMC or FHPlus product unless the Contractor first agrees to such re-enrollment.

e) [Applicable to HIV SNP Program Only]: For an HIV negative homeless Enrollee, the Contractor must have a process to transition the Enrollee to other health plan options once the Enrollee resides in permanent housing as defined by SDOH.

8.8 SDOH, Enrollment Broker, NYSoH or LDSS Initiated Disenrollment

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a) The SDOH, Enrollment Broker, NYSoH or LDSS is responsible for promptly initiating Disenrollment when:

i) an Enrollee is no longer eligible for MMC or FHPlus; or

ii) an Enrollee is no longer the financial responsibility of the LDSS; or

iii) an Enrollee becomes ineligible for Enrollment pursuant to Section 6.1 of this Agreement.

8.9 Passive Reassignment of Enrollees in Receipt of Medicare\

a) On a monthly basis, the Enrollment Broker, or LDSS, shall transmit to the Contractor a disenrollment file of current Enrollees in receipt of Medicare, and thus subject to disenrollment from the plan.

i) From this disenrollment file, the Contractor shall identify Enrollees who will require more than 120 days of LTSS, as defined in Appendix S, and are therefore eligible for MLTC. Within 5 business days of receipt of the disenrollment file, the Contractor shall transmit the results of the file match, in a format to be determined by SDOH, to the Enrollment Broker or LDSS.

A) If the Contractor has a Managed Long Term Care Plan (MLTCP) product, the Enrollment Broker will process a passive reassignment into the MLTCP. The Enrollment Broker or LDSS will work with the MLTCP to facilitate such action.

B) If the Contractor does not have a MLTCP product, the Contractor shall outreach to Enrollees who will be disenrolled from the Contractor's MMC plan and encourage the affected Enrollee to contact the Enrollment Broker or LDSS to select a MLTCP.

I) If the Enrollee does not select a MLTCP before the pull down that occurs prior to the disenrollment effective date, the Enrollment Broker or LDSS will process a passive reassignment to another MLTCP that serves the Enrollee's service area and transmit a report to the Contractor identifying the affected Enrollee and the MLTCP to which the Enrollee was reassigned.

C) The Contractor must coordinate with the new MLTCP to ensure there is no gap in coverage.

ii) Enrollees age 65 or older that are not receiving Medicare are not subject to reassignment to a MLTCP and will remain in the Contractor's MMC plan.

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# 10. BENEFIT PACKAGE REQUIREMENTS

## 10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

   i) In accordance with 42 CFR 438.102 (a)(2), if the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must have furnished information to SDOH about the services it does not cover concurrently with its application for qualification for the MMC program.

   ii) If the Contractor elects not to furnish information to an Enrollee regarding how and where to obtain services objected to in subsection (a)(i) above, the SDOH shall furnish such information to the Contractor's Enrollees.

b) [Applicable to the HIV SNP Program Only]: The Contractor must promote access and ensure referrals to fee-for-service Medicaid benefits through the HIV SNP care and benefit coordination process for Enrollees determined to be in need of such services.

c) [Applicable to the HARP and HIV SNP Programs Only]: The Contractor must provide or arrange for the provision of care management and eligibility assessments for Behavioral Health Home and Community Based Services as outlined in Section 10.41.

d) [Applicable to the HARP and HIV SNP Programs only]: The Contractor, through a Health Home wherever possible or other State-designated entity, must promote access and ensure referrals to fee-for-service Medicaid benefits and to other social and behavioral health resources necessary to promote recovery outcomes and wellness, including housing subsidies and supports, public benefits, meaningful employment, social networks and legal services, for Enrollees determined to be in need of such services, through the HARP and HIV SNP care coordination processes.

e) The Contractor shall participate in a coordination of benefits agreement with the Medicare program, and in the automated claims crossover process, as directed by the State.

## 10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

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a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and any federal waiver applicable to the provision of Medicaid services by a managed care plan approved by CMS under Section-1115 of the Social Security Act, as applicable, shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals. The Contractor shall ensure that services or supplies provided under this Agreement are provided in compliance with 18 NYCRR 513.4(c), whereby the ordering practitioner and servicing provider are responsible for assuring that, in their best professional judgement, the ordered and requested medical, dental and remedial care, services or supplies will meet the Enrollee's medical needs; reduce the Enrollee's physical or mental disability; restore the Enrollee to his or her best possible functional level; or improve the Enrollee's capacity for normal activity; and that the ordered or requested services or supplies are necessary to prevent, diagnose, correct or cure a condition in light of the Enrollee's specific circumstances and the Enrollee's functional capacity to make use of the requested care, services or supplies.

d) The Contractor shall ensure that any cost sharing imposed on an Enrollee is in accordance with the State Medicaid Plan and with requirements at 42 CFR 447.50 through 42 CFR 447.60.

   i) The Contractor shall exempt from MMC premiums any Native American Enrollee who is eligible to receive or has received a covered item or service furnished by an Indian Health Care Provider or through referral made by an Indian Health Care Provider.

   ii) The Contractor shall exempt from all cost sharing requirements any Native American Enrollee who is eligible to receive or has received a covered item or service furnished by an Indian Health Care Provider or through referral made by an Indian Health Care Provider.

e) The Contractor shall not expend any funds provided through this Agreement for roads, bridges, stadiums, or any item or service not described in the State Medicaid Plan, except when such expenditures are for an item or service:

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i) otherwise permissible under this Agreement;

ii) allowable under 42 CFR 438.3; or

iii) that the Contractor has been directed by SDOH to provide pursuant to Section 4.3 of this Agreement.

f) The SDOH shall assure that no payment is made to a Participating Provider other than by the Contractor for services provided under the Benefit Package, except when such additional payment is specifically required to be made by the SDOH in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the SDOH makes direct payments to Participating Providers for graduate medical education costs approved under the State Medicaid Plan.

g) The Contractor shall not expend any funds provided under this Agreement for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

h) Mental Health and Substance Use Disorder Benefits Parity Requirements

i) The Contractor shall comply with mental health and substance use disorder benefits parity requirements for aggregate lifetime and annual dollar limits specified in 42 CFR 438.905.

ii) The Contractor shall comply with mental health and substance use disorder benefits parity requirements for financial requirements and treatment limitations specified in 42 CFR 438.910.

10.3 Definitions

The Contractor agrees to the definitions of "Benefit Package" and "Non-Covered Services" contained in Appendix K, which is incorporated by reference as if set forth fully herein.

10.4 Child Teen Health Program/Adolescent Preventive Services

a) The Contractor and its Participating Providers are required to provide the Child Teen Health Program (C/THP) services outlined in Appendix K of this Agreement and comply with applicable Early Periodic Screening and Diagnostic Testing (EPSDT) requirements specified in 42 CFR Part 441, sub-part B, 18NYCRR Part 508 and the New York State Department of Health C/THP manual. The Contractor and its Participating Providers are required to provide C/THP services to Enrollees under twenty-one (21) years of age when:



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i) The care or services are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition.

ii) The care or services are essential to the overall physical, cognitive and mental growth and developmental needs of the Enrollee.

iii) The care or service will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for individuals of the same age as the Enrollee.

b) The Contractor shall base its determination on medical and other relevant information provided by the Enrollee's PCP, other health care providers, school, local social services, and/or local public health officials that have evaluated the Enrollee.

i) The Contractor will ensure C/THP care and services are provided in sufficient amount, duration and scope to reasonably be expected to produce the intended results and to have the expected benefits that outweigh the potential harmful effects.

c) The Contractor and its Participating Providers must comply with the C/THP program standards and must do at least the following with respect to all Enrollees under age 21:

i) Educate Enrollees who are pregnant women or who are parents of Enrollees under age 21 about the program and its importance to a child's or adolescent's health.

ii) Educate Participating Providers about the program and their responsibilities under it.

iii) Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure children are kept current with respect to their periodicity schedules.

iv) Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments. This also applies to dental service appointments for children and adolescents.

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v) Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.

vi) Achieve and maintain an acceptable compliance rate for screening schedules during the contract period.

d) In addition to C/THP requirements, the Contractor and its Participating Providers are required to comply with the American Medical Association's Guidelines for Adolescent Preventive Services which require annual well adolescent preventive visits which focus on health guidance, immunizations, and screening for physical, emotional, and behavioral conditions.

10.5 Foster Care Children – Applies to MMC Program Only

The Contractor shall comply with the health requirements for foster children specified in 18 NYCRR § 441.22 and Part 507 and any subsequent amendments thereto. These requirements include thirty (30) day obligations for a comprehensive physical and behavioral health assessment and assessment of the risk that the child may be HIV+ and should be tested. The Contractor shall provide comprehensive assessments and coordinate care for these Enrollees with the LDSS.

10.6 Child Protective Services

The Contractor shall comply with the requirements specified for child protective examinations, provision of medical information to the child protective services investigation and court ordered services as specified in 18 NYCRR Part 432, and any subsequent amendments thereto. Medically necessary services must be covered, whether provided by the Contractor's Participating Providers or not. Non-Participating Providers will be reimbursed at the Medicaid fee schedule by the Contractor.

10.7 Welfare Reform – Applies to MMC Program only

a) The LDSS is responsible for determining whether each public assistance or combined public assistance/Medicaid applicant is incapacitated or can participate in work activities. As part of this work determination process, the LDSS may require medical documentation and/or an initial mental and/or physical examination to determine whether an individual has a mental or physical impairment that limits his/her ability to engage in work (12 NYCRR §1300.2(d)(13)(i)). The LDSS may not require the Contractor to provide the initial district mandated or requested medical examination necessary for an Enrollee to meet welfare reform work participation requirements.

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b) The Contractor shall require that the Participating Providers in its MMC product, upon MMC Enrollee consent, provide medical documentation and health, mental health and chemical dependence assessments as follows:

i) Within ten (10) days of a request of an MMC Enrollee or a former MMC Enrollee, currently receiving public assistance or who is applying for public assistance, the MMC Enrollee's or former MMC Enrollee's PCP or specialist provider, as appropriate, shall provide medical documentation concerning the MMC Enrollee or former MMC Enrollee's health or mental health status to the LDSS or to the LDSS' designee. Medical documentation includes but is not limited to drug prescriptions and reports from the MMC Enrollee's PCP or specialist provider. The Contractor shall include the foregoing as a responsibility of the PCP and specialist provider in its provider contracts or in their provider manuals.

ii) Within ten (10) days of a request of an MMC Enrollee, who has already undergone, or is scheduled to undergo, an initial LDSS required mental and/or physical examination, the MMC Enrollee's PCP shall provide a health, or mental health and/or chemical dependence assessment, examination or other services as appropriate to identify or quantify an MMC Enrollee's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. The LDSS, may, upon written notice to the Contractor, specify the format and instructions for such an assessment.

c) The Contractor shall designate a Welfare Reform liaison who shall work with the LDSS or its designee to (1) ensure that MMC Enrollees receive timely access to assessments and services specified in this Agreement and (2) ensure completion of reports containing medical documentation required by the LDSS.

d) The Contractor will be responsible for the provision and payment of Chemical Dependence Services/Substance Use Disorder in the Benefit Package for MMC Enrollees mandated by the LDSS under Welfare Reform. Notwithstanding Section 10.23 of this Agreement, the Contractor shall provide LDSS mandated services regardless of whether the mandate requires services to be provided by a Participating or Non-Participating Provider or at a level of care that is inconsistent with the LOCADTR determination, however, nothing herein prohibits the Contractor from consulting with the LDSS regarding the LOCADTR review and seeking agreement to a level of care that is different from that originally contemplated by the mandate. Non-Participating Providers shall be reimbursed at no less than the Medicaid fee-for-service rate.

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e) The Contractor is responsible for the provision of services in Sections 10.9, 10.15 (a) and 10.23 of this Agreement for MMC Enrollees requiring LDSS mandated Chemical Dependence Services.

10.8 Adult Protective Services

The Contractor shall cooperate with LDSS in the implementation of 18 NYCRR Part 457 and any subsequent amendments thereto with regard to medically necessary health and mental health services including referrals for mental health and/or chemical dependency evaluations and all Court Ordered Services for adults. Court-ordered services that are included in the Benefit Package must be covered, whether provided by the Contractor's Participating Provider or not. Non-Participating Providers will be reimbursed at the Medicaid fee schedule by the Contractor.

10.9 Court-Ordered Services

a) The Contractor shall provide any Benefit Package services to Enrollees as ordered by a court of competent jurisdiction, regardless of whether the court order requires such services to be provided by a Participating Provider or by a Non-Participating Provider. Non-Participating Providers shall be reimbursed by the Contractor at the Medicaid fee schedule. The Contractor is responsible for court-ordered services to the extent that such court-ordered services are covered by the Benefit Package and reimbursable by Medicaid or Family Health Plus, as applicable.

b) Court Ordered Services are those services ordered by the court performed by, or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including mental health and/or Chemical Dependence), or other Benefit Package covered services. The Contractor is responsible for payment of those services as covered by the Benefit Package, even when provided by Non-Participating Providers.

c) Any Court-Ordered Services for mental health treatment outpatient visits by the Contractor's Enrollees that specify the use of Non-Participating Providers shall be reimbursed at the Medicaid rate of payment.

10.10 Family Planning and Reproductive Health Services

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a) Nothing in this Agreement shall restrict the right of Enrollees to receive Family Planning and Reproductive Health services, as defined in Appendix C of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein.

i) MMC Enrollees may receive such services from any qualified Medicaid provider, regardless of whether the provider is a Participating or a Non-Participating Provider, without referral from the MMC Enrollee's PCP and without approval from the Contractor.

ii) FHPlus Enrollees may receive such services from any Participating Provider if the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, or from any qualified Medicaid provider if such services are not included in the Contractor's Benefit Package, as specified in Appendix M of this Agreement, without referral from the FHP Enrollee's PCP and without approval from the Contractor.

b) The Contractor shall permit Enrollees to exercise their right to obtain Family Planning and Reproductive Health services.

i) If the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, the Contractor shall comply with the requirements in Part C.2 of Appendix C of this Agreement, including assuring that Enrollees are fully informed of their rights.

ii) If the Contractor does not include Family Planning and Reproductive Health services in its Benefit Package, the Contractor shall comply with the requirements of Part C.3 of Appendix C of this Agreement, including assuring that Enrollees are fully informed of their rights.

10.11 Prenatal Care and Elective Deliveries Less Than 39 Weeks Gestation

a) The Contractor agrees to provide or arrange for comprehensive prenatal care services to be provided in accordance with standards and guidelines established by the Commissioner of Health pursuant to Section 365-k of the Social Services Law.

b) The Contractor shall reduce payment to Providers for elective cesarean section deliveries and induction of labor without medical indication when the pregnancy is less than 39 weeks gestation in accordance with SDOH guidance.

10.12 Direct Access

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The Contractor shall offer female Enrollees direct access to primary and preventive obstetrics and gynecology services, follow-up care as a result of a primary and preventive visit, and any care related to pregnancy from Participating Providers of her choice, without referral from the PCP as set forth in PHL § 4406-b(1).

10.13 Emergency Services

a) The Contractor shall maintain coverage utilizing a toll free telephone number twenty-four (24) hours per day seven (7) days per week, answered by a live voice, to advise Enrollees of procedures for accessing services for Emergency Medical Conditions and for accessing Urgently Needed Services. Emergency mental health calls must be triaged via telephone by a trained mental health professional.

b) The Contractor shall advise its Enrollees how to obtain Emergency Services when it is not feasible for Enrollees to receive Emergency Services from or through a Participating Provider. The Contractor agrees to inform its Enrollees that access to Emergency Services is not restricted and that Emergency Services may be obtained from a Non-Participating Provider without penalty.

c) The Contractor agrees to bear the cost of Emergency Services provided to Enrollees by Participating or Non-Participating Providers.

d) The Contractor agrees to cover and pay for services as follows:

i) Participating Providers

A) Payment by the Contractor for general hospital emergency department services provided to an Enrollee by a Participating Provider shall be at the rate or rates of payment specified in the contract between the Contractor and the hospital. Such contracted rate or rates shall be paid without regard to whether such services meet the definition of Emergency Medical Condition.

B) Payment by the Contractor for physician services provided to an Enrollee by a Participating Provider while the Enrollee is receiving general hospital emergency department services shall be at the rate or rates of payment specified in the contract between the Contractor and the physician. Such contracted rate or rates shall be paid without regard to whether such services meet the definition of Emergency Medical Condition.

ii) Non-Participating Providers

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A) Payment by the Contractor for general hospital emergency department services provided to an Enrollee by a Non-Participating Provider shall be at the Medicaid fee-for-service rate, inclusive of the capital component, in effect on the date that the service was rendered without regard to whether such services meet the definition of Emergency Medical Condition.

B) Payment by the Contractor for physician services provided to an Enrollee by a Non-Participating Provider while the Enrollee is receiving general hospital emergency department services shall be at the Medicaid fee-for-service rate in effect on the date the service was rendered without regard to whether such services meet the definition of Emergency Medical Condition.

C) Payment by the Contractor for CPEP services by Non-Participating Providers shall be at the same rate as for Participating Providers pursuant to this Section.

D) Payment by the Contractor for Crisis Intervention Services by Non-Participating Providers shall be at the same rate as for Participating Providers pursuant to this Section.

e) The Contractor agrees that it will not require prior authorization for services in a medical or behavioral health emergency, or for Crisis Intervention services. Nothing herein precludes the Contractor from entering into contracts with providers or facilities that require providers or facilities to provide notification to the Contractor after Enrollees present for Emergency Services and are subsequently stabilized. The Contractor may not deny payments to a Participating Provider or a Non-Participating Provider for failure of the Emergency Services provider or Enrollee to give such notice.

f) The Contractor agrees to abide by requirements for the provision and payment of Emergency Services and Post-stabilization Care Services which are specified in Appendix G, which is hereby made a part of this Agreement as if set forth fully herein.

10.14 Reserved

10.15 Services for Which Enrollees Can Self-Refer

a) Mental Health and Substance Use Disorder Services

i) The Contractor will allow Enrollees to make unlimited self referrals for mental health and Substance Use Disorder assessments from Participating Providers without requiring preauthorization or referral from the Enrollee's Primary Care Provider. This provision does not apply to ACT,



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inpatient psychiatric hospitalization, partial hospitalization, or Behavioral Health Home and Community Based Services, for which no self-referrals for assessments are permitted.

For the MMC Program, in the case of children, such self-referrals may originate at the request of a school guidance counselor (with parental or guardian consent, or pursuant to procedures set forth in Section 33.21 of the Mental Hygiene Law); LDSS Official; Judicial Official; Probation Officer; parent, caregiver or legal guardian; Voluntary Foster Care Agency where the Agency is assigned care and custody of the child by the LDSS; or similar source.

ii) The Contractor shall make available to all Enrollees a complete listing of their participating mental health and Substance Use Disorder Services providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.

iii) The Contractor will also ensure that its Participating Providers have available and use formal assessment procedures to identify Enrollees requiring mental health or Substance Use Disorder Services. The Contractor shall ensure that its' Participating Providers and/or Contractor's utilization management staff use the LOCADTR assessment tool to make initial and ongoing level of care determinations for Substance Use Disorder Services.

iv) The Contractor will implement policies and procedures to ensure that Enrollees receive follow-up Benefit Package services from appropriate providers based on the findings of their mental health and/or Substance Use Disorder assessment(s), consistent with Sections 10.15(a)(iii), 15.2(a)(x) and (xi) of this Agreement.

v) The Contractor will implement policies and procedures to ensure that Enrollees are referred to appropriate Substance Use Disorder providers based on the findings of the Substance Use Disorder assessment by the Contractor's Participating Provider, consistent with Section 10.15(a)(iii), 15.2(a)(x) and (xi) of this Agreement.

vi) As provided by Section 10.41 and Appendix T of this Agreement, the Contractor shall ensure that BHHCBS eligibility assessments are conducted only by a Health Home or other State-designated entity. The Contractor shall ensure that BHHCBS eligibility assessments are conducted by a provider in compliance with Federal conflict-free case management requirements.

vii) [Applicable to the HIV SNP Program]: The Contractor must have arrangements to allow any HIV SNP participating PCP, with appropriate



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enrollee consent, to request that a representative of the HIV SNP Contractor or behavioral health provider contact any HIV SNP Enrollee they believe to be in need of mental health or Chemical Dependence Services and attempt to arrange for an evaluation of their needs.

b) Vision Services

The Contractor will allow its Enrollees to self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services and, for Enrollees diagnosed with diabetes, for an annual dilated eye (retinal) examination as described in Appendix K of this Agreement. Enrollees may self-refer to Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services as described in Section 10.28 of this Agreement.

c) Diagnosis and Treatment of Tuberculosis

Enrollees may self-refer to public health agency facilities for the diagnosis and/or treatment of TB as described in Section 10.18(a) of this Agreement.

d) Family Planning and Reproductive Health Services

Enrollees may self-refer to family planning and reproductive health services as described in Section 10.10 and Appendix C of this Agreement.

e) Article 28 Clinics Operated by Academic Dental Centers

MMC Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services as described in Section 10.27 of this Agreement.

10.16 Second Opinions for Medical or Surgical Care

The Contractor will allow Enrollees to obtain second opinions for diagnosis of a condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. In the event that the Contractor determines that it does not have a Participating Provider in its network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the Contractor shall make a referral to an appropriate Non-Participating Provider. The Contractor shall pay for the cost of the services associated with obtaining a second opinion regarding medical or surgical care, including diagnostic and evaluation services, provided by the Non-Participating Provider.

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10.17 Contractor Responsibilities Related to Public Health

a) The Contractor will coordinate its public health-related activities with the Local Public Health Agency (LPHA). Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with the LPHA and Contractor and be customized to reflect local public health priorities.

b) The Contractor shall provide the State with existing information as requested to facilitate epidemiological investigations.

c) The Contractor shall make reasonable efforts to assure timely and accurate compliance by Participating Providers with public health reporting requirements relating to communicable diseases and conditions mandated in Article 21 of the NYS Public Health Law and, for Contractors operating in New York City, the New York City Health Code (24 RCNY §§ 11.03 -11.07).

d) The Contractor shall make reasonable efforts to assure timely and accurate compliance by Participating Providers with other mandated reporting requirements, including the following:

   i) Infants and toddlers suspected of having a developmental delay or disability;

   ii) Suspected instances of child abuse; and

   iii) Additional reporting requirements pursuant to State law and, for Contractors operating in New York City, the New York City Health Code.

e) For purposes of items c) and d) above, reasonable efforts shall include:

   i) Educating Participating Providers regarding applicable treatment guidelines and reporting requirements;

   ii) Including reporting requirements in the Contractor's provider manual or in other written instructions or guidelines;

   iii) For item c) above, only, following up with Participating Providers who, based on claims or other information provided to the Contractor, may have encountered an Enrollee with a reportable disease or condition to encourage and instruct the Provider in reporting.

f) For purposes of reporting to SDOH on quality metrics and internal performance improvement projects pursuant to Sections 18.5 v) and x) of this Agreement, the Contractor shall obtain immunization and lead screening data

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from the New York State Immunization Information System (NYSIIS) and, where available, the Lead Screening Registry.

g) The Contractor shall provide health education to Enrollees on an on-going basis through methods such as posting information on the Contractor's web site, distribution (electronic or otherwise) of Enrollee newsletters, health education classes or individual counseling on preventive health and public health topics, such as:

i) HIV/AIDS, including availability of HIV testing and sterile needles and syringes;
ii) STDs, including how to access confidential STD services;
iii) Lead poisoning prevention;
iv) Maternal and child health, including importance of developmental screening for children;
v) Injury prevention;
vi) Domestic violence;
vii) Smoking cessation;
viii) Asthma;
ix) Immunization;
x) Mental health services;
xi) Diabetes;
xii) Family planning;
xiii) Screening for cancer;
xiv) Chemical dependence;
xv) Physical fitness and nutrition;
xvi) Cardiovascular disease and hypertension;
xvii) Dental care, including importance of preventive services such as dental sealants; and
xviii) Screening for Hepatitis C for individuals born between 1945 and 1965.

h) The Contractor shall ensure that appropriate MCO staff, such as member services staff and case managers, are generally knowledgeable about early intervention services and provide referrals to the applicable early intervention official in the Enrollee's county of residence to obtain technical assistance and consultation to Enrollees concerning early intervention services (including eligibility, referral processes and coordination of services).

i) The Contractor shall provide technical assistance to Participating Providers in documenting cases of domestic violence, provide referrals for Enrollees or their Participating Providers to community resources where the Enrollee may obtain protective, legal and/or supportive social services, and ensure that Participating Providers are aware of community resources for suspected victims of domestic violence.

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j) For Contractors operating in New York City, only, the Contractor shall: educate Enrollees regarding prevention and treatment of diseases and conditions included in the Take Care New York initiative (TCNY); disseminate TCNY materials containing content approved by the New York City Department of Health and Mental Health (DOHMH) to Enrollees; disseminate reminders concerning recommended health screenings at age appropriate intervals to Enrollees; and, educate Participating Providers on recommended clinical guidelines regarding prevention, treatment and management of diseases and conditions described in the TCNY initiative.

10.18 Public Health Services

a) Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB\DOT):

i) Tuberculosis Screening, Diagnosis and Treatment services are included in the Benefit Package.

A) It is the State's preference that Enrollees receive TB diagnosis and treatment through the Contractor to the extent that Participating Providers experienced in this type of care are available.

B) The SDOH will coordinate with the LPHA to evaluate the Contractor's protocols against State and local guidelines and to review the tuberculosis treatment protocols and networks of Participating Providers to verify their readiness to treat Tuberculosis patients. State and local departments of health will also be available to offer technical assistance to the Contractor in establishing TB policies and procedures.

C) The Contractor is responsible for screening, diagnosis and treatment of TB, including TB/DOT services.

D) The Contractor shall inform all Participating Providers of their responsibility to report TB cases to the LPHA.

ii) Enrollees may self-refer to LPHA facilities for the diagnosis and/or treatment of TB.

A) The Contractor agrees to reimburse public health clinics when physician visit and patient management or laboratory and radiology services are rendered to Enrollees, within the context of TB diagnosis and treatment.

B) The Contractor will make best effort to negotiate fees for these services with the LPHA. If no agreement has been reached, the

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Contractor agrees to reimburse the public health clinics for these services at Medicaid fee-for-service rates.

C) The LPHA is responsible for: 1) giving notification to the Contractor before delivering TB related services, if so required in the public health agreement established pursuant to Section 10.17 of this Agreement, unless these services are ordered by a court of competent jurisdiction; 2) making reasonable efforts to verify with the Enrollee's PCP that he/she has not already provided TB care and treatment; and 3) providing documentation of services rendered along with the claim.

D) Prior authorization for hospital admission may not be required by the Contractor for an admission pursuant to a court order or an order of detention issued by the local commissioner or director of public health.

E) The Contractor shall provide the LPHA with access to health care practitioners on a twenty-four (24) hour a day, seven (7) day a week basis who can authorize inpatient hospital admissions. The Contractor shall respond to the LPHA's request for authorization within the same day.

F) The Contractor will not be financially liable for treatments rendered to Enrollees who have been institutionalized as a result of a local health commissioner's order due to non-compliance with TB care regimens.

iii) Directly Observed Therapy (TB/DOT) is included in the Benefit Package as set forth in Appendix K.2 (43) of this Agreement.

A) The Contractor is capitated and is financially liable for these costs.

B) TB/DOT is provided under the authority of the local government and shall be reimbursed if provided by the Local Public Health Agency or designated site (New York City). The Contractor shall not require prior authorization for TB/DOT services if provided under the authority of the Local Public Health Agency.

C) The Contractor agrees to make all reasonable efforts to ensure communication, cooperation and coordination with TB/DOT Providers regarding clinical care and services.

D) The Contractor shall not mandate which Provider will provide the service or the location of the service.

E) The Contractor shall reimburse at the Medicaid fee for service (FFS) rate if the Provider is not contracted with the Contractor. Through July 31, 2014, if there is a revision of the FFS rates, the Contractor shall

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mirror those rates for the balance of the period. The rate does not include TB medications, which are also the responsibility of the Contractor. The Enrollee may fill the prescriptions and keep medications, and remain in receipt of TB/DOT care.

iv) The Contractor is responsible for HIV testing provided to a MMC Enrollee during a TB related visit at a public health clinic that is directly operated by a LPHA. If no agreement has been reached, the Contractor agrees to reimburse the LPHA for these services at Medicaid fee-for-service rates established by SDOH.

b) Immunizations

i) Immunizations are included in the Benefit Package as provided in Appendix K of this Agreement.

A) The Contractor is responsible for all costs associated with vaccine purchase and administration associated with adult immunizations.

B) The Contractor is responsible for all costs associated with vaccine administration associated with childhood immunizations. The Contractor is not responsible for vaccine purchase costs associated with childhood immunizations and will inform all Participating Providers that the vaccines may be obtained free of charge from the Vaccine for Children Program.

ii) Enrollees may self refer to the LPHA facilities for their immunizations.

A) The Contractor agrees to reimburse the LPHA when an Enrollee has self referred for immunizations. The Contractor shall not require prior authorization or a referral for the above mentioned services.

B) The Contractor will make best effort to negotiate fees for these services with the LPHA. If no agreement has been reached, the Contractor agrees to reimburse the public health clinics for these services at Medicaid fee-for-service rates determined by SDOH.

C) The LPHA is responsible for making reasonable efforts to (1) determine the Enrollee's managed care membership status; and (2) ascertain the Enrollee's immunization status. Reasonable efforts shall consist of client interviews, medical records and, when available, access to the Immunization Registry. When an Enrollee presents a membership card with a PCP's name, the LPHA is responsible for calling the PCP. If the LPHA is unable to verify the immunization status from the PCP, the LPHA is responsible for delivering the service as appropriate.

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c) Prevention and Treatment of Sexually Transmitted Diseases

The Contractor will be responsible for ensuring that its Participating Providers educate their Enrollees about the risk and prevention of sexually transmitted disease (STD). The Contractor also will be responsible for ensuring that its Participating Providers screen and treat Enrollees for STDs and report cases of STD to the LPHA and cooperate in contact investigation, in accordance with existing state and local laws and regulations.

The Contractor is responsible for coverage of STD diagnostic and treatment services rendered by LPHAs; LPHAs must render such services free of charge pursuant to Public Health Law Section 2304 (l). In addition the Contractor is responsible for coverage of HIV testing provided to an MMC Enrollee during an STD related visit at a public health clinic, directly operated by a LPHA; such services will be covered by the Contractor. If no agreement has been reached, the Contractor agrees to reimburse the LPHA for these services at Medicaid fee-for-service rates established by SDOH.

d) Lead Poisoning – Applies to MMC Program Only

The Contractor will be responsible for carrying out and ensuring that its Participating Providers comply with lead poisoning screening and follow-up as specified in 10 NYCRR Sub-part 67-1. The Contractor shall require its Participating Providers to coordinate with the LPHA to assure appropriate follow-up in terms of environmental investigation, risk management and reporting requirements.

e) Lead Poisoning – Applies to FHPlus Program Only

The Contractor will be responsible for carrying out and ensuring that its Participating Providers comply with lead poisoning screening and follow-up as specified in 10 NYCRR Sub-part 67-1.5 – Lead Screening and follow-up of pregnant women by prenatal care providers. The Contractor shall require its Participating Providers to coordinate with the LPHA to assure appropriate follow-up in terms of environmental investigation, risk management and reporting requirements.

f) Matching to Immunization and Lead Data Files

i) The Contractor shall participate in matches of its enrollees to the NYC and/or NYS immunization and lead data files, when available, through submission of files in formats specified by the NYC DOHMH and NYS DOH.

A) Matches to the data files shall occur, at a minimum, once a year, in October, but may occur more frequently at the Contractor's discretion.



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B) The immunization data file matches will include all children ages 6 months through 36 months who are enrolled in the Contractor's MMC product at the time of the match, regardless of the child's length of enrollment in the Contractor's MMC.

C) Matches to the immunization data files for adolescents will include adolescents who turn 12 years old in the year of the match and those 12 through 18 years old who are enrolled in the Contractor's MMC product at the time of the match, regardless of the adolescent's length of enrollment in the Contractor's MMC.

D) The lead data file matches, when available, will include all children ages 9 months through 36 months who are enrolled in the Contractor's MMC product at the time of the match, regardless of the child's length of enrollment in the Contractor's MMC product.

ii) Reports from the NYC DOHMH and NYS DOH to the Contractor based on these matches shall be developed by the NYC DOHMH and NYS DOH upon thirty days written notice to the Contractor.

iii) The Contractor is encouraged to follow up with participating providers of enrollees and with enrollees who have not been appropriately immunized or screened for lead poisoning to facilitate provision of appropriate services.

g) New York City Only

i) The Contractor shall reimburse New York City Department of Health and Mental Health (DOHMH) for Enrollees who receive the following services from DOHMH facilities, except in those instances where DOHMH may bill Medicaid fee-for-service. The Contractor will make reasonable efforts to negotiate fees for these services with the DOHMH. In the absence of an agreement, the Contractor agrees to reimburse the clinics for these services at Medicaid fee-for-service rates.

A) Diagnosis and/or treatment of TB

B) HIV testing

C) Adult and child immunizations

ii) DOHMH must submit claims for services provided to Enrollees no later than one year from the date of service.

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iii) The Contractor shall not require pre-authorization, notification to the Contractor or contact with the PCP for the above mentioned services.

iv) DOHMH shall make reasonable efforts to notify the Contractor that it has provided the above mentioned services to an Enrollee.

10.19 Adults with Chronic Illnesses and Physical or Developmental Disabilities

a) The Contractor will implement all of the following to meet the needs of its adult Enrollees with chronic illnesses and physical or developmental disabilities:

i) Satisfactory methods for ensuring that the Contractor is in compliance with the ADA and Section 504 of the Rehabilitation Act of 1973. Program accessibility for persons with disabilities shall be in accordance with Section 24 of this Agreement.

ii) [Not Applicable to HIV SNP Program]: Clinical case management which uses satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, home health services, self-management education and training, etc. and evaluating the outcomes. The Contractor shall:

A) develop protocols describing the Contractor's case management services and minimum qualification requirements for case management staff and provide a general description to SDOH of the case management program, staffing structure, relationship to disease management and utilization management programs, member services, and new patient health assessment processes;

B) develop and implement protocols for monitoring effectiveness of case management based on patient outcomes and submit all required data to SDOH for quality measurement and outcome evaluation in a format determined by SDOH (examples of required data include case management rosters with dates of identification and enrollment in case management, selected quality indicators of both process and outcome, and copy of the comprehensive assessment tool(s) used to evaluate Enrollee needs for services under the case management program);

C) develop and implement protocols for monitoring service utilization, including emergency room visits and hospitalizations, with adjustment of severity of patient conditions and submit all required data to SDOH for quality measurement and outcome evaluation (examples of required data include provider visits and emergency room and hospital utilization);

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D) provide regular information to Participating Providers on the case management services available to Enrollees, including Health Home care management, and the criteria for referring Enrollees for case management services.

E) The Contractor may also refer eligible Enrollees requiring more intensive care management for Health Home services as described in 21.27 of this agreement.

iii) [Not Applicable to HIV SNP Program]: Satisfactory methods/guidelines for determining which patients are in need of case management services, including establishment of severity thresholds, and methods for identification of patients including monitoring of hospitalizations and ER visits, provider referrals, new Enrollee health screenings and self referrals by Enrollees. The Contractor will provide all required data describing the criteria used for identifying Enrollees for case management and the number of Enrollees who are involved in case management services (examples of data include the numbers of Enrollees who are identified for each case management program and the number of Enrollees who are successfully contacted and enrolled in the case management program).

iv) [Not Applicable to HIV SNP Program]: Guidelines for determining specific needs of Enrollees in case management, including specialist physician referrals, durable medical equipment, home health services, self management education and training, etc.

v) Satisfactory systems for coordinating service delivery with Non-Participating Providers, including behavioral health providers for all Enrollees.

vi) Policies and procedures to allow for the continuation of existing relationships with Non-Participating Providers, consistent with PHL § 4403(6)(e) and Section 15.6 of this Agreement.

10.20 Children with Special Health Care Needs

a) Children with special health care needs are those who have or are suspected of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The Contractor will be responsible for performing all of the same activities for this population as for adults as described in Section 10.19 a) ii) A-E) and Section 10.19 a) iii). In addition, the Contractor will implement the following for these children:

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i) Satisfactory methods for interacting with school districts, preschool services, child protective service agencies, early intervention officials, behavioral health, and developmental disabilities service organizations for the purpose of coordinating and assuring appropriate service delivery.

ii) An adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet such children's medical needs.

iii) Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.

iv) Satisfactory arrangements for assuring access to specialty centers in and out of New York State for diagnosis and treatment of rare disorders.

v) A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists, and Audiologists) experienced in dealing with children and families.

b) Medically fragile children are those individuals under 21 who have a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meet one or more of the following criteria: is technologically dependent for life or health sustaining functions; requires complex medication regimen or medical interventions to maintain or to improve their health status; or is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include, but are not limited to: bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

i) In addition to meeting the requirements of this Section, Section 10.4, and Appendix S of this Agreement, for medically fragile children, the Contractor shall:

A) develop procedures for the arrangement and authorization of services consistent with the SDOH guidance document "Principles for Medically Fragile Children."

B) ensure medical necessity determinations are not based solely upon clinical standards designed for adults and that such determinations consider the specific needs of the child and circumstances pertaining to their growth and development.

C) develop effective mechanisms to accommodate unique stabilization needs and discharge delays which may be necessary to: respond to the

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Enrollee's sudden reversals of condition or progress; identify appropriate specialized facility care; identify appropriate home or home-like environment for specialized care; or ensure informal and formal caregivers have had the training necessary to meet the specialized care needs of the Enrollee.

10.21 Mental Health Services

a) The Contractor shall ensure Service Authorization Determinations for mental health services are in accordance with State-issued utilization management and level of care guidelines for making initial and ongoing mental health level of care decisions and with utilization management criteria approved by the Office of Mental Health.

b) The Contractor will implement all of the following for its Enrollees with chronic or ongoing mental health service needs:

i) Inclusion of all of the required provider types listed in Section 21 of this Agreement. For the HARP and HIV SNP Programs, this includes providers of Behavioral Health Home and Community Based Services.

ii) Satisfactory methods for identifying Enrollees requiring such services and encouraging self-referral and early entry into treatment.

iii) Satisfactory methods for ensuring that services are provided in the most integrated setting appropriate to meet Enrollees' needs;

vi) Satisfactory case management systems or satisfactory case management, including referral to Health Home care management services as described in Section 21.27 of this Agreement.

v) Satisfactory systems for coordinating service delivery between physical health, Substance Use Disorder, and mental health providers, and coordinating services with other available services, including Health Homes and Social Services.

vi) The Contractor shall, at OMH's discretion, develop linkages with local governmental units on coordination and procedures related to mental health services and related activities. The Contractor shall participate in the Regional Planning Consortium planning process and, to the extent requested by OMH, the Contractor shall participate in the county planning process under Section 5.07 of the Mental Hygiene Law for Enrollees with mental health needs.

vii) Procedures to identify network providers who are qualified to prescribe Schedule III, IV and V narcotic drugs, and who have received a waiver

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from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to administer buprenorphine for the treatment of opioid addiction, and procedures to refer Enrollees to such providers and to OASAS-certified Opiate Treatment Programs (formerly referred to as MMTP programs) and OASAS certified outpatient chemical dependence clinics for buprenorphine treatment. A list of buprenorphine prescribers in NYS is available at http://buprenorphine.samhsa.gov/pls/bwns_locator/!provider_search.process_query?alternative=CHOICEG&one_state=NY#programs .

c) The Contractor shall comply with the following requirements for approving and locating a provider of mental health services for Enrollees, and agrees to cover and reimburse for mental health services as follows:

i) The Contractor shall not deny coverage of an ongoing course of care based upon a determination that an alternate level of care is appropriate unless the Contractor shall have identified an appropriate Provider of such alternate level of care and approved coverage for such care.

ii) If the Contractor shall have determined that such alternate level of care is appropriate, but shall not have identified an appropriate Provider of such care, Contractor shall continue to approve coverage of and continue to reimburse for services provided by the current Provider.

A) For continued services provided by a Participating Provider, such services shall be reimbursed at the contract rate, which may include provision for an alternate level of care rate, unless a payment rate is otherwise specified by this Agreement, or is required by law.

B) If such care is provided by a Non-Participating Provider, such payment shall be at no less than the Medicaid fee-for-service rate.

iii) Services provided to an individual determined to be appropriate for admission to and awaiting transfer to a State-operated psychiatric hospital or other hospital licensed under Article 31 of the Mental Hygiene Law that is certified by Medicare and Medicaid shall not be reimbursed at an alternate level of care rate.

d) The Contractor shall reimburse any OMH licensed provider, including out of network providers, at Medicaid Fee for Service rates for 24 months from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area for ambulatory mental health services provided to Enrollees.

e) For services provided by OMH licensed providers, the Contractor shall permit the Enrollee to continue receiving services from such Enrollee's provider(s)

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for Continuous Behavioral Health Episodes of Care for 24 months from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area. The Contractor may use OMH approved utilization review criteria to review duration and intensity of Continuous Behavioral Health Episodes of Care as set forth in this Agreement.

f) For services provided by OMH licensed providers, the Contractor shall accept such providers' treatment plans for Continuous Behavioral Health Episodes of Care and shall not apply utilization review criteria for a period of 90 days from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area.

g) The Contractor shall reimburse Comprehensive Psychiatric Emergency Program Services as follows:

   i) Payment by the Contractor for Comprehensive Psychiatric Emergency Program (CPEP) services, other than for Extended Observation Bed (EOB) services, provided to an Enrollee by a Participating or out of network provider during the first 24 months after the Behavioral Health Benefit Inclusion Date shall be at the rate or rates of payment established by the Office of Mental Health.

   ii) Payment by the Contractor for CPEP EOB services provided to an Enrollee by a Participating or out of network provider during the first 24 months after the Behavioral Health Benefit Inclusion Date shall be at no less than the lower of the rate of payment established by the Office of Mental Health or the rate paid by the Contractor for the initial three days of an inpatient psychiatric admission at the hospital at which the CPEP is located.

h) The Contractor shall reimburse for Crisis Intervention Services provided to an Enrollee by a Participating or out of network Provider during the first 24 months after the Behavioral Health Benefit Inclusion Date at the rate or rates of payment established by the Office of Mental Health. Such contracted rate or rates shall be paid without regard to whether such services meet the definition of Emergency Medical Condition.

i) The Contractor agrees that it will not require prior authorization for Comprehensive Psychiatric Emergency Program or Crisis intervention services.

10.22 Member Needs Relating to HIV

a) The Contractor must inform MMC Enrollees newly diagnosed with HIV infection or AIDS, who are known to the Contractor, of their option to

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disenroll from the Contractor's MMC product and to enroll into HIV SNPs, if such plan is available.

b) The Contractor will inform Enrollees about HIV testing services available through the Contractor's Participating Provider network and HIV testing services available when performed as part of a Family Planning and Reproductive Health encounter. HIV testing rendered outside of a Family Planning and Reproductive Health encounter, as well as services provided as the result of an HIV+ diagnosis, will be furnished by the Contractor in accordance with standards of care. The HIV testing provided shall be done in accordance with all Public Health Laws, including Article 27-F.

c) The Contractor agrees that anonymous testing may be furnished to the Enrollee without prior approval by the Contractor and may be conducted where available. Services provided for HIV treatment may only be obtained from the Contractor during the period the Enrollee is enrolled in the Contractor's MMC or FHPlus product.

d) The Contractor shall implement policies and procedures consistent with Chapter 308 of the Laws of 2010 and SDOH Guidance for HIV Testing and Laboratory Reporting Requirements, including:

i) Methods for promoting HIV prevention to all Enrollees. HIV prevention information, both primary as well as secondary, should be tailored to the Enrollee's age, sex, and risk factor(s) (e.g., injection drug use and sexual risk activities), and should be culturally and linguistically appropriate. HIV primary prevention means the reduction or control of causative factors for HIV, including the reduction of risk factors. HIV Primary prevention includes strategies to help prevent uninfected Enrollees from acquiring HIV, i.e., behavior counseling for HIV negative Enrollees with risk behavior. Primary prevention also includes strategies to help prevent infected Enrollees from transmitting HIV infection, i.e., behavior counseling with an HIV infected Enrollee to reduce risky sexual behavior or providing antiviral therapy to a pregnant, HIV infected female to prevent transmission of HIV infection to a newborn. HIV Secondary Prevention means promotion of early detection and treatment of HIV disease in an asymptomatic Enrollee to prevent the development of symptomatic disease. This includes: regular medical assessments; treatment adherence, immunizations, screenings and monitorings consistent with AIDS Treatment Guidelines; and partner notification services which lead to the early detection and treatment of other infected persons. All Enrollees should be informed of the availability of HIV testing, referral and partner notification services to reduce transmission of HIV.

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ii) Policies and procedures that promote HIV testing for all persons between 13 and 64 years of age as a routine part of medical care and include: assessment methods for recognizing the early signs and symptoms of HIV disease; screening for HIV risk factors through administration of sexual behavior and drug and alcohol use assessments.

iii) Policies and procedures that require Participating Providers to provide HIV counseling and recommend HIV testing to women early in their prenatal care , as well as in their third trimester. Such policies and procedures shall be updated to reflect the most current CDC recommendations as published in the MMWR where consistent with New York State laws and SDOH Guidance on HIV Testing. The HIV testing provided shall be done in accordance with all Public Health Laws, including Article 27-F. Such policies and procedures shall also direct Participating Providers to refer any HIV positive women in their care to clinically appropriate services for both the women and their newborns.

iv) [Not Applicable to HIV SNP Program]: A network of providers sufficient to meet the needs of its Enrollees with HIV. The Contractor must identify within their network HIV experienced providers to treat Enrollees with HIV/AIDS and explicitly list those providers in the Provider Directory. HIV experienced provider is defined as either:

1) an M.D. or a Nurse Practitioner providing ongoing direct clinical ambulatory care of at least 20 HIV infected persons who are being treated with antiretroviral therapy in the preceding twelve months, or

2) a provider who has met the criteria of one of the following accrediting bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, or
- HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM), or
- Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

The Contractor is responsible for validating that providers meet the above criteria. In cases where members select a non-HIV experienced provider as their PCP and in regions where there is a shortage of HIV experienced providers, the Contractor shall identify HIV experienced providers who will be available to consult with non-HIV experienced PCPs of Enrollees with HIV/AIDS. The Contractor shall inform Participating Providers about how to obtain information about the availability of Experienced HIV Providers and HIV Specialist PCPs. In addition, the Contractor shall include within their network and explicitly identify Designated AIDS

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Center Hospitals, where available, and contracts or linkages with providers funded under the Ryan White HIV/AIDS Treatment Act.

v) [Not Applicable to HIV SNP Program]: Case Management Assessment for Enrollees with HIV Infection. The Contractor shall establish policies and procedures to ensure that Enrollees who have been identified as having HIV infection are assessed for case management services. The Contractor shall arrange for any Enrollee identified as having HIV infection and needing case management services to be referred to an appropriate case management services provider, including Contractor provided case management, and/or, with appropriate consent of the Enrollee, HIV community-based psychosocial case management services and/or Health Home care management.

vi) The Contractor shall require its Participating Providers to report positive HIV test results and diagnoses and known contacts of such persons to the New York State Commissioner of Health. In New York City, these shall be reported to the New York City Commissioner of Health and Mental Hygiene. Access to partner notification services must be consistent with 10 NYCRR Part 63.

vii) The Contractor's Medical Director shall review Contractor's HIV practice guidelines at least annually and update them as necessary for compliance with recommended SDOH AIDS Institute and federal government clinical standards. The Contractor will disseminate the HIV Practice Guidelines or revised guidelines to Participating Providers at least annually, or more frequently as appropriate.

10.23 Substance Use Disorder Services

a) The Contractor shall utilize the Level of Care and Drug Treatment Referral ("LOCADTR") tool for making initial and ongoing Substance Use Disorder level of care decisions in NYS. LOCADTR is developed and updated, as appropriate, by the New York State Office of Alcoholism and Substance Abuse Services; and is the clinical level of care tool that assesses the intensity and need of services for an individual with a Substance Use Disorder.

b) The Contractor will have in place all of the following for its Enrollees requiring Substance Use Disorder Services:

i) A Participating Provider network which includes of all the required provider types listed in Section 21 of this Agreement. For the HARP and HIV SNP Programs, this includes providers of Behavioral Health Home and Community Based Services.

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ii) Satisfactory methods for identifying Enrollees requiring such services and encouraging self-referral and early entry into treatment and methods for referring Enrollees to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for appropriate services beyond the Contractor's Benefit Package (e.g., halfway houses).

iii) Satisfactory systems of care, including Participating Provider networks and referral processes sufficient to ensure that emergency services, including crisis services, can be provided in a timely manner and in the most integrated settings appropriate to meet the enrollee's needs.

iv) Satisfactory systems for coordinating service delivery between physical health, Substance Use Disorder, and mental health providers, and coordinating services received from Participating Providers with other services, including Health Homes and Social Services.

v) The Contractor shall at OASAS's discretion, develop linkages with local governmental units on coordination, and procedures related to Substance Use Disorder Services and related activities. The Contractor shall participate in the Regional Planning Consortium planning process and, to the extent requested by OASAS, the Contractor shall participate in the county planning process under Section 5.07 of the Mental Hygiene Law for Enrollees with Substance Use Disorders.

c) The Contractor shall comply with the following requirements for approving and locating a provider of Substance Use Disorder services for Enrollees, and agrees to cover and reimburse for Substance Use Disorder services as follows:

i) The Contractor shall not deny coverage of an ongoing course of care based upon a determination that an alternate level of care is appropriate unless the Contractor shall have identified an appropriate Provider of such alternate level of care and approved coverage for such care.

ii) If the Contractor shall have determined that such alternate level of care is appropriate, but shall not have identified an appropriate Provider of such care, Contractor shall continue to reimburse for services provided by the current Provider.

A) For continued services provided by a Participating Provider, such services shall be reimbursed at the contract rate, which may include provision for an alternate level of care rate, unless a payment rate is otherwise specified by this Agreement, or is required by law.

B) If such care is provided by a Non-Participating Provider, such payment shall be at no less than the Medicaid fee-for-service rate.

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d) The Contractor shall reimburse any OASAS certified provider, including out of network providers at Medicaid Fee for Service rates for 24 months from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area, for ambulatory substance use disorder services provided to Enrollees.

e) For services provided by OASAS certified providers, the Contractor shall permit the Enrollee to continue receiving services from such Enrollee's provider(s) for Continuous Behavioral Health Episodes of Care for 24 months from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area. The Contractor may use OASAS approved utilization review criteria to review duration and intensity of Continuous Behavioral Health Episodes of Care as set forth in this Agreement.

f) For services provided by OASAS certified providers, the Contractor shall accept such providers' treatment plans for a Continuous Behavioral Health Episode of Care and shall not apply utilization review criteria for a period of 90 days from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area.

g) Notwithstanding the provisions in subsection 10.21(d) of this Agreement, the Contractor shall reimburse providers of OASAS Certified Residential Addiction Treatment Services at no less than the State-provided treatment per diem rate schedule.

10.24 Native Americans

If an Enrollee is a Native American and the Enrollee chooses to access primary care services through his/her tribal health center, the PCP authorized by the Contractor to refer the Enrollee for services included in the Benefit Package must develop a relationship with the Enrollee's PCP at the tribal health center to coordinate services for said Native American Enrollee.

10.25 Women, Infants, and Children (WIC)

The Contractor shall develop linkage agreements or other mechanisms to refer Enrollees who are pregnant and Enrollees with children younger than five (5) years of age to WIC local agencies for nutritional assessments and supplements.

10.26 Urgently Needed Services

The Contractor is financially responsible for Urgently Needed Services. Urgently Needed Services are covered only in the United States, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. The Contractor may require the Enrollee or the Enrollee's

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designee to coordinate with the Contractor or the Enrollee's PCP prior to receiving care.

10.27 Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers Not Participating in Contractor's Network - Applies to MMC Program Only

a) Consistent with Chapter 697 of Laws of 2003 amending Section 364-j of the Social Services Law, dental services provided by Article 28 clinics operated by academic dental centers may be accessed directly by MMC Enrollees without prior approval and without regard to network participation. The Contractor may require prior approval for orthodontic treatment by academic dental centers.

b) The Contractor will reimburse non-participating Article 28 clinics operated by academic dental centers for covered dental services, including orthodontic services, provided to MMC Enrollees at approved Article 28 Medicaid clinic rates in accordance with the protocols issued by the SDOH.

10.28 Optometry Services Provided by Article 28 Clinics Affiliated with the College of Optometry of the State University of New York

a) Consistent with Chapter 37 of the Laws of 2010 amending Section 364-j of the Social Services Law, optometry services provided by Article 28 clinics affiliated with the College of Optometry of the State University of New York may be accessed directly by Enrollees without the Contractor's prior approval and without regard to network participation.

b) The Contractor will reimburse non-participating Article 28 clinics affiliated with the College of Optometry of the State University of New York for covered optometry services provided to Enrollees at Article 28 Medicaid fee-for-service clinic rates.

10.29 Hospice Services

a) The Contractor shall provide a coordinated hospice program of home and inpatient services which provides non-curative medical and support services for MMC/FHPlus Enrollees certified by a physician to be terminally ill with a life expectancy of six (6) months or less for FHPlus and one (1) year or less for MMC. Hospices must be certified under Article 40 of the New York State Public Health Law. Hospice services shall be provided as described in the SDOH "Guidelines for the Provision of Hospice Services in Mainstream Managed Care", which are hereby made a part of this Agreement as if set forth fully herein.

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b) The Contractor shall notify Enrollees of the availability of Hospice by including a description of Hospice services in the Member Handbook, in accordance with Appendix E of this Agreement.

c) The Contractor shall reimburse Hospice providers at the Medicaid fee-for-service per diem rate, or higher, consistent with Article 40 of the Public Health Law, for the first year of the benefit transition period, October 1, 2013 through March 31, 2015, after which the Contractor may negotiate a different rate.

   i) The transition of Hospice services to Medicaid managed care shall not preclude the Hospice Provider from administering the full range of services under Article 40 of the Public Health Law, as long as it is within the scope of the benefit, and is appropriate for the Enrollee.

d) The Contractor will review Service Authorization Requests and make Service Authorization Determinations for Hospice services in accordance with Appendix F of this Agreement.

   i) If not ended sooner, coverage for Hospice shall end on the date of the Enrollee's death. The Contractor shall inform the LDSS of the date of death.

e) The Contractor is responsible for monitoring the quality of care provided by participating Hospice providers.

10.30 Prospective Benefit Package Change for Retroactive SSI Determinations – Applies to MMC Program Only

The Benefit Package and associated Capitation Rate for MMC Enrollees who become SSI or SSI related retroactively shall be changed prospectively as of the effective date of the Roster on which the Enrollee's status change appears.

10.31 Coordination of Services

a) The Contractor shall coordinate care for Enrollees, as applicable, with:

   i) the court system (for court ordered evaluations and treatment);

   ii) specialized providers of health care for the homeless, and other providers of services for victims of domestic violence;

   iii) family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers;

   iv) WIC, Head Start, Early Intervention;



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v) programs funded through the Ryan White CARE Act;

vi) other pertinent entities that provide services out of network;

vii) local governmental units responsible for public health, mental health, mental retardation, foster care or Chemical Dependence Services;

viii) specialized providers of long term care for people with developmental disabilities;

ix) School-based health centers; and

x) local government Adult Protective Services, Child Protective Services and Foster Care programs.

b) Coordination may involve contracts or linkage agreements (if entities are willing to enter into such an agreement), or other mechanisms to ensure coordinated care for Enrollees, such as protocols for reciprocal referral and communication of data and clinical information on MCO Enrollees.

c) To prevent duplication of activities, upon notification, directive or request by the State or another MCO serving an Enrollee, the Contractor shall share the results of any identification and assessment of such Enrollee's needs with the State, or such MCO.

10.32 Pharmacy Services

a) The Contractor shall submit formulary changes, if any, to SDOH on a quarterly basis. New drugs added to the Medicaid fee-for-service outpatient formulary shall be made available to Enrollees through the Contractor's brand name and therapeutic category exception process (if the request for such drug meets the step therapy and/or authorization criteria established by the Contractor). The Contractor must have a process in place to review new FDA approved drugs within ninety (90) days of their approval. Formulary decisions regarding coverage should be submitted with the following quarterly formulary submission.

b) The Contractor shall ensure that participating pharmacies and prescribers are notified of any formulary changes in advance of the effective date of the change, whenever possible. The Contractor shall make all reasonable efforts to ensure that Enrollees affected by a formulary change do not experience delays or disruptions in obtaining medically necessary medications as a result of the formulary change.

c) Transitional Fill Requirements

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i) The Contractor shall ensure that new Enrollees receiving pharmacy services are permitted a one-time fill for up to a thirty (30) day supply within the first ninety (90) days of his/her enrollment in the Contractor's plan for:

A) non formulary drugs;

B) formulary drugs that require prior authorization or step therapy under the utilization management policies; and

C) specialty drugs and drug classes of concern as described in this Section. Specialty drugs and drug classes of concern include:

I) antipsychotics;

II) immuno-suppresants;

III) anti-retroviral therapy;

IV) anticonvulsants; and

V) antidepressants.

ii) For non-participating pharmacy providers:

A) the Contractor shall arrange for a transfer of a prescription for a refill to a participating pharmacy that is convenient for the Enrollee.

B) the Contractor shall coordinate with the Enrollee and the Enrollee's prescriber to obtain a new prescription.

iii) The Contractor shall ensure continued access to specialty drugs in one of the following ways:

A) the Contractor may permit the Enrollee to continue to use his/her pharmacy at the time of initial enrollment in the Contractor's plan; or

B) the Contractor may transition the Enrollee to one of the Contractor's specialty pharmacies utilizing the transition fill requirement in Section 10.32 c) i) during the first ninety (90) days, and work with the Enrollee and the Enrollee's prescriber to ensure there is a seamless transition to the Contractor's specialty pharmacy.

iv) For drug classes of concern, the Contractor shall:

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A) ensure continued access for Enrollees already established on medications that are included in these drug classes; and

B) implement processes and criteria during the ninety (90) day transitional period to ensure:

I) immediate identification of these drug classes; and

II) special handling of prior authorization or exception requests.

d) The Contractor must have procedures in place to immediately authorize a seventy-two (72) hour emergency supply of a prescribed drug when the Contractor determines that an emergency condition exists, as defined below pursuant to § 270 of Article 2-A of the Public Health Law:

i) "Emergency condition" means a medical or behavioral condition, as determined by the Contractor or its pharmacy benefit manager or utilization review agent, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, and for which delay in beginning treatment prescribed by the patient's health care practitioner would result in:

A) placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;

B) serious impairment to such person's bodily functions;

C) serious dysfunction of any bodily organ or part of such person;

D) serious disfigurement of such person; or

E) severe discomfort. For Enrollees with a behavioral condition, a determination of severe discomfort shall include a situation where the Enrollee is:

1. experiencing substantial discomfort or the expectation that such discomfort will result without the medication;

2. stable on a medication that is prescribed by the Enrollee's current provider, but is transferring to a new provider, or to a new level of care;

3. stable on a medication and is changing health care plans; and/ or

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4. experiencing a return or worsening of behavioral health symptomatology as a result of the anticipation of cessation of the medication.

ii) Where an individual with a behavioral condition experiences an emergency condition as a result of severe discomfort, as defined in subsection (d)(i)(E)(1)-(4) of this section, except where otherwise prohibited by law, the Contractor shall allow immediate access without prior authorizations to a seventy-two (72) hour emergency supply of the prescribed drug or medication.

e) The Contractor will be required to immediately authorize a seven day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, except where otherwise prohibited by law.

f) MMC Enrollee co-payment requirements pursuant to Section 367 of the Social Services Law are applicable to prescription and over-the-counter drugs only. The Contractor shall ensure that the total co-payment liability for any Enrollee, while enrolled in the Contractor's Medicaid managed care or HIV SNP product, does not exceed $200 in any calendar year. To the extent that an Enrollee provides the Contractor with credible documentation of co-payments the Enrollee paid during the calendar year while enrolled in another MMC plan, the Contractor must accept such documentation and count the total paid amount toward the Enrollee's $200 maximum liability.

g) The Contractor may waive co-payments for drugs on the condition that:

i) the cost of foregoing the co-payment is not reported in the Contractor's cost reports (MMCOR); and

ii) the Contractor does not offer the waiver of co-payments as an incentive for Prospective Enrollees to enroll in the Contractor's plan.

h) i) The Contractor shall cover medically necessary prescription drugs in the following therapeutic classes, including non-formulary drugs, upon demonstration by the prescriber, after consulting with the Contractor, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted:

A) the atypical antipsychotic therapeutic class;

B) the anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes.

ii) The Contractor may require prior authorization for such drugs but must accept the prescriber's reasonable professional judgment if the prescriber

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provides appropriate clinical rationale and information that the requested medication is consistent with U.S. Food and Drug Administration's approved labeling for use or supported in at least one of the Official Compendia as defined in federal law under the Social Security Act § 1927 (g)(1)(B)(i). The prior authorization process must comply with the review and time frame requirements described in Appendix F, which is hereby made a part of this Agreement as if set forth fully herein.

i) The contractor shall not reimburse any pharmacy or pay its Pharmacy Benefit Manager in excess of usual and customary charges for a prescription drug.

j) The Contractor shall provide coverage of outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act, in alignment with standards for such coverage imposed by Section 1927 of the Social Security Act.

k) In accordance with 42 CFR 438.3(s)(4), the Contractor shall operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR 456, Subpart K.

l) All covered outpatient drugs that are dispensed by the Contractor to Enrollees shall be subject to rebate requirements under Section 1927 of the Social Security Act. The SDOH shall collect all applicable rebates from manufacturers of such drugs.

10.33 Personal Care Services

a) The responsibilities of SDOH, LDSS, the Contractor, and home attendant vendor agencies for the provision of personal care services (PCS) to MMC Enrollees are described in this section; the Benefit Package; Appendix S of this Agreement; and SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care," which are hereby made a part of this Agreement as if set forth fully herein.

b) The Contractor is responsible for determining the Enrollee's need for personal care services (PCS), including the level of services needed (Level I or Level II), according to assessment tools provided by SDOH, , and in accordance with SDOH Medicaid Managed Care personal care services assessment guidelines. The Contractor will provide the home attendant vendor agency with: the Enrollee's authorization, which shall include the diagnosis code; medical request form; and nursing/social assessments and coordinate with the home attendant vendor agency to develop a plan of care. The Contractor will conduct such assessments, and will ensure the Enrollee's care plan is developed in compliance with Person Centered Services Planning Requirements in accordance with Section 10.35 of this Agreement.

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c) The Contractor must permit Enrollees who are in receipt of PCS as of August 1, 2011 to continue their course of treatment as authorized by the LDSS, regardless of whether the PCS provider participates in the Contractor's network, until the Contractor has assessed the Enrollee's needs and an approved treatment plan is put into place. Contractor requirements for prior authorization or notification may not be applied to Non-Participating Providers until an approved treatment plan is put into place by the Contractor. For new enrollments on or after August 1, 2011, the Contractor must provide transitional care services consistent with Section 15.6(a)(i) of this Agreement and the SDOH's transitional care policy entitled, "Medicaid Managed Care and Family Health Plus Coverage Policy: New Managed Care Enrollees in Receipt of an On-going Course of Treatment". The Contractor will reimburse the home attendant vendor agencies as provided for in Section 22.17 of this Agreement.

d) The Contractor must reimburse home attendant vendor agencies for supervision of the personal care services worker by a registered nurse, subject to the terms of the agreement between the Contractor and Participating Provider. Supervision must occur no less than twice per year, including, but not limited to, when on-the-job instruction is needed to implement a plan of care or the Enrollee complains about the personal care services received.

e) The Contractor must provide case management services as appropriate and as medically necessary to Enrollees receiving PCS and must coordinate with appropriate local government programs to address any social and environmental issues necessary to maintain the Enrollee's health and safety in the home.

f) At the time the Contractor is made aware that an Enrollee in receipt of Level I or Level II personal care services is disenrolled, for any reason, the Contractor will notify the LDSS in a manner described by the LDSS and the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care" or via New York Medicaid Choice at such time as a system is in place for this information transfer. Upon request of the LDSS, the Contractor will provide information related to the Enrollee's personal care services as needed for the LDSS to appropriately manage the Enrollee's care.

10.34 Additional Requirements for the HIV SNP Program Only

a) HIV SNP Care and Benefits Coordination Services

i) HIV SNP Care and Benefits Coordination Services include the following:

A) Medical case management/care coordination services in consultation with the PCP;

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B) Assessment and service plan development that identifies and addresses the Enrollee's medical and psycho-social needs;

C) Service utilization monitoring and care advocacy services that promote Enrollee access to needed care and services;

D) Case manager provider participation in quality assurance and quality improvement activities;

E) Engagement efforts for Enrollees lost to-follow-up.

F) Care coordination services for Enrollees eligible for Behavioral Health Home and Community Based Services pursuant to Section 10.41 of this Agreement.

ii) Care Coordination services for Enrollees eligible for Behavioral Health Home and Community Based Services, pursuant to Section 10.41 of this Agreement:

A) The Contractor shall ensure that assessments for Behavioral Health Home and Community Based Services are provided for eligible Enrollees;

B) The Contractor shall ensure that a person-centered plan of care is developed for eligible Enrollees; and

C) The Contractor shall ensure that eligible Enrollees receive comprehensive care management services.

iii) Medical Case Management/Care Coordination

A) The Contractor shall promptly assign a Medical Case Manager/Care Coordinator to each Enrollee no later than thirty (30) days after enrollment.

B) All Medical Case Managers/Care Coordinators shall be participating providers or employees of the Contractor.

C) The Contractor shall establish reasonable caseload maximums for its Medical Case Managers/Care Coordinators which may not exceed one hundred fifty (150) Enrollees per FTE Medical Case Manager/Care Coordinator. "FTE" shall mean full-time equivalent hours of at least thirty-five (35) hours per week.

iv) Assessment of Case Management Needs

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A) The Contractor shall within the first thirty (30) days of enrollment assess Enrollees to determine the level and type(s) of case management required. Such assessment shall be documented.

B) The Contractor shall ensure that each Enrollee is reassessed for case management needs no less frequently than every one hundred eighty (180) days, and when warranted by a significant change in the Enrollee's medical condition or psycho-social crisis. Such reassessment shall consider whether a change in the Enrollee's Medical Case Management/Care Coordination or psycho-social case management is required, and if so, the Contractor shall promptly arrange for the appropriate level of case management services. Such reassessment shall be documented.

C) The Contractor shall identify the psycho-social case management provider and unless the Enrollee declines the offer of psycho-social case management, assign the Enrollee to such case management provider within the first thirty (30) days of enrollment.

D) The Contractor shall provide information to its network providers on the case management services available to the Contractor's Enrollees and the criteria for referring Enrollees to the Contractor for case management services.

E) The Contractor shall establish capacity to ensure that all Enrollees determined by assessment to be in need of psycho-social case management receive this service. Psycho-social case management may be provided:

I) through contractual agreements with Health Homes, through qualified community-based case management providers who are able to provide SNP Enrollees access to case management and other support services; and/or

II) directly by the Contractor if the Contractor can demonstrate the ability to comply with AIDS Institute standards for providing Case Management; and/or

III) with the consent of the Enrollee, by a referral to a qualified external case management provider that has an agreement with the Contractor.

v) Service Utilization Monitoring and Care Advocacy

A) The Contractor shall ensure that the provider(s) of case management services have in place a comprehensive case management assessment

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for each Enrollee and an updated service plan within sixty (60) days of the effective date of SNP enrollment.

B) The Contractor shall ensure that the service plan is updated at appropriate intervals and that progress notes document service utilization monitoring including hospitalizations and ER visits, provider referrals and care advocacy efforts provided on behalf of the Enrollee.

vi) Quality Assurance

A) The Contractor shall develop and implement a system of quality review for Contractor-provided case management and care coordination services. The Contractor also shall ensure that any case management sub-contractors or linkage referral providers shall maintain a system of quality review for the Contractor's Enrollees.

B) The Contractor's system of quality review shall include protocols for monitoring effectiveness of case management/care coordination based on patient outcomes and indicators developed by the AIDS Institute.

vii) Engagement Efforts for Enrollees Lost to Follow-up

A) The Contractor shall have systems that identify unstable Enrollees that have not presented for care and treatment nor received a Case Management encounter for a period of six (6) consecutive months.

B) The Contractor must have a plan in place that documents reasonable efforts to find Enrollees lost to follow-up and re-engage them with appropriate provider.

C) When requested, the Contractor shall provide to SDOH documentation of plan's efforts to engage Enrollee in care.

D) Homeless Persons: The Contractor is required to make best efforts to conduct outreach to Enrollees who are homeless to assure that services are accessible and to identify and reduce barriers to adherence to treatment regimens.

b) HIV Primary and Secondary Prevention and Risk Reduction Services

i) The Contractor must provide the following services:

A) HIV primary and secondary prevention and risk reduction education and counseling;

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B) Harm reduction education and services;

C) Sponsorship of or participation in HIV community education, outreach and health promotion activities.

ii) The Contractor will be responsible for ensuring that its Participating Providers provide to Enrollees the following HIV Primary Prevention, HIV Secondary Prevention and Risk Reduction Education services:

A) Education and counseling regarding reduction of perinatal transmission;

B) HIV prevention and risk reduction education and counseling;

C) Education to enrollees regarding STDs and services available for STD treatment and prevention;

D) Counseling and supportive services for partner/spousal notification (pursuant to Chapter 163 of the Laws of 1998).

c) HIV Treatment Adherence Services

i) The Contractor shall provide education and programs to promote adherence to prescribed HIV treatment regimens for all Enrollees. The Contractor shall provide access to treatment adherence services including treatment readiness and supportive services that are integrated into the continuum of HIV care services. In addition, the Contractor must develop and present management and operational designs that promote coordination and unification of treatment adherence services.

10.35 Person Centered Services Plan

a) A Person Centered Services Plan (PCSP) is required for all Enrollees using Long-Term Services and Supports. The Contractor will ensure Long Term Services and Supports are provided in accordance with Appendix S of this Agreement.

b) The Contractor is responsible for determining the Enrollee's need for Long-Term Services and Supports according to assessment tools provided by SDOH, , and in accordance with this Agreement. An assessment of the Enrollee's medical, environmental, and social needs must be conducted at least twice per year. As part of the PCSP, the Contractor must consider the current and unique psycho-social and medical needs and history of the Enrollee, as well as the Enrollee's functional level, and support systems.

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i) The Contractor will ensure the Uniform Assessment System for New York (UAS-NY) is utilized to assess Enrollee medical, environmental and social needs for services described in the UAS-NY Transition Guide.

ii) The Contractor may not utilize the UAS-NY as an assessment tool to determine the need for RHCF services. The Contractor will ensure the UAS-NY is utilized to conduct initial and on-going assessments for an Enrollee after the Enrollee has been permanently placed in an RHCF.

c) The Contractor must establish and implement a written care plan and assist Enrollees in accessing services authorized under the PCSP.

d) The PCSP must be developed in accordance with all applicable state quality assurance and utilization review standards and, ~~A~~at a minimum, the PCSP must include:

i) Participation of the Enrollee, and as appropriate, the Enrollee's physician(s), a registered nurse, social worker, service providers, family members and others chosen by the Enrollee to be involved in service planning and delivery;

ii) Determination of the Enrollee's self-care capabilities including integration of formal and informal supports in meeting all assessed needs; and

iii) Consideration of the Enrollee's values, culture, traditions, experiences and preferences in the definition of quality.

e) The Contractor is required to retain a copy of the PCSP in the Enrollee's case record and provide a copy to the Enrollee.

f) The Contractor is responsible for assuring the PCSP is developed based upon all assessment documentation and is developed with the assistance of the Enrollee, the service provider, and those individuals selected by the Enrollee to participate in service planning and delivery. The PCSP must identify the strengths, capacities, and preferences of the Enrollee, as well as identify the Enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options when indicated.

g) The PCSP includes all services and supports required to meet all the Enrollee's assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services being delivered in the home and in community based settings.

h) The Contractor must develop and maintain a process to permit the Enrollee to request a change to the PCSP if the Enrollee's circumstances necessitate a

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change. All PCSPs must be updated and/or revised at least twice a year or sooner if there is a significant change in the Enrollee's health status.

i) The Contractor shall ensure that meetings related to the Enrollee's PCSP are held at a location, date, and time convenient to the Enrollee and his/her chosen participants.

j) The Contractor shall require that the PCSP includes a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the plan are temporarily unavailable. The back-up plan may include other individual assistants or services.

k) The Contractor is responsible for assuring that the Enrollee's required services are delivered in accordance with the PCSP, including the type, scope, amount, and frequency.

l) The Contractor must ensure that Enrollees receiving long-term services and supports have a choice of provider, where available, which has the capacity to serve the individuals within the network, in accordance with Section 21 of this Agreement.

m) The Contractor shall have policies and procedures to monitor appropriate implementation of each Enrollee's PCSP.

10.36 Consumer Directed Personal Assistance Services (CDPAS) – MMC Program Only

a) The Contractor will provide Consumer Directed Personal Assistance Services (CDPAS) to Enrollees in a manner consistent with 18 NYCRR Part 505.28 and as described in this section; the Benefit Package; Appendix S of this Agreement; and SDOH Guidelines for Consumer Directed Personal Assistance Services, which is hereby made a part of this Agreement as set forth fully herein.

b) CDPAS allows chronically ill and/or disabled Enrollees receiving home health services greater flexibility and freedom of choice in obtaining such services. The Contractor shall notify Enrollees of the option to apply for CDPAS, including feasible alternatives for receiving needed care:

i) at the time of a request for home care including personal care services, home health aide services and skilled nursing tasks; and

ii) annually, for Enrollees in receipt of qualifying home care services; and

iii) by including a description of the CDPAS option in the Member Handbook, in accordance with Appendix E of this Agreement.

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c) If an Enrollee elects to apply for CDPAS, the Contractor will determine eligibility for such services in a manner consistent with 18 NYCRR §505.28 (c) and (d) and according to assessment tools provided by SDOH. The Contractor shall conduct the nursing and social assessments in accordance with the requirements of Person Centered Service Planning as provided by Section 10.35 of this Agreement.

i) If the Contractor determines the Enrollee is eligible for CDPAS:

A) The Contractor will inform the Enrollee of their specific responsibilities for receipt of CDPAS, as provided by 18 NYCRR §505.28 (g)(1)-(7). The Contractor will require the Enrollee to sign a written acknowledgement that the Enrollee is willing and able to fulfill the Enrollee's responsibilities and that the Enrollee understands the respective responsibilities of the Enrollee and the Contractor prior to the Contractor authorizing CDPAS.

B) The Contractor will authorize the number of hours per day or week of CDPAS necessary to complete the tasks identified by the assessments as necessary to maintain the Enrollee's health and safety in the home. Notice of authorization will include the applicable diagnosis code and the plan of care developed in conjunction with the Enrollee. No authorization will exceed six (6) months. The Contractor will send a copy of the authorization to the Fiscal Intermediary (FI) chosen by the Enrollee.

C) The Contractor will provide the Enrollee with the name, address and phone number of at least two Fiscal Intermediaries so the Enrollee may arrange for wage and benefit processing for the Enrollee's consumer directed personal assistant. The Contractor will provide reasonable assistance to the Enrollee to establish a relationship with a Fiscal Intermediary, to complete any necessary forms or to take other procedural steps to effectively direct and manage their self-directed care. The Contractor, through its agreements with the FI, may require the FI to provide training and assistance in utilizing the FI's services to its Enrollees receiving CDPAS.

D) Timeframe for review and authorization of CDPAS will comply with the Service Authorization Request timeframes in Appendix F of this Agreement.

ii) If the Contractor determines the Enrollee is ineligible for CDPAS:

A) the Contractor will issue a Notice of Action in accordance with Appendix F of this Agreement; and

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B) the Contractor will arrange for and authorize home care or other services as medically necessary for the Enrollee's care.

iii) Prior to the end of the authorization period, the Contractor will reassess the Enrollee for continued eligibility as provided by (c) above.

iv) The Contractor will monitor the Enrollee's ongoing eligibility for CDPAS, including prompt review of any notification from the Fiscal Intermediary, Enrollee or Enrollee's representative of any circumstances that may affect the Enrollee's ability to carry out their responsibilities. If at any time the Contractor determines the Enrollee is no longer eligible for CDPAS, the Contractor will issue a Notice of Action in accordance with Appendix F of this Agreement; and arrange for and authorize home care or other services as medically necessary for the Enrollee's care.

d) The Contractor must ensure that Enrollees receiving CDPAS have a choice of at least two Fiscal Intermediaries, as defined by Appendix K.2, 37) b) ii).

i) For the period November 1, 2012 through October 31, 2013 (Transition Period), the Contractor must enter into agreements with Fiscal Intermediaries that currently have a contract or memorandum of understanding (MOU) with an LDSS and currently provide fiscal intermediary services to the Contractor's Enrollees. If the Contractor has less than five (5) Enrollees receiving CDPAS within a county, the Contractor may encourage Enrollees to select an alternate FI to minimize the number of FIs with which the Contractor must enter into an agreement. The rate of payment must be at least the FFS rate of payment provided for in the contract or MOU between the FI and the LDSS. The Contractor is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the Contractor maintains at least two FIs for each county. To adequately meet the needs of Enrollees who are newly assessed and considered eligible to receive CDPAS, the Contractor also include in the Contractor's network FIs that do not have a contract or MOU with the LDSS. The Contractor must maintain at least two (2) FIs per county where such resources exist, even if the Contractor had no Enrollees receiving CDPAS as of November 1, 2012.

ii) Beginning November 1, 2013, the Contractor may enter into an agreement with an FI to cover Enrollees in multiple counties.

iii) The Contractor will ensure FI subcontracts are compliant with Section 22.5 and other applicable provisions of this Agreement. Contractor agreements with FIs are not health care provider agreements as provided by 10 NYCRR Subpart 98-1. No such agreement may contain provisions

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that would be considered management functions under 10 NYCRR Subpart 98-1 without the express written approval of the SDOH.

iv) The Contractor shall inform FIs of its claims procedures. The Contractor shall process all claims and pay clean claims in a timely manner, as determined by the agreement with the FI, and notify FIs in writing as to the reason(s) claims are fully or partially denied, in accordance with Appendix F of the this Agreement. SDOH may require a plan of correction, impose sanctions or take other regulatory action should it determine the Contractor consistently delays payments to FIs without due cause.

v) The Contractor must submit a list of participating FIs by county to SDOH annually and upon request in a manner and form described by SDOH.

e) During the Transition Period, the Contractor shall not require an Enrollee in receipt of CDPAS prior to November 1, 2012 to change their consumer directed personal assistant due to an existing relationship with an FI that is not within the Contractor's network. The Contractor is prohibited from coercing or threatening a personal assistant to change FIs.

10.37 Discharge Planning

a) The Contractor will make all reasonable efforts to work with hospitals, Article 31 mental health facilities, Article 32 OASAS programs, RHCFs and outpatient and community based providers in developing discharge plans for their Enrollees when a change in the Enrollee's level of care is proposed. As part of discharge planning, the Contractor shall arrange for and authorize covered services as medically necessary for the Enrollee's care. If the Enrollee is in need of Long Term Services and Supports, the discharge plan will be prepared in accordance with Appendix S of this Agreement. For the purposes of this Section, "reasonable efforts" include, but are not limited to, as applicable and appropriate to the Enrollee's circumstances: participation in discharge planning meetings; face to face meetings with the Enrollee to assess needs and preferences for care; identification of medical, environmental or social obstacles to safe discharge; referral to the Contractor's care management program; assignment to a Health Home and collaboration with its outreach, enrollment and care management efforts; referral to Medicaid waiver programs; and/or referral to state and local government agencies.

b) Consistent with this Agreement, where the Enrollee has intensive medical or behavioral health needs, the Contractor will ensure sufficient time is provided to fully implement the discharge plan and PCSP, including assurance of informal and formal supports at the lower level of care, and may consider authorizing trial discharges, if clinically appropriate.

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c) Where safe discharge from a hospital, Article 31 mental health facility, Article 32 OASAS program, or skilled nursing facility cannot be arranged solely due to the Enrollee's lack of housing, the Contractor shall continue coverage of the stay, and work collaboratively with the facility to explore all options and referrals available considering the Enrollee's specific circumstances, including coordination with housing providers, homeless services and Health Home care management agencies, as applicable.

d) In accordance with Appendix K.2 (2) of this Agreement, the Contractor is responsible for covering the continued stay in a hospital, Article 31 mental health facility, Article 32 OASAS program, or RHCF until the Enrollee may be safely discharged. Unless the reimbursement rate is set by statute, regulation or this Agreement, the Contractor may negotiate a reimbursement rate for the period of stay beyond the date the Contractor determines the Enrollee no longer requires the facility level of care or cannot be discharged solely due to lack of housing. For those stays where the Enrollee's safe discharge cannot be arranged solely due to lack of housing, the plan's obligation to continue coverage of such stay will end when the Contractor has determined that the Enrollee no longer requires facility level of care, and when:

   i) the Enrollee is safely discharged; or

   ii) the Enrollee refuses to comply with a safe discharge plan, which, where applicable, includes a PCSP developed in accordance with this Agreement; or

   iii) the facility ceases to work collaboratively with the Contractor to explore options for the Enrollee's safe discharge, in which case the Contractor must maintain sufficient documentation regarding the facility's unwillingness to work with the Contractor toward a safe discharge, to demonstrate, upon SDOH request, that the denial of continued coverage of the stay was justified.

10.38 Critical Incidents

a) The Contractor must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum:

   i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance;

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ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks;

iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the Contractor's attention, and subsequent investigation or referral of the incidents to oversight agencies; and

iv) reporting critical incidents to SDOH as provided by Section 18.5(a)(vi)(D) of this Agreement.

10.39 Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC)

a) ADHC and AIDS ADHC shall be provided as set forth below in this Section, Appendix K and Appendix S of this Agreement, in the SDOH "Guidelines for the Transition of Adult Day Health Care and AIDS Adult Day Health Care Services in Medicaid Managed Care" which is hereby made a part of this Agreement as if set forth fully herein, and as defined in 10 NYCRR § 425.1 and 759.

i) Effective August 1, 2013, the Contractor is capitated and financially responsible for the cost of these services.

ii) For the period August 1, 2013 through January 31, 2015, ADHC/AIDS ADHC providers shall be reimbursed at the Medicaid fee-for-service per diem rate.

A) During the transition year, assessments must be conducted by Participating ADHC/AIDS ADHC providers. When an Enrollee presents a medical order or when a Participating ADHC/AIDS ADHC Provider notifies the Contractor of an Enrollee presenting with a medical order for assessment, the Contractor must arrange for coverage of up to two (2) visits for completion of the assessment. The Contractor may require prior authorization for additional visits, up to a total of five (5) visits within thirty (30) days, to complete the assessment. The Contractor shall cover the assessment visit(s) even if it does not authorize the Enrollee for ADHC/AIDS ADHC services.

iii) The Contractor shall make Service Authorization Determinations in accordance with Appendix F of this Agreement. The Contractor shall reassess for ADHC/AIDS ADHC services at least once every six (6) months.

b) ADHC and AIDS ADHC Transitional Care



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i) Enrollees receiving ADHC or AIDS ADHC services on the August 1, 2013 transition date shall receive 90 days of transitional care with the current care plan, or until the Contractor authorizes an alternate care plan, whichever is later.

ii) The Contractor shall allow Enrollees receiving these services to continue with the current Provider for one year, unless the Enrollee elects to change Providers. The Contractor shall not initiate Provider changes during the transition year.

10.40 Residential Health Care Facility (Nursing Home) Benefit for Long Term Placement

a) The responsibilities of the Contractor, local departments of social services (LDSS) and Nursing Homes for the provision of long term placement nursing home services to MMC Enrollees are described in this Section; the Benefit Package; Appendix S of this Agreement; and the SDOH "Transition of Nursing Home Benefit and Population into Managed Care" policy, which is hereby made a part of this Agreement as if set forth fully herein.

b) Beginning January 1, 2015 or a date to be determined by the SDOH, a phased transition of all Medicaid eligible beneficiaries over age 21 in New York City, Nassau, Suffolk and Westchester counties in need of long term placement in a nursing facility, as defined by the Social Security Act §1919(a)(1)(C) or 42 U.S.C. 1396r for nursing facilities, requires enrollment in a Medicaid managed care plan.

c) The Contractor shall notify Enrollees of the availability of the Nursing Home benefit by including a description of Nursing Home services in the Member Handbook, in accordance with Appendix E of this Agreement.

d) All Medicaid beneficiaries in Long Term Placement in a skilled nursing facility on that county's effective implementation date will continue to receive benefits through fee-for-service Medicaid and are not required to enroll in a Managed Care Organization.

e) The Contractor is required to reimburse Nursing Homes the current fee-for-service Medicaid (Benchmark) rate or a negotiated rate, acceptable to both the Contractor and the nursing home, for three (3) years after a County is phased in.

i) For phase 1, the transition period for payment will extend from the implementation date for a three year period, or as directed by SDOH.

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ii) For phase 2, the upstate phase in, the transition period will extend from six months after the phase 1 implementation date, or a date to be determined by SDOH, for a three year period, or as directed by SDOH.

iii) After the transition period, Nursing Homes and Contractors will negotiate a rate of payment for services.

f) The Contractor and its Participating Nursing Homes shall follow the procedures as outlined in the SDOH "Transition of Nursing Home Benefit and Population into Managed Care."

i) The Contractor shall make a clinical determination of the need for long term nursing facility services, in consultation with the Provider, Enrollee or their designee and pursuant to a Person Centered Services Plan in accordance with Section 10.35 of this Agreement. All parties shall consider and, to the extent possible, arrange for services in the most integrated, least restrictive environment.

ii) The Contractor shall make Service Authorization Determinations, in accordance with Appendix F and Appendix S of this Agreement, for all Long Term Placements in nursing homes. If the Contractor approves the placement, the Contractor will facilitate notification of the placement and the Enrollee's completion of the chronic care Medicaid application, in conjunction with the nursing home. The Contractor will pay the Nursing Home while a determination of chronic care Medicaid eligibility is conducted by the LDSS.

iii) Once the chronic care Medicaid eligibility determination is completed, the LDSS is responsible for notifying the Contractor, the Enrollee, and the Nursing Home.

iv) If the Enrollee is determined by the LDSS to be eligible for Medicaid, the Contractor shall continue to pay the Nursing Home and collect, or arrange for the collection of, any associated Net Available Monthly Income (NAMI) from the Enrollee, if applicable. The Contractor shall receive the premium associated with Nursing Home placement from the SDOH.

v) If the Enrollee is found ineligible for Medicaid coverage of long term nursing facility services, the Contractor shall recoup any payment made for long term placement during the period pending. If the Enrollee is to return to the community, the Contractor must arrange for a safe discharge and authorize supportive services, as appropriate and in accordance with Appendix S of this Agreement.

g) Access to Veterans' Homes for Eligible Enrollees

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i) The Contractor shall ensure that Enrollees who are eligible Veterans, spouses of eligible Veterans or eligible Gold Star parents are allowed to receive long term placement at a veterans' home.

ii) The Contractor shall contract with at least one veterans' home that operates in its service area, provided that at least one veterans' home operates in a county in the approved service area. If the Contractor operates in a county where a veterans' home exists and does not have a contract with the veterans' home, the Contractor must allow the Enrollee access out of network.

iii) If the Contractor does not have a veterans' home operating in its network and an Enrollee eligible to receive services at a veterans' home requests long term placement at a veterans' home, the Enrollee shall be allowed to change his/her enrollment into a MCO that has a veterans' home in its network.

A) While the Enrollee's request to change MCOs is pending, the Contractor shall allow the Enrollee access to the veterans' home and the Contractor shall pay the veterans' home the fee-for-service Medicaid rate until the Enrollee has changed MCOs.

10.41 Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program [Applicable to the HARP and HIV SNP Programs]

a) The Contractor shall provide the services described in this Section to HARP Enrollees and/or HARP-Eligible Enrollees in the HIV SNP Program. Additional requirements for the HARP and HIV SNP Programs are described in Appendix T of this Agreement, which is hereby made a part of this Agreement as if set forth fully within.

b) The State-issued "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations," provides additional guidance for the provision of services described in this Section. In order to ensure there is no duplication of services, HARP and HARP-Eligible Enrollees who are also recipients of Assertive Community Treatment (ACT) services shall receive care management from the ACT program and BHHCBS assessments for ACT recipients shall be governed by subsections (c)(i)(A)(I)-(II) of this section.

c) Assessments for Behavioral Health Home and Community Based Services (BHHCBS)

i) The Contractor shall ensure that each Enrollee receives an assessment for BHHCBS using the State-determined assessment tools. The assessment process includes both the brief assessment to determine eligibility for

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BHHCBS and a full assessment to assist in identifying BHHCBS appropriate for the Enrollee.

A) For Enrollees electing to enroll in a Health Home or who receive care management services from alternative care management entities approved by the State, the Contractor shall endeavor to ensure the assessment process is completed within 30 days of the individual's enrollment in the Health Home or engagement in such alternative care management entity, but in no case shall such process be completed more than 90 days after such enrollment or engagement unless such timeframe is extended by SDOH as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.

I) Notwithstanding c)i)A) above, for recipients who are admitted in an Assertive Community Treatment program at the time of the Behavioral Health Benefit Inclusion, the Contractor shall endeavor to ensure Enrollees receive a brief assessment to determine eligibility for BHHCBS within 90 days of the Effective Date of HARP Enrollment or determination of an HIV SNP Enrollee's HARP eligibility, and on an annual basis thereafter, and receive a full assessment to assist in identifying BHHCBS appropriate for the Enrollee at the time the Enrollee will be imminently discharged from the Assertive Community Treatment program.

II) Notwithstanding c)i)A) above, for Enrollees who are newly admitted to an Assertive Community Treatment program, the Contractor shall endeavor to ensure Enrollees receive a brief assessment to determine eligibility for BHHCBS within one year of their last brief assessment or 90 days of admission to the ACT program, whichever is later, and on an annual basis thereafter. Enrollees shall also receive a full assessment to assist in identifying BHHCBS appropriate for the Enrollee at the time the Enrollee will be imminently discharged from the Assertive Community Treatment program.

B) For Enrollees who do not elect to enroll in a Health Home and who are not receiving care management services from an alternate care management entity or from an ACT program, the Contractor shall endeavor to ensure the assessment process is completed through its subcontracts with State-designated entities within 90 days of the Enrollee's declination to enroll in a Health Home, unless the Enrollee elects to enroll in a Health Home or an alternative care management entity or is admitted to an ACT program within that time period. Such timeframe may be extended by SDOH as necessary for a limited

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period to manage the large number of assessments anticipated during the initial HARP enrollment period.

ii) The Contractor shall ensure that BHHCBS eligibility assessments are conducted by a State-designated provider in compliance with Federal conflict-free case management requirements.

d) Person-Centered Plan of Care

i) The Contractor shall ensure that a person-centered plan of care ("plan of care") is developed for each Enrollee through subcontracts with Health Homes wherever possible, through subcontracts with other State-designated entities, or by the Enrollee's ACT program, if applicable. The plan of care shall be comprehensive and integrated, including physical services, behavioral health services, and BHHCBS, as applicable. The plan of care shall be consistent with the requirements set forth in the State-issued "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations."

A) Notwithstanding d) i) above, a plan of care for BHHCBS is not required in instances where an Enrollee:

I) is determined to be ineligible for BHHCBS; or

II) declines BHHCBS offered through the assessment process.

ii) The Contractor shall ensure, for Enrollees identified as eligible for BHHCBS, that such services are included in the plan of care, including the type, scope, amount, duration and frequency of such services;

iii) The Contractor shall ensure that a plan of care includes consideration of the current and unique psycho-social and medical needs and history of each Enrollee, as well as each Enrollee's functional level and support systems.

iv) The Contractor shall ensure that the plan of care is developed based upon all assessment documentation and is developed with the assistance of the Enrollee, the service provider, and those individuals selected by the Enrollee to participate in service planning and delivery.

v) The Contractor shall ensure that the plan of care includes the services and supports required to meet the Enrollee's assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services being delivered in home and community based settings.

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vi) The Contractor shall ensure that the plan of care identifies the strengths, capacities, and preferences of the Enrollee, identifies the Enrollee's needs and the resources available to meet those needs and provides access to additional care options when indicated.

vii) The Contractor shall ensure the plan of care includes a back-up plan to ensure that needed assistance will be provided in the event that regular services and supports identified in the plan of care are temporarily unavailable. The back-up plan may include other individual assistants or services.

viii) The Contractor shall develop and maintain a process to:

A) permit the Enrollee to request a change to the plan of care if the Enrollee's circumstances necessitate such a change; and

B) ensure the plans of care are updated and/or revised at least annually or when warranted by changes in the Enrollee's needs.

ix) The Contractor shall ensure that meetings related to the Enrollee's plan of care are held at a location, date and time convenient to the Enrollee and the Enrollee's chosen participants.

x) The Contractor shall require that Enrollees receiving Behavioral Health Home and Community Based Services have a choice of provider, where applicable, which has the capacity to serve that Enrollee within the Contractor's network.

xi) The Contractor shall develop and implement policies and procedures to monitor appropriate implementation of Enrollee's plans of care, including the qualifications of individuals developing plans of care consistent with State guidance, types of assessments conducted and the method for how Enrollees are notified of available services.

e) Care Coordination

i) Each Enrollee electing to enroll in a Health Home shall have comprehensive care management services through subcontracts with State-designated Health Homes wherever possible, pursuant to Section 21.27 of this Agreement. Enrollees engaged through alternative care management entities shall access care management services pursuant to subcontracts with such entities. In instances where an Enrollee chooses not to enroll in a Health Home and is not receiving care management services from alternative entities or an ACT program, the Contractor is responsible for providing care coordination for the implementation of the Enrollee's plan of care, in accordance with this Agreement.

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ii) The Contractor shall review the plan of care developed by the Care Manager and the Enrollee and work collaboratively to finalize an approved plan of care. The Contractor shall be responsible for approving the plan of care.

iii) The Contractor shall ensure:

A) The Enrollee has access to all services identified in the Enrollee's approved plan of care, including the type, scope, amount, duration and frequency;

B) That the Enrollee's approved plan of care is documented in the Enrollee's MCO-administered care management record and, if the Enrollee is enrolled in a Health Home, in the Health Home record.

C) That the Enrollee plays a central and active role in the development and execution of the Enrollee's approved plan of care, agrees with the goals, interventions and time frames contained therein, and is not excluded from participation, to the extent practicable, in the event the Enrollee has a court-appointed guardian;

D) That the approved plan of care is reassessed no less frequently than annually, and when warranted by a significant change in the Enrollee's medical and behavioral health condition. Such reassessment shall document the Enrollee's progress in meeting his or her goals from prior plans of care and shall be documented in the Enrollee's record.

iv) The Contractor shall have policies and procedures in place to ensure appropriate communication and record sharing between Enrollees' care managers and treating providers.

v) The Contractor shall ensure that Enrollees have access to Care Management 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary.

vi) The Contractor shall have policies and procedures in place for engagement efforts for Enrollees lost to follow-up, including Enrollees who have not received a Care Management service for a period of two (2) consecutive months.

f) The Contractor shall collaborate with Assertive Community Treatment programs and the local Single Point of Access agency to assist in management of service capacity and utilization for its Enrollees.

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10.42 Behavioral Health Home and Community Based Services [Applicable to the HARP and HIV SNP Programs]

a) The responsibilities of SDOH, OMH, OASAS, the Contractor, and the Contractor's subcontractors and Participating Providers for the provision of Behavioral Health Home and Community Based Services (BHHCBS) to HARP and HARP-eligible HIV SNP Enrollees are described in the Benefit Package; Appendices K and T of this Agreement; and State-issued "Transition of Behavioral Health Benefit into Managed Care and HARP Program Implementation," (Behavioral Health Guidance) which are hereby made a part of this Agreement as if set forth fully herein.

b) The Contractor is responsible for determining the Enrollee's need for Behavioral Health Home and Community Based Services through the provision of assessments.

c) The Contractor shall approve the duration and intensity of Behavioral Health Home and Community Based Services.

d) The Contractor shall reimburse Behavioral Health Home and Community Based Services providers subject to the terms of the agreement between the Contractor and Participating Provider and Appendix T of this Agreement.

e) The Contractor shall have effective mechanisms to obtain information from Health Home and BHHCBS providers, and report such information and related analytical data in a manner and format to be determined by the State, as required to support State compliance with the BHHCBS provisions of the Special Terms and Conditions of the New York State Section 1115 Partnership Plan and related additional assurances as CMS may require to evaluate the Enrollee's level of care; adequacy of service plans; provider qualifications; Enrollee health and safety; financial accountability and compliance with the terms of this Agreement.

10.43 Cost-Effective Alternative Services

a) The Contractor may provide cost-effective services or settings that are an alternative to those services and settings covered under the Benefit Package, as permitted by 42 C.F.R. 438.3(e) and approved by the State. If the Contractor intends to offer such cost-effective alternative services, the Contractor shall submit requests for State approval to offer such services in a form and format to be determined by SDOH, in consultation with OMH and OASAS. Cost-effective alternative services approved by the State are indicated in Appendix M of this Agreement.

b) The Contractor shall not require an Enrollee to utilize a cost-effective alternative Service as a substitute for a service covered under the Benefit Package. Upon approval of a cost-effective alternative service, the Contractor



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shall provide notice to Enrollees of the availability of the cost-effective alternative services, in a form and format as determined by SDOH, in consultation with OMH and OASAS.

c) Termination of cost-effective alternative services

i) SDOH reserves the right to terminate approval of a cost-effective alternative service if, at the sole discretion of the State, it is determined to be harmful to an Enrollee or is not cost effective.

ii) The Contractor may terminate a cost-effective alternative service upon written notice to the SDOH. The Contractor will submit a transition plan for termination of the cost-effective alternative service, which will include an impact/disruption analysis; draft Enrollee notices for Enrollees in receipt of the service; and other information the State may require to ensure a smooth transition.

iii) Unless the State has determined that the cost-effective alternative service must be terminated due a threat against the health, safety or welfare of Enrollees, the Contractor shall provide at least 90 days' notice to Enrollees of such termination.

## 10.44 Settings for Home and Community Based Services

The Contractor, or its Subcontractor where delegated to authorize such services on behalf of the Contractor, shall ensure that HCBS included in the Benefit Package is authorized only where the service setting is compliant with requirements of 42 CFR §§ 441.301(c)(4); 441.530; and 441.710(a)(1) and (2) or the Special Terms and Conditions of the 1115 Medicaid Redesign Team Waiver, as applicable, including that, where an Enrollee lives or receives HCBS in a provider-owned, controlled residential, or non-residential setting, any modification of the additional conditions for provider-owned, controlled residential or non-residential settings required under 42 CFR §§441.301(c)(4)(vi), 441.530(a)(1)(vi), or 441.710(a)(1)(iv), or the Special Terms and Conditions of the 1115 Medicaid Redesign Team Waiver, will be supported by a specific assessed need and justified in the Enrollee's PCSP.

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## 11. OUTREACH/ADVERTISING

### 11.1 Media

The Contractor may conduct media campaigns, including television, radio, billboards, subway and bus posters, electronic messages, and social media on any platform or device. All media materials must be pre-approved by the SDOH. Routine postings on social media sites such as basic reminders of the availability of smoking cessation programs and flu vaccinations, and items such as healthier living related tips do not require prior approval by the SDOH. All electronic means of interaction with potential Enrollees of public health insurance programs, while not directly approved by the SDOH, will be routinely monitored for compliance with this Section.

### 11.2 Prior Approval of Advertising Material and Procedures

a) The Contractor shall submit all materials, developed for purposes of this Agreement, related to advertising to the uninsured and/or potential Enrollees to the SDOH for prior written approval. The Contractor shall not use any materials that the SDOH has not approved. Advertising and outreach materials shall be made available by the Contractor throughout its entire service area. Advertising and outreach materials may be customized for specific counties and populations within the Contractor's service area.

b) Written materials may be developed for use at LDSS, community centers, markets, pharmacies, hospitals, and other provider sites, schools, health fairs and other areas where the uninsured are likely to gather.

c) The material must not contain false, misleading, or ambiguous information.

d) The material must not contain any assertion or statement, whether written or oral, that the Contractor is endorsed by CMS, the federal or state government, or a similar entity.

e) The material must accurately reflect general information which is applicable to the average consumer of the Medicaid/FHPlus Programs.

f) The SDOH must take action within sixty (60) calendar days on materials submitted by the Contractor or the Contractor may deem the materials approved. If the Contractor requires an expedited review from the SDOH, the Contractor must justify the need for an expedited review when submitting the material.

### 11.3 Restricted Activities and Remedial Actions

a) The Contractor shall not engage in the following practices:

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i) Outreach to current Medicaid/FHPlus Enrollees of other health plans. If the Contractor becomes aware during a Facilitated Enrollment encounter that an individual is already enrolled in Medicaid fee-for-service and the individual wants to enroll in Managed Care, the Facilitated Enroller may assist the consumer in contacting the Enrollment Broker, LDSS or the NYSoH. If the Contractor becomes aware during a Facilitated Enrollment encounter that the individual is enrolled in a MMC/FHPlus health plan, the encounter must be promptly terminated. If the individual voluntarily suggests dissatisfaction with the health plan in which he or she is enrolled, the individual should be referred to the Enrollment Broker, LDSS or the NYSoH.

ii) Pursuant to 42 CFR 438.104(b)(1)(iv), influencing MMC enrollment in conjunction with the sale or offering of any private insurance.

b) If the Contractor's outreach activities do not comply with the policies set forth in this Section, the SDOH, in consultation with the LDSS, may take any of the following actions as it, in its sole discretion, deems necessary to protect the interests of Enrollees and the integrity of the MMC and FHPlus Programs. The Contractor shall take the corrective and remedial actions directed by the SDOH within the specified timeframes.

i) If the Contractor or its representatives commit a first time infraction and the SDOH, in consultation with the LDSS, deems the infraction to be minor or unintentional in nature, the SDOH and/or the LDSS may issue a warning letter to the Contractor.

ii) If the Contractor engages in outreach activities that SDOH determines, in its sole discretion, to be an intentional or serious breach of the policies and procedures set forth in this Section, or a pattern of minor breaches, SDOH, in consultation with the LDSS, may require the Contractor to prepare and implement a corrective action plan acceptable to SDOH within a specified timeframe. In addition, or alternatively, SDOH may impose sanctions, including monetary penalties, as permitted by law.

iii) If the Contractor commits further infractions, fails to pay monetary penalties within the specified timeframe, fails to implement a corrective action plan in a timely manner or commits an egregious first-time infraction, the SDOH, in consultation with the LDSS, may in addition to any other legal remedy available to SDOH in law or equity, take any or all of the following actions:

A) direct the Contractor to suspend its outreach activities for a period up to the end of the Agreement period;

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B) suspend new Enrollments, other than newborns, for a period up to the remainder of the Agreement period; or

D) terminate this Agreement pursuant to termination procedures described in Section 2.7 of this Agreement.

c) The corrective and remedial actions described in Section 11.3 apply to violations of the reporting requirements described in Section 18.5 (a)( xiiixiv).

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# 12. MEMBER SERVICES

## 12.1 General Functions

a) The Contractor shall operate a Member Services Department during regular business hours, which must be accessible to Enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines) not less than during regular business hours to address complaints and utilization review inquiries. In addition, the Contractor must have a telephone system capable of accepting, recording or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received.

b) At a minimum, the Member Services Department must be staffed at a ratio of at least one (1) full time equivalent Member Service Representative for every four thousand (4,000) or fewer Enrollees.

c) Member Services staff must be responsible for the following:

i) Explaining the Contractor's rules for obtaining services and assisting Enrollees in making appointments.

ii) Assisting Enrollees to select or change Primary Care Providers.

iii) Fielding and responding to questions and complaints from Enrollees and their authorized representatives, and advising of the right to complain to the SDOH and LDSS at any time.

iv) Clarifying information in the member handbook for Enrollees.

v) Advising Enrollees of the Contractor's complaint and appeals program, the utilization review process, and Enrollee's rights to a fair hearing or external review.

vi) Clarifying for MMC Enrollees current categories of exemptions and exclusions. The Contractor may refer to the LDSS or the Enrollment Broker, where one is in place, if necessary, for more information on exemptions and exclusions.

vii) For Contractors that cover non-emergency transportation services in the Prepaid Benefit Package, assisting Enrollees to arrange for special (non-public transportation) services such as livery/ambulettes.

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viii) For Contractors that cover non-emergency transportation in the Prepaid Benefit Package, assisting Enrollees with transportation requests to all medical care and services that are covered under the Medicaid program, either by directly arranging for transportation or by referring the Enrollee to an approved transportation vendor, regardless of whether the specific service is included in the Prepaid Benefit Package or paid for on a fee-for-service basis.

ix) Assisting Enrollees to select or change dental care providers or facilitating referral to the Contractor's dental vendor.

x) Directing Enrollees to appropriate member-serving systems including, but not limited to, social services, State or federally funded non-Medicaid behavioral health services, the Office for People with Developmental Disabilities, the NYS Justice Center, law enforcement and community-based organizations providing services to criminal justice-involved Enrollees. Contractor shall ensure other appropriately-trained staff are available to provide such information or direction.

d) Member services staff assisting Enrollees with understanding how to access services; their covered benefits; notices of Action or Action Appeal determinations; their complaint, appeal or fair hearing rights; or providing Enrollees with information on the status of Service Authorization Requests, will ask the Enrollee if their questions were answered to their satisfaction, and, if the Enrollee remains unsatisfied, offer the Enrollee the option to file a Complaint with the Contractor. The Contractor shall investigate and respond to such Complaints in accordance with Appendix F of this Agreement.

e) The Contractor shall ensure those Member Services staff who are responsible for providing intake, referral, or crisis response referrals to Enrollees, whether employed by the Contractor directly or through subcontracts, receive adequate training relating to:

i) covered services, including BHHCBS if applicable;

ii) New York State managed care rules;

iii) New York State's behavioral health services delivery system;

iv) approved behavioral health utilization management criteria;

v) provider networks; and,

vi) emergency/crisis calls, including procedures for transferring Enrollees identified to be in crisis to properly trained crisis clinicians.

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12.2 Translation and Oral Interpretation

a) The Contractor must make available written outreach/advertising materials and other informational materials (e.g., member handbooks) in a language other than English whenever at least five percent (5%) of the Prospective Enrollees of the Contractor in any county of the service area speak that particular language and do not speak English as a first language.

b) In addition, verbal interpretation services must be made available to Enrollees and Potential Enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

c) The SDOH will determine the need for other than English translations based on county-specific census data or other available measures.

d) SDOH-approved English language versions of outreach/advertising materials and other informational materials (e.g. Member handbooks) that are then translated into other languages in accordance with Appendix D, D.1 (9) of this Agreement, do not need to be resubmitted to SDOH for approval. The Contractor, however, is required to keep a copy of the Certificate of Accuracy on file and submit the certificate and/or the translated material to the State if requested.

12.3 Communicating with the Visually, Hearing and Cognitively Impaired

The Contractor also must have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include Braille or audio tapes for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

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## 13. ENROLLEE RIGHTS AND NOTIFICATION

### 13.1 Information Requirements

a) The Contractor shall provide new Enrollees with the information identified in PHL § 4408, SSL § 364-j, SSL § 369-ee and 42 CFR § 438.10 (f) and (g).

b) The Contractor shall provide such information to the Enrollee within fourteen (14) days of the Effective Date of Enrollment. The Contractor may provide such information to the Enrollee through the Member Handbook referenced in Section 13.4 of this Agreement.

c) The Contractor must provide Enrollees with an annual notice that this information is available to them upon request.

d) The Contractor must inform Enrollees that oral interpretation service is available for any language and that information is available in alternative formats and how to access these formats.

e) The Contractor shall post on a public section of its website the following information:

i) the Member Handbook described in Appendix E of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein;

ii) the provider directory, as described in Section 13.2 of this Agreement;

iii) the Contractor's formulary drug list; and

iv) in accordance with 42 CFR 438.602(g)(3), the name and title of individuals that have ownership and control interest of the Contractor, as described in 42 CFR 455.104.

v) In accordance with 42 CFR 438.10, the information required in paragraph (ii) and (iii) above must be posted in machine readable file and format specified by CMS.

f) The Contractor shall comply with information and formatting requirements described in 42 CFR 438.10(d).

### 13.2 Provider Directories/Office Hours for Participating Providers

a) The Contractor shall maintain and update, on a ~~quarterly~~ monthly basis, a listing by specialty of the names, addresses and telephone numbers of all Participating Providers, including facilities. Such a list/directory shall include names, office addresses, telephone numbers, board certification for

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physicians, information on language capabilities and wheelchair accessibility of Participating Providers. The list should also identify providers that are not accepting new patients.

i) The Contractor shall update applicable records contained in the electronic version of such provider listing no later than thirty (30) days after it receives updated provider information.

b) New Enrollees must receive the most current complete listing in hardcopy, along with any updates to such listing. Alternatively, new Enrollees may be provided written notification that a complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

c) Enrollees must be notified of updates in writing at least annually in one of the following methods: (1) provide updates in hardcopy; (2) provide a new complete listing/directory in hardcopy; or (3) provide written notification that a new complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

d) In addition, the Contractor must make available to the LDSS the office hours for Participating Providers. This requirement may be satisfied by providing a copy of the list or Provider Directory described in this Section with the addition of office hours or by providing a separate listing of office hours for Participating Providers.

13.3 Member ID Cards

a) The Contractor must issue an identification card to the Enrollee containing the following information:

i) the name of the Enrollee's clinic (if applicable);

ii) the name of the Enrollee's PCP and the PCP's telephone number (if an Enrollee is being served by a PCP team, the name of the individual shown on the card should be the lead provider);

iii) the member services toll free telephone number;

iv) the twenty-four (24) hour toll free telephone number that Enrollees may use to access information on obtaining services when his/her PCP is not available; and

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v) the Enrollee's Client Identification Number (CIN).

b) PCP information may be embossed on the card or affixed to the card by a sticker.

c) The Contractor shall issue an identification card within fourteen (14) days of an Enrollee's Effective Date of Enrollment. If unforeseen circumstances, such as the lack of identification of a PCP, prevent the Contractor from forwarding the official identification card to new Enrollees within the fourteen (14) day period, alternative measures by which Enrollees may identify themselves such as use of a Welcome Letter or a temporary identification card shall be deemed acceptable until such time as a PCP is either chosen by the Enrollee or auto assigned by the Contractor. The Contractor agrees to implement an alternative method by which individuals may identify himself/herself as Enrollees prior to receiving the card (e.g., using a "welcome letter" from the Contractor) and to update PCP information on the identification card. Newborns of Enrollees need not present ID cards in order to receive Benefit Package services from the Contractor and its Participating Providers. The Contractor is not responsible for providing Benefit Package services to newborns Excluded from the MMC Program pursuant to Appendix H of this Agreement, or when the Contractor does not offer an MMC product in the mother's county of fiscal responsibility.

d) [Applicable to HIV SNP Program Only]: If the Contractor is certified as both a mainstream MCO and an HIV SNP, identification cards may distinguish the individual as an Enrollee of the HIV SNP only through use of an alphanumeric code. No plan shall use the words "HIV," "AIDS," "Special Needs Plan," or "SNP" on a member card to denote participation in an HIV SNP.

e) [Applicable to HARP Program Only]: If the Contractor is certified as both mainstream MCO and a HARP, identification cards may distinguish the Enrollee of the HARP only through the use of alphanumeric code. No plan shall use the words "HARP," "Health and Recovery Plan," "behavioral health," "Special Needs Plan" or any other language that identifies the individual as a recipient of behavioral health services on a member card to denote participation in a HARP.

13.4 Member Handbooks

a) The Contractor shall issue to a new Enrollee within fourteen (14) days of the Effective Date of Enrollment a Member Handbook, ~~which~~that is consistent with ~~the SDOH~~ guidelines described in Appendix E of this Agreement~~, which is hereby made a part of this Agreement as if set forth fully herein~~ and meets information and formatting requirements specified in 42 CRF 438.10(d).

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i) The Member Handbook shall be issued by the Contractor by any one of the following modalities:

A) mailing a printed copy to the Enrollee's mailing address;

B) emailing an electronic copy to the Enrollee after obtaining the Enrollee's consent to receive it by email;

C) posting an electronic copy on the Contractor's website and advising the Enrollee in paper or electronic format that the Member Handbook is available on the internet and including the applicable internet address, provided that:

I) Enrollees with disabilities who cannot access the Member Handbook on the internet are provided auxiliary aids and services by the Contractor upon such Enrollee's request; or

II) if so requested by the Enrollee, a printed copy is mailed to the Enrollee's mailing address.

D) any other method that can reasonably be expected to result in the Enrollee receiving the Member Handbook, if such method is prior approved by the State.

b) The Contractor shall give each Enrollee notice of any change in the information specified in the Member Handbook that the State has defined as significant. Such notice shall be provided as least 30 days before the effective date of such change.

13.5 Notification of Effective Date of Enrollment

The Contractor shall inform each Enrollee in writing within fourteen (14) days of the Effective Date of Enrollment of any restriction on the Enrollee's right to terminate enrollment. The initial enrollment information and the Member Handbook shall be adequate to convey this notice.

13.6 Notification of Enrollee Rights

a) The Contractor agrees to make all reasonable efforts to contact new Enrollees, in person, by telephone, or by mail, within thirty (30) days of their Effective Date of Enrollment. "Reasonable efforts" for non-HIV SNP and non-HARP MMC and FHPlus products are defined to mean at least three (3) attempts, with more than one method of contact being employed. "Reasonable efforts" for HIV SNPs and HARPs are defined as at least six attempts, with more than one method of contact being employed, including a home visit.

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[Applicable to HARP Program Only]: After three unsuccessful attempts to contact a new Enrollee, the Contractor may delegate additional attempts to contact a new Enrollee to the Enrollee's Health Home Care Manager, if the Enrollee is engaged in a Health Home as outlined in the State-issued Behavioral Health Guidance.

Upon contacting the new Enrollee(s), the Contractor agrees to do at least the following:

i) Inform the Enrollee about the Contractor's policies with respect to obtaining medical and dental services, including services for which the Enrollee may self-refer pursuant to Section 10.15 of this Agreement, and what to do in an emergency.

ii) Offer assistance in arranging an initial visit to the Enrollee's PCP for a baseline physical and other preventive services, including an assessment of the Enrollee's potential risk, if any, for specific diseases or conditions.

iii) Inform new Enrollees about their rights for continuation of certain existing services.

iv) Provide the Enrollee with the Contractor's toll free telephone number that may be called twenty-four (24) hours a day, seven (7) days a week if the Enrollee has questions about obtaining services and cannot reach his/her PCP (this telephone number need not be the Member Services line and need not be staffed to respond to Member Services-related inquiries). The Contractor must have appropriate mechanisms in place to accommodate Enrollees who do not have telephones and therefore cannot readily receive a call back.

v) Advise Enrollee about opportunities available to learn about the Contractor's policies and benefits in greater detail (e.g., welcome meeting, Enrollee orientation and education sessions).

vi) Assist the Enrollee in selecting a primary care provider and/or an HIV Specialist PCP (for the HIV SNP Program only) if one has not already been chosen.

vii) [Applicable to HIV SNP Program Only]:

A) Inform the Enrollee about procedures for obtaining standing referrals, the use of specialty care centers, the use of a specialist as primary care provider, and what to do in an emergency. The Contractor must also inform the Enrollee regarding any exceptions in effect to the travel time/distance standards to HIV Specialist PCP sites in certain counties as described in Section 15.5 (b) of this Agreement.

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B) Provide Enrollees information on Contractor's HIV SNP Care and Benefit Coordination Services and how to access medical and non-medical support services such as HIV counseling, testing, referral, and partner notification, nutrition, and housing assistance.

C) Provide all new Enrollees with information regarding basic primary and preventive services specific to the care, treatment, and prevention of HIV infection, as well as the advantages of new treatment regimens and therapies and information on different primary care options, if available, such as those that provide co-located primary care and substance abuse services.

b) The Contractor agrees to make all reasonable efforts to conduct a brief health screening, within sixty (60) days of the Enrollee's Effective Date of Enrollment, to assess the Enrollee's need for any special health care (e.g., prenatal, dental or behavioral health services) or language/communication needs. Reasonable efforts are defined to mean at least (3) attempts, with more than one method of contact being employed. If a special need is identified, the Contractor shall assist the Enrollee in arranging for an appointment with his/her PCP or other appropriate provider.

13.7 Enrollee's Rights

a) The Contractor shall, in compliance with the requirements of 42 CFR § 438.3(j)(1) and 42 CFR Part 489 Subpart I, maintain written policies and procedures regarding Advance Directives and inform each Enrollee in writing at the time of enrollment of an individual's rights under State law to formulate Advance Directives and of the Contractor's policies regarding the implementation of such rights. The Contractor shall include in such written notice to the Enrollee materials relating to Advance Directives and health care proxies as specified in 10 NYCRR Part 98 and § 700.5. The written information must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

b) The Contractor shall have policies and procedures that protect the Enrollee's right to:

i) receive information about the Contractor and managed care in a manner which does not disclose the Enrollee as participating in the MMC and/or FHP Programs, provided that inclusion of the Contractor's name is not considered a violation of this provision;

ii) be treated with respect and due consideration for his or her dignity and privacy;

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iii) receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

iv) participate in decisions regarding his or her health care, including the right to refuse treatment;

v) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in Federal regulations on the use of restraints and seclusion; and

vi) If the privacy rule, as set forth in 45 CFR Parts 160 and 164, Subparts A and E, applies, request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

c) The Contractor's policies and procedures must require that neither the Contractor nor its Participating Providers adversely regard an Enrollee who exercises his/her rights in 13.7(b) above.

13.8 Approval of Written Notices

a) The Contractor shall submit the format and content of all written notifications described in this Section to SDOH for review and prior approval by SDOH

b) Upon the request of SDOH, the Contractor shall submit the format and content of all written notifications regarding disease management, medication adherence, health literacy, preventive health and SDOH-identified public health initiatives, for review and prior approval by SDOH. Such materials shall be submitted by the Contractor to the SDOH within 30 days of such request.

i) The SDOH must take action within sixty (60) calendar days on materials submitted by the Contractor in response to Section 13.8 (b) above or the Contractor may deem the materials approved. If the Contractor requires an expedited review from the SDOH, the Contractor must justify the need for an expedited review when submitting the material.

c) All written notifications must be written at a fourth (4th) to sixth (6th) grade level, ~~and~~be printed in a font that is at least ~~ten~~ (1~~0~~2) point print, and meet formatting requirements as directed in 42 CFR 438.10(d).

13.9 Contractor's Duty to Report Lack of Contact

The Contractor must inform the State or its designee of any Enrollee it is unable to contact within ninety (90) days of Enrollment using reasonable efforts as



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defined in Section 13.6 of the Agreement and who have not presented for any health care services through the Contractor or its Participating Providers.

13.10 LDSS Notification of Enrollee's Change in Address

The LDSS is responsible for notifying the Contractor of any known change in address of Enrollees.

13.11 Contractor Responsibility to Notify Enrollee of Effective Date of Benefit Package Change

The Contractor must provide written notification of the effective date of any Contractor-initiated, SDOH-approved Benefit Package change to Enrollees. Notification to Enrollees must be provided at least thirty (30) days in advance of the effective date of such change.

13.12 Contractor Responsibility to Notify Enrollee of Termination, Service Area Changes and Network Changes

a) With prior notice to and approval of the SDOH, the Contractor shall inform each Enrollee in writing of any withdrawal by the Contractor from the MMC or FHPlus Program pursuant to Section 2.7 of this Agreement, withdrawal from the service area encompassing the Enrollee's zip code, and/or significant changes to the Contractor's Participating Provider network pursuant to Section 21.1(d) of this Agreement, except that the Contractor need not notify Enrollees who will not be affected by such changes.

b) The Contractor shall provide the notifications within the timeframes specified by SDOH, and shall obtain the prior approval of the notification from SDOH.

13.13 Post Enrollment Follow-Up [Applicable to the HIV SNP Program Only]

The Contractor shall utilize the services of community-based organizations (CBOs) experienced with the care and treatment of persons with HIV infection to contact those Enrollees who are lost to follow-up (e.g., an initial appointment was met but the individual has failed to arrive for subsequent appointments). If a contractual agreement does not exist between the Contractor and the CBO for such follow-up services, the CBO may only provide this type of assistance for those individuals that the Contractor has met with at least once and who have signed a release indicating that the Contractor may release identifying information regarding that individual to CBOs for purposes of treatment follow-up.

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## 14. ACTION AND GRIEVANCE AND APPEAL SYSTEM

### 14.1 General Requirements

a) The Contractor shall establish, ~~and~~ maintain, and follow ~~-~~written Service Authorization and Action policies and procedures. The Contractor~~s~~ shall establish~~, maintain and follow written policies and procedures for and~~ a comprehensive Grievance and Appeal System that complies with the Managed Care Action and Grievance and Appeal System Requirements for MMC and FHPlus Programs described in Appendix F of this Agreement. Nothing herein shall release the Contractor from its responsibilities under SSL § 364-j, Articles 44 and ~~of PHL § 4408-a or PHL Article~~ 49 of the PHL, Article 43 of the~~r~~ INSL, 18 NYCRR Part 360-10, and 10 NYCRR Part 98 that is not otherwise expressly established in Appendix F.

b) The Contractor's Action procedure and Grievance and Appeal System shall be approved by the SDOH and kept on file with the Contractor and SDOH.

c) The Contractor shall not modify its Action procedure or Grievance and Appeal System without the prior written approval of SDOH, and shall provide SDOH with a copy of the approved modification within fifteen (15) days of its approval.

d) The Contractor shall not take punitive action against a provider who either requests an expedited resolution or supports an Enrollee's appeal.

### 14.2 Actions

a) The Contractor must have in place effective mechanisms to ensure consistent application of review criteria for Service Authorization Determinations and consult with the requesting provider when appropriate.

   i) The State reserves the right to review and approve Contractor's utilization review criteria and level of care guidelines for Service Authorization Determinations related to mental health and Substance Use Disorder services included in the Benefit Package.

b) If the Contractor subcontracts for Service Authorization Determinations and utilization review, the Contractor must ensure that its S~~s~~ubcontractors have in place and follow written policies and procedures for delegated activities regarding processing requests for initial and continuing authorization of services consistent with SSL § 364-j ~~(~~SSL § 364-j, Article 44 and Article 49 of the PHL, Article 43 of the INSL, 18 NYCRR Part 360-10, and 10 NYCRR Part 98~~25), Article 49 of the PHL, 10 NYCRR Part 98~~, 42 CFR Part 438, Appendix F of this Agreement, and the Contractor's policies and procedures.

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c) The Contractor must ensure that compensation to individuals or entities that perform Service Authorization Determination and utilization management activities is not structured to include incentives that would result in the denial, limiting, or discontinuance of medically necessary services to Enrollees.

d) The Contractor or its subcontractors may not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or Enrollee's condition. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity or utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

i) The Contractor shall make Service Authorization determinations for covered services supporting Enrollees with ongoing or chronic conditions or who require LTSS in a manner that reflect the Enrollee's ongoing need for services and supports.

ii) In accordance with Appendix S of this Agreement, the Contractor shall authorize LTSS in accordance with the Enrollee's current assessment and consistent with the PCSP.

14.3 Grievance and Appeal System

a) The Contractor shall ensure that its Grievance and Appeal System includes methods for prompt internal adjudication of Enrollee Complaints, Complaint Appeals and Action Appeals and provides for the maintenance of a written record of all Complaints, Complaint Appeals and Action Appeals received and reviewed and their disposition, as specified in Appendix F of this Agreement.

b) The Contractor shall ensure that persons with authority to require corrective action participate in the Grievance and Appeal System.

14.4 Notification of Action and Grievance and Appeal System Procedures

a) The Contractor will advise Enrollees of their right to a fair hearing as appropriate and comply with the procedures established by SDOH for the Contractor to participate in the fair hearing process, as set forth in Section 25 of this Agreement. The Contractor will also advise Enrollees of their right to an External Appeal, in accordance with Section 26 of this Agreement.

b) The Contractor will provide written notice of the following Complaint, Complaint Appeal, Action Appeal and fair hearing procedures to all Participating Providers, and subcontractors to whom the Contractor has delegated utilization review and Service Authorization Determination procedures, at the time they enter into an agreement with the Contractor:

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i) the Enrollee's right to a fair hearing, how to obtain a fair hearing, and representation rules at a hearing;

ii) the Enrollee's right to file Complaints, Complaint Appeals and Action Appeals and the process and timeframes for filing;

iii) the Enrollee's right to designate, through written consent, a representative to file Complaints, Complaint Appeals, ~~and~~ Action Appeals and request a State Fair Hearing on his/her behalf;

iv) the availability of assistance from the Contractor for filing Complaints, Complaint Appeals and Action Appeals;

v) the toll-free numbers to file oral Complaints, Complaint Appeals and Action Appeals;

vi) the Enrollee's right to request continuation of benefits while an Action Appeal or state fair hearing is pending;~~, and~~ that the provider may not request continuation of benefits on behalf of the Enrollee; and that if the Contractor's Action is upheld ~~in a hearing~~, the Enrollee may be liable for the cost of any continued benefits;

vii) the right of the provider to reconsideration of an Adverse Determination pursuant to Section 4903(6) of the PHL; and

viii) the right of the provider to appeal a retrospective Adverse Determination pursuant to Section 4904(1) of the PHL.

14.5 Complaint Investigations by SDOH, OMH, OASAS and the LDSS

a) The Contractor must cooperate with SDOH, OMH, OASAS, and the LDSS in their investigation of any Complaint filed with one or more state or local agencies.

b) The Contractor must respond to requests for information or resolve the issue under investigation, as directed by SDOH, OMH, OASAS, or the LDSS, within 15 days of receipt of the request. In cases where the Enrollee's health would be seriously jeopardized by a delay, SDOH, OMH, OASAS and the LDSS may require the Contractor to provide an immediate response (within 24 hours). Any state or local government agency may extend either the standard or the expedited time for response as needed to fully address the complaint, if the extension does not jeopardize the Enrollee's health. The Contractor shall respond either verbally or in writing, as directed by the investigating agency.

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c) The Contractor must adhere to determinations resulting from Complaint investigations conducted by SDOH, OMH, OASAS, or the LDSS.

d) If SDOH, OMH, OASAS, and the LDSS are investigating the same Complaint, the determination of SDOH will take precedence. The State will make reasonable efforts to coordinate the investigation of complaints to avoid overlapping determinations.

e) For purposes of Section 14.5, Complaint means a written or verbal contact to SDOH, OMH, OASAS, or the LDSS, in which the Enrollee, or the Enrollee's designee, or provider describes dissatisfaction with any aspect of the Contractor's operations, benefits, employees, vendors or providers, including Complaints related to the Contractor's provision of culturally competent services to Enrollees.

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## 15. ACCESS REQUIREMENTS

### 15.1 General Requirement

The Contractor will establish and implement mechanisms to ensure that Participating Providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

### 15.2 Appointment Availability Standards

a) The Contractor shall comply with the following minimum appointment availability standards, as applicable [1].

i) For emergency care: immediately upon presentation at a service delivery site.

ii) For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services: immediately upon presentation at a service delivery site.

iii) For urgent care: within twenty-four (24) hours of request.

iv) For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs: within twenty-four (24) hours of request.

v) Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.

vi) Routine non-urgent, preventive appointments except as otherwise provided in this Section: within four (4) weeks of request.

vii) Specialist referrals (not urgent), except as otherwise provided in this Section: within four (4) to six (6) weeks of request.

viii) Behavioral health specialist referrals (not urgent):

A) For Continuing Day Treatment, Intensive Psychiatric Rehabilitation

[1] These are general standards and are not intended to supersede sound clinical judgement as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate. The standards set forth in Sections 15.2 a) i), a) ii), and a) iv) are also applicable to dental services.



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Treatment programs and Rehabilitation services for residential Substance Use Disorder treatment services: within two (2) to (4) weeks of request; and

B) For PROS programs other than clinic services: within two (2) weeks of request.

ix) Initial prenatal visit: within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester.

x) Adult Baseline and routine physicals: within twelve (12) weeks from enrollment. (Adults >21 years). [Applicable to HIV SNP Program only]: Adult Baseline and routine physicals: within four (4) weeks from enrollment. (Adults >21 years).

xi) Well child care: within four (4) weeks of request.

xii) Initial family planning visits: within two (2) weeks of request.

xiii) Pursuant to an emergency hospital discharge or release from incarceration, where the Contractor is informed of such release, mental health or Substance Use Disorder follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.

xiv) Non-urgent mental health or Substance Use Disorder visits with a Participating Provider that is a Mental Health and/or Substance Use Disorder Out Patient Clinic, including a PROS clinic within one(1) week of request.

xv) Initial PCP office visit for newborns: within two (2) weeks of hospital discharge; [Applicable to HIV SNP Program only]: Initial PCP office visit for newborns within forty-eight (48) hours of hospital discharge or the following Monday if the discharge occurs on a Friday.

xvi) Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS: within ten (10) days of request by an MMC Enrollee, in accordance with Section 10.7 of this Agreement.

xvii) Appointment availability standards for Behavioral Health Home and Community Based Services are outlined in Appendix T: Additional Requirements for HARP and HIV SNP Programs.



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15.3 Twenty-Four (24) Hour Access

a) The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour a day, seven (7) day a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends.

b) The Contractor may satisfy the requirement in Section 15.3(a) by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after hours "on-call" telephone resource to members with medical problems. Under no circumstances may the Contractor routinely refer calls to an emergency room.

15.4 Appointment Waiting Times

a) Enrollees with appointments shall not routinely be made to wait longer than one hour.

b) [Applicable to HIV SNP Program only]: The Contractor shall be responsible for ensuring network providers have policies and procedures addressing Enrollees, and in particular adolescents and persons presenting with a behavioral health conditions, who present for unscheduled, non-urgent care with the aim of promoting Enrollee access to appropriate care.

c) [Applicable to the HARP Program only]: The Contractor shall be responsible for ensuring network providers have policies and procedures addressing Enrollees who present for unscheduled, non-urgent care with the aim of promoting Enrollee access to appropriate care.

15.5 Travel Time Standards

a) The Contractor will maintain a network that is geographically accessible to the population to be served.

b) Primary Care

i) Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Enrollee's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee's residence in non-metropolitan areas. Transport time and distance in rural areas to primary care sites may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice. Applicable to HIV SNP Program only, travel time to HIV Specialist PCP sites shall not exceed thirty (30) minutes except that in certain counties identified by the AIDS Institute, based on



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the community standard for accessing HIV specialist care, travel time shall not exceed thirty (30) minutes/thirty (30) miles.

ii) Enrollees may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves. In the case of a Restricted Enrollee as described in Appendix Q of this Agreement, the Contractor may allow the Restricted Enrollee to select an RRP PCP provider further from their home as long as they are able to arrange and pay for transportation to the RRP PCP Provider themselves.

iii) Contractors that cover non-emergency transportation services in the Prepaid Benefit Package shall inform their Enrollees, in writing, of the Enrollee's responsibility to arrange and pay for transportation to their PCP if the Enrollee selects a participating PCP outside of the time and distance standards.

c) Other Providers

Travel time/distance for LTSS provider types in which an Enrollee must travel to the provider to receive services, or to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas for LTSS provider types in which an Enrollee must travel to the provider to receive services, or to specialty care, hospitals, mental health, lab and x-ray providers may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice.

15.6 Service Continuation

a) New Enrollees

i) If a new Enrollee has an existing relationship with a health care provider who is not a member of the Contractor's provider network, the Contractor shall permit the Enrollee to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the Effective Date of Enrollment if the Enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition.

ii) If the Enrollee has entered the second trimester of pregnancy at the Effective Date of Enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of post-partum care directly related to the delivery up to sixty (60) days after the delivery.



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iii) If the new Enrollee elects to continue to receive care from such Non-Participating Provider, such care shall be authorized by the Contractor for the transitional period only if the Non-Participating Provider agrees to:

A) accept reimbursement from the Contractor at rates established by the Contractor as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Contractor's network for such services; and

B) adhere to the Contractor's quality assurance requirements and agrees to provide to the Contractor necessary medical information related to such care; and

C) otherwise adhere to the Contractor's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by the Contractor.

iv) In no event shall this requirement be construed to require the Contractor to provide coverage for benefits not otherwise covered.

v) The Contractor shall request service utilization information from the LDSS or the Enrollee's previous Medicaid MCO, if such Enrollee is in receipt of LTSS or is an individual included in a SDOH-identified special population, as necessary to ensure the Enrollee's continued access to necessary services.

b) Enrollees Whose Health Care Provider Leaves Network

i) The Contractor shall permit an Enrollee, whose health care provider has left the Contractor's network of providers, for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with the Enrollee's current health care provider during a transitional period, consistent with PHL § 4403(6)(e).

ii) The transitional period shall continue up to ninety (90) days from the date the provider's contractual obligation to provide services to the Contractor's Enrollees terminates; or, if the Enrollee has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through sixty (60) days post partum. If the Enrollee elects to continue to receive care from such Non-Participating Provider, such care shall be authorized by the Contractor for the transitional period only if the Non-Participating



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Provider agrees to:

A) accept reimbursement from the Contractor at rates established by the Contractor as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Contractor's network for such services;

B) adhere to the Contractor's quality assurance requirements and agrees to provide to the Contractor necessary medical information related to such care; and

C) otherwise adhere to the Contractor's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by the Contractor.

iii) In no event shall this requirement be construed to require the Contractor to provide coverage for benefits not otherwise covered.

iv) In accordance with Section 21.10 of this Agreement, the Contractor shall notify impacted Enrollees whose health care provider has left the Contractor's network.

c) Enrollees Who Have Been Disenrolled

i) If an Enrollee has been disenrolled from the Contractor's MMC product, the Contractor shall:

A) promptly provide the Enrollee's service utilization information to the Enrollee's new Medicaid MCO, upon request by the new Medicaid MCO; and

B) promptly provide the Enrollee's service utilization information to the SDOH and/or LDSS, upon request by the SDOH and/or LDSS.

d) The Contractor shall implement a transition of care policy that is consistent with the requirements of 42 CFR 438.62(b)(1) and complies with the SDOH-issued transition of care policy.

15.7 Standing Referrals

The Contractor will implement policies and procedures to allow for standing



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referrals to specialist physicians for Enrollees who have ongoing needs for care from such specialists, consistent with PHL § 4403(6)(b).

15.8 Specialist as a Coordinator of Primary Care

a) The Contractor will implement policies and procedures to allow Enrollees with a life-threatening or degenerative and disabling disease or condition, which requires prolonged specialized medical care, to receive a referral to a specialist, who will then function as the coordinator of primary and specialty care for that Enrollee, consistent with PHL § 4403(6)(c).

b) [Applicable to HIV SNP Program only]: If the specialist does not meet the qualifications of an HIV Specialist, and the Enrollee is HIV infected, then a co-management model must be employed in which an HIV Specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist.

15.9 Specialty Care Centers

The Contractor will implement policies and procedures to allow Enrollees with a life-threatening or a degenerative and disabling condition or disease, which requires prolonged specialized medical care to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition, consistent with PHL § 4403(6)(d).

15.10 Cultural and Linguistic Competence

a) The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse sexual orientations, gender identities and member of diverse faith communities. For the purpose of this Agreement, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor's organization.

b) In order to comply with this section, the Contractor shall:

i) Maintain an inclusive, culturally competent provider network, as provided in Section 21 of this Agreement, including culturally competent network of Behavioral Health Providers, individual behavioral health practitioners, community-based providers and peer-delivered services;



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ii) Adopt policies and procedures that incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities;

iii) Maintain a Cultural Competence component of the Contractor's Internal Quality Assurance program referenced in Section 16.1 (d) of this Agreement;

iv) Develop and execute a comprehensive cultural competence plan based on Culturally and Linguistically Appropriate Services (CLAS) national standards of the US Department of Health and Human Services, Office of Minority Health and managed through the Contractor's Internal Quality Assurance Program;

v) Perform internal cultural competence activities including, but not limited to conducting:

A) Organization-wide cultural competence self-assessment;

B) Community needs assessments to identify threshold populations in each Service Area in which the Contractor operates; and

C) Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards.

vi) Facilitate annual training in cultural competence for all the Contractor's staff members. All elements of the curriculum shall be consistent with and/or reflect CLAS national standards. The Contractor's cultural competence training materials are subject to the review and approval by the State.

c) The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.

15.11 Language Interpreter Services for Enrollee Encounters

a) The Contractor is required to reimburse Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms, diagnostic and treatment centers, federally qualified health centers, and office-based practitioners to provide medical language interpreter services for Enrollees with limited English proficiency (LEP) and communication services for people who are deaf and



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hard of hearing.

b) An Enrollee with limited English proficiency shall be defined as an individual whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit the Enrollee to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record.

c) Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face, by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

d) The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.

15.12 Telehealth Health Care and Telepsychiatry Services

a) The Contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc and 2999-dd of the Public Health Law and any implementing regulations.

b) Effective January 1, 2016, the Contractor is responsible for covering Telepsychiatry Services delivered in accordance with OMH regulations as applicable. Telepsychiatry means the use of two-way real-time interactive audio and video to provide and support clinical psychiatric care at a distance. Telepsychiatry providers are providers of mental health services licensed pursuant to Article 31 of the Mental Hygiene Law.

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## 16. QUALITY ASSURANCE

16.1 Internal Quality Assurance Program

a) The Contractor must operate a quality assurance program which is approved by SDOH and which includes methods and procedures to control the utilization of services consistent with Article 49 of the PHL and 42 CFR Part 456. Enrollee's records must include information needed to perform utilization review as specified in 42 CFR §§ 456.111 and 456.211. The Contractor's quality assurance program shall also include all applicable requirements for long term services and supports described in 42 CFR 438.330(b). The Contractor's approved quality assurance program must be kept on file by the Contractor. The Contractor shall not modify the quality assurance program without the prior written approval of the SDOH.

b) The Contractor shall incorporate the findings from reports in Section 18 of this Agreement into its quality assurance program. Where performance is less than the statewide average or another standard as defined by the SDOH and developed in consultation with MCOs and appropriate clinical experts, the Contractor will be required to develop and implement a plan for improving performance that is approved by the SDOH and that specifies the expected level of improvement and timeframes for actions expected to result in such improvement. In the event that such approved plan proves to be impracticable or does not result in the expected level of improvement, the Contractor shall, in consultation with SDOH, develop alternative plans to achieve improvement, to be implemented upon SDOH approval. If requested by SDOH, the Contractor agrees to meet with the SDOH to review improvement plans and quality performance.

c) The Contractor's quality assurance program shall contain a behavioral health component which is approved by OMH and OASAS and shall include, but shall not be limited to, the following components:

i) The Contractor shall develop and maintain mechanisms to:

A) monitor service quality;

B) solicit feedback and recommendations from key stakeholders including Enrollees, family members, subcontracted Plans, RPCs and other agencies serving Enrollees;

C) develop quality improvement initiatives to improve quality of care and member outcomes; and

D) incorporate findings from behavioral health quality reports issued by OMH and OASAS.

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ii) The Contractor shall establish and maintain a Behavioral Health Quality Management (BH QM) Committee. The BH QM Committee shall include, in an advisory capacity, members, family members, peer specialists, and provider representatives. The BH QM shall be responsible for carrying out the planned activities of the BH QM program and be accountable to and report regularly to the governing board or its designee concerning BH QM activities. The Contractor's BH QM administrator shall lead quarterly BH QM committee meetings and maintain records documenting attendance by members, family members, and providers, as well as the BH QM Committee's findings, recommendations, and actions.

iii) The Contractor shall implement a Behavioral Health Utilization Management (BH UM) Committee chaired by the Behavioral Health Medical Director and charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization data, interpret any variances, review outcomes, and develop and/or approve interventions based on the findings in the following areas:

A) Under and overutilization of behavioral health services and cost data;

B) Readmission rates, trends, and the average length of stay for all mental health inpatient, SUD inpatient and residential levels of care facilities;

C) Commitment to an inpatient setting pursuant to Article 9 of the Mental Hygiene Law;

D) Outpatient civil commitment pursuant to Article 9.60 of the Mental Hygiene Law (Assisted Outpatient Treatment);

E) Follow up after discharge from mental health inpatient, SUD inpatient and residential care facilities;

F) SUD initiation and engagement rates;

G) Emergency Department utilization and crisis services use;

H) Behavioral health prior authorization/denial and notices of action;

I) Psychotropic medication utilization;

J) Addiction medication utilization.

iv) The Contractor shall ensure intervention strategies have measurable outcomes and are recorded in the BH UM committee meeting minutes.

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d) The Contractor's quality assurance program shall include a cultural competency function, with the goal of reducing disparities affecting cultural groups and increasing access to health and behavioral health care. The program components shall include, but shall not be limited to, the following:

i) Integrating cultural competence concerns into the Contractor's quality improvement activities;

ii) Improving the quality of service delivery to Enrollees;

iii) Advising on educational and operational issues affecting various cultural groups;

iv) Implementing and maintaining community linkages; and

v) Comparing all metrics related to access, utilization and outcomes of cultural groups in the Contractor's service area with the purpose of identifying and addressing disparities.

e) The Contractor shall establish and maintain a member advisory committee that meets the requirements of 42 CFR 438.110.

16.2 Standards of Care

a) The Contractor must adopt practice guidelines consistent with current standards of care, and, where available, evidence-based practices, complying with recommendations of professional specialty groups or the guidelines of programs such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American Psychiatric Association, the US Task Force on Preventive Care, the New York State Child/Teen Health Program (C/THP) standards for provision of care to individuals under age twenty-one (21), the American Medical Association's Guidelines for Adolescent and Preventive Services, the US Department of Health and Human Services Center for Substance Abuse Treatment, New York State OASAS clinical standards, American Society of Addiction Medicine (ASAM), US Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetricians and Gynecologists, the American Diabetes Association, the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care developed by the Office of Minority Health of the US Department of Health and Human Services, and the AIDS Institute clinical standards for adult, adolescent, and pediatric care.

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b) The Contractor must ensure that its decisions for utilization management, enrollee education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines.

c) The Contractor must have mechanisms in place to disseminate any changes in practice guidelines to its Participating Providers at least annually, or more frequently, as appropriate.

d) The Contractor shall develop and implement protocols for identifying Participating Providers who do not adhere to practice guidelines and for making reasonable efforts to improve the performance of these providers.

e) Annually, the Contractor shall select a minimum of two practice guidelines and monitor the performance of appropriate Participating Providers (or a sample of providers) against such guidelines. [Applicable to HARP Program Only] One of the two practice guidelines required by this subsection must be related to behavioral health.

16.3 Incentivizing Enrollees to Complete a Health Goal

a) Upon approval by SDOH, the Contractor may offer its Enrollees incentives for completing a health goal, such as finishing all prenatal visits, participating in a smoking cessation session, attending initial orientation sessions upon enrollment, undergoing assessments for determining eligibility for Benefit Package services, and timely completion of immunization or other health related programs. Additionally, the Contractor may offer its Enrollees incentives to promote the delivery of preventive care services, as defined in 42 CFR 1003.101. SDOH will determine if the incentive meets the requirements at 42 CFR 1003.101 and outlined in DHHS OIG Special Advisory Bulletin "Offering Gifts and Other Inducements to Beneficiaries."

b) Enrollee incentives described in this section of this Agreement may not be cash or instruments convertible to cash (e.g., checks, money orders, or debit cards) and must be related to the delivery of preventive care services to the Enrollee or the Enrollee achieving a health goal. The value of such incentives may not be disproportionally large in relationship to the value of the preventive care service or health goal completed by the Enrollee.

i) The Contractor should consider SSI earned income thresholds that may apply to SSI Enrollees when developing incentive programs.

ii) Under no circumstances shall the Contractor establish incentives or incentive programs that result in Enrollees that have achieved the same health goal or received the same preventive care service receiving an incentive of differing value.

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iii) The Contractor shall maintain contemporaneous records identifying the Enrollee, CIN, date, amount paid and the nature of the health goal for which the incentive is being paid.

c) The Contractor may not make reference to Enrollee incentives in its pre-enrollment marketing materials or discussions.

d) The Contractor shall not offer an incentive or incentive program to Enrollees that has not been approved by SDOH.

i) The Contractor shall submit all incentive program related materials to the SDOH for review and approval at least 60 days prior to the commencement of the incentive program and include documentation that supports that the value of the incentive complies with subsection (b) above.

ii) [Applicable to HARP and HIV SNP Programs only]: The Contractor must submit a plan for review and approval by the SDOH specifying the health goals and criteria that will be used to measure achievement of each health goal, and the associated incentive.

16.4 Quality Management (QM) Committee [Applicable to HIV SNP Program Only]

The Contractor will establish a QM Committee charged with implementing a comprehensive quality management plan under the direction of the HIV SNP Medical Director and the Governing Board of the Contractor. The Committee will meet, at a minimum, quarterly. QM functions of the Committee will include oversight of the QM peer review process and the provision of periodic written and oral reports to the Governing Board. The Committee will be made up of representatives of HIV SNP network members and individuals responsible for implementation of Quality Improvement (QI), including PCPs, other HIV specialists and non-clinician providers.

16.5 Quality Management Plan (QMP) [Applicable to HIV SNP Program Only]

The Contractor must maintain a QMP that includes:

a) Measurement of adherence to clinical and preventive health guidelines consistent with prevailing standards of professional medical practice and with standards as published on the AIDS Institute's web site for HIV Clinical Resources established and updated by the AIDS Institute;

b) Lines of accountability for the QM program indicating that the governing board is ultimately responsible for QM program activities;

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c) The responsibilities and composition of the QM committee, including QI committee(s), the frequency of meetings, and the methods for establishing agendas;

d) Description of the Medical Director's responsibility for the development, implementation, and review of the HIV SNP's comprehensive QM plan;

e) Methods for adopting clinical and preventive health guidelines and establishing performance standards to be utilized for the QM review;

f) Descriptions of routine data reports and other data sources that will be used to identify problems related to quality of care;

g) Procedures used to identify and review incidents and potential quality of care issues, develop timely and appropriate responses/recommendations, follow-up on implementation and recommendations for the resolution of problems, and develop strategies to improve quality;

h) Description of credentialing/re-credentialing procedures;

i) Standards for service accessibility;

j) A description of how quality management activities differ from utilization review activities and how utilization review activities are integrated with quality management activities;

k) A description of how consumer concerns will be identified, considering sources including but not limited to complaints and satisfaction surveys and how consumer concerns will be integrated into the overall QM plan and QI activities; and

l) Description of a QI Program and a formal QI Plan, including:

   i) a description of methods to be used for medical record review, including sampling techniques for performance measurement;

   ii) a description of how quality improvement teams will be utilized to implement clinical and other performance improvements;

   iii) a description of the QI process that will be used to improve quality of care;

   iv) a description of how decisions will be made and priorities set for measurement and review by chartering QI teams, with a clear delineation of responsibility for these activities and accountability through governance structures;

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v) a description of how performance data and information from QI activities will be distributed throughout the plan; and

vi) a description of how improvement interventions will be developed and implemented in response to findings from QI studies.

16.6 Quality Management (QM) Procedures [Applicable to HIV SNP Program Only]

The Contractor must have QM procedures in place to measure the following:

a) Compliance with performance, quality, access and availability standards promulgated by the SDOH;

b) Appropriateness, accessibility, timeliness, and quality of care delivered;

c) Referrals, coordination, monitoring, and follow-up with regard to HIV and other providers with appropriate consent;

d) Access to specialty services outside the HIV SNP's network or panel when an appropriately trained and experienced provider is not available in the panel;

e) That comprehensive services are delivered and that the QM program covers all provider types in network and ensures consistency across multiple provider types and sites; and

f) That culturally and linguistically appropriate member information is made available to Enrollees.

16.7 HIV SNP Medical Director Requirements [Applicable to HIV SNP Program Only]

a) The Medical Director must meet the qualifications for an HIV Specialist.

b) The Medical Director is responsible for the development, implementation, and review of the HIV SNP's comprehensive Quality Management/Quality Improvement Plan.

c) The Contractor's Medical Director shall participate in HIV SNP Quality meetings with the Medical Directors of the other HIV SNPs and representatives of the AIDS Institute. The Medical Director shall be responsible to attend all periodic meetings, which shall not exceed one (1) per month. In the event that the Medical Director is unable to attend a particular meeting, the Contractor will designate an appropriate clinical practitioner to attend the meeting.

16.8 HIV Education for Staff [Applicable to HIV SNP Program Only]

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a) The Contractor shall provide HIV education at least annually for its clinical, member services and case management staff. Topics should include, as appropriate to staff job functions, the following:

i) HIV Overview, including basic primary and preventive services specific to care, treatment and prevention of HIV infection;

ii) New advances in HIV clinical care, including advantages of new treatment regimens and therapies and advances in diagnostic HIV testing;

iii) Treatment adherence;

iv) Oral Health issues related to HIV;

v) Cross-cultural care issues appropriate to the enrolled populations being served;

vi) Family-centered psychosocial issues;

vii) Occupational exposure management and post-exposure prophylaxis;

viii) Mental health issues related to HIV; and

ix) Prevention strategies focused on incorporating HIV Prevention into the medical care of HIV infected persons ("Prevention for Positives").

b) The Contractor shall ensure that all HIV SNP staff and authorized agents receive HIV confidentiality training within seven (7) days of employment and prior to commencement of duties involving contact with confidential Enrollee health-related information.

c) Educational programs are to be conducted in coordination with the New York State Clinical Education Initiative or the AIDS Institute when possible

16.9 Quality Management (QM) and Provider Manuals [Applicable to HIV SNP Program Only]

As part of the QM program, the Contractor is required to develop an HIV SNP Quality Management Manual and an HIV SNP Provider Manual. These manuals are subject to review by SDOH and approval of the AIDS Institute.

a) Quality Management Manual

The HIV Quality Management Manual shall describe the HIV SNP Quality Management program, policies and procedures, utilization management

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procedures, and all other policies and procedures required by SDOH for licensure.

b) HIV SNP Provider Manual

The HIV SNP Provider Manual shall include all policies and procedures required by SDOH for licensure and also include policies and procedures describing the following HIV SNP-specific requirements:

i) Member to provider ratios;

ii) HIV Specialist PCP criteria including reassessment procedures and PCP criteria for HIV SNP Enrollees who are not infected;

iii) HIV Specialist PCP co-management requirements;

iv) Provider education requirements;

v) Treatment adherence services;

vi) Provider responsibility for HIV primary and secondary prevention activities and risk reduction education;

vii) HIV SNP Case Management policies and procedures including role of the provider in SNP medical case management/care coordination services;

viii) Referral to services including services outside of the Contractor's prepaid benefit package and services provided through HIV SNP linkage agreements;

ix) HIV SNP QM program's QM measurement standards for providers and requirements for exchange of data;

x) Requirements for care in accordance with AIDS Institute clinical standards;

xi) Enrollee access to clinical trials;

xii) Required use of approved assessment instruments for mental health and chemical dependence patient assessments; and

xiii) Required policies and procedures addressing Enrollees presenting for unscheduled, non-urgent care.

16.10 Quality Management (QM) Committee [Applicable to HARP Program Only]

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The Contractor shall establish and maintain a QM Committee charged with implementing a comprehensive Quality Management Plan under the direction of the HARP Medical Director and the Governing Board of the Contractor. QM functions of the Committee shall include oversight of the QM peer review process, the provision of periodic oral and written reports to the Governing Board and carrying out the planned activities of the QM program. The Committee shall meet, at a minimum, quarterly. The Committee shall report regularly to the governing board or its designee concerning QM activities. The Committee shall include, in an advisory capacity, Plan Enrollees, family members, peer specialists, peer advocates and provider representatives. The Committee shall maintain records documenting attendance by Plan Enrollees, family members, peer specialists, peer advocates and providers, as well as the Committee's findings, recommendations and actions.

16.11 HARP Quality Management Plan (QMP) [Applicable to HARP Program Only]

The Contractor must maintain a QMP that includes:

a) Lines of accountability for the QM program indicating that the governing board is ultimately responsible for QM program activities;

b) The responsibilities and composition of the QM committee, including QI committee(s), the frequency of meetings, and the methods for establishing agendas;

c) Description of the Behavioral Health Medical Director's responsibility for the development, implementation and review of the HARP's comprehensive QM plan;

d) Performance standards to be utilized for the QM review;

e) Descriptions of routine data reports and other data sources that will be used to identify problems related to quality of care;

f) Procedures used to identify and review incidents and potential quality of care issues, develop timely and appropriate responses/recommendations, follow-up on implementation and recommendations for the resolution of problems, and develop strategies to improve quality;

g) Description of credentialing and re-credentialing procedures consistent with Section 21.4 of this Agreement;

h) Standards for service accessibility consistent with Section 15 of this Agreement;

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i) A description of how quality management activities differ from utilization review activities and how utilization review activities are integrated with quality management activities;

j) A description of how consumer concerns will be identified, considering sources including, but not limited to, complaints and satisfaction surveys and how consumer concerns will be integrated into the overall QM plan and QI activities; and

k) Description of a QI Program and a formal QI Plan, including:

   i) a description of the QI process that will be used to improve quality of care;

   ii) a description of how performance data and information from QI activities will be distributed throughout the plan; and

   iii) a description of how improvement interventions will be developed and implemented in response to findings from QI studies

l) The Plan shall develop and maintain mechanisms to:

   i) Monitor service quality and develop quality improvement initiatives.

   ii) Solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes.

   iii) At a minimum, these mechanisms shall include consumer and other stakeholder advisory boards and key stakeholders. Key stakeholders shall include members, family members, care managers, any subcontractor involved in behavioral health benefit management, RPCs and other member serving agencies.

16.12 Quality Management (QM) Procedures [Applicable to HARP Program Only]

The Contractor must have QM procedures in place to measure the following:

a) Compliance with performance, quality, access and availability standards promulgated by the SDOH, OMH and OASAS;

b) Appropriateness, accessibility, timeliness, and quality of care delivered;

c) Referrals, coordination, monitoring, and follow-up with regard to behavioral health and other providers with appropriate consent;

d) Access to specialty services outside the HARP's network when a provider is not available in the network;

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e) That comprehensive services are delivered and that the QM program covers all provider types in network and ensures consistency across multiple provider types and sites;

f) That culturally and linguistically appropriate member information is made available to Enrollees; and

g) That appropriate member information is available for Enrollees with hearing and visual impairments, such as large print materials, audio materials and Braille materials.

16.13 Behavioral Health Clinical and Medical Directors Requirements

a) The requirements for Contractor's employment of Clinical and Medical Directors are contained in this section and in the State-issued Behavioral Health Guidance.

i) Behavioral Health Clinical Director: The Contractor shall retain a Behavioral Health Clinical Director who shall be a New York State licensed Behavioral Health Practitioner and meet the State-issued qualifications for the position.

ii) Behavioral Health Medical Director: The Contractor shall retain a Behavioral Health Medical Director who shall hold a valid New York State license to practice as a Physician and meet the State-issued qualifications for the position.

iii) [Applicable to HARP Program Only] HARP Behavioral Health Clinical Director: The Contractor shall retain a HARP Behavioral Health Clinical Director who shall be a New York State licensed Behavioral Health Practitioner and meet the State-issued qualifications for the position. For Contractors that operate a HARP with 4,000 or more Enrollees, the HARP Behavioral Health Clinical Director shall be a full-time employee dedicated to the HARP.

iv) [Applicable to HARP Program Only] HARP Behavioral Health Medical Director: The Contractor shall retain a HARP Behavioral Health Medical Director who shall hold a valid New York State license to practice as a Physician and meet the State-issued qualifications for the position. For Contractors that operate a HARP with 4,000 or more Enrollees, the HARP Behavioral Health Medical Director shall be a full-time employee dedicated to the HARP.

v) [Applicable to HARP Program Only] HARP Medical Director for General Medicine: The Contractor shall retain a Medical Director for General

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Medicine who shall hold a valid New York State license to practice as a Physician and meet the State-issued qualifications for the position. The HARP Medical Director for General Medicine, in collaboration with the Behavioral Health Medical Director, shall oversee the integration of general medicine with behavioral health services.

b) [Applicable to HARP Program Only] The Behavioral Health Medical Director and HARP Behavioral Health Clinical Director are responsible for the development, implementation, and review of the HARP's comprehensive Quality Management/Quality Improvement Plan.

c) [Applicable to HARP Program Only] The Contractor's Behavioral Health Medical Director, HARP Behavioral Health Clinical Director and HARP Medical Director for General Medicine shall participate in HARP Quality meetings with the Medical Directors of the other HARPs and representatives of OMH, OASAS, and the RPCs. The Behavioral Health Medical Director and HARP Behavioral Health Clinical Director shall be responsible to attend all periodic meetings, which shall not exceed one (1) per month. In the event that the Behavioral Health Medical Director and HARP Behavioral Health Clinical Director are unable to attend a meeting, the Contractor shall designate an appropriate clinical practitioner to attend the meeting.

16.14 HARP Behavioral Health Education for Staff [Applicable to the HARP and HIV SNP Programs]

a) The Contractor shall provide behavioral health training programs for its clinical, member services and case management staff. The training objectives shall be to strengthen the knowledge, skills, expertise and coordination efforts within the respective outreach, utilization management, care management, pharmacy and provider relations workforce. The training shall incorporate New York State's vision, mission, and operating principles for behavioral health managed care programs and services. The Contractor shall submit all staff training plans to DOH, OMH and OASAS for review as directed by the State. DOH, OMH and OASAS will facilitate Contractor access to training resources.

b) Training topics shall include, as appropriate to job function, the following:

i) The New York State behavioral health service delivery system, including range of services, local service systems, local populations and crisis services;

ii) The Contractor's policies and procedures regarding screening, referral and management of high risk individuals with behavioral health and/or co-occurring behavioral health and medical conditions;

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iii) Integrated care management principles;

iv) Recovery-oriented, person-centered principles and services;

v) Behavioral Health Home and Community Based Services definitions, assessment process and care plan development;

vi) Supportive housing and related services and supports;

vii) Issues specific to First Episode Psychosis;

viii) Use of medication-assisted treatment, including methadone, buprenorphine, vivitrol and naltexone;

ix) The revised behavioral health policies and procedures in the member handbook;

x) The use of LOCADTR; and

xi) Cross-cultural care issues appropriate to the enrolled populations being served.

c) The Contractor shall ensure that all HARP staff and authorized agents receive Mental Health and Substance Use Disorder confidentiality training within seven (7) days of employment and prior to commencement of duties involving contact with confidential Enrollee Behavioral Health information.

d) The Contractor shall conduct educational programs in consultation with the RPCs and in coordination with OMH and OASAS.

16.15 Quality Management (QM) and Provider Manuals [Applicable to HARP Program Only]

As part of the QM program, the Contractor is required to develop a HARP Quality Management Manual and a HARP Provider Manual. These manuals are subject to review and approval by SDOH, OMH and OASAS.

a) HARP Quality Management Manual

The HARP Quality Management Manual shall describe the HARP Quality Management program, policies and procedures, utilization management procedures, and all other policies and procedures required by SDOH for licensure.

b) HARP Provider Manual

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The HARP Provider Manual shall include all policies and procedures required by SDOH, OMH, and OASAS for licensure and also include policies and procedures describing the following HARP-specific requirements:

i) Expectation on providers to adhere to recovery-oriented principles, including provision of person-centered services;

ii) HARP Eligibility assessment process;

iii) Credentialing criteria for:

   A) OMH-licensed and OASAS-certified behavioral health providers;

   B) Designated Behavioral Health Home and Community Based Services providers; and

   C) Individual behavioral health practitioners.

iv) The use of the LOCATDR 3 tool for level of care determinations for OASAS services;

v) BHHCBS assessment, including use of the State-determined assessment tool, guidance on care planning process, guidance on care management, care coordination, and working with health homes;

vi) Referral process for BHHCBS;

vii) Provider education and training requirements;

viii) Utilization review criteria for BHHCBS and required documentation, including Enrollee service plans and member chart contents;

ix) Guidance on billing compliance;

x) Guidance on required documentation for reimbursement;

xi) Data reporting requirements;

xii) HARP-specific Grievance/Appeal procedures (if applicable).

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## 17. MONITORING AND EVALUATION

### 17.1 Right to Monitor Contractor Performance

The SDOH, OMH, OASAS or their designees, and DHHS shall each have the right, during the Contractor's normal operating hours, and at any other time a Contractor function or activity is being conducted, to monitor and evaluate, through inspection or other means, the Contractor's performance, including, but not limited to, the quality, appropriateness, and timeliness of services provided under this Agreement.

### 17.2 Cooperation During Monitoring and Evaluation

The Contractor shall cooperate with and provide reasonable assistance to the SDOH, OMH, OASAS, or their designees, and DHHS in the monitoring and evaluation of the services provided under this Agreement. This includes the monitoring and oversight roles of these agencies for behavioral health within the Quality Steering Committee (QSC)

### 17.3 Cooperation During On-Site Reviews

The Contractor shall cooperate with SDOH, OMH, and, OASAS and/or their designees in any on-site review of the Contractor's operations. SDOH, OMH, or OASAS shall give the Contractor notification of the date(s) and survey format for any full operational review at least forty-five (45) days prior to the site visit. This requirement shall not preclude SDOH or its designee from site visits upon shorter notice for other monitoring purposes.

### 17.4 Cooperation During Review of Services by External Review Agency

The Contractor shall comply with all requirements associated with any review of the quality of services rendered to its Enrollees to be performed by an external review agent selected by the SDOH.

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## 18. CONTRACTOR REPORTING REQUIREMENTS

### 18.1 General Requirements

a) The Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas, including but not limited to, utilization, amounts paid to providers and subcontractors, including Pharmacy Benefit Managers, relating to patient care services, and medical supplies, Complaints and Appeals, and Disenrollments for other than loss of Medicaid or FHPlus eligibility. The system must be sufficient to provide the data necessary to comply with the requirements of this Agreement.

   i) The Contractor's health information system shall comply with 42 CFR 438.242(b).

b) The Contractor must take the following steps to ensure that data received from Participating Providers is accurate and complete: verify the accuracy and timeliness of reported data; screen the data for completeness, logic and consistency; and collect utilization data in standardized formats as requested by SDOH.

c) [Applicable to HIV SNP and HARP Program only]: The Contractor must develop and implement HIV SNP and/or HARP-related computer systems (or system modifications for existing MMCs). The system should easily identify Enrollees for maintenance of accounts related to payment of HIV SNP and/or HARP capitation rates and monitor HIV SNP and/or HARP enrollments and transfers on a timely basis. The HIV SNP and HARP must be reported as a separate line of business, including the profit and loss statement. The system needs to provide data to be transmitted through the Health Commerce System (HCS) and must have ability to link with various data bases such as encounter reports and laboratory utilization.

d) The Contractor must take the following steps to reasonably ensure that data received from Non-Participating Providers is accurate and complete: screen the data for completeness, logic and consistency; and collect utilization data in standardized formats as requested by SDOH.

e) In a frequency and format specified by DOH, all data, documentation and information submitted to the State by the Contractor shall be certified by one of the following:

   i) The Contractor's Chief Executive Officer (CEO);

   ii) The Contractor's Chief Financial Officer (CFO); or

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iii) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for such certification.

18.2 Time Frames for Report Submissions

Except as otherwise specified herein, the Contractor shall prepare and submit to SDOH the reports required under this Agreement in an agreed media format within sixty (60) days of the close of the applicable semi-annual or annual reporting period, and within fifteen (15) business days of the close of the applicable quarterly reporting period.

18.3 SDOH Instructions for Report Submissions

SDOH, OMH and/or OASAS will provide Contractor with instructions for submitting the reports required by the agencies in Section 18.5 of this Agreement, including time frames, and requisite formats. The instructions, time frames and formats may be modified by SDOH, OMH and/or OASAS upon sixty (60) days written notice to the Contractor.

18.4 Notification of Changes in Report Due Dates, Requirements or Formats

SDOH may extend due dates, or modify report requirements or formats upon a written request by the Contractor to the SDOH, where the Contractor has demonstrated a good and compelling reason for the extension or modification. The determination to grant a modification or extension of time shall be made by SDOH.

18.5 Reporting Requirements

a) The Contractor shall submit the following reports to SDOH (unless otherwise specified). The Contractor will certify the data submitted pursuant to this section as required by SDOH. The certification shall be in the manner and format established by SDOH and must attest, based on best knowledge, information, and belief to the accuracy, completeness and truthfulness of the data being submitted.

i) Annual Financial Statements:

Contractor shall submit Annual Financial Statements to SDOH. The due date for annual statements shall be April 1 following the report closing date.

ii) Quarterly Financial Statements and Staffing Data

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A) Contractor shall submit Quarterly Financial Statements to SDOH. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter.

B) [Applicable to the HARP Program only] Contractor shall also submit quarterly Statements of staffing levels to DOH, OMH and OASAS in a format to be determined by the State. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter.

iii) Other Financial Reports:

Contractor shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to SDOH and the State Insurance Department (SID) in a timely manner as required by State laws and regulations, including but not limited to PHL §§ 4403-a, 4404 and 4409, Title 10 NYCRR Part 98; and when applicable, SIL §§ 304, 305, 306, and 310. The SDOH may require the Contractor to submit such relevant financial reports and documents related to its financial condition to the LDSS.

iv) Encounter Data:

A) Effective January 1, 2015, the Contractor shall prepare and submit encounter data twice a month, as specified by SDOH, to SDOH through SDOH's designated Fiscal Agent. Unless otherwise directed by SDOH, encounter data shall not be submitted to the SDOH, or its designee, more than 15 days from the ~~data~~date of adjudication of the corresponding claim. Each Contractor is required to have a unique identifier including a valid MMIS Provider Identification Number. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claim records of all contracted services rendered to the Enrollee in the current or any preceding months.

Effective January 1, 2015, twice a month submissions must be received by the SDOH, or its designee, , consistent with the timeframes specified above, to assure the submission is included in the SDOH's, or its designee's, twice a month production processing. The Contractor shall submit an annual notarized attestation that the encounter data submitted through the SDOH or its designee is, to the best of the Contractor's information, knowledge and belief, accurate and complete. The encounter data submission must comply with the format prescribed by the SDOH, or its designee, and shall include the name, ~~and~~ provider number and location of any ordering, referring,



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prescribing, servicing or attending provider and information on the rendering/operating/other professional. Generic Provider IDs shall be used only when specific Provider IDs remain unknown after reasonable inquiry. NPI numbers of providers not enrolled in Medicaid must be reported.

The Contractor may report encounter data records that have not been adjudicated from the provider submitted claim/encounter in the regular claims system, such as data collected through medical record review, if the following conditions are met:

1) The Contractor shall ensure that medical records, notes and documentation constituting the source of the submitted data be available for review by the ~~Department~~ SDOH and OMIG for a period of six years from the date of service. For any records maintained by the Contractor under this Section, the Contractor shall retain such records in accordance with Section 19.4 of this Agreement.

2) Proof is maintained by the Contractor that an Explanation of Benefits (EOB) was sent to the provider for all Medicaid Encounter Data collected and submitted to the SDOH or its designee, with the diagnosis and procedures clearly specified.

3) The internal data system storing these records is subject to audit.

4) All records created or modified through this information gathering process must be made identifiable to SDOH using unique encounter control numbers (ECNs). Algorithms used to assign ECNs for these records must be sent to SDOH prior to data submission.

B) Effective January 1, 2015 the Contractor shall submit pharmacy data in a format prescribed by the SDOH or its designee, to the SDOH, or its designee, on a daily basis. Such data will be included in the SDOH's or its designee's daily production processing. Unless otherwise directed by SDOH, encounter data shall not be submitted to the Fiscal Agent more than 1 business day from the date of adjudication of the corresponding claim. In addition, all adjustments to claims must be reported no later than 45 days after the end of the quarterly rebate period for which the claim was originally submitted.

Encounter data for 340B drug claims shall be tagged as 340B in accordance with SDOH requirements, as follows:

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| Claim Type | Field | 340B Identifier |
|---|---|---|
| 837P/837I | Modifier | UD |
| NCPDP | 420-DK, Submission Clarification Code (SCC) | 20 |

The contractor or its designee must ensure that all 340B entities and or pharmacies have their 340B drug claims identified properly – either upon initial submission or through adjustments – no later than 45 days after the end of each quarterly rebate period.

C) I) The Contractor shall report the amount paid by a PBM for pharmaceutical services, where such services are paid on a fee-for-service basis. Where the PBM pays a derived sub-capitated amount for pharmaceutical services, the Contractor shall enter the required code and derived amount in the encounter.

II) The contractor shall report the amount paid to a PBM by the Contractor for pharmaceutical services, where such services are paid on a fee-for-service basis. Where the amount paid reflects a derived sub-capitated amount for pharmaceutical services, the Contractor shall enter the required code and derived amount in the encounter.

D) Contractor shall ensure to the best of the Contractor's knowledge, information and belief, that all required encounter data fields are submitted to the SDOH, or its designee, and are populated with accurate and complete data.

E) The Contractor shall maintain information as to:

1) the ordering/referring, prescribing, servicing, or attending provider(s);
2) the rendering/operating/other professional;
3) the provider group(s) that bill on behalf of their members and the members of each such group; and
4) the supervising providers in hospital settings;

relating to an encounter and the Contractor shall report such ordering/referring, prescribing, servicing or attending provider and information on the rendering/operating/other professional information via data provided to the SDOH, or its designee in accordance with Sections 18.5(a)(iv)(A) and 18.5(a)(iv)(B) of this Agreement.

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F) Consistent with the procedures established and in a format to be developed by SDOH, the Contractor shall report the NYS provider license number and NPI of any subcontractor performing services. Where the subcontractor performing services does not have a NYS provider license number or NPI, the Contractor shall report the Tax Payer ID of the subcontractor.

G) If the Contractor fails to submit encounter data within timeframes specified in Section 18.5 of this Agreement, the SDOH shall impose monetary sanctions upon the Contractor. These sanctions shall be $2,000 for each calendar day that the encounter data is not submitted. The SDOH may waive these sanctions if it is determined that the Contractor was not at fault for the late submission of the data.

H) If the Contractor fails to correct a deficiency in submitted encounter data upon notification and within the timeframes specified in a corrective action plan approved by the Department, the SDOH shall impose monetary sanctions upon the Contractor. These sanctions shall be $2,000 for each calendar day that exceeds the timeframes specified in the corrective action plan. The SDOH may waive these sanctions if it is determined that the Contractor was not at fault for the failure to correct the deficiency within the time frame specified in the approved corrective action plan.

v) Quality of Care Performance Measures:

A) The Contractor shall prepare and submit reports to SDOH, as specified in the Quality Assurance Reporting Requirements (QARR). The Contractor must arrange for an NCQA-certified entity to audit the QARR data prior to its submission to the SDOH unless this requirement is specifically waived by the SDOH. The SDOH will select the measures which will be audited.

B) [Applicable to HIV SNP Program only]: The Contractor is required to develop MIS capacity to collect and maintain data that can be translated to meet the specification of quality indicator measures used or adopted by the AIDS Institute. Such measures include but are not limited to Enrollee-specific laboratory data (viral loads, CD4 counts, resistance test profiles, ARV and other medications, and public health screenings such as TB, STD and Hepatitis). SDOH reserves the right to require submission of such indicator measures in a format and frequency as determined by the AIDS Institute.

C) By December 1 of each calendar year, SDOH will issue the general parameters of the Quality Incentive measures to be implemented for the subsequent year which form the basis for awarding the Quality

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Incentive in the year following the measurement. After the Behavioral Health Benefit Inclusion date, such parameters will include additional HEDIS/QARR measures or other metrics, expanded or supplementary satisfaction surveys, new behavioral health preventable services indicators and an expanded Statement of Deficiency component.

vi) Service Authorization, Complaint and Action Appeal Reports:

A) The Contractor must provide the SDOH, on a quarterly basis in a manner and format determined by SDOH, a summary of the number of Service Authorization Requests received regarding medically necessary prescription medications in the atypical antipsychotic, anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, smoking cessation agents, prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, hematologic or immunologic therapeutic drug classes for Enrollees, including the disposition of such requests and the number authorized pursuant to SSL §§ 364-j (25) and (25-a).

B) The Contractor must provide the SDOH on a quarterly basis, and within fifteen (15) business days of the close of the quarter, a summary of all Complaints and Action Appeals subject to PHL § 4408-a received during the preceding quarter via the Summary Complaint Form on the Health Commerce System (HCS). The Summary Complaint Form has been developed by the SDOH to categorize the type of Complaints and Action Appeals subject to PHL § 4408-a received by the Contractor.

C) The Contractor agrees to provide on a quarterly basis, via Summary Complaint Form on the HCS, the total number of Complaints and Action Appeals subject to PHL § 4408-a that have been unresolved for more than forty-five (45) days. The Contractor shall maintain records on these and other Complaints, Complaint Appeals and Action Appeals pursuant to Appendix F of this Agreement.

D) The Contractor must provide SDOH on a quarterly basis, in a manner and format determined by SODH, a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports.

E) Nothing in this Section is intended to limit the right of the SDOH, OMH and OASAS or their designee to obtain information immediately from a Contractor pursuant to investigating a particular Enrollee or provider Complaint, Complaint Appeal or Action Appeal.

vii) Fraud, Waste and Abuse Reporting Requirements:

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A) Pursuant to 42 CFR 438.608(a)(7), the Contractor, and its Subcontractors shall report all cases of potential fraud, waste, and abuse to OMIG.

I) Reporting of potential fraud, waste, and abuse under this section includes all potential fraud, waste, or abuse committed by, including but not limited to, the Contractor, Participating or Non-Participating Providers, Subcontractors, vendors, Enrollees, rendering professionals, ordering or referring professionals, the Contractor's or Subcontractor's employees, management or any third party.

II) The Contractor and its Subcontractors must submit to the ~~SDOH and~~ OMIG the following information ~~on an ongoing basis~~ for each ~~reasonably suspected or confirmed~~ case of potential fraud, waste and abuse it identifies through ~~C~~complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, Enrollees, or any other source:

~~I)~~ 1) The name of the individual or entity that committed, or is ~~reasonably~~ suspected of committing the potential fraud, waste, or abuse and any available contact information;

~~II)~~ 2) The source that identified the ~~reasonably suspected or confirmed~~ potential fraud, waste, or abuse;

~~III)~~ 3) The type of provider, entity or organization that committed, or is ~~reasonably~~ suspected of committing the potential fraud, waste, or abuse;

~~IV)~~ 4) A description of the ~~reasonably suspected or confirmed~~potential fraud, waste, or abuse and relevant time period;

~~V)~~ 5) The approximate dollar amount of the ~~reasonably suspected or confirmed~~potential fraud, waste, or abuse;

6) The claims detail which are the subject of the potential fraud, waste, or abuse;

7) Specify whether the allegation is potential:

*a)* fraud,

*b)* waste, or

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*c)* abuse;

VI) 8) The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred. No disposition of any case by the Contractor shall limit the authority of the New York State Office of the Attorney General (OAG), SDOH, OMIG, or the Office of the State Comptroller (OSC) to investigate, audit or obtain recoveries including overpayments, penalties and damages from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party; and

VII) 9) Other data/information as prescribed by SDOH and OMIG.

B) III) Procedures for Reporting

1) Such report shall be submitted The Contractor or Subcontractor shall submit such report to OMIG, in a form and format to be determined by OMIG, within ten (10) business days of the Contractor, or Subcontractor, identifyingwhen cases of the potential fraud, waste, and abuse are reasonably suspected or confirmed, and shall be reviewed and signed by an executive officer of the Contractor or of the Subcontractor.

2) If the approximate dollar amount of the potential fraud, waste, or abuse is less than two thousand five hundred dollars ($2,500), the Contractor or Subcontractor may, after reporting the potential fraud, waste, or abuse to OMIG, proceed with recovery efforts.

3) If the approximate dollar amount of the potential fraud, waste, or abuse exceeds two thousand five hundred dollars ($2,500) or the Contractor or Subcontractor is unable to determine an approximate dollar amount of the potential fraud, waste, or abuse, the Contractor or Subcontractor shall not take any of the following actions without written authorization from OMIG:

I) Unless prior written approval is obtained from SDOH or OMIG, after reporting a case of reasonably suspected or confirmed fraud or abuse, the Contractor shall not take any of the following actions:

1*a*) Inform the subject of the report of the existence of the referral or investigation by the State;

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~~2~~*b*) File a legal action or ~~E~~enter into or attempt to negotiate any settlement or agreement regarding the case of potential fraud, waste, or abuse; or

~~3~~*c*) Impose or accept any credit, debit, or offset in connection with the case of potential fraud, waste, or abuse.

4) For all reports of potential fraud, waste, or abuse OMIG receives from the Contractor or Subcontractor where the approximate dollar amount of the potential fraud, waste, or abuse exceeds two thousand five hundred dollars ($2,500), OMIG shall, within thirty (30) days of receiving the report, notify the Contractor or Subcontractor that:

*a)* The report has been accepted and the prohibitions, unless otherwise directed by OMIG, under Section 18.5(a)(vii)(A)(III)(3) of this Agreement remain in effect; or

*b)* The report has been returned to the Contractor or Subcontractor to proceed with recovery efforts.

5) If the Contractor or Subcontractor does not receive a response from OMIG within thirty (30) days of submitting a report of potential fraud, waste, or abuse, the Contractor or Subcontractor, may conclude that it is authorized to proceed with recovery efforts.

IV) For all reports of potential fraud, waste, or abuse, in determining the approximate dollar amount of the potential fraud, waste, or abuse, the Contractor or Subcontractor shall:

1) include all claims which are the subject of the potential fraud, waste, or abuse;

2) aggregate the claims into a single report if the matter includes any combination of potential fraud, waste, or abuse; and

3) not limit the scope of its review or otherwise attempt to reduce, for the purposes of reporting to OMIG, the approximate dollar amount of the potential fraud, waste, or abuse below two thousand five hundred dollars ($2,500).

V) The provisions of Sections 18.5(a)(vii)(A)(III)(2) – (5) of this Agreement do not apply to any report which OMIG determines and notifies the Contractor or Subcontractor does not meet the

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requirements of Section 18.5(a)(vii)(A) of this Agreement. For any report returned to the Contractor or Subcontractor as incomplete, the Contractor or Subcontractor shall resubmit the report in the same manner new reports are submitted pursuant to Section 18.5(a)(vii)(A)(III) of this Agreement.

VI) The provisions of 18.5(a)(vii)(A)(III) notwithstanding, the Contractor or Subcontractor shall cooperate with OMIG and comply with all directions of OMIG with respect to reports of potential fraud, waste, or abuse.

B) In addition to the Contractor's obligation to refer all cases of potential fraud to OMIG, and to comply with all of the requirements of Section 18.5(a)(vii)(A) of this Agreement, the Contractor or Subcontractor, may also refer cases of potential fraud to the OAG. With respect to any case of potential fraud referred to the OAG, the Contractor, or Subcontractor, may, unless otherwise directed by the OAG, continue to investigate, but shall not unless prior written approval is obtained from the OAG and OMIG, take any of the following actions:

I) Inform the subject of the report of the existence of the referral or investigation by the State;

II) File a legal action or enter into or attempt to negotiate any settlement or agreement regarding the case of potential fraud; or

III) Impose or accept any credit, debit, or offset in connection with the case of potential fraud.

C) ~~The Contractor will report to SDOH and OMIG, any reasonably suspected criminal activity or fraud or abuse committed by an Enrollee, provider, rendering professional, the Contractor, subcontractor or the Contractors' or subcontractors' employee or management, or third party where there is suspicion of such activity, within seven (7) days of learning of such behavior. Such report will be in a manner prescribed by SDOH, in consultation with OMIG.~~ For the purposes of this Section, ~~reasonably suspected or confirmed criminal activity and/or~~ potential fraud, waste. and abuse includes but is not limited to, submitting claims for services not rendered, providing unnecessary services, or possessing forged documents including prescriptions and other unacceptable practices listed in 18 NYCRR 515.2.

~~D) The Contractor shall report the identity of the Pharmacy Benefit Manager (PBM) for its pharmacy encounters.~~

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~~E) The Contractor shall report monthly to SDOH and OMIG, in a form and format to be determined by SDOH and OMIG, any Participating Providers who the Contractor has terminated "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.~~

~~F) The Contractor shall report monthly to SDOH and OMIG, in a form and format to be determined by SDOH and OMIG, any Participating Providers who the Contractor has not renewed its Participating Provider agreement with "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.~~

viii) Program Integrity Reporting:

A) Recipient Restriction Program

I) The Contractor shall report Enrollee Restriction(s) at the time the restriction becomes effective in a format specified by the SDOH and OMIG. Any continued restriction period must be reported to the OMIG in the same manner as for a newly restricted Enrollee.

II) The Contractor shall report monthly, in a format specified by the SDOH and OMIG, any change to an existing restriction.

B) Comprehensive Provider Report

The Contractor shall submit to the SDOH and OMIG quarterly, in a form and format to be determined by SDOH and OMIG, a report which shall include the total dollar amount of claims submitted by Participating and Non-Participating Providers under the MMC Program to the Contractor or any agent of the Contractor, including any Pharmacy Benefit Manager, the total dollar amount paid to Participating and Non-Participating Providers under the MMC Program by the Contractor or any agent of the Contractor, including any Pharmacy Benefit Manager, and the total dollar amount of services ordered, referred or prescribed by Participating and Non-Participating Providers under the MMC Program during the reporting period.

C) Program Integrity Annual Assessment Report

The Contractor shall conduct an annual assessment and submit to OMIG an annual report, in a form and format to be determined by SDOH and OMIG, of the status of their conformity with all Contractor regulatory and contractual Medicaid program integrity obligations (list to be developed by SDOH and OMIG) by December 31 of each calendar year.

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D) Pharmacy Benefit Manager Quarterly Report

The Contractor shall submit to SDOH and OMIG a quarterly report of the amount paid to a PBM for pharmaceutical services by categories, including amounts for each prescription drug by NDC code, and also paid to a PBM for administrative services.

E) Deficit Reduction Act Certification

The Contractor, if subject to the requirements of section 1902(a)(68) of the Social Security Act, shall submit to OMIG in December of each year, a certification that it maintains the written policies, and any employee handbook, required in accordance with section 1902(a)(68) of the Social Security Act and that they have been properly adopted and published by the Contractor, and disseminated among employees, subcontractors and agents. The certification shall be made using a form provided by the OMIG on its website. Upon SDOH request, the Contractor shall provide to SDOH proof of the Contractor's submission to OMIG of such certification.

F) Provider Investigate Report

The Contractor shall submit to SDOH and OMIG a ~~quarterly~~ monthly report, in a form and format to be determined by OMIG in consultation with SDOH, of all Participating Provider and Non-Participating Provider investigate and educational or re-educational activities. The report will include, but is not limited to~~,~~:

1) copies of any agreements executed between the Contractor and Participating Providers or Non-Participating Providers as a result of the action and a summary of the investigative results;

2) if not referred to in such agreements, the total amount withheld from each Participating Provider or Non-Participating Provider;

…….

3) all overpayments identified or recovered from Participating or Non-Participating Providers, specifying the overpayments due to potential fraud, and shall keep or return such overpayments in accordance with Section 22.7 of this Agreement;

4) all unsolicited refunds the Contractor receives from Participating or Non-Participating Providers; and

5) Section 18.5(a)(viii)(F)(1)-(4) activities by a Subcontractor

G) Contractor Overpayment Report



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Pursuant to 42 CFR 438.608(c)(3), the Contractor shall report to SDOH and OMIG within sixty (60) days after it identifies, or has received notice of, any capitation payments or other payments in excess of amounts specified in this Agreement, and shall return such overpayments to SDOH in accordance with Section 23.3 of this Agreement. Such report shall be in a form and format to be determined by SDOH and OMIG.

H) The Contractor shall report the identity of the Pharmacy Benefit Manager (PBM) for its pharmacy encounters

I) If the Contractor or its Subcontractor reasonably suspects criminal activity by any of the individuals or entities identified in 18.5(a)(vii)(A)(I) of this Section, the Contractor or its Subcontractor shall immediately refer such matters to OMIG and the OAG, in a form and format to be determined by OMIG and the OAG and take no further action without written approval from OMIG and OAG.

J) The Contractor shall report monthly to SDOH and OMIG, in a form and format to be determined by SDOH and OMIG, any change in a Participating Provider's circumstances that may affect eligibility to participate in the managed care program, including, but not limited to, Participating Providers with whom the Contractor ~~has~~did not renew its Participating Provider agreement "for cause" or the Contractor terminated "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.

~~viii~~ix) Participating Provider Network Reports:

The Contractor shall submit electronically, to the Health Commerce System (HCS) as well as a hard-copy in a manner prescribed by OMH, to OMH, an updated provider network report on a quarterly basis. The Contractor shall submit an annual notarized attestation that the providers listed in each submission have executed an agreement with the Contractor to serve Contractor's MMC and/or FHPlus Enrollees, as applicable. The report submission must comply with the Managed Care Provider Network Data Dictionary. Networks must be reported separately for each county in which the Contractor operates.

~~i~~x) Appointment Availability/Twenty-four (24) Hour Access and Availability Surveys:

The Contractor will conduct a county specific (or service area if appropriate) review of appointment availability and twenty-four (24) hour access and availability surveys annually. Required access and availability



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standards are described in section 15 of this Agreement. The Contractor shall take appropriate corrective action with providers who fail to meet these standards. Results of such surveys must be kept on file and be readily available for review by the SDOH, upon request.

xi) Clinical Studies:

A) The Contractor will participate in up to four (4) SDOH sponsored focused clinical studies annually. The purpose of these studies will be to promote quality improvement.

B) The Contractor is required to conduct at least one (1) internal performance improvement project each year in a priority topic area of its choosing with the mutual agreement of the SDOH and SDOH's external quality review organization. Performance improvement projects conducted by the Contractor shall meet all requirements described in 42 CFR 438.330(d). The Contractor may conduct its performance improvement project in conjunction with one or more MCOs. The purpose of these projects will be to promote quality improvement within the Contractor's MMC and/or FHPlus product. SDOH will provide guidelines which address study structure and reporting format. Written reports of these projects will be provided to the SDOH and validated by the external quality review organization.

C) [Applicable to HIV SNP Program only]: The Contractor shall collaborate in established research being conducted by the AIDS Institute designed to evaluate patient access to care, patient satisfaction and quality of life. The Contractor shall obtain appropriate patient consent and IRB consent if required.

D) [Applicable to HARP Program Only] The Contractor shall participate in at least one (1) focused clinical study and at least one (1) internal performance improvement project relevant to behavioral health each year in a priority topic area of the State's choosing or subject to the State's approval.

xii) Independent Audits:

The Contractor must submit copies of all certified financial statements and QARR validation audits by auditors independent of the Contractor to the SDOH within thirty (30) days of receipt by the Contractor.

xiii) New Enrollee Health Screening Completion Report:

The Contractor shall submit a quarterly report within sixty (60) days of the close of the quarter showing the percentage of new Enrollees for which the

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Contractor was able to complete a health screening consistent with Section 13.6(b) of this Agreement. The formula for this report is as follows: the total number of new Enrollee health screenings completed within sixty (60) days of the Enrollee's Effective Date of Enrollment, divided by the total number of new Enrollees during the quarter. Enrollees returning to the same product line within one year and newborns should not be counted in the formula.

xi~~ii~~v) Facilitated Enroller Staffing Reports:

The Contractor shall submit a monthly staffing report during the last fifteen (15) calendar days of each month showing the number of full-time equivalents (FTEs) employed or funded for purposes of facilitated enrollment and/or community outreach designed to develop enrollment opportunities or present coverage options for , all Public Health Insurance Programs and solely for Medicaid Advantage and/or Medicaid Advantage Plus programs, as applicable.

x~~i~~v) Enrollee Primary Care Provider Assignment Reports:

The Contractor shall submit electronically, to the Health Commerce System (HCS), an updated Enrollee primary care provider assignment report on a quarterly basis. The Contractor shall submit an annual notarized attestation, to the best of the Contractor's information, knowledge and belief, that the Enrollees listed in each submission are assigned to the primary care providers. The report submission must comply with the Panel Size Data Dictionary as posted on the Health Commerce System (HCS).

xvi) MCO Covered Drugs Report:

Pursuant to requirements of the federal Patient Protection and Affordable Care Act (PPACA), P.L. 111-148 and Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, together called the Affordable Care Act, Managed Care Organizations (MCOs) must provide information on drugs provided to individuals enrolled in the MCO if the MCO is responsible for coverage of such drugs. Specifically, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of PPACA, requires the State to provide utilization information for MCO covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to the Centers for Medicare and Medicaid Services.

To support the SDOH's mandate to invoice and report on MCO covered drugs, the Contractor shall provide data to the SDOH for dates of service beginning March 23, 2010, as follows:

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A) The Contractor shall submit the data required in Section 18.5 a) xv) C) of this Agreement to the SDOH for the period March 23, 2010 through September 19, 2012. The SDOH will send the Contractor a list of encounters submitted for this period, with reported rebate eligible drugs. The Contractor shall submit updated encounter records for the listed encounters, to the extent the data is available, within two (2) weeks of receipt of this list.

B) The Contractor shall submit drug utilization information on a weekly basis until such time as an alternate schedule is determined by SDOH.

C) The Contractor shall report information on: total number of units of each dosage form; strength and package size by National Drug Code (NDC) of each drug provided to MCO Enrollees; and, such other data as the SDOH determines necessary.

~~xvi) Recipient Restriction Program~~

~~A) The Contractor shall report Enrollee Restriction(s) at the time the restriction becomes effective in a format specified by the SDOH and OMIG. Any continued restriction period must be reported to the OMIG in the same manner as for a newly restricted Enrollee.~~

~~B) The Contractor shall report monthly, in a format specified by the SDOH and OMIG, any change to an existing restriction.~~

xvii) [Applicable to HIV SNP Program Only]:

Within fifteen (15) business days of the close of each quarter, the Contractor must provide, in a format specified by the AIDS Institute, a report of new Enrollees with verification of eligibility to enroll, as specified in Section 6.11 of this Agreement.

~~xviii) Comprehensive Provider Report~~

~~The Contractor shall submit to the SDOH and OMIG quarterly, in a form and format to be determined by SDOH and OMIG, a report which shall include the total dollar amount of claims submitted by Participating and Non-Participating Providers under the MMC Program to the Contractor or any agent of the Contractor, including any Pharmacy Benefit Manager, the total dollar amount paid to Participating and Non-Participating Providers under the MMC Program by the Contractor or any agent of the Contractor, including any Pharmacy Benefit Manager, and the total dollar amount of services ordered, referred or prescribed by Participating and Non-~~

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~~Participating Providers under the MMC Program during the reporting period.~~

~~xix) Program Integrity Annual Assessment Report~~

~~The Contractor shall conduct an annual assessment and submit to OMIG an annual report, in a form and format to be determined by SDOH and OMIG, of the status of their conformity with all Contractor regulatory and contractual Medicaid program integrity obligations (list to be developed by SDOH and OMIG) by December 31 of each calendar year.~~

~~xx) Pharmacy Benefit Manager Quarterly Report~~

~~The Contractor shall submit to SDOH and OMIG a quarterly report of the amount paid to a PBM for pharmaceutical services by categories, including amounts for each prescription drug by NDC code, and also paid to a PBM for administrative services.~~

x~~x~~viii) The Contractor shall submit to OMH and OASAS a quarterly report of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers. The Contractor shall report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

~~xxii) Deficit Reduction Act Certification~~

~~The Contractor, if subject to the requirements of section 1902(a)(68) of the Social Security Act, shall submit to OMIG in December of each year, a certification that it maintains the written policies, and any employee handbook, required in accordance with section 1902(a)(68) of the Social Security Act and that they have been properly adopted and published by the Contractor, and disseminated among employees, subcontractors and agents. The certification shall be made using a form provided by the OMIG on its website.~~

~~xxiii) Provider Investigative Report~~

~~The Contractor shall submit to SDOH and OMIG a quarterly report, in a form and format to be determined by OMIG in consultation with SDOH, of all Participating Provider and Non-Participating Provider investigative and educational or re-educational activities. This report will include, but is not limited to, copies of any agreements executed between the Contractor and Participating Providers or Non-Participating Providers as a result of the action and a summary of the investigative results.~~

xix) Drug Utilization Review Program Report



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Pursuant to 42 CFR 438.3(s)(5), the Contractor shall submit to SDOH an annual report, in a form and format to be determined by SDOH, containing a detailed description of the Contractor's drug utilization review program activities.

xx) Medical Loss Ratio (MLR) Reporting

For each MLR reporting year, the Contractor must report the information identified in 42 CFR 438.8(k)(1) to SDOH in a form and format and timeframe to be determined by SDOH, but no later than twelve (12) months after the end of each MLR reporting year.

xxi) Accreditation Reporting Requirements

A) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall inform the SDOH of receipt of such accreditation. The Contractor shall authorize the private independent accrediting entity that accredited the Contractor to provide the SDOH a copy of its most recent accrediting review, including:

I) accreditation status, survey type and level (as applicable);

II) accreditation results, including recommended actions or improvements, corrective action plans and summaries of findings; and

III) expiration date of the accreditation.

xxii) Mental Health and Substance Use Disorder Parity Reporting Requirements

Upon request by the SDOH, OMH or OASAS the Contractor shall prepare and submit documentation and reports, in a form and format specified by SDOH, OMH or OASAS, necessary for the SDOH, OMH or OASAS to establish and demonstrate compliance with 42 CFR 438 Subpart K, and applicable State statute, rules and guidance.

xxi~~v~~ii) Additional Reports:

Upon request by the SDOH, OMH or OASAS the Contractor shall prepare and submit other operational data reports. Such requests will be limited to situations in which the desired data is considered essential and cannot be obtained through existing Contractor reports. Whenever possible, the Contractor will be provided with ninety (90) days notice and the

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opportunity to discuss and comment on the proposed requirements before work is begun. However, the SDOH reserves the right to give thirty (30) days notice in circumstances where time is of the essence.

18.6 Ownership and Related Information Disclosure

a) Ownership and/or control interest in the Contractor/disclosing entity must be collected in accordance with this section. A person with an ownership or control interest means a person or corporation that:

i) has an ownership interest totaling five (5) percent or more in the Contractor/disclosing entity;

ii) has an indirect ownership interest equal to five (5) percent or more in the Contractor/disclosing entity;

iii) has a combination of direct and indirect ownership interests equal to 5 percent or more in the Contractor/disclosing entity;

iv) owns an interest of five (5) percent or more in any mortgage, deed of trust, note or other obligation secured by the Contractor/disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the Contractor/disclosing entity;

v) is an officer or director of the Contractor/disclosing entity that is organized as a corporation; or

vi) is a partner in a disclosing entity that is organized as a partnership.

b) Pursuant to 42 CFR 455.104, the Contractor must disclose complete ownership, control and relationship information to the SDOH as specified in c) i) A-G below:

i) upon execution of a contract with the SDOH;

ii) upon execution of a renewal or extension of the contract with the SDOH; or

iii) within 35 days after any change in ownership of the Contractor.

c) Pursuant to 42 CFR 455.104, the Contractor will obtain a disclosure of complete ownership, control, and relationship information from disclosing entities. For the purposes of this section, a disclosing entity is any entity other than an individual practitioner or group of practitioners, as defined by 42 CFR 455.101, that is a Participating Provider in the Contractor's network.

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i) The Contractor must require each disclosing entity to disclose:

A) the name and address of each person (individual or corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership;

B) the date of birth and Social Security number for any individual with an ownership or control interest;

C) whether any of the persons named, in compliance with (A) of this section , is related to another as spouse, parent, child, or sibling;

D) a tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest;

E) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling;

F) the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

G) The name, address, date of birth and social security number of any managing employee of the disclosing entity.

ii) In order to minimize the Provider's reporting requirements, the Contractor must accept the following:

A) For New York State fee for service providers who also participate in Medicaid managed care, the Contractor shall accept a copy and/or update of the standard Medicaid fee for service enrollment form to satisfy this requirement.

B) If the provider is not a Medicaid fee for service provider, but participates in Medicaid managed care, such information will be provided in a format prescribed by SDOH.

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iii) The Contractor must keep evidence of all requests to obtain this information and copies of the information obtained from disclosing entities, and make this information available to the State within 35 days of the request.

iv) A disclosing entity must supply the information specified in c) i) of this section to the Contractor upon an application for participation; upon execution of an agreement with Contractor; and/or within 35 days after a change in ownership of the disclosing entity.

d) Pursuant to 42 CFR 455.105 (Business Transactions):

i) the Contractor and its contracted providers must submit, within 35 days of the date of the request by the SDOH or Secretary of DHHS, full and complete information about:

A) the ownership of any subcontractor with whom the Contractor has had a business transaction(s) totaling more than $25,000 during the 12 month period ending on the date of the request; and

B) the ownership of any subcontractor with whom the Provider has had a business transaction(s) totaling more than $25,000 during the 12 month period ending on the date of the request; and

C) any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5 year period ending on the date of the request; and

D) any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5 year period ending on the date of the request.

ii) For the purposes of section 18.6 d) i) C) and D), a "wholly owned supplier" shall mean a supplier of services or items under this Agreement whose total ownership is held by the Contractor/provider or by a person, persons, or other entity with an ownership or control interest in the Contractor/provider.

iii) A supplier means an individual, agency, or organization from which a Contractor/provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

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iv) For purposes of this subsection, a subcontractor means an individual, agency or organization to which the Contractor or disclosing entity has contracted or delegated some of its management functions or responsibilities for providing medical care, service or supplies to Enrollees.

18.7 Public Access to Reports

Any data, information, or reports collected and prepared by the Contractor and submitted to NYS authorities in the course of performing their duties and obligation under this Agreement will be deemed to be a record of the SDOH subject to and consistent with the requirements of Freedom of Information Law. This provision is made in consideration of the Contractor's participation in the MMC and/or FHPlus Program for which the data and information is collected, reported, prepared and submitted.

18.8 Professional Discipline

a) Pursuant to PHL § 4405-b, the Contractor shall have in place policies and procedures to report to the appropriate professional disciplinary agency within thirty (30) days of occurrence of any of the following:

i) the termination of a health care Provider Agreement pursuant to Section 4406-d of the PHL for reasons relating to alleged mental and physical impairment, misconduct or impairment of patient safety or welfare; or

ii) the voluntary or involuntary termination of a contract or employment or other affiliation with such Contractor to avoid the imposition of disciplinary measures; or

iii) the termination of a health care Participating Provider Agreement in the case of a determination of fraud or in a case of imminent harm to patient health.

b) The Contractor shall make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Articles 130 and 131-A of the New York State Education Law (Education Law).

c) Pursuant to 42 CFR 1002.3, prior to the Contractor entering into or renewing any agreement with a Participating Provider or Subcontractor, or at any time upon written request by SDOH, the Participating Provider or Subcontractor must disclose to the Contractor the identity of any person described in 42 CFR § 1001.1001(a)(1).

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d) Contractor Notification Requirements of this Section

i) The Contractor must notify the SDOH of any disclosures made under subsection c) within 20 working days from the date it receives the information.

ii) The Contractor must notify the SDOH within 20 working days of any determination it makes on the provider's application for enrollment in its network.

iii) The Contractor must notify the SDOH within 20 working days of any determination it makes to limit the ability of an individual or entity to continue participating in its network, regardless of what such determination is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

e) Contractor Refusal Rights to Providers Under this Section

i) Unless otherwise authorized by SDOH, the Contractor should refuse to enter into or renew an agreement with a provider if any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or Title XX services program.

ii) Unless otherwise authorized by SDOH, the Contractor should refuse to enter into, or may opt to terminate, a Participating Provider agreement if it determines that the provider did not fully and accurately make the required disclosures.

18.9 Certification Regarding Prohibited Affiliations and Individuals Who Have Been Debarred Or Suspended By Federal or State Government

a) Contractor will certify to the SDOH initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual or entity who has been debarred or suspended by the federal or state government, ~~or otherwise~~ excluded from participating in procurement activities, or otherwise excluded under Section 21.5 of this Agreement:

i) as a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the Contractor's equity; ~~or~~

ii) as a ~~party to~~Participating Provider or person with an employment, consulting or other agreement with the Contractor for the provision of items and services that are significant and material to the Contractor's



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obligations in the MMC Program and/or the FHPlus Program, consistent with requirements of SSA § 1932 (d)(1)~~.~~;

iii) as a Subcontractor, as governed by 42 CFR 438.230.

b) Pursuant to 42 CFR 455. 436 and 42 CFR 438.610, the Contractor shall:

i) confirm the identity and determine the exclusion status of any employee in the capacity of general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations at initial hiring and any person with an ownership or control interest or who is an agent or managing employee of the Contractor through routine checks of Federal and State databases. These include the Social Security Administration's Death Master file, and the National Plan and Provider Enumeration System (NPPES), and the ~~Excluded Parties List System (EPLS)~~ System for Award Management (SAM), and ~~either~~ the List of Excluded Individuals and Entities (LEIE~~) or the Medicare Excluded Database (MED)~~, the NYS OMIG Exclusion List, and any such other databases as the Secretary may prescribe; and

ii) check the LEIE ~~(or MED)~~, the ~~EPLS~~SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and NYS OMIG Exclusions List no less frequently than monthly.

c) Pursuant to 42 CFR 455.436 and 42 CFR 438.610, the Contractor shall

i) confirm the identity and determine the exclusion status of new Participating Providers, re-enrolled Participating Providers and all current Participating Providers, any subcontractors, and any person with an ownership or control interest or who is an agent or managing employee of the Participating Provider or subcontractor through routine checks of Federal and State databases. These include the Social Security Administration's Death Master file, the National Plan and Provider Enumeration System (NPPES), the ~~Excluded Parties List System (EPLS)~~SAM, ~~either~~ the List of Excluded Individuals and Entities (LEIE) ~~or the Medicare Excluded Database (MED)~~, the NYS OMIG Exclusion List, and any such other databases as the Secretary may prescribe; and

ii) confirm the identity and determine the exclusion status of Non-Participating Providers, upon or no later than 30 days of payment of first claim through routine checks of Federal and State databases. These include the Social Security Administration's Death Master file (SSDM), the National Plan and Provider Enumeration System (NPPES), the ~~Excluded Parties List System (EPLS)~~SAM, ~~either~~ the List of Excluded Individuals and Entities (LEIE) ~~or the Medicare Excluded Database~~

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~~(MED)~~, the NYS OMIG Exclusion List, and any such other databases as the Secretary may prescribe; ~~and~~

iii) check the SSDM and NPPES for new providers, re-enrolled providers and any current provider who were not checked upon enrollment into Contractor's Medicaid program; and

iv) check the LEIE ~~(or the MED)~~, the ~~EPLS~~SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and the NYS OMIG Exclusion List no less frequently than monthly.

d) The Contractor must:

i) confirm that providers have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, ~~T~~the National Plan and Provider Enumeration System (NPPES), ~~T~~the ~~Excluded Parties List System (EPLS)~~SAM, ~~either~~ the List of Excluded Individuals and Entities (LEIE)~~or the Medicare Excluded Database (MED)~~, and any such other databases as the Secretary may prescribe; and

ii) check the LEIE ~~(or the MED)~~, the ~~EPLS~~SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and the NYS OMIG Exclusion List no less frequently than monthly.

18.10 Conflict of Interest and Business Transaction Disclosures

Conflict of Interest Disclosure: Contractor shall report to SDOH documentation, including but not limited to, the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the Contractor, or with any subcontract(s) in which the Contractor has a five percent (5%) or more ownership interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR §§ 455.100 through 455.104.

18.11 Physician Incentive Plan Reporting

The Contractor shall submit to SDOH annual reports containing the information on all of its Physician Incentive Plan arrangements in accordance with 42 CFR § 438.6(h) or, if no such arrangements are in place, attest to that fact. The contents and time frame of such reports shall comply with the requirements of 42 CFR §§ 422.208 and 422.210 and be in a format provided by SDOH.

18.12 Disclosure of Criminal Activity

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a) Pursuant to 42 CFR 455.106, the Contractor will disclose to SDOH any criminal convictions by managing employees related to Medicare, Medicaid, or Title XX programs at the time the Contractor applies or renews an application for participation in the Medicaid managed care program or Family Health Plus program or at any time on request. For the purposes of this section, managing employee means a general manager, business manager, administrator, director, or other individual who exercises control or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

b) Pursuant to 42 CFR 455.106, before the Contractor enters into or renews a provider agreement, or at any time upon written request by the State, the Contractor must disclose to the State the identity of any person who:

   i) has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

   ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

c) Notification to the U.S. Department of Health and Human Services (DHHS) Inspector General.

   i) The SDOH shall notify the DHHS Inspector General of any disclosures made under this section within 20 working days from the date it receives the information; and

   ii) The SDOH shall also promptly notify the DHHS Inspector General of any action it takes with respect to the provider's participation in the program.

d) Denial or Termination of Provider Participation

   i) Unless otherwise authorized by SDOH, the Contractor shall refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or Title XX services program; and

   ii) Unless otherwise authorized by SDOH, the Contractor shall refuse to enter into or shall terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under Section 18.12 (a).

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iii) Such denial or termination of a provider's participation under this section may afford the provider a right to a hearing pursuant to Public Health Law § 4406-d (2).

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## 19. RECORDS MAINTENANCE AND AUDIT RIGHTS

19.1 Maintenance of Contractor Performance Records, Records Evidencing Enrollment Fraud and Documentation Concerning Multiple CINs

a) The Contractor shall maintain and shall require its subcontractors, including its Participating Providers, to maintain appropriate records relating to Contractor performance under this Agreement, including:

i) records related to services provided to Enrollees, including a separate Medical Record for each Enrollee;

ii) all financial records and statistical data that LDSS, SDOH, OMH, OASAS, the Office of the Medicaid Inspector General (OMIG), the New York State Office of the Attorney General, and any other authorized governmental agency may require, including, but not limited to: books, accounts, journals, ledgers, communications, manuals, rates, fees, claiming instructions, or other communications to providers; and all financial records relating: to capitation payments, supplemental payments, third party health insurance recovery, other revenue received, and any reserves related thereto and expenses incurred under this Agreement;

iii) all documents concerning enrollment fraud or the fraudulent use of any CIN;

iv) all documents concerning multiple CINs;

A) The Contractor shall, on a quarterly basis, review and identify any Enrollees with multiple CIN(s). The Contractor shall then report within 30 days of identification, Enrollees with multiple CIN(s) to the LDSS or NYSoH, as applicable.

v) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of the Contractor or its subcontractors, including its Participating Providers, if applicable, to bear the risk of potential financial losses;

vi) The Contractor shall maintain appropriate records identifying every subcontract to a subcontractor, including any and all agreements arising out of said subcontract.

b) The Contractor shall maintain all Access NY Health Care (DOH-4220), Medicaid Choice, and SDOH enrollment applications (DOH-4097) and recertification forms completed by the Contractor or its subcontractors in

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fulfilling its responsibilities related to Facilitated Enrollment as set forth in Appendix P of this Agreement.

c) The Contractor shall take reasonable steps to ensure that, upon payment of the first claim to a Non-Participating Provider, the Contractor requests that the Non-Participating Provider comply with the requirements of Section 19.1(a) of this Agreement.

d) For every claim submitted to or paid by the Contractor, the Contractor shall maintain appropriate records identifying every subcontractor, person or entity performing the services under said claim, including amounts paid.

e) The Contractor shall maintain appropriate records of the amounts paid by the Contractor to the PBM for pharmaceutical services.

f) The record maintenance requirements of this Section shall survive the termination, in whole or in part, of this Agreement.

19.2 Maintenance of Financial Records and Statistical Data

The Contractor shall maintain all financial records and statistical data according to generally accepted accounting principles.

19.3 Access to Contractor Records and Facilities

a) The Contractor shall provide ~~SDOH,~~ OMH, OASAS, the Comptroller of the State of New York, ~~the Office of the Medicaid Inspector General (OMIG),~~ the New York State Office of the Attorney General, ~~DHHS, the Comptroller General of the United States,~~ and their ~~authorized representatives~~designees with access to all records relating to Contractor performance under this Agreement for the purposes of examination, audit, and copying. The Contractor shall give access to such records on two (2) business days prior written notice, during normal business hours, unless otherwise provided or permitted by applicable laws, rules, or regulations.

b) Notwithstanding Section 19.3(a) of this Agreement and in accordance with 42 C.F.R. § 438.3(h), SDOH, the Office of the Medicaid Inspector General (OMIG), the New York State Office of the Attorney General, DHHS, the Comptroller General of the United States, and their designees, at any time, have the right to inspect and audit any records or documents of the Contractor or its subcontractors that relate to the Contractor's performance under this Agreement and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. Upon request, the Contractor shall take all reasonable actions not otherwise required in this Agreement or applicable authority to provide or ensure access to such records or document, and to the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.



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c) The right to audit under this section exists for ten (10) years from the final date of the contract period, as specified in this Agreement, or from the date of completion of any audit, whichever is later.

d) When records are sought in connection with an investigation, all costs associated with production and reproduction shall be the responsibility of the Contractor.

19.4 Retention Periods

a) The Contractor shall preserve and retain all records relating to Contractor performance under this Agreement in readily accessible form, and require its' Subcontractors to do same in accordance with the terms of Section 22.5(b)(v) of this Agreement, during the term of this Agreement and for a period of ~~six~~ ten (~~6~~10) years thereafter except that the Contractor shall retain Enrollees' medical records that are in the custody of the Contractor for ~~six~~ ten (~~6~~10) years after the date of service rendered to the Enrollee or cessation of Contractor operation, and in the case of a minor, for ~~six~~ten (~~6~~10) years after the date of service or three (3) years after majority, whichever occurs later, and except that such periods shall be deemed amended to implement any longer term that shall be required by applicable Federal or State law regulation. All provisions of this Agreement relating to Contractor and Subcontractor record maintenance and audit access shall survive the termination of this Agreement and shall bind the Contractor until the expiration of a period of ten (10) years commencing with termination of this Agreement or, if an audit is commenced, until the completion of the audit, whichever occurs later. If the Contractor becomes aware of any litigation, claim, financial management review or audit that is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims, financial management reviews or audit findings involving the record have been resolved and final action taken.

b) Notwithstanding Section 19.4(a) of this Agreement, ~~T~~the Contractor shall require and make reasonable efforts to assure that Enrollees' medical records are retained by providers for six (6) years after the date of service rendered to the Enrollee or cessation of Contractor operation, and in the case of a minor, for three (3) years after majority or for six (6) years after ~~majority. All provisions of this Agreement relating to record maintenance and audit access~~the date of service, whichever occurs later. The Contractor's duty to make such reasonable effort shall survive the termination of this Agreement and shall bind the Contractor until the expiration of a period of six (6) years commencing with termination of this Agreement or if an audit is commenced, until the completion of the audit, whichever occurs later. If the Contractor becomes aware of any litigation, claim, financial management review or audit that is started before the expiration of the six (6) year period, the records shall

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be retained until all litigation, claims, financial management reviews or audit findings involv~~ed~~ing ~~in~~ the record have been resolved and final action taken.

19.5 OMIG's Right to Audit and Recover Overpayments Caused by Contractor Submission of Misstated Reports

The Office of the Medicaid Inspector General (OMIG) can perform audits of financial reports filed by Contractors after SDOH reviews and accepts the Contractor's report. If the audit determines that the Contractor's filed report contained a misstatement of fact within the reported costs and revenue that impacts the accuracy of the data used in the rate setting process, the OMIG can assess a penalty equal to the Contractor's member months for region, divided by the total member months for the region, multiplied by the amount of the misstatement of fact, multiplied by two. This penalty will be due from the Contractor whose filed report contained the misstatement of fact as a prior period cost adjustment on their next Medicaid Managed Care Operating Report (MMCOR). A misstatement of fact includes any failure by the Contractor to follow written guidance from SDOH regarding proper completion of an MMCOR. Examples of misstatements of fact include, but are not limited to: improper completion of the Claims Analysis – Claims incurred During Current Period Table, improper completion of prior period incurred but not reported adjustment schedules, improper recognition of reinsurance recoveries, improper recognition of third party recoveries and/or coordination of benefits, improper completion of the Global Capitation Surplus or Loss Tables, improper completion of the administrative cost tables, including improper allocation of administrative costs between insurance product lines, reporting non allowable administrative expenses as allowable on the Administrative Tables, improper reporting of member months and improper reporting on any other table used by SDOH in the rate setting process. The Contractor will be entitled to the audit rights afforded to providers in Section 517.5 and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York. Nothing in this section shall limit SDOH, OMIG, or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period, or limit other remedies or rights available to SDOH, OMIG, or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.

19.6 OMIG's Right to Audit and Recover Overpayments Caused by Contractor's Misstated Encounter Data

The Office of the Medicaid Inspector General (OMIG) can perform audits of the Contractor's submitted encounter data after DOH has reviewed and accepted the Contractor's encounter data submission. If the audit determines the Contractor's encounter data was incorrectly submitted and the Contractor received additional or higher Medicaid managed care capitation rate payments and/or Supplemental

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Newborn Capitation Payments and/or Supplemental Maternity Capitation Payments, and/or other reimbursement due to the incorrect encounter data, OMIG can recover from the Contractor the additional Medicaid funds that the Contractor received because of the encounter data misstatement. The Contractor will be entitled to the audit rights afforded to providers in Section 517.5 and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York. Nothing in this section shall limit SDOH, OMIG or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period or limit other remedies or rights available to SDOH, OMIG or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.

19.7 OMIG Audit Authority

In accordance with New York State Public Health Law Sections 30 – 36, and as authorized by federal or state laws and regulations, the Office of the Medicaid Inspector General (OMIG) may review, ~~and~~ audit, and investigate contracts, encounter data, cost reports, plan benefit design or any other information used, directly or indirectly, to determine expenditures, claims, bills and all other expenditures of medical assistance program funds to determine compliance with federal and state laws and regulations and take such corrective actions as are authorized by federal or state laws and regulations. The right to review, audit, and investigate under this section exists for ten (10) years from the final date of the contract period, as specified in this Agreement or from the date of completion of any review, audit, or investigation, or review, whichever is later.

19.8 OMIG Compliance Review Authority

In accordance with New York State Public Health Law sections 30 – 36, and as authorized by federal or state laws and regulations, OMIG may conduct reviews of Participating Providers' compliance programs, as well as Contractors' compliance with the requirements of 42 U.S.C. § 1396a(a)(68) and 18 NYCRR Part 521.

19.9 Notification to Audit

a) The Contractor shall notify the OMIG of its intention to initiate an audit of a Participating Provider or Non-Participating Provider. The following shall constitute the notification process. For purposes of this Section, an audit refers to activity which will or may result in a post payment recovery and/or referral to the OMIG in accordance with Section 18.5 (a)(vii) of this Agreement.

   i) The notification to audit shall be communicated by the Contractor to the OMIG in a form and format to be determined by SDOH and OMIG. The

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notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed.

ii) Upon receipt of the Contractor's notification to audit, the OMIG shall within ten (10) business days:

A) Acknowledge receipt of the notification; and

B) Acknowledge that there is no conflict with the Contractor conducting the audit; or

C) Alert the Contractor to stop the audit or any further activity if a conflict exists.

iii) If the Contractor does not receive a response from the OMIG in ten (10) business days, the Contractor may proceed with its audit.

iv) Notwithstanding the above, the OMIG may initiate an audit of the Contractor's provider at any time.

b) The OMIG shall notify the Contractor of its intention to initiate an audit of a Participating Provider in the Contractor's network or Non-Participating Provider. The following shall constitute the notification process.

i) The OMIG shall email the notification to audit to the Contractor's designee. The notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed.

ii) Upon receipt of OMIG's notification to initiate an audit, the Contractor's designee shall respond within ten (10) business days as follows:

A) Acknowledge receipt of the notification by email; and/or

B) Alert the OMIG of a conflict;

iii) If the OMIG does not receive a response from the Contractor within ten (10) business days, the OMIG may proceed with its audit.

iv) Upon receipt of OMIG's notification to initiate an audit, the Contractor shall provide to OMIG, in a form and format required by OMIG, all records required by OMIG to complete its audit, investigation or review of the Contractor's Participating or Non-Participating Provider, or subcontractor. The Contractor shall provide such records to the OMIG within ten (10) business days of OMIG's notification to initiate an audit.

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c) Once notified of OMIG's intent to audit a Participating Provider or Non-Participating Provider, the Contractor shall not take any of the following actions as they specifically relate to Medicaid claims, and the audit scope and time period identified in OMIG's notification of intent to audit:

i) Initiate an audit of the same provider;

ii) Enter into or attempt to negotiate any settlement agreement with the provider; or

iii) Accept any monetary or other thing of valuable consideration offered by the provider.

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## 20. CONFIDENTIALITY

20.1 Confidentiality of Identifying Information about Enrollees, Potential Enrollees and Prospective Enrollees

All information relating to services to Enrollees, Potential Enrollees and Prospective Enrollees which is obtained by the Contractor, shall be confidential pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the PHL, including PHL Article 27-F, the provisions of Section 369(4) of the SSL, 42 U.S.C. § 1396a(a)(7) (Section 1902(a)(7) of the SSA), Section 33.13 of the Mental Hygiene Law, and regulations promulgated under such laws including 45 CFR Parts 160 and 164 and 42 CFR Part 2 pertaining to Alcohol and Substance Abuse Services, and for Contractors operating in New York City, the New York City Health Code §§11.07 (c) and (d). Such information, including information relating to services provided to Enrollees, Potential Enrollees and Prospective Enrollees under this Agreement, shall be used or disclosed by the Contractor only for a purpose directly connected with performance of the Contractor's obligations. It shall be the responsibility of the Contractor to inform its employees and contractors of the confidential nature of MMC and/or FHPlus information, as applicable.

20.2 Medical Records of Foster Children

Medical records of Enrollees enrolled in foster care programs shall be disclosed to local social service officials in accordance with Sections 358-a, 384-a and 392 of the SSL and 18 NYCRR § 507.1.

20.3 Confidentiality of Medical Records

Medical records of Enrollees pursuant to this Agreement shall be confidential and shall be disclosed to and by other persons within the Contractor's organization, including Participating Providers, only as necessary to provide medical care, to conduct quality assurance functions and peer review functions, or as necessary to respond to a complaint and appeal under the terms of this Agreement.

20.4 Length of Confidentiality Requirements

The provisions of this Section shall survive the termination of this Agreement and shall bind the Contractor so long as the Contractor maintains any individually identifiable information relating to Enrollees, Potential Enrollees and Prospective Enrollees.

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# 21. PROVIDER NETWORK

## 21.1 Network Requirements

a) The Contractor will establish and maintain a network of Participating Providers.

i) In establishing the network, the Contractor must consider the following: anticipated Enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services in the Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

ii) The Contractor's network must contain all of the provider types necessary to furnish the prepaid Benefit Package, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, DME providers, home health providers, and pharmacies, if applicable.

A) The Contractor must demonstrate that its network contains sufficient Indian Health Care Providers to ensure access, within time/distance standards as set forth in Section 15.5 of this Agreement, to Native American Enrollees.

iii) To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible (meeting time/distance standards) and being accessible for the disabled. For the HIV SNP Program, this includes the following requirements [Applicable to the HIV SNP Program only]:

A) Designated AIDS Centers: At least one Designated AIDS Center per borough/county or access availability for at least seventy-five percent (75%) of the enrollee population by borough/county, whichever is greater.

B) HIV Primary Care Medicaid Programs: Access availability for at least twenty-five percent (25%) of the enrollee population.

C) Maternal/Pediatric HIV Specialized Care Centers: Access availability for one hundred percent (100%) of HIV infected women enrollees with HIV infected and/or HIV-exposed children up to the age of 18 months.

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D) HIV Co-located Substance Abuse & Primary Care Programs: Access availability for at least fifty percent of the enrollee population with diagnosed substance abuse problems.

b) The Contractor shall not include in its network any provider

i) who has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or

ii) who has had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

iii) who has not enrolled with the State as a Medicaid provider, unless such provider is not required to be enrolled as a Medicaid provider. The Contractor may provisionally credential a non-enrolled provider for 120 days pending enrollment with SDOH.

A) An enrolled Medicaid provider is not required to provide services to a Medicaid beneficiary who is not enrolled in MMC.

c) The Contractor must require that Participating Providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider serves only MMC Enrollees and/or FHPlus Enrollees, comparable to hours offered for Medicaid fee-for-service patients.

d) The Contractor shall submit its network for SDOH to assess for adequacy through the HCS prior to execution of this Agreement, quarterly thereafter throughout the term of this Agreement, and upon request by SDOH when SDOH determines there has been a significant change that could affect adequate capacity and quarterly thereafter.

e) Contractor must limit participation to providers who agree that payment received from the Contractor for services included in the Benefit Package is payment in full for services provided to Enrollees, except for the collection of applicable co-payments from Enrollees as provided by law.

21.2 Absence of Appropriate or Available Network Provider

a) In the event that the Contractor determines that it does not have a Participating Provider with appropriate training and experience to meet the particular health or behavioral health care needs of an Enrollee, or who does not have an available appointment, the Contractor shall make a referral to an appropriate Non-Participating Provider, pursuant to a treatment plan approved by the Contractor in consultation with the Primary Care Provider, the Non-Participating Provider and the Enrollee or the Enrollee's designee. The Contractor shall pay for the cost of the services in the treatment plan provided

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by the Non-Participating Provider for as long as the Contractor is unable to provide the service through a Participating Provider.

i) In accordance with 42 CFR 438.910(d)(3), the Contractor shall not apply more stringent processes, strategies, evidentiary standards or other factors for Enrollees to access behavioral health services from Non-Participating Providers than those that the Contractor applies to Enrollees to access physical health benefits from Non-Participating Providers.

21.3 Suspension of Enrollee Assignments To Providers

The Contractor shall ensure that there is sufficient capacity, consistent with SDOH standards, to serve Enrollees under this Agreement. In the event any of the Contractor's Participating Providers are no longer able to accept assignment of new Enrollees due to capacity limitations, as determined by the SDOH, the Contractor will suspend assignment of any additional Enrollees to such Participating Provider until such provider is capable of further accepting Enrollees. When a Participating Provider has more than one (1) site, the suspension will be made by site.

21.4 Credentialing

a) Credentialing/Recredentialing Process

i) The Contractor shall have in place a formal process, consistent with SDOH Recommended Guidelines for Credentialing Criteria, for credentialing Participating Providers on a periodic basis (not less than once every three (3) years) and for monitoring Participating Providers performance. This shall include, but not be limited to, requesting and reviewing any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last time the Contractor credentialed the Participating Provider.

ii) When credentialing OMH-licensed, OMH-operated and OASAS-certified providers, the Contractor shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. The Contractor shall still collect and accept program integrity related information from these providers, as required in Sections 18 of this Agreement, and shall require 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.

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iii) [Applicable to HIV SNP Program only]: The Contractor shall have in place a formal process for assessing on a periodic basis (not less than annually) that all HIV Specialist PCPs meet the qualifications for HIV Specialist PCP as defined in Section 1 of this Agreement.

iv) [Applicable to HARP and HIV SNP Programs only] When credentialing BHHCBS providers, the Contractor shall accept the State-issued BHHCBS designation in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. The Contractor shall still collect and accept program integrity related information from these providers, as required in Sections 18 of this Agreement, and shall require 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.

v) As part of the credentialing or re-credentialing processes, the Contractor shall require that Mental Health Providers certify that they will not seek reimbursement from the Contractor for Conversion Therapy provided to an Enrollee.

A) For the purposes of Section 21.4 (a) (v) of this Agreement, Mental Health Providers means a person subject to the provisions Education Law Article 131, 153, 154, or 163; or any other person designated as a mental health professional pursuant to law, rule, or regulation.

b) Licensure

The Contractor shall ensure, in accordance with Article 44 of the PHL, that persons and entities providing care and services for the Contractor in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such person or entity satisfy all applicable licensing, certification, or qualification requirements under New York law and that the functions and responsibilities of such persons and entities in providing Benefit Package services under this Agreement do not exceed those permissible under New York law.

c) Minimum Standards

i) The Contractor agrees that all network physicians will meet at least one (1) of the following standards, except as specified in Section 21.15 (c) and Appendix I of this Agreement:

A) Be board-certified or board-eligible in their area of specialty;

B) Have completed an accredited residency program; or



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C) Have admitting privileges at one (1) or more hospitals participating in the Contractor's network.

ii) [Applicable to HIV SNP Program only]: The Contractor agrees that all physicians acting as PCPs for Enrollees with HIV infection must possess the qualifications for HIV Specialist PCP as defined in Section 1 of this Agreement.

A) Modifications for homeless Enrollees include the following:

I) A Homeless HIV infected HIV SNP Enrollee may designate a shelter physician, who may not be HIV experienced, as his or her PCP while in the shelter system.

II) If a newly enrolled homeless HIV infected person is engaged in care with a primary care provider who is not HIV experienced, the Contractor may designate that PCP until such time as the Enrollee can be transitioned to an HIV experienced PCP.

III) In both cases, the Contractor must employ a co-management model in which an HIV Specialist assists the non-HIV experienced PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the non-HIV experienced PCP. The Contractor will provide the AIDS Institute with evidence of this ongoing co-management on request.

IV) Alternatively, the Contractor may designate an HIV Experienced PCP for a homeless Enrollee in a shelter, but allow the Enrollee to seek urgent and non-HIV primary care from the shelter provider.

21.5 Exclusion or Termination of Providers and Other Prohibited Relationships

a) If SDOH excludes or terminates a provider from its Medicaid program, the Contractor shall, upon learning of such exclusion or termination, immediately terminate the Provider Agreement with the Participating Provider with respect to the Contractor's MMC and/or FHPlus product, and agrees to no longer utilize the services of the subject provider, as applicable. The Contractor shall access information pertaining to excluded Medicaid providers through the SDOH Health Commerce System (HCS). Such information available to the Contractor on the HCS shall be deemed to constitute constructive notice. The HCS should not be the sole basis for identifying current exclusions or termination of previously approved providers. Should the Contractor become aware, through the HCS or any other source, of an SDOH exclusion or

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termination, the Contractor shall validate this information with the Office of Health Insurance Programs and comply with the provisions of this Section.

b) Consistent with 42 CFR 455.416(c), if a Participating Provider has been terminated, as defined in 42 CFR 455.101, on or after January 1, 2011, under the Medicare Program, the Medicaid program or CHIP program of any other State, or the network of another NYS Medicaid Managed Care Organization, the Contractor shall, upon notification of such termination from SDOH or OMIG, immediately terminate the Provider Agreement with the Participating Provider with respect to the Contractor's MMC and/or FHPlus product, and agrees to no longer utilize the services of the subject provider, as applicable.

c) Prohibited Relationships

i) The Contractor may not have a relationship of a type described in 42 U.S.C. § 1320a–7(b)(8)(A) with a person described by 42 U.S.C. § 1320a–7(b)(8)(B).

ii) The Contractor may not have a substantial contractual relationship as defined in 42 C.F.R § 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes as described in 42 U.S.C. § 1320a–7(b)(8)(B) or with an individual or entity described in 42 C.F.R. § 438.610(a) or (b).

iii) The Contractor may not contract, directly or indirectly, for the furnishing of healthcare, utilization review, medical social work, or administrative services with:

A) an individual or entity described in 42 C.F.R. § 438.610(a) or (b); or

B) an individual or entity that would provide such services through an individual or entity identified in 42 C.F.R. § 438.610(a) or (b).

iv) The Contractor may not have a relationship of a type described by 42 C.F.R. § 438.610(c) with an individual or entity described in 42 C.F.R. § 438.610(a) or (b).

d) If Medicaid payments are made by the Contractor to ~~an excluded or terminated provider~~any person, individual, or entity identified in Section 21.5 of this Agreement, for dates of service after the ~~provider's~~applicable exclusion or termination effective date, the Contractor shall report and explain within sixty (60) days of identifying the payment, in a form and format to be determined by OMIG in consultation with SDOH, when and how the payment was identified, and the date on which the encounter data was adjusted to reflect the recovery.

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## 21.6 Application Procedure

a) The Contractor shall establish a written application procedure to be used by a health care professional interested in serving as a Participating Provider with the Contractor. The criteria for selecting providers, including the minimum qualification requirements that a health care professional must meet to be considered by the Contractor, must be defined in writing and developed in consultation with appropriately qualified health care professionals. Upon request, the application procedures and minimum qualification requirements must be made available to health care professionals.

b) The selection process may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

c) The Contractor may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This does not preclude the Contractor from including providers only to the extent necessary to meet its needs; or from establishing different payment rates for different counties or different specialists; or from establishing measures designed to maintain the quality of services and control costs consistent with its responsibilities.

d) If the Contractor does not approve an individual or group of providers as Participating Providers, it must give the affected providers written notice of the reason for its decision.

## 21.7 Evaluation Information

The Contractor shall develop and implement policies and procedures to ensure that Participating Providers are regularly advised of information maintained by the Contractor to evaluate their performance or practice. The Contractor shall consult with health care professionals in developing methodologies to collect and analyze Participating Providers profiling data. The Contractor shall provide any such information and profiling data and analysis to its Participating Providers. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a Participating Provider shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each Participating Provider shall be given the opportunity to discuss the unique nature of his or her patient population which may have a bearing on the Participating Provider's profile and to work cooperatively with the Contractor to improve performance.

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21.8 Choice/Assignment of Primary Care Providers (PCPs)

a) The Contractor shall offer each Enrollee the choice of no fewer than three (3) Primary Care Providers within distance/travel time standards as set forth in Section 15.5 of this Agreement. This requirement does not apply to Enrollees restricted as specified in Appendix Q of this Agreement.

b) Contractor must assign a PCP to Enrollees who fail to select a PCP. The assignment of a PCP by the Contractor may occur after written notification to the Contractor of the Enrollment (through Roster or other method) and:

   i) after written notification of the Enrollee by the Contractor but in no event later than thirty (30) days after notification of Enrollment, and only after the Contractor has made reasonable efforts as set forth in Section 13.6 of this Agreement to contact the Enrollee and inform him/her of his/her right to choose a PCP; or

   ii) in the case of an Enrollee restricted for primary care services, in accordance with Appendix Q of this Agreement.

c) PCP assignments should be made taking into consideration the following:

   i) Enrollee's geographic location;

   ii) any special health care needs, if known by the Contractor; and

   iii) any special language needs, if known by the Contractor.

d) In circumstances where the Contractor operates or contracts with a multi-provider clinic to deliver primary care services, the Enrollee must choose or be assigned a specific provider or provider team within the clinic to serve as his/her PCP. When an Enrollee chooses or is assigned to a team, one of the practitioners must be designated as "lead" provider for that Enrollee. This "lead" provider will be held accountable for performing the PCP duties.

e) Pursuant to 42 USC 1396u-2(h), the Contractor shall permit a Native American Enrollee to select a Participating Indian Health Care Provider to serve as his/her PCP, provided that:

   i) such Indian Health Care Provider has the available capacity to serve such Enrollee, and

   ii) such Enrollee is not a Restricted Enrollee, as defined in Appendix Q of this Agreement.

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21.9 Enrollee PCP Changes

a) The Contractor must allow Enrollees the freedom to change PCPs, without cause, within thirty (30) days of the Enrollee's first appointment with the PCP. After the first thirty (30) days, the Contractor may elect to limit the Enrollee to changing PCPs every six (6) months without cause. This paragraph does not apply to Enrollees restricted to an RRP Provider for primary care in accordance with Appendix Q of this Agreement.

b) The Contractor must process a request to change PCPs and advise the Enrollee of the effective date of the change within thirty (30) days of receipt of the request. The change must be effective no later than the first (1st) day of the second (2nd) month following the month in which the request is made.

c) The Contractor will provide Enrollees with an opportunity to select a new PCP in the event that the Enrollee's current PCP leaves the network or otherwise becomes unavailable. Such changes shall not be considered in the calculation of changes for cause allowed within a six (6) month period. The Contractor will allow Enrollees to change PCPs with good cause as provided by 18 NYCRR Part 360-10.7 (b).

d) In the event that an assignment of a new PCP is necessary due to the unavailability of the Enrollee's former PCP, such assignment shall be made in accordance with the requirements of Section 21.8 of this Agreement.

e) In addition to those conditions and circumstances under which the Contractor may assign an Enrollee a PCP when the Enrollee fails to make an affirmative choice of a PCP, the Contractor may initiate a PCP change for an Enrollee under the following circumstances:

i) The Enrollee requires specialized care for an acute or chronic condition and the Enrollee and Contractor agree that reassignment to a different PCP is in the Enrollee's interest.

ii) The Enrollee's place of residence has changed such that he/she has moved beyond the PCP travel time/distance standard.

iii) The Enrollee's PCP ceases to participate in the Contractor's network.

iv) The Enrollee's behavior toward the PCP is disruptive and the PCP has made all reasonable efforts to accommodate the Enrollee.

v) The Enrollee has taken legal action against the PCP or the PCP has taken legal action against the Enrollee.

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vi) The Enrollee is newly restricted for primary care services or a condition for changing the RRP Provider is met, as specified in Appendix Q of this Agreement.

f) Whenever initiating a change, the Contractor must offer affected Enrollees, except for Enrollees restricted in accordance with Appendix Q of this Agreement, the opportunity to select a new PCP in the manner described in this Section.

21.10 Provider Status Changes

a) PCP Changes

i) The Contractor agrees to notify its Enrollees of any of the following PCP changes:

A) Enrollees will be notified within fifteen (15) days (five days for HIV SNPs) from the date on which the Contractor becomes aware that such Enrollee's PCP has changed his or her office address or telephone number.

B) If a PCP ceases participation in the Contractor's network, the Contractor shall provide written notice within fifteen (15) days (five days for HIV SNPs) from the date that the Contractor becomes aware of such change in status to each Enrollee who has chosen the provider as his or her PCP. In such cases, the notice shall describe the procedures for choosing an alternative PCP and, in the event that the Enrollee is in an ongoing course of treatment, the procedures for continuing care consistent with subdivision 6 (e) of PHL § 4403.

C) Where an Enrollee's PCP ceases participation with the Contractor, the Contractor must ensure that the Enrollee selects or is assigned to a new PCP within thirty (30) days of the date of the notice to the Enrollee.

b) Other Provider Changes

In the event that an Enrollee is in an ongoing course of treatment with another Participating Provider who becomes unavailable to continue to provide services to such Enrollee, the Contractor shall provide written notice to the Enrollee within fifteen (15) days from the date on which the Contractor becomes aware of the Participating Provider's unavailability to the Enrollee. In such cases, the notice shall describe the procedures for continuing care consistent with PHL § 4403(6)(e) and for choosing an alternative Participating Provider.

21.11 PCP Responsibilities



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In conformance with the Benefit Package, the PCP shall provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat conditions not requiring the services of a specialist; arrange inpatient care, consultations with specialists, and laboratory and radiological services when medically necessary; coordinate the findings of consultants and laboratories; and interpret such findings to the Enrollee and the Enrollee's family, subject to the confidentiality provisions of Section 20 of this Agreement, and maintain a current medical record for the Enrollee. The PCP shall also be responsible for determining the urgency of a consultation with a specialist and shall arrange for all consultation appointments within appropriate time frames.

21.12 Member to Provider Ratios

a) [Not applicable to HIV SNP Program]: The Contractor agrees to adhere to the member-to-PCP ratios shown below. These ratios are Contractor-specific, and assume the practitioner is a full time equivalent (FTE) (defined as a provider practicing forty (40) hours per week for the Contractor):

i) No more than 1,500 Enrollees for each physician, or 2,400 for a physician practicing in combination with a registered physician assistant or a certified nurse practitioner.

ii) No more than 1,000 Enrollees for each certified nurse practitioner.

b) [Applicable to HIV SNP Program only]:

i) The HIV SNP Contractor agrees to adhere to the member-to-HIV Specialist PCP ratios shown below. These ratios are Contractor-specific, and assume that the HIV Specialist PCP is a full-time equivalent (FTE) (defined as a provider practicing forty (40) hours per week for the Contractor):

A) No more than 350 Enrollees for each physician or PCP certified nurse practitioner, or

B) No more than 500 Enrollees for a physician practicing in combination with a registered physician assistant or a certified nurse practitioner.

ii) The above member-to-provider ratio may be waived under the following circumstances:

A) The HIV SNP can demonstrate that HIV Specialist PCPs are not available in sufficient number to achieve the required ratios, AND

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B) The proposed HIV SNP member-to-provider ratio demonstrates to the AIDS Institute Medical Director's satisfaction that the ratio is sufficient to meet the needs of the HIV SNP's Enrollee case-mix characteristics.

C) Waivers may be granted for a period of time to be determined by the AIDS Institute Medical Director, but not to exceed one year. A waiver of the member-to-provider ratio does not relieve the requirement that the PCP meet the HIV Specialist PCP criteria.

c) The Contractor agrees that these ratios will be prorated for Participating Providers who represent less than a FTE to the Contractor.

21.13 Minimum PCP Office Hours

a) General Requirements

A PCP must practice a minimum of sixteen (16) hours a week at each primary care site.

b) Waiver of Minimum Hours

The minimum office hours requirement may be waived under certain circumstances. A request for a waiver must be submitted by the Contractor to the Medical Director of the Office of Health Insurance Programs for review and approval; and the physician must be available at least eight hours/week; the physician must be practicing in a Health Provider Shortage Area (HPSA) or other similarly determined shortage area; the physician must be able to fulfill the other responsibilities of a PCP (as described in this Section); and the waiver request must demonstrate there are systems in place to guarantee continuity of care and to meet all access and availability standards (24-hour/7 days per week coverage, appointment availability, etc.).

21.14 Primary Care Practitioners

a) General Limitations

The Contractor agrees to limit its PCPs to the following primary care specialties: Family Practice, General Practice, General Pediatrics, and General Internal Medicine (and Infectious Diseases for HIV SNPs) except as specified in paragraphs (b), (c), (d) and (e) of this Section.

[Applicable to HIV SNP Program only]: In addition, the Contractor agrees to limit its HIV Specialist PCPs to PCPs who meet the HIV Specialist PCP qualifications as defined in Section 1 of this Agreement for all Enrollees who are HIV infected, except as allowed in Section 21.4 c) ii) of this Agreement.



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b) Specialist and Sub-specialist as PCPs

The Contractor is permitted to use specialist and sub-specialist physicians as PCPs when such an action is considered by the Contractor to be medically appropriate and cost-effective. As an alternative, the Contractor may restrict its PCP network to primary care specialties only, and rely on standing referrals to specialists and sub-specialists for Enrollees who require regular visits to such physicians.

c) OB/GYN Providers as PCPs

The Contractor, at its option, is permitted to use OB/GYN providers as PCPs, subject to SDOH qualifications and, applicable to the HIV SNP Program only, subject to the HIV Specialist PCP criteria in Section 1 of this Agreement.

d) Certified Nurse Practitioners as PCPs

The Contractor is permitted to use certified nurse practitioners as PCPs, subject to their scope of practice limitations under New York State Law and, applicable to the HIV SNP Program only, subject to the HIV Specialist PCP criteria in Section 1 of this Agreement for HIV infected Enrollees.

e) Behavioral Health Clinics

The Contractor is permitted to use Primary Care Providers employed by behavioral health clinics, including: mental health clinics operated pursuant to OMH regulations 14 NYCRR Part 598 or 599; OASAS-certified clinics, including Opioid Treatment Programs certified pursuant to OASAS regulations 14 NYCRR Parts 816.8, 822, or 825; and Diagnostic and Treatment Centers (D&TCs), authorized pursuant to NYCRR Part 404. Enrollees choosing to receive their primary care services at a Behavioral Health Clinic must choose or be assigned a specific provider or provider team within the clinic to serve as his/her PCP. When an Enrollee chooses or is assigned to a team, one of the practitioners must be designated as “lead” provider for that Enrollee. This "lead" PCP will be held accountable for performing all required PCP duties.

f) The following requirements related to PCPs are applicable to the HIV SNP Program’s HIV Specialist PCPs only:

i) PCP Education

A) The Contractor shall require that its PCPs participate annually in at least ten (10) hours of Continuing Medical Education that is consistent

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with guidelines for HIV specialty care as determined by the AIDS Institute.

B) In addition, the Contractor shall ensure that PCPs attend educational programs as required to ensure understanding of and familiarity with the following areas:

I) New advances in HIV clinical care, including management of antiretroviral therapy;

II) State-of-the-art diagnostic techniques including quantitative viral measures and resistance testing;

III) Strategies to promote treatment adherence;

IV) Management of opportunistic infections and diseases;

V) Management of HIV-infected patients with comorbid conditions;

VI) Access and referral to clinical trials;

VII) Occupational exposure management, post-exposure prophylaxis protocols and infection control issues;

VIII) Care coordination and medical case management;

IX) Patient education needs including primary and secondary prevention, risk reduction and harm reduction;

X) Cross-cultural care issues appropriate to the enrolled populations being served;

XI) Family-centered psychosocial issues; and

XII) Mental health and chemical dependence issues (to include training in the use of the Contractor's formal mental health and chemical dependence assessment instruments).

C) Educational programs are to be conducted in coordination with the New York State Clinical Education Initiative or the AIDS Institute when possible.

ii) Pediatric Co-Management Model of Care

A) The AIDS Institute Office of the Medical Director may approve a Pediatric Co-Management Model of Care by the Contractor under



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certain circumstances described below. An approved Pediatric Co-Management Model of Care will exempt the Contractor for a defined period of time, from the HIV Specialist PCP requirement in 21.14 (a) for HIV-infected child Enrollees up to the age of thirteen (13) years in specific counties/boroughs.

B) Upon AIDS Institute approval of the Contractor's proposed Model of Care, the Contractor may allow a non-HIV Specialist Pediatrician or Family Practice Practitioner to serve as a PCP for HIV-infected child Enrollees up to the age of thirteen (13) years provided that an HIV Specialist Pediatrician participates in an ongoing clinical management relationship for decisions related to HIV-specific clinical care, and sees such Enrollees in person as follows:

I) At least every three (3) months; and

II) Whenever the Enrollee has a rise in viral load by one (1) log; and

III) Whenever the Enrollee has a downward change in immunologic or clinical classification; and

IV) Whenever there is a change to the Enrollee's antiretroviral therapy regimen.

C) A Contractor-specific Pediatric Co-management Model may be approved at the sole discretion of the AIDS Institute Office of the Medical Director on a county/borough basis and for a defined period of time at the discretion of the AIDS Institute under the following circumstances:

I) The Contractor demonstrates to the Department's satisfaction that it has made best efforts to include a sufficient number of HIV Specialist PCP Pediatricians in its network, and that HIV Specialist PCP Pediatricians are not available in sufficient number to achieve network requirements for the Contractor in specific counties/boroughs; and

II) The Contractor demonstrates to the satisfaction of the AIDS Institute Office of the Medical Director that the proposed co-management model will meet the care principles established by the AIDS Institute's Pediatric Care Criteria Committee and will provide adequate access and availability; and

III) The Contractor agrees to limit its PCPs for the non-adult Enrollee in a co-management model to the following primary care specialties: General Pediatrics and Family Practice.



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iii) Homeless Enrollee Co-Management Model of Care

A) The AIDS Institute may approve a Homeless Enrollee Co-Management Model of Care submitted by the Contractor under certain circumstances described below. An approved Homeless Enrollee Co-Management Model of Care will exempt the Contractor for a defined period of time designated by the AIDS Institute from the HIV Specialist PCP requirement in Section 21.14 a) of this Agreement for HIV-infected homeless Enrollees.

B) Upon AIDS Institute approval of the Contractor's proposed Homeless Enrollee Co-Management Model of Care, the Contractor may allow a non-HIV Experienced Practitioner as described in Section 21.4 c) ii) of this Agreement to serve as a PCP for HIV-infected homeless Enrollees provided that the practitioner participates in an ongoing clinical management relationship for decisions related to HIV-specific clinical care, and such Enrollees receive ongoing HIV clinical care as follows:

I) At least every six (6) months; and

II) Whenever the Enrollee has a rise in viral load by one (1) log; and

III) Whenever the Enrollee has a downward change in immunologic or clinical classification; and

IV) Whenever there is a change to the Enrollee's antiretroviral therapy regimen.

C) A Contractor-specific Homeless Enrollee Co-Management Model of Care must be approved on a case-by-case basis and for a defined period of time at the sole discretion of the AIDS Institute.

21.15 PCP Teams

a) General Requirements

The Contractor may designate teams of physicians/certified nurse practitioners to serve as PCPs for Enrollees. Such teams may include no more than four (4) physicians/certified nurse practitioners and, when an Enrollee chooses or is assigned to a team, one of the practitioners must be designated as "lead provider" for that Enrollee. In the case of teams comprised of medical residents under the supervision of an attending physician, the attending physician must be designated as the lead physician.

b) Registered Physician Assistants as Physician Extenders



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The Contractor is permitted to use registered physician assistants as physician-extenders, subject to their scope of practice limitations under New York State Law.

c) Medical Residents and Fellows

The Contractor shall comply with SDOH Guidelines for use of Medical Residents and fellows as found in Appendix I, which is hereby made a part of this Agreement as if set forth fully herein.

21.16 Hospitals

a) Tertiary Services

The Contractor will establish hospital networks capable of furnishing the full range of tertiary services to Enrollees. Contractors shall ensure that all Enrollees have access to at least one (1) general acute care hospital within thirty (30) minutes/thirty (30) miles travel time (by car or public transportation) from the Enrollee's residence unless none are located within such a distance. If none are located within thirty (30) minutes travel time/ thirty (30) miles travel distance, the Contractor must include the next closest site in its network. Contractor shall also comply with the network requirements for inpatient psychiatric care provided in Section 21.19 of this Agreement.

b) Emergency Services

The Contractor shall ensure and demonstrate that it maintains relationships with hospital emergency facilities, including comprehensive psychiatric emergency programs (where available) within and around its service area to provide Emergency Services.

21.17 Dental Networks

a) The Contractor's dental network shall include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their Service Area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 MMC and/or Family Health Plus Enrollees and each 500 HIV SNP Enrollees.

Networks must also include at least one (1) pediatric dentist and one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must

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also be available by referral. The network should include dentists with expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients).

21.18 Presumptive Eligibility Providers

The Contractor must offer Presumptive Eligibility Providers the opportunity to be Participating Providers in its MMC product. The terms of the contract must be at least as favorable as the terms offered to other Participating Providers performing equivalent services (prenatal care). Contractors need not contract with every Presumptive Eligibility Provider in their counties, but must contract with a sufficient number to meet the distance/travel time standards defined for primary care.

21.19 Behavioral Health Service Providers

a) The Contractor will include a full array of mental health and Substance Use Disorder Service providers in its networks, in sufficient numbers to assure accessibility to Benefit Package services for both children and adults, using either individual, appropriately licensed practitioners or New York State Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs and clinics, or both.

   i) The Contractor shall monitor Participating Providers and ensure that such providers maintain quality of care pursuant to 42 CFR 438.230 and OASAS or OMH regulations codified in Title 14 of the New York Code of Rules and Regulations as applicable.

   ii) In addition to the requirements set forth in 21.19(b), upon the date of the Behavioral Health Benefit Inclusion in a geographic service area, the Contractor must establish contracts with any providers operated, licensed or certified by OMH or OASAS with five or more active Plan members in treatment, as determined by OMH and OASAS. The Contractor is not required to contract with such providers if they are unwilling to accept the Medicaid fee-for-service rate. Nothing in this subsection is intended to limit the Contractor's obligation to maintain an adequate network of Participating Providers.

b) Except as provided in Subsection (e) of this section, an adequate network shall contain, at a minimum, the following number of providers or, where unavailable, all of the providers in a county:

   i) Mental Health Service Provider Network

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A) Outpatient clinics operated under 14 NYCRR Part 599, other than State-operated clinics, or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 598:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; an

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider

B) PROS programs operated under 14 NYCRR Part 512, Continuing Day Treatment (CDT) programs operated under 14 NYCRR Part 587, and Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include 50% of all such providers or two providers per county, whichever is greater; and

II) For rural counties, the network must include 50% of all such providers or two providers per region, whichever is greater.

C) ACT programs operated under 14 NYCRR Part 508

I) For urban counties, the network must include two providers per county; and,

II) For rural counties, the network must include two providers per region.

D) Partial Hospitalization (PH) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

E) Inpatient Psychiatric Hospitalization Services operated under 14 NYCRR Parts 580 or 582:

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I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region

F) Comprehensive Psychiatric Emergency Programs operated under 14 NYCRR Part 590:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

ii) Substance Use Disorder Services

A) Chemical Dependence Outpatient clinics operated under 14 NYCRR Part 822 or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

B) Chemical Dependence Outpatient Rehabilitation Clinics operated under 14 NYCRR Part 822:

I) The network must include 50% of all such clinics or two clinics per county, whichever is greater.

C) Opioid Treatment Programs operated under 14 NYCRR Part 822 or Opioid Treatment Programs authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

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I) For urban counties: the network must include all programs in the county. In addition, for New York City, the network must include all programs in New York City;

II) For rural counties: the network must include all programs in the region; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

D) Buprenorphine Prescribers:

I) The network must include all authorized prescribers in the Contractor's service area; and

II) The Contractor is not required to contract with providers unwilling to accept the Medicaid fee-for-service rate.

E) Detoxification Services provided in inpatient facilities, including medically-managed and medically-supervised detoxification services, certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

F) Detoxification Services provided in an outpatient setting certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

G) Chemical Dependence Inpatient Rehabilitation Services operated under 14 NYCRR Part 818:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

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H) Residential Substance Use Disorder Treatment Services Operated Under 14 NYCRR Part 820:

I) For urban counties: The network must include two providers per county;

II) For rural counties: The network must include two providers per region; and

III) If an enrollee is mandated to an out of network residential program, the Contractor must enter into either a subcontract or a single case agreement with such program and that program's allied clinical service providers for coverage of medically necessary Benefit Package Services.

c) [Applicable to the HARP and HIV SNP Programs Only]: Behavioral Health Home and Community Based Services Providers

The Contractor must contract with an adequate network of BHHCBS providers. The State will provide the Contractor with updates of designated BHHCBS providers, as appropriate. Except as provided in Subsection (e) of this section, an adequate network is defined as:

A) For urban counties: The network must include a minimum of two providers of each HCB service per county and

B) For rural counties: The network must include a minimum of two providers of each HCB service per region.

d) Crisis Intervention Services Providers

The Contractor shall contract with an adequate number of Crisis Intervention service providers in accordance with the State issued Behavioral Health Guidance.

e) Essential Community Behavioral Health Providers

The Contactor shall contract with Essential Community Behavioral Health Providers as follows:

i) For State-operated ambulatory mental health services and State-operated providers of Behavioral Health Home and Community Based Services, the Contractor shall contract with all providers in each region that contains a county within the Contractor's Service Area.

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ii) For Opioid Treatment Programs, the Contractor shall comply with the requirements in Section 21.19(b)(ii)(C).

f) Pursuant to Chapter 111 of the Laws of 2010, Chapter 57 of the Laws of 2017, 14 NYCRR 841 and 14 NYCRR Part 599, the Contractor must reimburse hospital-based and free-standing clinics dually licensed and/or certified under Article 28 of the Public Health Law, and Article 31 or Article 32 of the Mental Hygiene Law, or mental health clinics and chemical dependence clinics (including outpatient and opioid treatment clinics) licensed or certified pursuant to either Article 31 or Article 32 of the Mental Hygiene Law for outpatient mental health services or outpatient Substance Use Disorder or opioid treatment services at an amount equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by SDOH, the Office of Alcoholism and Substance Abuse Services or by the Office of Mental Health for rate-setting purposes, including any such modifier codes as may affect the calculated reimbursement.

i) Outpatient mental health services are defined as:

A) For Article 28 facilities, medically necessary mental health assessments and psychotherapy;

B) For Article 31 facilities, ambulatory behavioral health services, medically necessary mental health assessments, psychotherapy, psychotropic medication treatment, complex care management, psychological and developmental testing, health monitoring, smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee), comprehensive medication services and crisis intervention, provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic and authorized to provide services under Office of Mental Health regulations or guidelines.

ii) Outpatient Substance Use Disorder services are defined as:

A) For facilities licensed or certified under Article 28 and 32 or Article 32, these include substance use disorder and treatment, treatment for addictions, ambulatory behavioral health services, medically necessary chemical dependence screening, assessments, complex care management, collateral visits, individual, group and family counseling, medication administration and management, medication assisted treatment, outreach, peer support services, intensive outpatient and outpatient rehabilitation, problem gambling counseling and smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee). Ambulatory

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behavioral health services may be provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic and authorized to provide services under Office of Alcoholism and Substance Abuse Services regulations or guidelines.

g) For the purposes of this section, urban counties refer to counties with populations of at least 200,000 inhabitants, including the five boroughs of New York City and Albany, Dutchess, Erie, Monroe, Nassau, Niagara, Oneida, Onondaga, Orange, Rockland, Saratoga, Suffolk, and Westchester Counties. For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential Community Behavioral Health Providers, a region is defined as the catchment area beyond the border of a county as determined by the State and set forth in the State-issued Behavioral Health Guidance.

h) The Contractor, in consultation with RPCs, shall analyze its behavioral health network and shall submit to the State an annual Behavioral Health Network Plan to address unmet Enrollee behavioral health service needs in accordance with the State-issued Behavioral Health Guidance. For HARPs and HIV SNPs only, such annual plan shall include an analysis of unmet Enrollee Behavioral Health Home and Community Based Service needs.

i) The Contractor shall consult with RPCs and the State to develop and implement a comprehensive provider training and support program for behavioral health network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to operate and provide quality behavioral health care within a managed care payer system, in accordance with State-issued Behavioral Health Guidance.

21.20 Laboratory Procedures

The Contractor agrees to restrict its laboratory provider network to entities having either a CLIA certificate of registration or a CLIA certificate of waiver.

21.21 Federally Qualified Health Centers (FQHCs)

a) In a county where Enrollment in the Contractor's MMC product is voluntary, the Contractor is not required to contract with FQHCs. However, when an FQHC is a Participating Provider of the Contractor network, the Provider Agreement must include a provision whereby the Contractor agrees to compensate the FQHC for services provided to Enrollees at a payment rate that is not less than the level and amount that the Contractor would pay another Participating Provider that is not an FQHC for a similar set of services.

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b) In a county where Enrollment in the Contractor's MMC product is mandatory and/or the Contractor offers an FHPlus product, the Contractor shall contract with FQHCs operating in that county. The contract with the FQHC must be between the Contractor and the FQHC clinic, not between the Contractor and an individual practitioner at the clinic.

c) The Department may on a case-by-case basis defer the contracting requirement if it determines there is sufficient access to FQHC services in a county. The Department reserves the right to rescind the deferment at any time should access to FQHC services in the county change.

d) When an MCO does not contract with an FQHC, but another MCO in the county contracts with an FQHC, outreach/advertising and educational materials must inform consumers about the availability of FQHC services. These materials should also advise consumers that they have good cause to disenroll from an MCO when the MCO does not contract with an FQHC and another MCO in the county contracts with an FQHC or is an FQHC sponsored MCO.

e) [Applicable to HIV SNP Program only]: In the HIV SNP program, the Contractor is not required to contract with FQHCs. However, when an FQHC is a Participating Provider of the Contractor's network, the Provider Agreement must include a provision whereby the Contractor agrees to compensate the FQHC for services provided to Enrollees at a payment rate that is not less than the level and amount that the Contractor would pay another Participating Provider that is not an FQHC for a similar set of services.

f) The Contractor shall compensate a non-participating Indian Health Care Provider that has been designated as an FQHC for services provided to a Native American Enrollee at a payment rate that is equal to the level and amount that the Contractor would pay a participating FQHC that is not an Indian Health Care Provider for a similar set of services.

21.22 Provider Services Function

a) The Contractor will operate a Provider Services function during regular business hours. At a minimum, the Contractor's Provider Services staff must be responsible for the following:

i) Assisting providers with prior authorization and referral protocols.

ii) Assisting providers with claims payment procedures.

iii) Fielding and responding to provider questions and complaints.

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21.23 Selective Contracting for Breast Cancer Surgery

The Contractor agrees to provide breast cancer surgery only at hospitals and ambulatory surgery centers designated as meeting high volume thresholds as determined by SDOH. SDOH will update the list of eligible facilities annually.

21.24 Patient Centered Medical Home

a) PCPs that meet SDOH's medical home standards will be eligible to receive additional compensation for assigned Enrollees as described in Section 3.18 of this Agreement.

b) PCPs that operate in the upper northeastern region of New York and are approved to participate in the Adirondack Health Care Home Multipayor Demonstration Program will be eligible to receive additional compensation for assigned Enrollees as described in Section 3.18 of this Agreement.

21.25 Pharmacies

a) The Contractor shall include pharmacies as Participating Providers in sufficient numbers and geographic dispersion to meet Medicare Part D access standards per CFR §423.120(a).

b) The Contractor must contract with twenty-four (24) hour pharmacies and must ensure that all Enrollees have access to at least one such pharmacy within thirty (30) minutes travel time (by car or public transportation) from the Enrollee's residence, unless none are located within such a distance. If none are located within thirty (30) minutes travel time from the Enrollee's residence, the Contractor must include the closest site in its network.

c) For certain conditions, such as hemophilia, PKU and cystic fibrosis, the Contractor is encouraged to make pharmacy arrangements with specialty centers treating these conditions, when such centers are able to demonstrate quality and cost effectiveness.

d) The Contractor may make use of mail order prescription deliveries, where clinically appropriate. The Contractor must permit each Enrollee to fill any mail order covered prescription, at his or her option, at any mail order pharmacy or non-mail order retail pharmacy in the Contractor's network. If the Contractor has designated one or more pharmacies for filling prescriptions for a particular drug or drugs, then such prescriptions may be filled, at the Enrollee's option, at any other pharmacy in the Contractor's network, if the network pharmacy chosen by the Enrollee offers to accept a price that is comparable to that of the pharmacy designated by the Contractor.

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e) The Contractor may utilize formularies and utilization management controls and may employ the services of a pharmacy benefit manager or utilization review agent, provided that such manager or agent covers a prescription drug benefit equivalent to the requirements for prescription drug coverage described in Appendix K of this Agreement and maintains an internal and external review process consistent with the requirements in Appendix F of this Agreement for medical exceptions.

f) The Contractor must require that all network retail pharmacies collect a paper or electronic signature to confirm pick-up or receipt of each prescription and OTC drug. In lieu of maintaining a signature log, network pharmacies providing drugs via mail order must maintain the applicable shipping information, including the Enrollee's name, address and prescription number(s), shipped date and carrier. This information may be maintained electronically or on paper. Prescriptions for controlled substances require a signature upon delivery and must be shipped by a method that can be tracked. The Contractor must require that all network DME providers collect a signature to confirm pick-up of medical supplies. All electronic signatures must be retrievable. Signatures must be maintained consistent with Section 19.4 of this Agreement.

21.26 Communication with Patients

The Contractor shall instruct its Participating Providers regarding the following requirements applicable to communications with their patients about the MMC and FHPlus products offered by the Contractor and other MCOs with which the Participating Providers may have contracts:

a) Participating Providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts.

b) Participating Providers who wish to communicate with their patients about managed care options must advise patients taking into consideration ONLY the MCO that best meets the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one plan over another.

c) Participating Providers may display the Contractor's Outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the Participating Provider has a contract.

d) Upon termination of a Provider Agreement with the Contractor, a provider that has contracts with other MCOs that offer MMC and FHPlus products may notify their patients of the change in status and the impact of such change on the patient.

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21.27 Health Home

a) The Health Home program provides reimbursement for care management to approved Health Home providers for the following services provided to Enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services, as described in the State Plan Amendment and the "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations:" comprehensive care management, care coordination and health promotion; transitional care from inpatient to other settings, including follow-up; individual and family support, which includes authorized representatives, referrals to community and social support services; and use of health information technology (HIT) to link services. The Contractor shall identify a single point of contract and establish communication protocols with Health Homes' single point of contract. A Contractor that operates a HARP may appoint a second point of contract for the HARP.

i) For the purposes of this Section 21.27:

A) Health Home Participant means an Enrollee who has elected to enroll in a Health Home.

B) Reassignment means the Contractor assigns an Enrollee who has not yet enrolled in a Health Home to an alternate Health Home

C) Transfer means the Contractor assigns an Enrollee who has elected to enroll in a Health Home to an alternate Health Home

D) Deactivation means the Enrollee's enrollment in a Health Home as ended.

b) The Contractor must subcontract with State designated Health Homes. The Contractor's network must include a sufficient number of Health Homes to serve all Enrollees eligible for Health Home services.

i) The subcontract, or template subcontract if a template is used, between the Contractor and the Health Home must contain the SDOH key contract provisions and be approved by SDOH.

ii) The subcontract between the Contractor and the Health Home shall be consistent with, and subject to, the requirements described in this Agreement.

iii) The subcontract must establish clear lines of responsibility to ensure services are not duplicated. The subcontract must include a process for

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cooperative and coordinated sharing of Enrollee information and other documentation as necessary so that:

A) in the event a Health Home Participant Transfers to an alternate subcontracted Health Home; the new Health Home receives sufficient information to continue care management services; or

B) in the event a Health Home Participant is Deactivated from a Health Home, the Contractor has sufficient information to minimize disruption of the Enrollee's access to Benefit Package services and, as needed, the Enrollee is engaged by the Contractor's case management systems as provided by this Agreement; and

C) In the event a Health Home Participant is Deactivated from a Health Home, the Contractor has sufficient information to fulfill Contractor's responsibilities pursuant to Section 10.41 of the this Agreement.

iv) Except where an Enrollee assigned to a Health Home or a Health Home Participant receives care management through an Assertive Community Treatment program Health Home services will be reimbursed at a per member per month care management rate established by the State. The Contractor must pass through the rate established by the State in whole or in part to the Health Home provider(s) on a timely basis, consistent with the terms of the contract executed between the Contractor and the Health Home, commensurate with the scope of services provided by the subcontractor. The Contractor must submit claims for Health Home reimbursement to SDOH no less frequently than once every 14 days, and make appropriate payments to the Health Home within 14 days of receipt of payment from SDOH.

A) Where an Enrollee receives care management through an Assertive Community Treatment program, the Contractor shall reimburse such Assertive Community Treatment provider directly the monthly ACT rate established by the State. The Assertive Community Treatment provider is responsible for reimbursing the Health Home from such rate an amount approved by the State.

c) Enrollee Health Home Assignments.

i) The Contractor must have effective methods for identifying Enrollees who may be eligible for Health Home services. The Contractor is responsible for verifying Health Home eligibility for all Enrollees; this responsibility may be delegated to subcontracted Health Homes.

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A) The Contractor must assign Enrollees it has identified as eligible for Health Home services to a Health Home based on an analysis of its own data.

B) The Contractor must also consider for assignment Enrollees referred through a community referral process, as described in the Health Home Provider Manual.

C) The SDOH will transmit a list containing suggested Health Home assignments for the Contractor's Enrollees based on a loyalty analysis of claims and encounter data. The Contractor shall analyze its own data and either accept SDOH's suggested assignment, or request the Enrollee be assigned to another Health Home.

ii) An Enrollee determined eligible for Health Home services shall have a choice of Health Homes to the extent practicable.

iii) The Contractor shall assign SDOH-identified Enrollees to a Health Home as soon as possible, but no longer than 45 business days from the date the Enrollee first appears on the SDOH list, as long as the Health Home has the capacity to serve the Enrollee. This timeframe may be extended by SDOH as determined necessary for a limited period to manage the large number of assignments anticipated during the initial HARP enrollment period, or to facilitate prioritization of Enrollees who are in critical need of services. In a manner and format established by SDOH, the Contractor shall report delays in assignments, the cause of delay, and any corrective actions taken.

iv) Upon assignment to a Health Home, the Contractor shall provide Enrollees with at least the following information within 30 days of such assignment:

A) the name, address, and telephone contact information of the Health Home;

B) a brief summary of the services and benefits provided by the Health Home; and

C) notice that the Enrollee has a choice of Health Homes and instructions on how to request assignment to another participating Health Home.

d) Health Home Outreach and Engagement

i) The Contractor shall advise new Enrollees in writing of the availability of Health Home services, which may be combined with the Welcome Letter.

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ii) The Contractor shall notify their Participating Provider Network about Health Homes and how they benefit eligible Enrollees.

iii) The Contractor shall require that the Health Home promptly assign a Care Manager to each assigned Enrollee. The Contractor shall assist the Health Home and its Care management partners with outreach, engagement and enrollment of assigned Enrollees, to the extent possible.

iv) The Contractor shall share data with Health Homes and care management partners, consistent with the terms of the subcontract between the Health Home and the Contractor, to assist in outreach and engagement efforts, subject to any required agreements for sharing Medicaid Confidential Data in accordance with HIPAA and other State requirements regarding confidentiality.

v) The Contractor shall continue periodic education to Enrollees eligible for Health Home services, which may include, but is not limited to, activities such as: informational notices or sessions; case management outreach during or following critical events; or reminders to the Enrollee's trusted providers, until the member enrolls in a Health Home.

vi) The Contractor shall inform and assist Health Homes in conducting outreach when an Enrollee eligible for Health Home services experiences a critical event, including but not limited to an appearance at an emergency room, inpatient hospitalization, discharge planning, or appearance in crisis at a location that provides opportunity for outreach.

vii) The Contractor shall require the Health Home undertake re-engagement efforts for Enrollees lost to follow-up, including Enrollees who have not received a Health Home core service for a period of two (2) consecutive months.

e) Comprehensive Care Management for Health Home Participants.

i) The Contractor shall assist its subcontracted Health Homes, to the extent possible, with the collection of required care management and patient experience of care data. The Contractor shall share current claims data, demographic data, and information received from the Enrollment Broker, in accordance with HIPAA and State confidentiality requirements.

ii) Except where the Enrollee refuses these services, the Contractor shall ensure, consistent with the terms of the subcontract executed between the Contractor and the Health Home, that all Health Homes provide comprehensive Care Management to all Health Home Participants, which shall include the following:

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A) A comprehensive assessment that identifies the Health Home Participant's medical, behavioral health, and social service needs;

B) Integrated medical and behavioral care management services coordinated by a dedicated Care Manager; and

C) Development of a person-centered plan of care, as defined in Section 10.41 of this Agreement, by the Care Manager and the Health Home Participant.

iii) The Contractor shall require Health Homes provide Health Home Participants access to Health Home Care Management 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary.

iv) To promote appropriate and timely follow-up and coordination of services and to ensure that the Health Home Participant is safely transitioned, the Contractor shall inform the Enrollee's Health Home when the Contractor is made aware the Enrollee has received services at an emergency room, Comprehensive Psychiatric Emergency Program, crisis respite, residential addiction treatment program, or inpatient setting. The Contractor will assist the Health Home and its care management partners' access to data to facilitate appropriate and timely follow-up, and coordination of services post-discharge, as needed, and that the Enrollee's plan of care is updated, as necessary.

f) Health Home person-centered plan of care.

i) The Contractor shall review the plan of care developed by the Health Home Care Manager and the Health Home Participant, and work collaboratively to finalize an approved plan of care.

A) The Contractor shall be responsible for approving the plan of care and shall document the approved plan of care in the Enrollee's record. This requirement shall initially be applicable for Enrollees for whom BHHCBS have been recommended. Upon 60 days' notice from SDOH and subject to the availability of the operational systems to support such review, the Contractor shall review and approve plans of care for all Enrollees. Notwithstanding the requirements of this section, the Contractor may request the plan of care for any Enrollee, as deemed clinically necessary.

ii) Through its review and approval of the plan of care, the Contractor shall ensure that the Health Home plan of care adheres to requirements set forth in Section 10.41 of this Agreement.

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A) The Contractor will verify the Health Home Participant played a central and active role in the development and execution of his or her approved plan of care; agreed with the goals, interventions, and time frames contained therein; and was not excluded from participation, to the extent practicable, in the event the Health Home Participant has a court-appointed guardian.

B) The Contractor will verify the Health Home Participant was offered a choice of Participating Providers, including providers not part of the Health Home, to ensure the provision of conflict-free provider referrals.

iii) The Contractor shall ensure the Health Home Participant has access to all covered services identified in the Health Home Participant's approved plan of care.

iv) The Contractor shall ensure that the approved Health Home plan of care is reassessed no less frequently than annually, and when warranted by a significant change in the Health Home Participant's medical and/or behavioral health condition. Such reassessment shall include documentation of the Health Home Participant's progress in meeting his or her goals from prior plans of care and shall be documented in the Enrollee's record.

g) Health Home Participant Reassignment, Transfer and Deactivation.

i) Upon prior written notice to the Health Home and consistent with the terms of the subcontract between the Health Home and the Contractor, the Contractor may re-assign or transfer a Health Home Participant to another Health Home if:

A) The Health Home Participant relocates or changes their PCP to a PCP that affiliates with another Health Home;

B) The Health Home loses its State designation as a Health Home for any reason; or

C) The Health Home Participant requests a reassignment or transfer to another Health Home.

ii) If a Health Home Participant requests a transfer to another Health Home, the Contractor shall ensure the Health Home Participant has choice of another Health Home, if available. The Contractor shall ensure that the Transfer takes place within a reasonable timeframe, not to exceed 30 days; that the necessary records are shared with the alternate Health Home within a reasonable timeframe (consistent with State and Federal

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Confidentiality laws); and that the Health Home cooperates fully with the entity assuming responsibility for providing care management to the Enrollee.

iii) The Contractor shall Deactivate or Transfer a Health Home Participant in instances where the Contractor determines that the Health Home has not performed adequately, consistent with the terms of the subcontract executed between the Contractor and the Health Home. To the extent possible, before Deactivating or Transferring a Health Home Participant, the Contractor shall take into account the Health Home Participant's own assessment of the Health Home's performance and shall not Deactivate or Transfer a Health Home Participant if the Health Home Participant objects to the Deactivation or Transfer, except where Deactivation or Transfer is required to address a serious physical or behavioral health need. If no other participating or non-participating Health Home is available, the Contractor shall immediately assume responsibility for the Enrollee's case management, care coordination and the Enrollee's plan of care, as provided by this Agreement.

h) The Contractor shall monitor the performance of the Health Home consistent with the terms of the subcontract executed between the Contractor and the Health Home.

i) The Contractor shall share performance, billing, encounter, and outreach data and hold meetings, at least semi-annually, with Health Homes and care management partners to evaluate and improve Health Home performance.

ii) In a manner and format determined by SDOH, the Contractor shall share information regarding Health Home performance, including identifying Health Homes that appear best suited for assisting Enrollees with certain conditions, such as Serious Mental Illness or functionally limiting substance use disorder.

iii) The Contractor shall notify the SDOH if the Contractor intends to terminate a subcontract with a Health Home 60 days prior to termination. Such notice shall include the reason for the termination, including attempted remediation. Such termination shall be consistent with terms and procedures of the subcontract executed between the Contractor and the Health Home.

iv) In the event that the Contractor determines to terminate its subcontract with a Health Home, the Contractor shall timely notify affected Health Home Participants after notifying SDOH and no later than 20 days before termination and reassign such Participants to another Health Home. Such notice shall be approved by the SDOH.

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21.28 Case Management Providers [Applicable to HIV SNP Program Only]

The Contractor must establish capacity to ensure that all Enrollees determined by assessment to be in need of psychosocial case management, receive this service. Psychosocial case management provided through Contractor contract or linkage must be provided by qualified community-based case management providers who have AIDS Institute-approved case management programs and are able to provide HIV SNP Enrollees access to case management and other support services. The Contractor may opt to directly provide psychosocial case management services if the Contractor can demonstrate the ability to comply with AIDS Institute Standards for Case Management.

21.29 Linkage Agreement Providers [Applicable to HIV SNP Program Only]

The Contractor is responsible for facilitating Enrollees' access to health and psychosocial service providers that support Enrollees' ability to sustain wellness and to adhere to treatment regimens. Providers of such services are often supported by private or public grant funds or other fiscal arrangements. To promote Enrollee access to these service providers, the Contractor shall establish linkage agreements in the form of either contractual arrangements or memoranda of understanding (MOU) with providers including, as appropriate, but not limited to, those listed in Section 10.31 (b) of this Agreement.

21.30 Primary Care Rate Increase

a) Until the effective date of the termination of the program, the Contractor will provide enhanced payments to eligible providers (including network providers and out of network providers providing services as authorized by the Contractor) who provide certain primary care services pursuant to Subpart G of CFR Part 447. Funding for this program will receive enhanced federal financial participation. The Contractor is responsible for the following activities in accordance with Section 3.20 of this Agreement and/or any guidelines issued by SDOH:

   i) Compile a list of providers eligible for the Primary Care Rate Increase (PCRI) and report to SDOH on such providers;

   ii) Make PCRI payments to eligible providers;

   iii) The PCRI payments must be made to providers at least quarterly after implementation;

   iv) Facilitate and cooperate with SDOH on periodic audits to verify provider eligibility for PCRI payments, including validating eligibility for providers qualifying for PCRI based on specialty and reporting the results to SDOH;



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v) Retain such records as may be required by SDOH to allow SDOH to validate that all revenues were passed through to providers to enhance payments up to 100% of the Medicare fee schedule as required by federal law and regulations;

vi) Provide any information required by SDOH to effectuate the PCRI initiative;

vii) Develop a process to respond to provider complaints or concerns regarding the PCRI initiative; and

viii) Otherwise administer the PCRI initiative consistent with SDOH guidelines.

21.31 Hospice Providers

The Contractor shall ensure that Enrollees receiving Hospice services have a choice of at least two (2) Hospice providers when available. In counties where there is only one (1) Hospice Provider, the Contractor shall contract with that agency.

21.32 Veterans' Homes

The Contractor shall contract with at least one veterans' home that operates in its service area, provided that at least one veterans' home operates in its service area.

21.33 Indian Health Care Providers

a) Subject to Section 21.21(f), the Contractor shall compensate participating and non-participating Indian Health Care Providers for services provided to a Native American Enrollee at the payment rate negotiated between the Contractor and the provider involved or, if such rate has not been negotiated, at a payment rate that is not less than the level and amount that the Contractor would pay a Participating Provider that is not an Indian Health Care Provider for a similar set of services.

b) Notwithstanding the provisions set forth in Section 21.33 (a) above, the Contractor shall not compensate either a participating or a non-participating Indian Health Care Provider for services provided to a Native American Enrollee an amount less than the Medicaid fee-for-service rate for similar services. This provision does not apply to an Indian Health Care Provider that has been designated as an FQHC.

i) If such compensation is less than the encounter rate amount published annually in the Federal Register by the Indian Health Service, the SDOH



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shall make a supplemental payment to the Indian Health Care Provider to make up the difference between the amount paid by the Plan and the applicable encounter rate.

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## 22. SUBCONTRACTS AND PROVIDER AGREEMENTS

22.1 Written Subcontracts

a) The Contractor may not enter into any subcontracts related to the delivery of services to Enrollees, except by a written agreement.

b) If the Contractor enters into subcontracts for the performance of work pursuant to this Agreement, the Contractor shall retain full responsibility for performance of the subcontracted services. Nothing in the subcontract shall impair the rights of the State under this Agreement. No contractual relationship shall be deemed to exist between the ~~s~~Subcontractor or Participating Provider and the State.

c) The delegation by the Contractor of its responsibilities assumed by this Agreement to any subcontractors will be limited to those specified in the subcontracts.

22.2 Permissible Subcontracts

The Contractor may subcontract for provider services as set forth in Sections 2.6 and 21 of this Agreement and management services including, but not limited to, quality assurance and utilization review activities and such other services as are acceptable to the SDOH. The Contractor must evaluate the prospective ~~s~~Subcontractor's or Participating Provider's ability to perform the activities to be delegated or performed.

22.3 Provision of Services through Provider Agreements

a) All medical care and/or services covered under this Agreement, with the exception of seldom used subspecialty and Emergency Services, Family Planning Services, and services for which Enrollees can self refer, pursuant to Section 10.15 of this Agreement, shall be provided through Provider Agreements with Participating Providers.

b) Under no circumstances shall the Contractor condition the participation of a Behavioral Health Provider, as defined in this Agreement, in the Contractor's MMC network upon such Provider's agreement to participate in the Contractor's non-Medicaid lines of business.

22.4 Approvals

a) Provider Agreements shall require the approval of SDOH as set forth in PHL §4402 and 10 NYCRR Part 98.

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b) If a subcontract is for management services under 10 NYCRR Part 98, it must be approved by SDOH prior to its becoming effective.

c) The Contractor shall notify SDOH of any material amendments to any Provider Agreement as set forth in 10 NYCRR Part 98.

22.5 Required Components

a) All subcontracts, including ~~Provider Agreements~~those with Participating Providers and Subcontractors, entered into by the Contractor to provide program services under this Agreement shall contain provisions specifying:

i) the activities and report responsibilities delegated to the ~~s~~Subcontractor or Participating Provider; and provide for revoking the delegation, in whole or in part, and imposing other sanctions if the ~~s~~Subcontractor's or Participating Provider's performance does not satisfy standards set forth in this Agreement, and an obligation for the provider to take corrective action;

ii) that the work performed by the ~~s~~Subcontractor or Participating Provider must be in accordance with the terms of this Agreement;

iii) that the ~~s~~Subcontractor or Participating Providers specifically agrees to be bound by the confidentiality provisions set forth in this Agreement; and

iv) that the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of medical care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by Participating Providers enrolled in an MCO apply to such Participating Providers and any ~~s~~Subcontractors, regardless of whether the Participating Provider or ~~s~~Subcontractor is an enrolled Medicaid provider, including 18 NYCRR 515.2, except to the extent that any reference in the regulations establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

v) that the New York State Office of the Attorney General, SDOH, the Office of the Medicaid Inspector General and the Office of the State Comptroller (OSC) have the right to audit, investigate or review the ~~s~~Subcontractor or Participating Provider and recover overpayments, penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq;

vi) that the Contractor will not provide reimbursement for Conversion Therapy;



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vii) any Value Based Payment arrangements, as described in Section 22.18 of this Agreement, as applicable to the subcontract~~ or Provider Agreement~~, including those with Participating Providers and Subcontractors;

viii) that the Contractor shall, upon notification from SDOH, terminate the ~~Participating Provider~~subcontract where the Subcontractor or Participating Provider failed or refused to pay, or enter into a repayment agreement to pay, the full amount of any overpayment, fine or monetary penalty owed to the Medicaid program, including interest thereon; and

ix) if the subcontract is a Provider Agreement, that the ~~subcontractor~~Participating Provider is required to report to the Contractor provider-preventable conditions, as described in Section 22.16 of this Agreement, associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

b) All subcontracts entered into by the Contractor for services that relate directly or indirectly to Contractor's performance of its obligations under this Agreement shall contain additional provisions specifying:

i) that notwithstanding Section 22.5(a)(v) of this Agreement, the Subcontractor shall, upon two (2) business days prior written notice, during normal business hours, unless otherwise provided or permitted by applicable laws, rules, or regulations, provide OMH, OASAS, the Comptroller of the State of New York, the New York State Office of the Attorney General, or their designees, access to all records for the purposes of examination, audit, and copying that pertain to its performance in connection with the subcontract and this Agreement;

ii) that notwithstanding Section 22.5(a)(v) and (b)(i) of this Agreement, SDOH, OMIG, DHHS, and the Comptroller General of the United States, the New York State Office of the Attorney General or their designees may, at any time, inspect and audit any records or documents of the Subcontractor, or of the Subcontractor's contractor, that pertain to its performance in connection with the subcontract and this Agreement;

iii) that the Subcontractor shall make available to SDOH, OMIG, DHHS, and the Comptroller General of the United States, the New York State Office of the Attorney General or their designees, at any time, its premises, physical facilities, and equipment where Medicaid-related activities or work is conducted;

iv) that upon request, the Subcontractor shall take all reasonable actions not otherwise required by the subcontract or other applicable authority to provide or ensure access to such records or documents described in

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Section 22.5(a) and (b) of this Agreement and to the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted;

v) that the Subcontractor shall preserve and retain all records and document that pertain to its performance in connection with the subcontract and this Agreement in a readily accessible form during the term of the subcontract or this Agreement, whichever occurs later, for a period of ten (10) years thereafter, except that the Subcontractor shall retain Enrollee's medical records that are in its possession for a period of ten (10) years after the date of service rendered to the Enrollee of cessation of Contractor operation , and in the case of a minor, for ten (10) years after the date of service or three (3) years after majority, whichever occurs later;

vi) that the right to audit under Sections 19.3 and 22.5(a) and (b) of this Agreement will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;

vii) that the provisions of the subcontract relating to record maintenance and audit shall survive the termination of the subcontract and this Agreement and shall bind the Subcontractor until the expiration of a period of ten (10) years commencing with the termination of the subcontract or this Agreement or, if an audit is commenced, until the completion of the audit, whichever occurs later. If the Subcontractor becomes aware of any litigation, claim, financial management review or audit that is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims, financial management reviews or audit findings involving the record have been resolved and final action taken;

viii) that the Subcontractor shall withhold payments to Participating Providers and Non-Participating Providers as directed by SDOH or OMIG and Section 23.7(a) of this Agreement;

ix) that the Subcontractor shall report to SDOH and OMIG, in accordance with Section 18.5(a)(viii)(G) of this Agreement, and in a form and format determined by SDOH and OMIG, within sixty (60) days after it identifies, or received notice of, any capitation payments or other payments in excess of amounts specified in the Agreement, and shall return such overpayments to SDOH within sixty (60) days of identification, unless otherwise specified by SDOH or OMIG;

x) that the Subcontractor shall report such information, or make such information available, to Contractor as is applicable to the Subcontractor's roles and responsibilities under the subcontract, and in a time and fashion necessary to enable Contractor to produce or report such information

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required under Section 18.5(a) of this Agreement, or other sections, and related guidance from SDOH or OMIG: and

xi) the Subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance, directives of SDOH, and the terms of this Agreement.

c) Section 22.5(b) of this Agreement shall only apply to Subcontractors meeting the definition of such term under 42 C.F.R. § 438.2. A Participating Provider is not a Subcontractor by virtue of their Provider Agreement with the Contractor.

d) The Contractor shall, upon contracting with a Participating Provider or Subcontractor, provide the following information about the grievance and appeal system to such Participating Provider or Subcontractor:

i) the right of the Enrollee, or, with the Enrollee's written consent, a provider or an authorized representative, to file grievances and appeals;

ii) the requirements and timeframes for filing a grievance or appeal;

iii) the availability of assistance in the filing process;

iv) the right to request a State fair hearing after the Contractor has made a determination on an Enrollee's appeal which is adverse to the Enrollee; and

v) the fact that, when requested by the Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the Enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the Enrollee.

e) The Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's service authorization request, appeal, or grievance.

~~b~~f) The Contractor shall impose obligations and duties on its ~~s~~Subcontractors, ~~including its~~ and Participating Providers, that are consistent with this Agreement, and that do not impair any rights accorded to LDSS, SDOH, OMH, OASAS, DHHS, Office of the Medicaid Inspector General (OMIG), Office of the State Comptroller (OSC) or the New York State Office of the Attorney General.

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~~e~~g) No subcontract, including any Provider Agreement, shall limit or terminate the Contractor's duties and obligations under this Agreement.

~~d~~h) Nothing contained in this Agreement shall create any contractual relationship between SDOH and any ~~s~~Subcontractor~~ of the Contractor, including its~~ Participating Provider~~s~~, Non-Participating Provider~~s~~ or third parties~~ and SDOH~~. Nothing in this paragraph shall be construed to limit the authority of the New York State Office of the Attorney General to commence any action pursuant to 31 U.S.C. § 3729 et seq., State Finance Law § 187 et seq., Social Services Law § 145-b or other New York or Federal statutes, regulations or rules.

~~e~~i) Any subcontract, including any Provider Agreement, entered into by the Contractor shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated or performed under such subcontract, including HCBS settings requirements that comply with Section 10.44 of this Agreement.

~~f~~j) The Contractor shall also require that, in the event the Contractor fails to pay any ~~s~~Subcontractor~~, including any~~ or Participating Provider in accordance with the subcontract~~ or Provider Agreement~~, the ~~s~~Subcontractor or Participating Provider will not seek payment from the SDOH, LDSS, the Enrollees, or persons acting on an Enrollee's behalf.

~~g~~k) The Contractor shall include in every Provider Agreement a procedure for the resolution of disputes between the Contractor and its Participating Providers.

~~h~~l) The Contractor shall ensure that all Provider Agreements entered into with Participating Providers require acceptance of a woman's Enrollment in the Contractor's MMC or FHPlus product as sufficient to provide services to her newborn, unless the newborn is excluded from Enrollment in the MMC Program pursuant to Section 6.1 of this Agreement, or the Contractor does not offer a MMC product in the mother's county of fiscal responsibility.

~~i~~m) The Contractor must monitor the ~~s~~Subcontractor's or Participating Provider's performance on an ongoing basis and subject it to formal review according to time frames established by the State, consistent with State laws and regulations, and the terms of this Agreement. When deficiencies or areas for improvement are identified, the Contractor and ~~s~~Subcontractor or Participating Provider must take corrective action and report deficiencies as required by section 18.5(x~~xi~~viii) of this Agreement.

~~j~~n) The Contractor shall not enter into any agreement with any Participating Provider, Non-Participating Provider, ~~s~~Subcontractor or third party that would limit any right to commence an action or to obtain recovery from such



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providers by the State, including, but not limited to, the New York State Office of the Attorney General, SDOH, OMIG and OSC, even under circumstances where the Contractor has obtained an overpayment recovery from a provider. Nothing in this Agreement shall be construed to limit the amount of any recovery sought or obtained by the New York State Office of the Attorney General, SDOH, OMIG, and OSC from any Contractor, Participating Provider, Non-Participating Provider, ~~s~~Subcontractor, or from any third party.

~~k~~o) Each year the Contractor must meet the percentage of total provider payment targets that are detailed in the NYS Value-Based Payment Roadmap. The Contractor must submit a proposed plan to the SDOH by December 1st each year to identify which providers will be impacted by the alternate payment arrangements, the type of arrangements the Contractor has implemented or plans to implement, and the percent of provider payments impacted. The Contractor must receive approval from DOH, OMH, and OASAS for alternative payment arrangements affecting licensed, certified or designated Behavioral Health Providers if the methodology differs from traditional fee for service.

~~l~~p) The Contractor shall include the following contract provisions in Provider Agreements with providers operated, licensed or certified by OMH or OASAS with five or more active Plan members in treatment required pursuant to Section 21.19(a)(ii) of this Agreement:

i) The Provider Agreement shall be for a minimum term of 24 months from the Behavioral Health Inclusion Date in each geographic service area, unless otherwise prohibited by the terms of this Agreement; and

ii) The Contractor shall pay at least the applicable Medicaid fee-for-service rate for a minimum of 24 months effective on the date of the Behavioral Health Benefit Inclusion in each geographic Service Area.

~~m~~q) [Applicable to the HARP and HIV SNP Programs Only]: The Contractor shall include in every Provider Agreement with a provider of Behavioral Health Home and Community Based Services a procedure for monitoring BHHCBS utilization for each Enrollee.

~~n~~r) For subcontracted Pharmacy Benefit Manager(s) and pharmacies providing services to the Contractor's Enrollees:

i) Notwithstanding the timely access to records provision of Section 19.3(~~a~~b) of this Agreement, the Contractor shall require its subcontracted Pharmacy Benefit Manager(s) to grant SDOH, OMIG, and the New York State Office of the Attorney General access to view real time point of sale claims transactions, including but not limited to, any paid, denied,



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reversed and/or adjusted claims, submitted by any pharmacy to the Contractor's Pharmacy Benefit Manager;

ii) In the event the Contractor does not utilize a Pharmacy Benefit Manager for some or all pharmacy claims, and notwithstanding the timely access to records provision of Section 19.3(a) of this Agreement, the Contractor shall grant SDOH, OMIG, and the New York State Office of the Attorney General access to view real time point of sale claims transactions, including but not limited to, any paid, denied, reversed and/or adjusted claims submitted by any pharmacy to the Contractor's pharmacy claims processing system; and

iii) The Contractor shall not reimburse any subcontracted pharmacy, and shall require its subcontracted Pharmacy Benefit Managers(s) to not reimburse any subcontracted pharmacy, in excess of usual and customary charges for any prescription drug.

22.6 Timely Payment

a) Contractor shall make payments to Participating Providers and to Non-Participating Providers, as applicable, for items and services covered under this Agreement on a timely basis, consistent with the claims payment procedures described in SIL § 3224-a.

b) In processing payments, the Contractor shall comply with requirements at 42 CFR 447.45(d)(5) and (6).

22.7 Recovery of Overpayments ~~to Providers~~

a) i) Consistent with the exception language in Section 3224-b of the Insurance Law and with 10 NYCRR 98-1.17, the Contractor shall have and retain the right to audit ~~participating~~ providers' claims for a six (6) year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This six (6) year limitation does not apply to situations in which fraud may be involved or in which the provider or an agent of the provider prevents or obstructs the Contractor's auditing.

ii) The parties acknowledge that the New York State Office of the Attorney General, SDOH, the Office of the Medicaid Inspector General (OMIG) and the Office of the State Comptroller (OSC) have the right to recover overpayments, penalties, and other damages from Participating Providers, Non-Participating Providers, Contractors, subcontractors, and third parties in the Contractor's network as a result of any investigation, audit or action commenced by the New York State Office of the Attorney General, SDOH, OMIG, and OSC, including, but not limited to any litigation



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brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. by, or on behalf of the New York State Office of the Attorney General. The Contractor shall not have a right to recover from the State any recovery obtained by the State pursuant to 31 U.S.C. § 3729 et seq., State Finance Law § 187 et seq., 18 NYCRR Parts 515, 516, 517, or 518, or other New York or Federal statutes, regulations or rules.

iii) The parties agree that where the Contractor has previously recovered overpayments, by whatever mechanism utilized by the Contractor, from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable ~~claims~~overpayments that are the subject of a further investigation, audit or action commenced by the agencies listed in Section 22.7 d).

iv) The parties agree that where the Contractor has recovered overpayments from a Participating Provider, the Contractor shall retain said recoveries, except where such recoveries are made on behalf of the OMIG or SDOH as provided in Section 22.7 (b), or pursuant to a combined audit as provided in Section 22.7 (c) of this Agreement.

v) Where the Contractor has recovered overpayments from a Participating Provider, a Non-Participating Provider, or a Subcontractor due to fraud, waste or abuse, the Contractor shall retain said recoveries, except where such recoveries were made in violation of the Contractor's obligation to comply with the fraud, waste and abuse reporting requirements of Section 18.5(a)(vii) of this Agreement. If SDOH or OMIG, or with respect to cases of potential fraud, the New York State Office of the Attorney General, determines that the Contractor has recovered an overpayment in violation of Section 18.5(a)(vii) of this Agreement, the Contractor shall either remit the full amount it recovered to the SDOH within five (5) business days of notification or SDOH shall withhold the amount recovered from a payment otherwise owed to the Contractor.

b) The OMIG or ~~or~~ SDOH shall have the ~~right~~authority to ~~request~~require that the Contractor recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from ~~its Participating~~any ~~P~~provider consistent with the requirements of Insurance Law § 3224-b. In such cases the OMIG or SDOH may charge the ~~Participating P~~provider a collection fee as set forth in State Finance Law, in an amount to be determined by the OMIG or SDOH in its sole discretion. The Contractor shall remit, on a monthly basis, to the SDOH all amounts collected from the ~~Participating P~~provider. Upon collection of the full amount owed to the Medicaid program, the Contractor may retain the collection fee to account for the Contractor's reasonable costs incurred to collect the debt. The Contractor shall report the amounts recovered in its ~~Quarterly~~ Provider Investigative Report in accordance with



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Section 18.5(a)~~(xxii)~~(viii)(F) of this Agreement. OMIG or SDOH will only ~~request~~require that the Contractor recover an overpayment, penalty or other damage where there has been a final determination. For purposes of this section, a final determination is defined as:

i) a Notice of Agency Action issued by the OMIG pursuant to 18 NYCRR Part 515;

ii) a Notice of Agency Action issued by the OMIG pursuant to 18 NYCRR Part 516;

iii) a Final Audit Report issued by the OMIG pursuant to 18 NYCRR Part 517;

iv) a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or

v) an Administrative Hearing Decision issued by SDOH pursuant to 18 NYCRR Part 519; however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision.

c) Consistent with 18 NYCRR § 517.6(g) the OMIG may enter into an agreement with the Contractor to conduct a combined audit or investigation of the Contractor's Participating Provider, Non-Participating Provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between the Contractor and OMIG as provided for in the combined audit or investigation agreement. In no event shall the Contractor share in any recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.

d) Nothing in this Agreement shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or SDOH to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party.

e) The Contractor shall have procedures in place for Participating Providers, Non-Participating Providers, Subcontractors, or all other third parties to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date



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on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The Contractor shall report any amount recovered in its quarterly Medicaid Managed Care Operating Report and its Provider Investigative Report in accordance with Section 18.5(a)(viii)(F) of this Agreement.

22.8 Restrictions on Disclosure

a) The Contractor shall not by contract or written policy or written procedure prohibit or restrict any health care provider from the following:

i) Disclosing to any subscriber, Enrollee, patient, designated representative or, where appropriate, Prospective Enrollee any information that such provider deems appropriate regarding:

A) a condition or a course of treatment with such subscriber, Enrollee, patient, designated representative or Prospective Enrollee, including the availability of other therapies, consultations, or tests; or

B) the provisions, terms, or requirements of the Contractor's MMC or FHPlus products as they relate to the Enrollee, where applicable.

ii) Filing a complaint, making a report or comment to an appropriate governmental body regarding the policies or practices of the Contractor when he or she believes that the policies or practices negatively impact upon the quality of, or access to, patient care.

iii) Advocating to the Contractor on behalf of the Enrollee for approval or coverage of a particular treatment or for the provision of health care services.

22.9 Transfer of Liability

No contract or agreement between the Contractor and a Participating Provider shall contain any clause purporting to transfer to the Participating Provider, other than a medical group, by indemnification or otherwise, any liability relating to activities, actions or omissions of the Contractor as opposed to those of the Participating Provider.

22.10 Termination of Health Care Professional Agreements

a) General Requirements

i) The Contractor shall not terminate a contract with a health care professional unless the Contractor provides to the health care professional



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a written explanation of the reasons for the proposed termination and an opportunity for a review or hearing as hereinafter provided. For purposes of this Section, a health care professional is an individual licensed, registered or certified pursuant to Title VII of the Education Law.

ii) These requirements shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

b) Notice of Health Care Professional Termination

i) When the Contractor desires to terminate a contract with a health care professional, the notification of the proposed termination by the Contractor to the health care professional shall include:

A) the reasons for the proposed action;

B) notice that the health care professional has the right to request a hearing or review, at the provider's discretion, before a panel appointed by the Contractor;

C) a time limit of not less than thirty (30) days within which a health care professional may request a hearing; and

D) a time limit for a hearing date which must be held within thirty (30) days after the date of receipt of a request for a hearing.

c) No contract or agreement between the Contractor and a health care professional shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination.

22.11 Health Care Professional Hearings

a) A health care professional that has been notified of his or her proposed termination must be allowed a hearing. The procedures for this hearing must meet the following standards:

i) The hearing panel shall be comprised of at least three persons appointed by the Contractor. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.



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ii) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the Contractor, provisional reinstatement subject to conditions set forth by the Contractor or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

iii) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision. Notwithstanding the termination of a health care professional for cause or pursuant to a hearing, the Contractor shall permit an Enrollee to continue an on-going course of treatment for a transition period of up to ninety (90) days, and post-partum care, subject to the provider's agreement, pursuant to PHL § 4403(6)(e).

iv) In no event shall termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

22.12 Non-Renewal of Provider Agreements

Either party to a Provider Agreement may exercise a right of non-renewal at the expiration of the Provider Agreement period set forth therein or, for a Provider Agreement without a specific expiration date, on each January first occurring after the Provider Agreement has been in effect for at least one year, upon sixty (60) days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for the purposes of this Section.

22.13 Notice of Participating Provider Termination

a) The Contractor shall notify SDOH of any notice of termination or non-renewal of an IPA or institutional network Provider Agreement, or medical group Provider Agreement that serves five percent or more of the enrolled population in a LDSS and/or when the termination or non-renewal of the medical group provider will leave fewer than two Participating Providers of that type within the LDSS, unless immediate termination of the Provider Agreement is justified. The Contractor shall also notify OMH and OASAS of any notice of termination or nonrenewal of a Provider Agreement with a Behavioral Health Provider that serves five percent or more of the enrolled population in a LDSS and/or when the termination or non-renewal of the provider will leave fewer than two Participating Providers of that type within the LDSS, unless immediate termination of the Provider Agreement is justified. The notice shall include an impact analysis of the termination or non-renewal with regard to Enrollee access to care.

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b) The Contractor shall provide the notification required in (a) above to the SDOH, and OMH and OASAS if applicable, if the Contractor and the Participating Providers have failed to execute a renewal Provider Agreement forty-five (45) days prior to the expiration of the current Provider Agreement.

c) In addition to the notification required in (a) above, the Contractor shall submit a contingency plan to SDOH, and OMH and OASAS if applicable, at least forty-five (45) days prior to the termination or expiration of the Provider Agreement, identifying the number of Enrollees affected by the potential withdrawal of the provider from the Contractor's network and specifying how services previously furnished by the Participating Provider will be provided in the event of its withdrawal from the Contractor's network. If the Participating Provider is a hospital, the Contractor shall identify the number of doctors that would not have admitting privileges in the absence of such Participating hospital.

d) If the Participating Provider is a hospital and the Contractor and the hospital are in agreement that the termination or non-renewal will occur on the scheduled date indicated, separate written notice must be submitted to SDOH from the hospital and the Contractor. Both letters must be submitted as part of the forty-five (45) day notification to the Department. The Contractor must also provide the hospital with a copy of the "MCO/Hospital Terminations and Non-Renewal Guidelines" making the hospital aware of its responsibilities during the cooling off period, including, but not limited to, submission of a sample member notice, if applicable, to SDOH for review and approval. In addition, the Contractor must submit the impact/disruption analysis.

e) If the Participating Provider is a hospital and either party desires to continue negotiations, all notices or requests submitted to the SDOH by the Contractor or hospital must include a copy to the other contracted party to the agreement. If the Contractor and the hospital do not submit a letter indicating the termination will occur as scheduled, the SDOH will assume the parties will continue to negotiate and Enrollees will be afforded the two months cooling off period as defined in statute. The Contractor must pay and the hospital must accept the previous contracted rate during the two month cooling off period. The Contractor must submit an impact/disruption analysis and draft notices to members and providers to SDOH for review upon the termination unless a contract extension is secured. If the Contractor and the hospital extend the term of the agreement, the extended date becomes the new termination date for purposes of PHL § 4406-c (5-c).

f) If the Participating Provider is a hospital and either party wishes to request a waiver of the cooling off period, a written request must be made to the Director of the Bureau of Certification and Surveillance no more than five business days after the Contractor submits the notice of termination to the SDOH. The waiver request must include a detailed rationale as to why the



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cooling off period should not be afforded to Enrollees. The SDOH will respond to the request within three business days. If the SDOH denies the waiver request, the Contractor and the hospital must adhere to the specifications above. If the SDOH issues a waiver of the cooling off period, the Contractor must immediately submit draft Enrollee notices and an impact/disruption analysis to SDOH in order to issue timely notification.

g) In addition to the notification required in (a) above, the Contractor shall develop a transition plan for Enrollees who are patients of the Participating Provider withdrawing from the Contractor's network subject to approval by SDOH, and OMH and OASAS if applicable. SDOH may direct the Contractor to provide notice to the Enrollees who are patients of PCPs or specialists including available options for the patients, and availability of continuing care, consistent with Section 13.8 of this Agreement, not less than thirty (30) days prior to the termination or expiration of the Provider Agreement. To the extent practicable, such notices shall be forwarded to SDOH for review and approval forty-five (45) days prior to the termination or expiration of the Provider Agreement. In the event that Provider Agreements, other than those with hospitals, are terminated or are not renewed with less than the notice period required by this Section, the Contractor shall immediately notify SDOH, and OMH and OASAS if applicable, and develop a transition plan on an expedited basis and provide notice to affected Enrollees upon SDOH consent to the transition plan and Enrollee notice.

h) If the Participating Provider is a hospital and the Contractor and the hospital agree to the termination or non-renewal so there will be no cooling off period, notices must be issued to Enrollees at least thirty (30) days prior to the termination and must reflect all transitional care requirements pursuant to PHL § 4406-c (5-c) and § 4403.6 (e). If notices are not sent thirty (30) days prior to the scheduled termination or non-renewal, the termination date must be adjusted to allow the required thirty (30) day notification to Enrollees.

i) If the Contractor and the hospital continue negotiations and a cooling off period begins, notices must be issued to Enrollees within fifteen (15) days of the commencement of the cooling off period and must include language regarding the cooling off period and transitional care. When a cooling off period is required, notice may not be issued to Enrollees by either party prior to the start of the cooling off period.

j) If the SDOH issues a waiver of the cooling off period, the Contractor must immediately submit draft Enrollee notices and an impact/disruption analysis to SDOH in order to issue timely notification. The notices must be sent to Enrollees at least thirty (30) days prior to the scheduled termination unless a contract extension is secured. If Enrollee notices are not sent at least thirty (30) days prior to the scheduled termination or non-renewal, the termination

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date must be adjusted to allow the required thirty (30) day notification to Enrollees.

k) Upon Contractor notice of failure to renew, or termination of, a Provider Agreement, the SDOH, in its sole discretion, may waive the requirement of submission of a contingency plan upon a determination by the SDOH that:

   i) the impact upon Enrollees is not significant, and/or

   ii) the Contractor and Participating Provider are continuing to negotiate in good faith and consent to extend the Provider Agreement for a period of time necessary to provide not less than thirty (30) days notice to Enrollees.

l) SDOH reserves the right to take any other action permitted by this Agreement and under regulatory or statutory authority, including but not limited to terminating this Agreement.

22.14 Physician Incentive Plan

a) If Contractor elects to operate a Physician Incentive Plan, the Contractor agrees that no specific payment will be made directly or indirectly to a Participating Provider that is a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. Contractor agrees to submit to SDOH annual reports containing the information on its Physician Incentive Plan in accordance with 42 CFR § 438.6(h). The contents of such reports shall comply with the requirements of 42 CFR §§ 422.208 and 422.210 and be in a format to be provided by SDOH.

b) The Contractor must ensure that any Provider Agreements for services covered by this Agreement, such as agreements between the Contractor and other entities or between the Contractor's subcontracted entities and their contractors, at all levels including the physician level, include language requiring that the Physician Incentive Plan information be provided by the sub-contractor in an accurate and timely manner to the Contractor, in the format requested by SDOH.

c) In the event that the incentive arrangements place the Participating physician or physician group at risk for services beyond those provided directly by the physician or physician group for an amount beyond the risk threshold of twenty-five percent (25%) of potential payments for covered services (substantial financial risk), the Contractor must comply with all additional requirements listed in regulation, such as: conduct Enrollee/disenrollee satisfaction surveys; disclose the requirements for the Physician Incentive Plans to its beneficiaries upon request; and ensure that all physicians and physician groups at substantial financial risk have adequate stop-loss

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protection. Any of these additional requirements that are passed on to the subcontractors must be clearly stated in their Provider Agreement.

22.15 Never Events

a) The Contractor is required to develop claims and payment policies and procedures regarding "never events" or "hospital acquired conditions" that are consistent with the Medicaid program. Specifically this includes:

i) Development of the capacity for claims systems to recognize the presence or absence of valid "present on admission" (POA) indicators for each inpatient diagnosis, using codes as described by the Centers for Medicare and Medicaid Services for Medicare;

ii) Development of the capacity for claims systems to reject/deny claims that do not have valid POA indicators (corrected claims can be resubmitted);

iii) Development of policies and procedures that will reject or modify any inpatient charges resulting from any "never event" or "hospital acquired condition" (pursuant to the current list of implemented items provided on the Department of Health and HCS websites);

A) The methodology for claims adjustment shall be consistent with current Medicaid program guidance provided on the Department of Health and HCS websites.

B) In the event that payment for inpatient claims is not based on DRGs, the Contractor shall develop a system that is equivalent in result to the methodology developed by Medicaid program.

iv) Development of an audit or review capacity to ensure that claims are submitted accurately and adjudicated consistent with this policy.

b) The Contractor is required to submit inpatient Encounter Data to MEDS III or its successor system with valid POA fields.

22.16 Other Provider-Preventable Conditions

a) The Contractor is required to develop claims and payment policies and procedures regarding "Other Provider-Preventable Conditions (OPPCs)" that are consistent with the Centers for Medicare and Medicaid Services requirement that Medicaid deny reimbursement for OPPCs. Specifically this includes:

i) Development of the capacity for claims systems to recognize procedures coded with the modifiers PA (surgical or other invasive procedure



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performed on the wrong body part), PB (surgical or other invasive procedure performed on the wrong patient), and PC (wrong surgical or invasive procedure performed on a patient).

ii) Development of the capacity for claims systems to reject/deny claims coded with the modifiers PA, PB and PC.

iii) Disallowance of reimbursement for OPPCs. This policy applies to free-standing and hospital-based clinics, free-standing and hospital based ambulatory surgery services, office based settings, and emergency departments that submit claims to the Contractor.

22.17 Personal Care Services Worker Wage Parity Rules

a) The Contractor shall be required to comply with the home care worker wage parity law at Section 3614-c of the PHL and all applicable notices and regulations issued pursuant to subdivisions 8 and 9 therein. These requirements apply to New York City and to the counties of Westchester, Nassau, and Suffolk, including the provisions of subdivision 4 of such section, which specifies that the provisions of any employer collective bargaining agreements in effect as of January 1, 2011 which provides for home care aides' health benefits shall supersede the provisions of subdivision 3 of such section.

b) During the period August 1, 2011 through February 29, 2012, the Contractor shall reimburse all home attendant vendor agencies currently contracting with the New York City Human Resources Administration (HRA) for participation in the Home Care Services Program for the provision of personal care services at least the personal care rate established by HRA as of August 1, 2011 minus $0.28, as so annotated on the official HRA publication of the personal care rate (not subject to any retroactive adjustments to such rate after such date). The Contractor must include in its network only home attendant vendor agencies having a contract with the HRA Home Care Services Program during the period August 1, 2011 through February 28, 2014. During the period August 1, 2011 through February 28, 2013, the Contractor shall reimburse all home attendant vendor agencies currently contracting with Nassau, Suffolk and Westchester counties at the Medicaid fee-for-service rate established by the SDOH. The Contractor must ensure continuity of the home care aide for enrolled members unless the agency is unwilling to contract with the Contractor, the home care aide is no longer working for the home attendant vendor agency or the member requests a different home care aide. The Contractor is not required to contract with home attendant vendor agencies unwilling to accept the applicable HRA rate or the Medicaid fee-for-service rate as long as the Contractor maintains an adequate network of Participating Providers to treat members.

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c) The Contractor will require that subcontractors employing home care aides certify annually, on forms provided by SDOH, to the Contractor that all home care aide services provided through the subcontractor are in compliance with PHL § 3614-c. Additionally, the Contractor shall certify to SDOH, in a manner determined by SDOH annually on forms provided by SDOH, that all home care aide services, whether provided by the Contractor or through a subcontractor, are in compliance with PHL § 3614-c.

d) The Contractor shall quarterly collect, and require subcontractors to provide, sufficient information to verify that subcontractors employing home care aides are in compliance with PHL § 3614-c. The Contractor shall develop protocols to establish a verification system to demonstrate compliance with requirements. Such verification system must be sufficient to verify that home care aide wages provided by each subcontractor meet or exceed the local wage requirements pursuant to subdivision 3 and applicable notices and regulations. Solely collecting the certification or an attestation of compliance is not sufficient to meet this requirement. The local wage requirements are subject to change pursuant to subdivision 3 and applicable notices and regulations, all wages provided must comply with the current rate in effect.

e) Failure to fully comply with the home care worker wage parity requirements may result in non-payment of services rendered, as required by PHL § 3614-c(2).

22.18 Value Based Payment (VBP) Arrangements

a) For the purposes of this Section, "On Menu VBP Arrangements" means Value-Based Payments arrangement types that are specifically identified in the NYS VBP Roadmap and the Clinical Advisory Groups (CAG) Playbooks, which are available on the SDOH website. "Off Menu VBP Arrangements" means Value-Based Payments arrangements that are not specifically identified in the NYS VBP Roadmap or the CAG Playbooks, but are aligned with the principles of VBP.

b) Pursuant to Section 22.5 (a)(vii) of this Agreement, the Contractor shall include VBP arrangements in subcontracts with Participating Providers. VBP arrangement types include:

i) On-Menu VBP Arrangements

A) The Contractor may utilize On-Menu VBP Arrangement types, as set forth in the NYS VBP Roadmap and the CAG Playbooks. These Playbooks contain the definitions of these VBP arrangements as well as the performance measures that the Participating Providers have to report to the MCO and the State. On-Menu VBP Arrangement types include:



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I) Total care for general population;

II) Integrated primary care;

III) Selected care bundles; and/or

IV) Special needs subpopulations.

ii) Off-Menu VBP Arrangements

A) In addition to utilizing On-Menu VBP arrangement options, the Contractor may also develop Off-Menu VBP arrangements with Participating Providers that are aligned with the principles of VBP. All Off-Menu VBP arrangements included in subcontracts are required to meet the criteria that is described in the NYS VBP Roadmap.

c) The contractor shall ensure that the Level of the arrangement (1, 2 or 3) is consistent with the Level definitions as outlined in the NYS VBP Roadmap.

d) SDOH shall classify subcontracts containing VBP arrangements pursuant to the NYS VBP Roadmap, and the SDOH-issued "Provider Contracting Guidelines." SDOH shall review such subcontracts according to the degree of provider risk included in the subcontract.

e) The VBP Innovator Program

i) SDOH shall notify the Contractor of designated qualified providers for participation in the VBP Innovator Program. Upon notification by SDOH of qualified providers for participation in the VBP Innovator Program, the Contractor shall modify subcontracts with such designated providers to include the parameters of the VBP Innovator Program, as set forth in the NYS VBP Roadmap.

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## 23. ~~FRAUD AND ABUSE~~PROGRAM INTEGRITY

23.1 Rights and Responsibilities

a) The Contractor, or Subcontractor, must comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR Part 455 and 42 CFR 438 Subpart H.

b) Pursuant to 42 CFR 438.608(a), the Contractor, or Subcontractor, shall implement and maintain arrangements or procedures to detect and prevent fraud, waste and abuse. The arrangements or procedures must meet all of the requirements of Section 23 of this Agreement.

~~23.5(b) 23.6(b)~~c) Nothing in this ~~Section~~ Agreement shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or the SDOH to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party.

23.~~1~~2 ~~General Requirements~~Compliance Program

a) ~~Pursuant to~~In accordance with 42 CFR 438.608(a)(1) and 18 NYCRR Part 521, the ~~MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to prevent fraud and abuse.~~Contractor must have a compliance program which includes all of the following:

~~b) The arrangements or procedures described in Section 23.1 a) must include the following:~~

i) written policies, procedures, and standards of conduct that articulate the ~~organization~~Contractor's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable Federal and State ~~standards~~requirements;

ii) the designation of a compliance officer ~~and a compliance committee that are accountable to senior management~~ who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the chief executive officer and the board of directors;

iii) the establishment of a regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Agreement;

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~~ii~~iv) ~~effective training and education for the compliance officer and the organization's employees~~a system for training and education for the compliance officer, the Contractor's senior management, and the organization's employees for the Federal and State standards and requirements under this Agreement;

~~i~~v) effective lines of communication between the compliance officer and the ~~organization~~Contractor's employees;

vi) enforcement of standards through well publicized disciplinary guidelines; and

vii) ~~a provision for internal monitoring and auditing; and~~establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement

~~vii) a provision for prompt response to detected offenses, and for the development of corrective action initiatives relating to the MCO's contract.~~

23.3 Contractor Obligation to Return Overpayments

Pursuant to 42 CFR 438.608(c)(3), the Contractor shall return, and shall require its subcontractors to return, to SDOH any capitation payments or other payments in excess of amounts specified in this Agreement, as reported to SDOH pursuant to Section 18.5(a)(viii)(G) or Section 22.5(b)(ix) of this Agreement, within sixty (60) days of identification, or receipt of notice, of such payments.

23.4 Program Integrity Reporting Requirements

Reporting requirements related to Fraud, Waste, and Abuse and other program integrity matters are specified in Section 18.5(a)(vii)-(viii) of this Agreement.

23.~~2~~5 Prevention Plans and Special Investigation Units

a) If the Contractor has over 10,000 Enrollees in the aggregate in any given year, the Contractor must file a Fraud and Abuse Prevention Plan with the Commissioner of Health and develop a special investigation unit for the detection, investigation and prevention of fraudulent activities to the extent required by PHL § 4414 and SDOH regulations.

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b) If the Contractor has fewer than 10,000 Enrollees or is otherwise not subject to 10 NYCRR § 98-1.21(a), the Contractor shall submit annually to the SDOH and OMIG, in a form and format to be determined by the SDOH or OMIG, a report of overpayments recovered.

c) The Contractor shall require its Special Investigations Unit (SIU) director, or his/her designee, to attend quarterly MCO SIU Meetings scheduled by the OMIG.

23.~~3~~6 Service Verification Process

Pursuant to 42 CFR ~~455.20~~438.608(a)(5), the Contractor will implement a service verification process that accurately evaluates the delivery of billed services to the recipient population by using statistically valid sample sizes and timeframes that determine whether Enrollees received services billed by Providers.

23.~~4~~7 Withholding of Payments

a) Pursuant to 42 CFR 438.608(a)(8) and consistent with 42 USC 1396(b)(i)(2)(C) and 42 CFR 447.90, ~~T~~the Contractor must, if directed by SDOH or OMIG, withhold payments to Participating Providers and Non-Participating Providers, in whole or in part, when SDOH or OMIG has determined ~~or has been notified~~ that a Participating Provider or Non-Participating Provider is the subject of a pending investigation of a credible allegation of fraud ~~unless SDOH or OMIG finds good cause not to direct the Contractor to withhold payments~~ in accordance with 42 CFR 455.23 and 18 NYCRR § 518.7. The ~~c~~Contractor shall begin withholding payments to Participating Providers and Non-Participating Providers not later than five (5) business days from the date of notification from the SDOH or OMIG.

b) The Contractor shall require its Subcontractors to withhold payments to Participating Providers and Non-Participating Providers in accordance with the directions of the SDOH or OMIG and Section 23.7(a) of this Agreement.

~~b~~c) ~~The Contractor shall~~ OMIG or SDOH will provide notice to the Participating Provider or Non-Participating Provider of the withhold ~~as directed by SDOH or OMIG and~~ in accordance with 18 NYCRR § 518.7(b) and § 518.7(c).

~~c~~d) The Contractor shall direct all ~~appeals of the withhold to:~~ inquiries from Participating Providers and Non-Participating Providers regarding the withholding action to OMIG.

~~Office of the Medicaid Inspector General~~
~~Office of Counsel~~
~~800 North Pearl Street~~



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~~Albany, New York 12204~~
~~ATTN: Withhold Appeal~~

e) The Contractor must have systems in place that are, at a minimum, capable of withholding all or part of a provider's payments and in the timeframe specified in 23.7(a) of this Section.

f) The Contractor shall, annually or upon a change, submit to OMIG the name(s), title(s), and contact information, including but not limited to email address(es), of those individual(s) responsible for receiving and processing notifications by OMIG and SDOH of withholds for pending investigations of credible allegations of fraud to mmcreporting@omig.ny.gov, or such other address as OMIG may direct, with the subject "CAF Withhold Contact Information".

g) The Contractor shall report in its Provider Investigative Report, in accordance with Section 18.5(a)(viii)(F) of this Agreement, the total amount it (or its subcontractors) have withheld from each Participating Provider or Non-Participating Provider.

23.~~5~~8 Shared Recovery Based on Referral

~~a)~~ In instances where the Contractor refers a ~~reasonably suspected or confirmed~~ case of potential fraud, waste or abuse to ~~the~~ OMIG, in accordance with Section 18.5(a)(vii) of this Agreement, the Contractor may be eligible to share in the portion of the non-federal share of the recovery made by ~~the~~ OMIG. OMIG shall determine whether the Contractor is eligible to share in the recovery, depending upon the extent to which the Contractor substantially contributed to the investigation and recovery, at a percentage to be solely determined by ~~the~~ OMIG. Where ~~the~~ OMIG determines that the Contractor substantially contributed to the investigation and recovery, the percentage shall be not less than 1% and not greater than 10% of the non-federal share of the amount of Medicaid payments recovered which were received by the Provider from the Contractor. The Contractor must report its portion of the shared recovery as part of the MMCOR reporting process. In no event shall the Contractor share in any recovery that results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.

~~b) Nothing in this Section shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or SDOH to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party.~~

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23.~~6~~9 Liquidated Damages for Failure to Report Recoveries

a) If the Contractor breaches this Agreement by failing to report or inaccurately reporting monies recovered on its ~~Quarterly~~ monthly Provider Investigative Report, in accordance with Section 18.5(a)(~~xxii~~viii)(F) of this Agreement, or on its MMCOR, the SDOH or OMIG will be entitled to monetary damages in the form of liquidated damages. In the event the SDOH or OMIG determines that they will impose liquidated damages in accordance with this Section, the SDOH or OMIG shall notify the Contractor in writing, in a Notice of Damages. The SDOH or OMIG may assess liquidated damages against the Contractor regardless of whether the breach is the fault of the Contractor (including the Contractor's subcontractors, Participating Providers, agents and/or consultants), provided the SDOH or OMIG has not materially caused or contributed to the breach.

~~b) Nothing in this Section shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or SDOH to investigate, audit or otherwise obtain recoveries from a Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party.~~

~~c~~b) The liquidated damages prescribed in this section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the SDOH's and OMIG's projected financial loss and/or damage to the program resulting from the Contractor's nonperformance, including financial loss as a result of audit, investigation or review delays. Accordingly, in the event the Contractor fails to perform in accordance with this Agreement, the SDOH or OMIG may assess liquidated damages as provided in this Section.

~~d~~c) If the Contractor fails to report or inaccurately reports monies it recovers during the reporting period in accordance with Section 18.5(a)(~~xxii~~viii)(F) of this Agreement or on its MMCOR submission, the SDOH or OMIG may assess liquidated damages in an amount equal to twice the amount not reported or inaccurately reported. Any liquidated damages assessed by the SDOH or OMIG shall take into consideration the amount involved, frequency, and nature of the breach and shall be due and payable to the SDOH or OMIG within thirty (30) days after the Contractor's receipt of the Notice of Damages, regardless of any dispute in the amount or interpretation which led to the notice.

~~e~~d) Dispute Resolution

i) The Contractor may, within thirty (30) days of the date of the Notice of Damages submit written arguments and documentation on whether:

A) the determination was based upon a mistake of fact; or

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B) the SDOH and/or OMIG were materially responsible for the breach.

ii) Written arguments and documentation shall be submitted to the address specified in the Notice of Damages.

iii) The Contractor waives any arguments it fails to raise in writing within thirty (30) days of the date of said Notice of Damages, and waives the right to use any materials, data, and/or information not contained in or accompanying the Contractor's submission within thirty (30) days of the date of the Notice of Damages in any subsequent legal, equitable, or administrative proceeding.

iv) Within sixty (60) days of receiving written arguments or documentation in response to the Notice of Damages, OMIG will review the determination and notify the Contractor of the results of that review. After the review, the determination to assess liquidated damages may be affirmed, reversed or modified, in whole or in part.

23.10 State and Federal False Claims, Written Policies

Pursuant to 42 CFR 438.608(a)(6), the Contractor, if it makes or receives annual payments under this Agreement of at least $5,000,000, must have written policies for all employees of the entity, and of any Subcontractor, contractor or agent, that provide detailed information about the Federal False Claims Act, and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, and the NY State Finance Law § 187 including information about the rights of employees to be protected as whistleblowers. Upon SDOH request, the Contractor shall provide to SDOH proof that it has certified to OMIG, in accordance with Section 18.5(a)(viii)(E) of this Agreement, that it has such written policies.

23.11 Contractor Obligation to Refer All Cases of Potential Fraud, Waste or Abuse

Pursuant to 42 CFR 438.608(a)(7), the Contractor shall refer all cases of potential fraud, waste, or abuse to OMIG, and may also refer cases of potential fraud to the New York State Office of the Attorney General, within ten (10) business days of identification. The Contractor shall include such referrals in reports submitted in accordance with the requirements of Section 18.5(a)(vii) of this Agreement.

## 24. AMERICANS WITH DISABILITIES ACT COMPLIANCE PLAN

Contractor must comply with Title II of the ADA and Section 504 of the Rehabilitation Act of 1973 for program accessibility, and must develop an ADA Compliance Plan consistent with the SDOH Guidelines for MCO Compliance with the ADA set forth in Appendix J, which is hereby made a part of this Agreement as if set forth fully herein.

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Said plan must be approved by the SDOH, be filed with the SDOH, and be kept on file by the Contractor.

## 25. FAIR HEARINGS

### 25.1 Enrollee Access to Fair Hearing Process

Enrollees may access the fair hearing process in accordance with applicable federal and state laws and regulations. Contractors must abide by and participate in New York State's Fair Hearing Process and comply with determinations made by a fair hearing officer.

### 25.2 Enrollee Rights to a Fair Hearing

Enrollees may request a fair hearing regarding adverse LDSS determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a State approved cost-effective alternative service, clinical treatment or other Benefit Package services by the Contractor. For issues related to disputed services, Enrollees must have received an adverse Action Appeal determination from the Contractor or its Subcontractor ~~approved utilization review agent~~ either overriding a recommendation to provide services by a Participating Provider or confirming the decision of a Participating Provider to deny those services. An Enrollee may also seek a fair hearing for a failure by the Contractor to act with reasonable promptness with respect to such services. Reasonable promptness shall mean compliance with the timeframes established for review of grievances and utilization review in Sections 44 and 49 of the Public Health Law, the ~~G~~grievance and Appeal S~~s~~ystem requirements of 42 CFR Part 438 and Appendix F of this Agreement. The Contractor may not act in any manner so as to restrict the Enrollee's right to a fair hearing or influence an Enrollee's decision to pursue a fair hearing.

### 25.3 Contractor Notice to Enrollees

a) Contractor must issue a written notice of Action and right to fair hearing within applicable timeframes to any Enrollee when taking an adverse Action and when making an Appeal determination as provided in Appendix F of this Agreement.

b) Contractor agrees to serve notice on affected Enrollees ~~by mail~~ and must maintain documentation of such.

### 25.4 Aid Continuing

a) Pursuant to SSL §365-a(8) and 18 NYCRR §360-10.8(g)(2), the Contractor shall be required to continue the provision of the Benefit Package services that are the subject of the fair hearing to an Enrollee (hereafter referred to as "aid

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continuing") if so ordered by the NYS Office of Administrative Hearings (OAH) under the following circumstances:

i) Contractor has or is seeking to restrict, reduce, suspend or terminate a treatment or Benefit Package service currently being provided; and

ii) Enrollee has filed a timely request for a fair hearing with OAH

b) If so ordered by OAH, the Contractor shall be responsible for providing aid continuing, and shall not cease to provide aid continuing until one of the following occurs:

i) the Enrollee withdraws the request for aid continuing or the fair hearing; or

ii) OAH determines that the Enrollee is not entitled to aid continuing; or

iii) OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or

iv) the provider order has expired, except in the case of a home bound Enrollee or where the Enrollee is challenging the restriction.

c) The Contractor shall provide aid continuing in a manner and duration as ordered by OAH. If the Contractor believes the Enrollee is not eligible for aid continuing, the Contractor may provide documentation of such to OAH and seek rescission of the aid continuing order.

d) If the services and/or benefits in dispute have been terminated, suspended or reduced and the Enrollee timely requests a fair hearing, Contractor shall, at the direction of either SDOH or LDSS, restore the disputed services and/or benefits consistent with the provisions of Section 25.4 (b) of this Agreement.

25.5 Responsibilities of SDOH

SDOH will make every reasonable effort to ensure that the Contractor receives timely notice in writing by fax, or e-mail, of all requests, schedules and directives regarding fair hearings.

25.6 Contractor's Obligations

a) Contractor shall appear at all scheduled fair hearings concerning its clinical determinations and/or Contractor-initiated disenrollments to present evidence as justification for its determination or submit written evidence as justification for its determination regarding the disputed benefits and/or services. If Contractor will not be making a personal appearance at the fair hearing, the

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written material must be submitted to OAH at least three (3) business days prior to the scheduled hearing and contain a phone number by which the hearing officer may contact a Contractor's representative, who has knowledge of the issue under review, during the hearing. If the hearing is scheduled fewer than three (3) business days after the request, Contractor must deliver the evidence to the hearing site no later than one (1) business day prior to the hearing, otherwise Contractor must appear in person. Notwithstanding the above provisions, Contractor may be required to make a personal appearance at the discretion of the hearing officer and/or SDOH.

b) The Contractor must provide to the Enrollee or the Enrollee's authorized representative copies of the documents the Contractor will present at the fair hearing, also known as the "evidence packet." Copies of the evidence packet must be provided without charge. Within ten (10) business days of receiving notification of a hearing request, the Contractor must mail copies of the evidence packet to the Enrollee or the Enrollee's authorized representative. If, due to the scheduling of the fair hearing, the evidence packet cannot be prepared at least five (5) business days before the hearing, and there is not sufficient time for the evidence packet to be mailed, the Contractor must provide the Enrollee or the Enrollee's authorized representative such copies no later than at the time of the hearing.

c) Upon request, the Contractor must provide the Enrollee or the Enrollee's authorized representative access to the Enrollee's case file, and provide copies of documents contained in the file. If so requested, copies of the case file must be provided without charge and within a reasonable time before the date of the hearing. If the request for copies of the case file is made less than five (5) business days before the hearing, the Contractor must provide the Enrollee and the Enrollee's authorized representative such copies no later than at the time of the hearing. Such documents must be provided to the Enrollee and the Enrollee's authorized representative by mail within a reasonable time from the date of the request if the Enrollee or the Enrollee's authorized representative request that such documents be mailed; provided however, if there is insufficient time for such documents to be mailed and received before the scheduled date of the hearing, such documents may be presented at the hearing instead of being mailed.

d) Despite an Enrollee's request for a State fair hearing in any given dispute, Contractor is required to maintain and operate in good faith its own internal Complaint and Appeal processes as required under state and federal laws and by Section 14 and Appendix F of this Agreement. Enrollees may seek redress of Adverse Determinations~~s simultaneously~~ through Contractor's internal process and the State fair hearing process, pursuant to Appendix F of this Agreement. If Contractor has reversed its initial determination and provided the service to the Enrollee, Contractor may request a waiver from appearing at

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the hearing and, in submitted papers, explain that it has withdrawn its initial determination and is providing the service or treatment formerly in dispute.

e) Contractor shall comply with all determinations rendered by OAH at fair hearings.

   i) Contractor shall cooperate with SDOH efforts to ensure that Contractor is in compliance with fair hearing determinations. Failure by Contractor to maintain such compliance shall constitute breach of this Agreement. Nothing in this Section shall limit the remedies available to SDOH, LDSS or the federal government relating to any non-compliance by Contractor with a fair hearing determination or Contractor's refusal to provide disputed services.

   ii) If the Contractor believes there is an error of law or fact in the fair hearing decision, the Contractor must comply with the fair hearing decision while seeking a correction or review of the decision from OAH, pursuant to 18 NYCRR Part 358-6.6.

f) If SDOH investigates a Complaint that has as its basis the same dispute that is the subject of a pending fair hearing and, as a result of its investigation, concludes that the disputed services and/or benefits should be provided to the Enrollee, Contractor shall comply with SDOH's directive to provide those services and/or benefits and provide notice to the Enrollee to which services have been authorized. The Contractor may request a waiver from appearing at the hearing and, in submitted papers, explain that it has withdrawn its initial determination and is providing the service or treatment formerly in dispute.

g) If SDOH, through its Complaint investigation process, or OAH, by a determination after a fair hearing, directs Contractor to provide a service that was initially denied by Contractor, Contractor may either directly provide the service, arrange for the provision of that service or pay for the provision of that service by a Non-Participating Provider. If the services were not furnished during the period the fair hearing was pending, the Contractor must authorize or furnish the disputed services promptly and as expeditiously as the Enrollee's health condition requires and no more than 72 hours from the date the Contractor receives notice of the fair hearing decision.

h) Contractor agrees to abide by changes made to this Section of the Agreement with respect to the fair hearing, Action, Service Authorization, Complaint and Appeal processes by SDOH in order to comply with any amendments to applicable state or federal statutes or regulations.

i) Contractor agrees to identify a contact person within its organization who will serve as a liaison to SDOH for the purpose of receiving fair hearing requests, scheduled fair hearing dates and adjourned fair hearing dates and compliance

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with State directives**.** Such individual: shall be accessible to the State by e-mail; shall monitor e-mail for correspondence from the State at least once every business day; and shall agree, on behalf of Contractor, to accept notices to Contractor transmitted via e-mail as legally valid.

j) The information describing fair hearing rights, aid continuing, Action, Service Authorization, utilization review, Complaint and Appeal procedures shall be included in all MMC and FHPlus member handbooks and shall comply with Section 14, Appendices E and F of this Agreement.

k) Contractor shall bear the burden of proof at hearings regarding the reduction, suspension or termination of ongoing services. In the event that Contractor's initial adverse determination is upheld as a result of a fair hearing, any aid continuing provided pursuant to that hearing request, may be recouped by Contractor.

## 26. EXTERNAL APPEAL

26.1 Basis for External Appeal

In accordance with PHL § 4910(2), Enrollees have the right to an External Appeal when one or more covered health care services have been denied by the Contractor on the basis that the service(s) is not medically necessary, is experimental or investigational, or is an out of network service that is not materially different from an alternate service available from the Contractor's network. A provider has an independent right to an External Appeal when these denials are the result of concurrent or retrospective utilization review.

26.2 Eligibility for External Appeal

a) An Enrollee is eligible for an External Appeal when the Contractor takes an Action, in accordance with Appendix F of this Agreement, to deny services as provided in Section 26.1 of this Agreement, and:

i) the Enrollee has exhausted the Contractor's internal Action Appeal procedure and has received a final adverse determination from the Contractor; or

ii) the Enrollee and the Contractor have jointly agreed to waive internal Action Appeal procedure; or

iii) the Enrollee has requested an expedited Action Appeal and requests an expedited External Appeal at the same time; or

iv) the Contractor fails to follow the Action Appeal process in accordance with Appendix F of this Agreement.

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26.3 External Appeal Determination

The External Appeal determination is binding on the Contractor; however, a fair hearing determination supersedes an External Appeal determination for Enrollees.

26.4 Compliance with External Appeal Laws and Regulations

The Contractor must comply with the provisions of Sections 4910-4917 of the PHL and 10 NYCRR Part 98 regarding the External Appeal program.

26.5 Member Handbook

The Contractor shall describe its Action and utilization review policies and procedures, including a notice of the right to an External Appeal together with a description of the External Appeal process and the timeframes for External Appeal, in the Member Handbook. The Member Handbook shall comply with Section 13 and the Member Handbook Guidelines, Appendix E, of this Agreement.

## 27. INTERMEDIATE SANCTIONS

27.1 General

The Contractor is subject to the imposition of sanctions as authorized by State and Federal law and regulation, including the SDOH's and OMIG's right to impose sanctions for unacceptable practices as set forth in 18 NYCRR Part 515, 18 NYCRR 360-10.10, 18 NYCRR 360-10.11 and civil and monetary penalties pursuant to 18 NYCRR Part 516 and 42 CFR Part 438, subpart I,, and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted for services.

27.2 Unacceptable Practices

a) Unacceptable practices for which the Contractor may be sanctioned include but are not limited to:

i) Failing to provide medically necessary services that the Contractor is required to provide under its contract with the State.

ii) Imposing premiums or charges on Enrollees that are in excess of the premiums or charges permitted under the MMC Program or FHPlus Program.

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iii) Discriminating among Enrollees on the basis of their health status or need for health care services.

iv) Misrepresenting or falsifying information that it furnishes to an Enrollee, Potential Enrollee, health care provider, the State or to CMS.

v) Failing to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR §§ 422.208 and 422.210.

vi) Distributing directly or through any agent or independent contractor, outreach/advertising materials that have not been approved by the State or that contain false or materially misleading information.

vii) Violating any other applicable requirements of SSA §§ 1903(m) or 1932 and any implementing regulations.

viii) Violating any other applicable requirements of 18 NYCRR or 10 NYCRR Part 98.

ix) Failing to comply with the terms of this Agreement.

x) Violating any relevant New York State or Federal law.

27.3 Intermediate Sanctions

a) Intermediate Sanctions may include but are not limited to:

i) Civil monetary penalties.

ii) Suspension of all new enrollment, including auto assignments, after the effective date of the sanction.

iii) Termination of the contract, pursuant to Section 2.7 of this Agreement.

iv) Temporary management, pursuant to 42 CFR 438.702, 42 CFR 438.706 and 18 NYCRR 360-10.11(e).

v) Denial of payment for new Enrollees, pursuant to 42 CFR 438.730.

27.4 Enrollment Limitations

The SDOH shall have the right, upon notice to the LDSS, to limit, suspend or terminate Enrollment activities by the Contractor and/or Enrollment into the Contractor's MMC and/or FHPlus product upon ten (10) days written notice to the Contractor. The written notice shall specify the action(s) contemplated and the reason(s) for such action(s) and shall provide the Contractor with an opportunity

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to submit additional information that would support the conclusion that limitation, suspension or termination of Enrollment activities or Enrollment in the Contractor's MMC and/or FHPlus product is unnecessary. Nothing in this paragraph limits other remedies available to the SDOH or the LDSS under this Agreement.

27.5 Due Process

The Contractor will be afforded due process pursuant to Federal and State Law and Regulations (42 CFR §438.710, 18 NYCRR Part 516, and Article 44 of the PHL).

## 28. ENVIRONMENTAL COMPLIANCE

The Contractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 1857(h)), Section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. § 1368), Executive Order 11738, and the Environmental Protection Agency ("EPA") regulations (40 CFR Part 15) that prohibit the use of the facilities included on the EPA List of Violating Facilities. The Contractor shall report violations to SDOH and to the Assistant Administrator for Enforcement of the EPA.

## 29. ENERGY CONSERVATION

The Contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation regulation issued in compliance with the Energy Policy and Conservation Act of 1975 (Pub. L. 94-165) and any amendment to the Act.

## 30. INDEPENDENT CAPACITY OF CONTRACTOR

The parties agree that the Contractor is an independent Contractor and that the Contractor, its agents, officers, and employees act in an independent capacity and not as officers or employees of LDSS, SDOH or the DHHS.

## 31. NO THIRD PARTY BENEFICIARIES

Only the parties to this Agreement and their successors in interest and assigns have any rights or remedies under or by reason of this Agreement.

## 32. INDEMNIFICATION

32.1 Indemnification by Contractor

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a) The Contractor shall indemnify, defend, and hold harmless the SDOH and the LDSS, and their officers, agents, and employees, and the Enrollees and their eligible dependents from:

i) any and all claims and losses accruing or resulting to any and all Contractors, subcontractors, materialmen, laborers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement;

ii) any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Contractor, its officers, agents, employees, or subcontractors, including Participating Providers, in connection with the performance of this Agreement;

iii) any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy by the Contractor, its officers, agents, employees or subcontractors, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this Agreement, or based on any libelous or otherwise unlawful matter contained in such data.

b) The SDOH will provide the Contractor with prompt written notice of any claim made against the SDOH, and the Contractor, at its sole option, shall defend or settle said claim. The SDOH shall cooperate with the Contractor to the extent necessary for the Contractor to discharge its obligation under Section 32.1 (a). Notwithstanding the foregoing, the SDOH reserves the right to join such action, at its sole expense, when it determines there is an issue involving a significant public interest.

c) The Contractor shall have no obligation under this section with respect to any claim or cause of action for damages to persons or property solely caused by the negligence of SDOH, its employees, or agents.

32.2 Indemnification by SDOH

Subject to the availability of lawful appropriations as required by State Finance Law § 41 and consistent with § 8 of the State Court of Claims Act, SDOH shall hold the Contractor harmless from and indemnify it for any final judgment of a court of competent jurisdiction to the extent attributable to the negligence of SDOH or its officers or employees when acting within the course and scope of their employment. Provisions concerning the SDOH's responsibility for any claims for liability as may arise during the term of this Agreement are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

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## 33. PROHIBITION ON USE OF FEDERAL FUNDS FOR LOBBYING

33.1 Prohibition of Use of Federal Funds for Lobbying

The Contractor agrees, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making of any federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Contractor agrees to complete and submit the "Certification Regarding Lobbying," Appendix B attached hereto and incorporated herein, if this Agreement exceeds $100,000.

33.2 Disclosure Form to Report Lobbying

If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Contractor shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

33.3 Requirements of Subcontractors

The Contractor shall include the provisions of this Section in its subcontracts, including its Provider Agreements. For all subcontracts, including Provider Agreements, that exceed $100,000, the Contractor shall require the subcontractor, including any Participating Provider to certify and disclose accordingly to the Contractor.

## 34. NON-DISCRIMINATION

34.1 Equal Access to Benefit Package

Except as otherwise provided in applicable sections of this Agreement the Contractor shall provide the Medicaid Managed Care and/or Family Health Plus Benefit Package(s) to MMC and/or FHPlus Enrollees, respectively, in the same manner, in accordance with the same standards, and with the same priority as members of the Contractor enrolled under any other contracts.

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34.2 Non-Discrimination

The Contractor shall not discriminate against Eligible Persons or Enrollees for Medicaid Managed Care and/or Family Health Plus on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services, or Capitation Rate that the Contractor will receive for such Eligible Persons or Enrollees.

34.3 Equal Employment Opportunity

Contractor must comply with Executive Order 11246, entitled "Equal Employment Opportunity", as amended by Executive Order 11375, and as supplemented in Department of Labor regulations.

34.4 Native Americans Access to Services From Tribal or Urban Indian Health Facility

The Contractor shall not prohibit, restrict or discourage enrolled Native Americans from receiving care from or accessing: a) Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center and/or b) Family Health Plus covered benefits from or through a tribal health or urban Indian health facility or center which is included in the Contractor's network.

## 35. COMPLIANCE WITH APPLICABLE LAWS

35.1 Contractor and SDOH Compliance With Applicable Laws

Notwithstanding any inconsistent provisions in this Agreement, the Contractor and SDOH shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345);for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement. The parties agree that this Agreement shall be interpreted according to the laws of the State of New York.

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35.2 Nullification of Illegal, Unenforceable, Ineffective or Void Contract Provisions

Should any provision of this Agreement be declared or found to be illegal or unenforceable, ineffective or void, then each party shall be relieved of any obligation arising from such provision; the balance of this Agreement, if capable of performance, shall remain in full force and effect.

35.3 Certificate of Authority Requirements

The Contractor must satisfy conditions for issuance of a certificate of authority, including proof of financial solvency, as specified in 10 NYCRR Part 98.

35.4 Notification of Changes in Certificate of Incorporation

The Contractor shall notify SDOH of any amendment to its Certificate of Incorporation or Articles of Organization pursuant to 10 NYCRR Part 98.

35.5 Contractor's Financial Solvency Requirements

The Contractor, for the duration of this Agreement, shall remain in compliance with all applicable state requirements for financial solvency for MCOs offering Medicaid Managed Care and/or Family Health Plus products, as applicable. The Contractor shall continue to be financially responsible as defined in PHL § 4403(1)(c) and shall comply with the contingent reserve fund and escrow deposit requirements of 10 NYCRR Part 98 and must meet minimum net worth requirements established by SDOH and the State Insurance Department. The Contractor shall make provision, satisfactory to SDOH, for protections for SDOH, LDSSs and the Enrollees in the event of Contractor or subcontractor insolvency, including but not limited to, hold harmless and continuation of treatment provisions in all provider agreements which protect SDOH, LDSSs and Enrollees from costs of treatment and assures continued access to care for Enrollees.

35.6 Compliance With Care for Maternity Patients

Contractor must comply with § 2803-n of the PHL and § 3216 (i) (10) (a) of the State Insurance Law related to hospital care for maternity patients.

35.7 Informed Consent Procedures for Hysterectomy and Sterilization

The Contractor is required and shall require Participating Providers to comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13.

35.8 Non-Liability of Enrollees for Contractor's Debts

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Contractor agrees that in no event shall the Enrollee become liable for the Contractor's debts as set forth in SSA § 1932(b)(6).

35.9 SDOH Compliance With Conflict of Interest Laws

SDOH and its employees shall comply with Article 18 of the General Municipal Law and all other appropriate provisions of New York State law, local laws and ordinances and all resultant codes, rules and regulations pertaining to conflicts of interest.

35.10 Compliance With PHL Regarding External Appeals

Contractor must comply with Article 49 Title II of the PHL regarding external appeal of adverse determinations.

35.11 Fair Labor Standards Act

The Contractor is required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA). The Contractor shall develop protocols to demonstrate compliance with requirements of the FLSA. Such protocols shall include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate of reimbursement. Such verification system and protocols are subject to audit by DOH, OMIG, and the Department of Labor.

## 36. STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

Appendix A (Standard Clauses as required by the Attorney General for all State contracts) is attached and incorporated by reference as if set forth fully herein and any amendment thereto, and takes precedence over all other parts of this Agreement.

## 37. Medicaid Update

The Contractor shall comply with all applicable guidance contained within the Medicaid Update publication issued by SDOH.

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# APPENDIX A

# STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

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**PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.**

October 2019

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## STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

**1. EXECUTORY CLAUSE.** In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

**2. NON-ASSIGNMENT CLAUSE.** In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

**3. COMPTROLLER'S APPROVAL.** In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $25,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law § 163.6-a). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

**4. WORKERS' COMPENSATION BENEFITS.** In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

**5. NON-DISCRIMINATION REQUIREMENTS.** To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment, nor subject any individual to harassment, because of age, race, creed, color, national origin, sexual orientation, gender identity or expression, military status, sex, disability, predisposing genetic characteristics, familial status, marital status, or domestic violence victim status or because the individual has opposed any practices forbidden under the Human Rights Law or has filed a complaint, testified, or assisted in any proceeding under the Human Rights Law. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

**6. WAGE AND HOURS PROVISIONS.** If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-

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a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

**7. NON-COLLUSIVE BIDDING CERTIFICATION.** In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

**8. INTERNATIONAL BOYCOTT PROHIBITION.** In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2 NYCRR § 105.4).

**9. SET-OFF RIGHTS.** The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

**10. RECORDS.** The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, the "Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

**11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.** (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

**12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.** In accordance with Section 312 of the Executive Law and 5 NYCRR Part 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of

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$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a," "b," and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this clause. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

**13. <u>CONFLICTING TERMS</u>.** In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

**14. <u>GOVERNING LAW</u>.** This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

**15. <u>LATE PAYMENT</u>.** Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

**16. <u>NO ARBITRATION</u>.** Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

**17. <u>SERVICE OF PROCESS</u>.** In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

**18. <u>PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS</u>.** The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by

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any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in § 165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

**19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES.** In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

**20. OMNIBUS PROCUREMENT ACT OF 1992.** It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority- and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

A directory of certified minority- and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp

The Omnibus Procurement Act of 1992 (Chapter 844 of the Laws of 1992, codified in State Finance Law § 139-i and Public Authorities Law § 2879(3)(n)–(p)) requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority- and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

**21. RECIPROCITY AND SANCTIONS PROVISIONS.** Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively, codified in State Finance Law § 165(6) and Public Authorities Law § 2879(5)) ) require that they be denied contracts which they would otherwise obtain. NOTE: As of October 2019, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii.

**22. COMPLIANCE WITH BREACH NOTIFICATION AND DATA SECURITY LAWS.** Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law § 899-aa and State Technology Law § 208) and commencing March 21, 2020 shall also comply with General Business Law § 899-bb.

**23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW.** If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4)(g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

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**24. PROCUREMENT LOBBYING.** To the extent this agreement is a "procurement contract" as defined by State Finance Law §§ 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law §§ 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

**25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.**
To the extent this agreement is a contract as defined by Tax Law § 5-a, if the contractor fails to make the certification required by Tax Law § 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law § 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

**26. IRAN DIVESTMENT ACT.** By entering into this Agreement, Contractor certifies in accordance with State Finance Law § 165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: https://ogs.ny.gov/list-entities-determined-be-non-responsive-biddersofferers-pursuant-nys-iran-divestment-act-2012

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law § 165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

**27. ADMISSIBILITY OF REPRODUCTION OF CONTRACT.** Notwithstanding the best evidence rule or any other legal principle or rule of evidence to the contrary, the Contractor acknowledges and agrees that it waives any and all objections to the admissibility into evidence at any court proceeding or to the use at any examination before trial of an electronic reproduction of this contract, in the form approved by the State Comptroller, if such approval was required, regardless of whether the original of said contract is in existence.

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# APPENDIX B

## Certification Regarding Lobbying

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**APPENDIX B**
**CERTIFICATION REGARDING LOBBYING**

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Contractor shall complete and submit Standard Form - LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The Contractor shall include the provisions of this section in all provider Agreements under this Agreement and require all Participating providers whose Provider Agreements exceed $100,000 to certify and disclose accordingly to the Contractor.

This certification is a material representation of fact upon which reliance was place when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

SIGNATURE: _____

TITLE: _____

ORGANIZATION: _____

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# APPENDIX B-1

## Certification Regarding
## MacBride Fair Employment Principles

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# APPENDIX B-1

## NONDISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND: MacBRIDE FAIR EMPLOYMENT PRINCIPLES

Note: Failure to stipulate to these principles may result in the contract being awarded to another bidder. Governmental and non-profit organizations are exempted from this stipulation requirement.

In accordance with Chapter 807 of the Laws of 1992 (State Finance Law Section 174-b), the Contractor, by signing this Agreement, certifies that it or any individual or legal entity in which the Contractor holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the Contractor, either:

- has business operations in Northern Ireland: Y____ N____

- if yes to above, shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to non-discrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles:

  Y____ N____

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# Appendix C

# New York State Department of Health Requirements for the Provision of Family Planning and Reproductive Health Services


**C.1 Definitions and General Requirements for the Provision of Family Planning and Reproductive Health Services**

**C.2 Requirements for MCOs that Include Family Planning and Reproductive Health Services in Their Benefit Package**

**C.3 Requirements for MCOs That Do Not Include Family Planning Services and Reproductive Health Services in Their Benefit Package**


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# C.1
# Definitions and General Requirements for the Provision of Family Planning and Reproductive Health Services

## 1. Family Planning and Reproductive Health Services

a) Family Planning and Reproductive Health services mean the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies.

i) Family Planning and Reproductive Health services include the following medically-necessary services, related drugs and supplies which are furnished or administered under the supervision of a physician, licensed midwife or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit for the purpose of:

A) contraception, including all FDA-approved birth control methods and devices, including diaphragms, insertion/removal of an intrauterine device (IUD) or insertion/removal of contraceptive implants, and injection procedures involving pharmaceuticals such as Depo-Provera (FHPlus does not cover OTC products such as condoms and contraceptive foam);

B) emergency contraception and follow up;

C) sterilization;

D) screening, related diagnosis, and referral to a Participating Provider for pregnancy;

E) medically-necessary induced abortions, which are procedures, either medical or surgical, that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration. In addition, if the pregnancy is the result of an act of rape or incest, the abortion is covered.

ii) Family Planning and Reproductive Health services include those education and counseling services necessary to effectively render the services.

iii) Family Planning and Reproductive Health services include medically-necessary ordered contraceptives and pharmaceuticals:

The contractor is responsible for pharmaceuticals and medical supplies such as IUDS and Depo-Provera that must be furnished or administered under the supervision of a physician, licensed midwife, or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit.

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b) When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit:

i) Screening, related diagnosis, ambulatory treatment and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology.

ii) Screening, related diagnosis and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease.

iii) Screening and treatment for sexually transmissible disease.

iv) HIV testing and pre- and post-test counseling.

**2. Free Access to Services for MMC Enrollees**

a) Free Access means MMC Enrollees may obtain Family Planning and Reproductive Health services, and HIV testing and pre-and post-test counseling when performed as part of a Family Planning and Reproductive Health encounter, from either the Contractor, if it includes such services in its Benefit Package, or from any appropriate Medicaid health care provider of the Enrollee's choice. No referral from the PCP or approval by the Contractor is required to access such services.

b) The Family Planning and Reproductive Health services listed above are the only services which are covered under the Free Access policy. Routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are not covered under the Free Access policy, and are the responsibility of the Contractor.

**3. Access to Services for FHPlus Enrollees**

a) FHPlus Enrollees may obtain Family Planning and Reproductive Health services, and HIV testing and pre-and post-test counseling when performed as part of a Family Planning and Reproductive Health Services encounter, from either the Contractor pursuant to C.2 below or any appropriate Medicaid health care provider pursuant to C.3 below, as applicable. No referral from the PCP or approval by the Contractor is required to access such services.

b) The Contractor is responsible for routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care, regardless of whether Family Planning and Reproductive Health services are included in the Contractor's Benefit Package.

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# C.2

## Requirements for MCOs that Include Family Planning and Reproductive Health Services in Their Benefit Package

### 1. Notification to Enrollees

a) If the Contractor includes Family Planning and Reproductive Health services in its Benefit Package (as per Appendix M of this Agreement), the Contractor must notify all Enrollees of reproductive age, including minors who may be sexually active, at the time of Enrollment about their right to obtain Family Planning and Reproductive Health services and supplies without referral or approval. The notification must contain the following:

i) Information about the Enrollee's right to obtain the full range of Family Planning and Reproductive Health services, including HIV counseling and testing when performed as part of a Family Planning and Reproductive Health encounter, from the Contractor's Participating Provider without referral, approval or notification.

ii) MMC Enrollees must receive notification that they also have the right to obtain Family Planning and Reproductive Health services in accordance with MMC's Free Access policy as defined in C.1 of this Appendix. There is no Free Access policy for FHPlus Enrollees.

iii) A current list of qualified Participating Family Planning Providers who provide the full range of Family Planning and Reproductive Health services within the Enrollee's geographic area, including addresses and telephone numbers. The Contractor may also provide MMC Enrollees with a list of qualified Non-Participating providers who accept Medicaid and provide the full range of these services.

iv) Information that the cost of the Enrollee's Family Planning and Reproductive Health care will be fully covered, including when a MMC Enrollee obtains such services in accordance with MMC's Free Access policy.

### 2. Billing Policy

a) The Contractor must notify its Participating Providers that all claims for Family Planning and Reproductive services must be billed to the Contractor and not the Medicaid fee-for-service program.

b) The Contractor will be charged for Family Planning and Reproductive Health services furnished to MMC Enrollees by Medicaid Non-Participating Providers at the applicable Medicaid rate or fee. In such instances, Medicaid Non-Participating Providers will bill Medicaid fee-for-service and the SDOH will issue a confidential

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charge back to the Contractor. Such charge back mechanism will comply with all applicable patient confidentiality requirements.

**3. Consent and Confidentiality**

a) The Contractor will comply with federal, state, and local laws, regulations and policies regarding informed consent and confidentiality and ensure Participating Providers comply with all of the requirements set forth in Sections 17 and 18 of the PHL and 10 NYCRR Section 751.9 and Part 753 relating to informed consent and confidentiality.

b) Participating Providers may share patient information with appropriate Contractor personnel for the purposes of claims payment, utilization review and quality assurance, unless the provider agreement with the Contractor provides otherwise. The Contractor must ensure that any Enrollee's, including a minor's, use of Family Planning and Reproductive Health services remains confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure.

**4. Informing and Standards**

a) The Contractor will inform its Participating Providers and administrative personnel about policies concerning MMC Free Access as defined in C.1 of this Appendix, where applicable; HIV counseling and testing; reimbursement for Family Planning and Reproductive Health encounters; Enrollee Family Planning and Reproductive Health education and confidentiality.

b) The Contractor will inform its Participating Providers that they must comply with professional medical standards of practice, the Contractor's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Task Force on Preventive Services and the New York State Child/Teen Health Program. These standards and laws recognize that Family Planning counseling is an integral part of primary and preventive care.

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# C.3

## Requirements for MCOs That Do Not Include Family Planning Services and Reproductive Health Services in Their Benefit Package

**1. Requirements**

a) The Contractor agrees to comply with the policies and procedures stated in the SDOH-approved statement described in Section 2 below.

b) Within ninety (90) days of signing this Agreement, the Contractor shall submit to the SDOH a policy and procedure statement that the Contractor will use to ensure that its Enrollees are fully informed of their rights to access a full range of Family Planning and Reproductive Health services, using the guidelines set forth below. The statement must be sent to the Director, Division of Health Plan Contracting and Oversight, NYS Department of Health, One Commerce Plaza, Room 1609, Albany, NY 12260. If the Contractor operates in New York City, an informational copy of the statement must also be sent to the NYC Department of Health & Mental Hygiene, Health Care Access and Improvement, Gotham Center, 42-09 28th Street, Long Island City, NY 11101-4132.

c) SDOH may waive the requirement in (b) above if such approved statement is already on file with SDOH and remains unchanged.

**2. Policy and Procedure Statement**

a) The policy and procedure statement regarding Family Planning and Reproductive Health services must contain the following:

i) Enrollee Notification

A) statement that the Contractor will inform Prospective Enrollees, new Enrollees and current Enrollees that:

I) Certain Family Planning and Reproductive Health services (such as abortion, sterilization and birth control) are not covered by the Contractor, but that routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are covered by the Contractor;

II) Such Family Planning and Reproductive Health Services that are not covered by the Contractor may be obtained through fee-for-service Medicaid providers for MMC and FHPlus Enrollees;

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III) No referral is needed for such services, and there will be no cost to the Enrollee for such services.

IV) HIV counseling and testing services are available through the Contractor and are also available as part of a Family Planning and Reproductive Health encounter when furnished by a fee-for-service Medicaid provider to MMC Enrollees and FHPlus Enrollees; and that anonymous counseling and testing services are available from SDOH, Local Public Health Agency clinics and other county programs.

B) A statement that this information will be provided in the following manner:

I) Through the Contractor's written outreach/advertising materials, including the Member Handbook. The Member Handbook and outreach/advertising materials will indicate that the Contractor has elected not to cover certain Family Planning and Reproductive Health services, and will explain the right of all MMC and FHPlus Enrollees to obtain such services through fee-for-service Medicaid from any provider/clinic which offers these services.

II) Orally at the time of Enrollment and any time an inquiry is made regarding Family Planning and Reproductive Health services.

III) By inclusion on any web site of the Contractor which includes information concerning its MMC or FHPlus product(s). Such information shall be prominently displayed and easily navigated.

C) A description of the mechanisms to provide all new MMC Enrollees and FHPlus Enrollees with an SDOH approved letter explaining how to access Family Planning and Reproductive Health services and the SDOH approved list of Family Planning providers. This material will be furnished by SDOH and mailed to the Enrollee no later than fourteen (14) days after the Effective Date of Enrollment.

D) A statement that if an Enrollee or consumer requests information about these non-covered services, the Contractor's Enrollment representative or member services department will advise the Enrollee or consumer as follows:

I) Family Planning and Reproductive Health services such as abortion, sterilization and birth control are not covered by the Contractor and that only routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are the responsibility of the Contractor.

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II) MMC and FHPlus Enrollees can use their Medicaid card to receive these non-covered services from any doctor or clinic that provides these services and accepts Medicaid.

III) Each MMC or FHPlus Enrollee and Prospective MMC or FHPlus Enrollee who calls will be mailed a copy of the SDOH approved letter explaining the Enrollee's right to receive these non-covered services, and an SDOH approved list of Family Planning Providers who participate in Medicaid in the Enrollee's community. These materials will be mailed within two (2) business days of the contact

IV) The SDOH has designated an organization to mail each MMC or FHPlus Enrollee or Prospective MMC or FHPlus Enrollee who requests family planning information from the Contractor, a copy of the SDOH approved letter explaining the Enrollee's right to receive such services, and an SDOH approved list of Family Planning Providers from which the Enrollee may access family planning services. The organization designated by the SDOH is required to mail these materials within fourteen (14) days of notice by the Contractor of a new Enrollee in the Contractor's MMC or FHPlus product

V) Enrollees can call the Contractor's member services number for further information about how to obtain these non-covered services. MMC and FHPlus Enrollees can also call the New York State Growing-Up-Healthy Hotline (1-800-522-5006) to request a copy of the list of Medicaid Family Planning Providers.

E) The procedure for maintaining a manual log of all requests for such information, including the date of the call, the Enrollee's client identification number (CIN), and the date the SDOH approved letter and SDOH or LDSS approved list were mailed, where applicable. The Contractor will review this log monthly and upon request, submit a copy to SDOH.

ii) Participating Provider and Employee Notification

A) A statement that the Contractor will inform its Participating Providers and administrative personnel about Family Planning and Reproductive Health policies under MMC Free Access, as defined in C.1 of this Appendix, where applicable; HIV counseling and testing; reimbursement for Family Planning and Reproductive Health encounters; Enrollee Family Planning and Reproductive Health education and confidentiality.

B) A statement that the Contractor will inform its Participating Providers that they must comply with professional medical standards of practice, the Contractor's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College

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of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Task Force on Preventive Services and the New York State Child/Teen Health Program. These standards and laws recognize that Family Planning counseling is an integral part of primary and preventive care.

C) The procedure(s) for informing the Contractor's Participating primary care providers, family practice physicians, obstetricians, gynecologists and pediatricians that the Contractor has elected not to cover certain Family Planning and Reproductive Health services, but that routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are covered; and that Participating Providers may provide, make referrals, or arrange for non-covered services in accordance with MMC's Free Access policy, as defined in C.1 of this Appendix, and/or through the appropriate Medicaid health care provider for FHPlus Enrollees.

D) A description of the mechanisms to inform the Contractor's Participating Providers that if they also participate in the fee-for-service Medicaid program and they render non-covered Family Planning and Reproductive Health services to MMC or FHPlus Enrollees, they do so as a fee-for-service Medicaid practitioner, independent of the Contractor.

E) A description of the mechanisms to inform Participating Providers that, if requested by the Enrollee, or, if in the provider's best professional judgment, certain Family Planning and Reproductive Health services not offered through the Contractor are medically indicated in accordance with generally accepted standards of professional practice, an appropriately trained professional should so advise the Enrollee and either:

I) offer those services to MMC and FHPlus Enrollees on a fee-for-service basis as a Medicaid health care provider, or

II) provide MMC and FHPlus Enrollees with a copy of the SDOH approved list of Medicaid Family Planning Providers, or

III) give Enrollees the Contractor's member services number to call to obtain either the list of Medicaid Family Planning Providers or the New York State Growing-Up Healthy Hotline (1-800-522-5006), as applicable.

F) A statement that the Contractor acknowledges that the exchange of medical information, when indicated in accordance with generally accepted standards of professional practice, is necessary for the overall coordination of Enrollees' care and assist Primary Care Providers in providing the highest quality care to the Contractor's Enrollees. The Contractor must also acknowledge that medical record information maintained by Participating Providers may include information relating to Family Planning and Reproductive Health services provided under the fee-for-service Medicaid program.

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iii) Quality Assurance Initiatives

A) A statement that the Contractor will submit any materials to be furnished to Enrollees and providers relating to access to non-covered Family Planning and Reproductive Health services to SDOH, Division of Health Plan Contracting and Oversight for review and approval before issuance, and if the Contractor operates in New York City, to the New York City Department of Health and Mental Hygiene for their information only. Such materials include, but are not limited to, Member Handbooks, provider manuals, and outreach/advertising materials.

B) A description of monitoring mechanisms the Contractor will use to assess the quality of the information provided to Enrollees.

C) A statement that the Contractor will prepare a monthly list of MMC and FHPlus Enrollees who have been sent a copy of the SDOH approved letter and the SDOH approved list of Family Planning providers. This information will be available to SDOH upon request.

D) A statement that the Contractor will provide all new employees with a copy of these policies. A statement that the Contractor's orientation programs will include a thorough discussion of all aspects of these policies and procedures and that annual retraining programs for all employees will be conducted to ensure continuing compliance with these policies.

E) A description of the mechanisms to provide the SDOH, or SDOH's subcontractor, with a monthly listing of all MMC and FHPlus Enrollees within seven (7) days of receipt of the Contractor's monthly Enrollment Roster and any subsequent updates or adjustments. A description of mechanisms to provide SDOH or SDOH's subcontractor with a list of prospective MMC and FHPlus Enrollees within two (2) business days of the prospective Enrollee encounter, and a list of Enrollees who call to request information within two (2) business days of an Enrollee's request.

**3. Consent and Confidentiality**

a) The Contractor must comply with federal, state, and local laws, regulations and policies regarding informed consent and confidentiality and ensure Participating Providers comply with all of the requirements set forth in Sections 17 and 18 of the PHL and 10 NYCRR § 751.9 and Part 753 relating to informed consent and confidentiality.

b) Participating Providers may share patient information with appropriate Contractor personnel for the purposes of claims payment, utilization review and quality assurance, unless the provider agreement with the Contractor provides otherwise. The

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Contractor must ensure that any Enrollee's, including a minor's, use of Family Planning and Reproductive Health services remains confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure.

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# Appendix D

# New York State Department of Health
# MCO Outreach/Advertising Activities

## D.1 Allowable Outreach and Integration of Facilitated Enrollment

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**D.1 Allowable Outreach and Integration of Facilitated Enrollment (FE)**

While costs associated with advertising are no longer included in the Capitation Rates for Medicaid, Family Health Plus and HIV SNP managed care programs, the Contractor may elect to perform outreach activities pursuant to the guidelines outlined below:

1. The Contractor may develop and conduct outreach campaigns as described in Section 11.

2. All outreach materials must be pre-approved by the New York State Department of Health (SDOH).

3. The Contractor may develop outreach materials as described in Section 11.

4. All outreach materials must be pre-approved by SDOH.

5. SDOH will adhere to a sixty (60) day "file and use" policy, whereby materials submitted by the Contractor must be reviewed and commented on within sixty (60) days of submission or the Contractor may assume the materials have been approved if the reviewer has not submitted any written comments to the Contractor.

6. All materials must accurately reflect general information which is applicable to the average consumer of the Medicaid/FHPlus Programs.

7. Materials must be written in prose that is understood at a fourth-to-sixth grade reading level and must be printed in at least ten (10) point type.

8. Materials must be made available throughout the Contractor's entire service area. Materials may be customized for specific counties and populations within the Contractor's service area.

9. The Contractor must make available written outreach material in a language other than English whenever at least five percent (5%) of the uninsured in any county of the service area speak that particular language and do not speak English as a first language. SDOH will inform the Contractor when the five percent (5%) threshold has been reached. Materials to be translated include those key materials, such as informational brochures, that are produced for routine distribution. SDOH will determine the need for other-than-English translations based on county-specific census data or other available measures.

   For all foreign language translation of Outreach/Advertising material, member handbooks, brochures and pamphlets, the Contractor must submit an annual certification that attests that the individual(s) that will be performing the foreign language translation of the materials described in this section will use his/her best efforts to accurately translate the material into the specified language. At a minimum, a reverse translation (translate the foreign language version back into English and compare to original document) must be performed. Translated materials must meet the readability standards described in Section 13.8 of this Agreement. Upon SDOH request, the Contractor must make available to SDOH any and all translated materials covered by this annual certification.

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Each year during the month of November, a blank Annual Certification/Attestation of Translation document will be transmitted by SDOH to the Contractor for completion. The Contractor will be required to submit the completed form back to the SDOH by December 15th. The certification form will cover all foreign language translations that will be performed during the following calendar year.

10. The Contractor may engage in outreach activities that include community-sponsored social gatherings, provider-hosted informational sessions, or Contractor-sponsored events for the purpose of reaching out to the uninsured population or retention of the Contractor's current membership as provided for in Appendix P. Events may include such activities as health fair workshops on health promotion, holiday parties and after school programs.

11. Outreach materials may be developed for use at provider sites, LDSS and FE encounters. Once these materials are approved by SDOH, the Contractor may make them available to such places as: LDSS, community centers, markets, pharmacies, hospitals and other provider sites, schools, health fairs, and other areas where the uninsured are likely to gather.

12. The Contractor, through the FE process, may continue to concentrate on the retention of their current membership through assistance with the eligibility recertification process.

13. If the Contractor becomes aware during an FE encounter that an individual is currently enrolled in Medicaid fee-for-service and the individual wants assistance in enrolling in a health plan, the FE may assist the individual in doing a phone enrollment with the LDSS, Enrollment Broker, or the New York State of Health. If during an FE encounter it is determined the individual is enrolled in an MMC health plan, the encounter must be promptly terminated. If during an FE encounter the individual voluntarily suggests dissatisfaction with a health plan in which he or she is enrolled, the individual should be referred to the enrollment broker, LDSS or the New York State of Health for assistance.

14. The Contractor is limited to using one vehicle per borough/county for facilitated enrollment. Vehicles include recreational vehicles, trailers, cars, SUVs and vans. The Contractor must supply written justification at least one month prior to the date on which the Contractor wants to use an additional vehicle in a county/borough. The justification must describe the rationale for being in the area and the time period for which they will be in the area. No more than one vehicle may be deployed in Manhattan on any given day. The Contractor is prohibited from deploying vehicles in zip codes in which the Contractor has a Community Enrollment Office in New York City, Erie, Nassau, Rockland, Suffolk and Westchester Counties. The Contractor is prohibited from parking its vehicles or setting up a table or kiosk within a two block radius of another MCO's Community Enrollment Office.

15. The Contractor must adhere to the following rules regarding setting up tables on the street:

    a) tables must be located within ten (10) feet of the Contractor's community office;

    b) tables may be set up where allowed by local law;

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c) tables may be set up at community events and in front of community outreach vehicles;

d) tables must be staffed at all times.

16. The Contractor shall limit the staffing involved in the facilitated enrollment program to 150 FTEs for New York City and 75 FTEs for the metropolitan New York City area defined as Nassau, Suffolk, Westchester and Rockland counties. FTEs subject to the limit include facilitated enrollers and any other staff that conduct new enrollment, provide community presentations on coverage options and/or engage in outreach activities designed to develop enrollment leads, including those who conduct these activities in connection with the NYSoH Marketplace. Managers and retention staff are not included in the limit as long as they do not personally conduct enrollments. This information must be reported on a monthly basis through the Health Commerce System.

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# Appendix E

# New York State Department of Health
# Member Handbook Guidelines

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# Member Handbook Guidelines

## 1. Purpose

a) This document contains Member Handbook guidelines for use by the Contractor to develop handbooks for MMC and FHPlus Enrollees covered under this Agreement.

b) These guidelines reflect the review criteria used by the SDOH Office of Managed Care in its review of all MMC and FHPlus Member Handbooks. Member Handbooks and addenda must be approved by SDOH prior to printing and distribution by the Contractor.

## 2. SDOH Model Member Handbook

a) The SDOH Model Member Handbook includes all required information specified in this Appendix, written at an acceptable reading level. The Contractor may adapt the SDOH Model Member Handbook to reflect its specific policies and procedures for its MMC or FHPlus product.

b) SDOH strongly recommends the Contractor use the SDOH Model Member Handbook language for the following required disclosure areas in the Contractor's Member Handbook:

i) access to Family Planning and Reproductive Health services;

ii) self referral policies, including for behavioral health services;

iii) obtaining OB/GYN services;

iv) the definitions of medical necessity and Emergency Services;

v) protocols for Action, utilization review, Complaints, Complaint Appeals, Action Appeals, External Appeals, and fair hearings;

vi) protocol for newborn Enrollment;

vii) listing of Enrollee entitlements, including benefits, rights and responsibilities, and information available upon request;

viii) obtaining and arranging transportation services;

ix) access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

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x) access to dental services.

xi) coverage of, and access to, behavioral health services and Care Management Services;

xii) [Applicable to HARP and HIV SNP Programs Only]: Coverage of, and access to, Behavioral Health Home and Community Based Services;

xiii) access to pharmacies for prescriptions and over-the-counter medications, medical supplies and durable medical equipment;

xiv) access to Transitional Care; and

xv) important resource telephone numbers.

c) A copy of the SDOH Model Member Handbook is available from the SDOH Division of Health Plan Contracting and Oversight, Bureau of Program Implementation and Enrollment.

**3. General Format**

a) The Contractor shall develop separate handbooks for their MMC, HIV SNP, HARP and FHPlus Enrollees. The Contractor must include the required contents as per Section 4 of this Appendix for the MMC, HIV SNP, HARP and FHPlus Programs, as applicable, and list the information available upon request in accordance with Section 5 of this Appendix in their Member Handbooks.

b) The Contractor must write Member Handbooks in a style and reading level that will accommodate the reading skills of many MMC and FHPlus Enrollees. In general the writing should be at no higher than a sixth-grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least ten-point font, preferably twelve-point font. The SDOH reserves the right to require evidence that a handbook has been tested against the sixth-grade reading-level standard.

c) The Contractor must make Member handbooks available in languages other than English whenever at least five percent (5%) of the Prospective Enrollees of the Contractor in any county in the Contractor's service area speak a language other than English as a first language. Member handbooks must be made accessible to non-English speaking and visually and hearing impaired Enrollees.

**4. Requirements for Handbook Contents**

a) General Overview (how the MMC or FHPlus product works)

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i) Explanation of the Contractor's MMC or FHPlus product, including what happens when an Eligible Person enrolls.

ii) Explanation of the Contractor-issued Enrollee ID card, obtaining routine medical care, help by telephone, and general information pertaining to the Contractor's MMC or FHPlus product, i.e., location of the Contractor, providers, etc.

iii) Invitation to attend scheduled orientation sessions and other educational and outreach activities.

iv) A statement that the Enrollee may be restricted to certain providers and the circumstances of such restriction, in accordance with Appendix Q of this Agreement.

v) Explanation of the Contractor's procedures to maintain the confidentiality of Mental Health and Substance Use Disorder records.

vi) Additional requirements applicable to the HIV SNP Program only:

A) Overview of HIV SNP services, including access to care networks which specialize in HIV/AIDS care.

B) Explanation of HIV SNP procedures to maintain confidentiality of a Member's HIV status.

C) Description of the role of Care and Benefit Coordination services and how the HIV SNP will offer access to medical case management, and psychosocial case management and coordinate with external case management providers.

vii) Additional Requirements applicable to the HARP Programs Only;

A) Overview of HARP services, including access to networks that specialize in Behavioral Health Care;

B) Description of the role of Care Management and how the HARP will ensure access to Care Management, eligibility assessments for Behavioral Health Home and Community Based Services and the development of person-centered plans of care; and

C) Explanation of HARP procedures to maintain the confidentiality of Mental Health and Substance Use Disorder records.

b) Provider Listings

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i) The Contractor may include the following information in the handbook, as an insert to the handbook, or produce this information as a separate document and reference such document in the handbook.

A) A current listing of providers, including facilities and site locations.

B) Separate listings of Participating Providers that are Primary Care Providers and specialty providers; including location, phone number, and board certification status.

C) Listing also must include a notice of how to determine if a Participating Provider is accepting new patients.

D) [Applicable to the HARP and HIV SNP Programs Only]: Listing of Participating Providers that are Behavioral Health Home and Community Based Services Providers.

c) Voluntary or Mandatory Enrollment - For MMC Program Only

i) Must indicate whether Enrollment is voluntary or mandatory.

ii) If the Contractor offers a MMC product in both mandatory and voluntary counties, an explanation of the difference, i.e., Disenrollment rules, etc.

iii) [Applicable to HIV SNP Program only]: Explanation that related children of the HIV SNP Enrollee may enroll in parent's HIV SNP or they may enroll in another managed care plan. Explanation that children and adults who are homeless can join the plan.

d) Choice of Primary Care Provider

i) Explanation of the role of PCP as a coordinator of care, giving some examples, and how to choose one for self and family.

ii) How to make an appointment with the PCP, importance of base line physical, immunizations and well-child care.

iii) Explanation of different types of PCPs, i.e., family practice, pediatricians, internists, behavioral health clinics as described in Section 21.14(e) of this Agreement, etc.

iv) Notification that the Contractor will assign the Enrollee to a PCP if one is not chosen in thirty (30) days.

v) OB/GYN choice rules for women.

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vi) [Applicable to HIV SNP Program only]: Initial appointment criteria: newborns within 48 hours of hospital discharge or the following Monday if the discharge occurs on a Friday; adult baseline physical within 4 weeks; well child visits within 4 weeks.

vii) [Applicable to HIV SNP Program only]: Explanation that PCPs for HIV+ Enrollees are required to meet the HIV Specialist PCP criteria as defined in Section 1 of this Agreement.

e) Changing Primary Care Provider

i) Explanation of the Contractor's policy, timeframes, and process related to an Enrollee changing his or her PCP. (Enrollees may change PCPs thirty (30) days after the initial appointment with their PCP, and the Contractor may elect to limit the Enrollee to changing PCPs without cause once every six months.)

ii) Explanation of process for changing OB/GYN when applicable.

iii) Explanation of requirements for choosing a specialist as PCP.

f) Referrals to Specialists (Participating or Non-Participating)

i) Explanation of specialist care and how referrals are accomplished.

ii) Explanation of the process for changing specialists.

iii) Explanation of self-referral services, i.e., OB/GYN services, HIV counseling and testing, eye exams, and assessments for Behavioral Health Services as provided in Section 10.15 of this Agreement, etc.

iv) Notice that an Enrollee may obtain a referral to a Non-Participating Provider when the Contractor does not have a Participating Provider with appropriate training or experience to meet the needs of the Enrollee; and the procedure for obtaining such referrals.

v) Notice that an Enrollee with a condition that requires ongoing care from a specialist may request a standing referral to such a specialist; procedure for obtaining such referrals.

vi) Notice that an Enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialist possessing the credentials to be responsible for providing or coordinating the Enrollee's medical care; and the procedure for obtaining such a specialist. Applicable to HIV SNP Program only, the Enrollee's PCP will continue to coordinate HIV care and other treatments.

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vii) Notice that an Enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center; and the procedure for obtaining such access. Applicable to HIV SNP Program only, the Enrollee's PCP will continue to coordinate HIV care.

viii) Explanation of dental benefits including how to select a dentist, how to change a dentist, how to make an appointment with the dentist and the importance of dental care.

g) Covered and Non-Covered Services

i) Benefits and services covered by the Contractor's MMC or FHPlus product, including benefit maximums and limits and State approved cost-effective alternative services.

ii) Definition of medical necessity, as defined in this Agreement, and its use to determine whether benefits will be covered.

iii) Medicaid covered services that are not covered by the Contractor's MMC product or are excluded from the MMC Program, and how to access these services. (MMC Program Member Handbooks only.)

iv) A description of services not covered by MMC, Medicaid fee-for-service or the FHPlus Programs.

v) Prior Authorization and other requirements for obtaining treatments and services.

vi) Access to Family Planning and Reproductive Health services, and for MMC Program Member Handbooks, the Free Access policy for MMC Enrollees, pursuant to Appendix C of this Agreement.

vii) HIV testing free access policy. (MMC Program Member Handbooks only.)

viii) Direct access policy for dental services provided at Article 28 clinics operated by academic dental centers. (MMC Program Member Handbooks only.)

ix) The Contractor's policy relating to emergent and non-emergent transportation, including who to call and what to do if the Contractor's MMC product does not cover emergent or non-emergent transportation. (MMC Program Member Handbooks only.)

x) For FHPlus Program Member Handbooks, coverage of emergent transportation and what to do if needed.

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xi) Contractor's toll-free number for Enrollee to call for more information.

xii) Any cost-sharing (e.g. copays for Contractor covered services).

xiii) For MMC Enrollees from birth until age 21 years, and FHPlus Enrollees age 19 and 20 years, how to access EPSDT services (including dental services) and including transportation to obtain these services.

xiv) [Applicable to HIV SNP Program only]: Regular and HIV Health Care

A) Explanation of the Contractor's role in providing comprehensive HIV and regular health care;

B) Explanation that the Contractor will coordinate member's access to combination therapies and pharmacy benefits;

C) Explanation that pregnancy requires specialized health care; transmission may occur through pregnancy, childbirth or breast milk; medication is recommended for mother and baby;

D) Notice that a newborn child will be automatically enrolled in the mother's HIV SNP and may be disenrolled any time at the mother's request;

E) Explanation of access to clinical trials; experimental treatments will be considered on a case by case basis.

xv) [Applicable to HIV SNP Program only]:

A) HIV testing and the Partner Notification Program.

B) List of services available which promote healthy living for persons with HIV/AIDS.

C) Describe HIV prevention services including access to free needles, syringes and condoms.

xvi) A description of Consumer Directed Personal Assistance Services and how Enrollees in need of or receiving home care services may apply for these services.

xvii) Notice that an eligible Enrollee has the right to receive Long Term Placement at a veterans' home.

h) Out of Area Coverage

Explanation of what to do and who to call if medical care is required when Enrollee is out of his or her county of fiscal responsibility or the Contractor's service area.

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i) Emergency and Post Stabilization Care Access

i) Definition of Emergency Services, as defined in law and regulation including examples of situations that constitute an emergency and situations that do not.

ii) What to do in an emergency, including notice that services in a true emergency are not subject to prior approval.

iii) A phone number to call if PCP is not available.

iv) Explanation of what to do in non-emergency situations (PCP, urgent care, etc.).

v) Locations where the Contractor provides Emergency Services and Post-stabilization Care Services.

vi) Notice to Enrollees that in a true emergency they may access services at any provider of Emergency Services.

vii) Definition of Post-Stabilization care services and how to access them.

j) Actions and Utilization Review

i) Circumstances under which Actions and utilization review will be undertaken (in accordance with Appendix F of this Agreement).

ii) Toll-free telephone number of the utilization review department or subcontractor.

iii) Time frames in which Actions and UR determinations must be made for prospective, retrospective, and concurrent reviews.

iv) Right to reconsideration.

v) Right to file an Action Appeal, orally or in writing, including expedited and standard Action Appeals processes and the timeframes for Action Appeals.

vi) Right to designate a representative.

vii) A notice that all Adverse Determinations will be made by qualified clinical personnel and that all notices will include information about the basis of the determination, and further Action Appeal rights (if any).

k) Enrollment and Disenrollment Procedures

i) Where appropriate, explanation of Lock-In requirements and when an Enrollee may change to another MCO, or for MMC Enrollees if permitted, return to

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Medicaid fee-for-service, for Good Cause, as defined in Appendix H of this Agreement.

ii) Procedures for Disenrollment.

iii) LDSS, or Enrollment Broker as appropriate, phone number for information on Enrollment and Disenrollment.

iv) [Applicable to HIV SNP Program only]: Explanation of HIV Uninsured Care programs, including AIDS Drug Assistance Program (ADAP) and ADAP Plus; may be available if member loses Medicaid benefits.

l) Rights and Responsibilities of Enrollees

i) Explanation of what an Enrollee has the right to expect from the Contractor in the way of medical care and treatment of the Enrollee as specified in Section 13.7 of this Agreement.

ii) General responsibilities of the Enrollee.

iii) Enrollee's potential financial responsibility for payment when services are furnished by a Non-Participating Provider or are furnished by any provider without required authorization, or when a procedure, treatment, or service is not a covered benefit. Also note exceptions such as family planning and HIV counseling/testing.

iv) Enrollee's rights under State law to formulate Advance Directives.

v) The manner in which Enrollees may participate in the development of Contractor policies.

m) Language

Description of how the Contractor addresses the needs of non-English speaking Enrollees.

n) Grievance Procedures (Complaints)

i) Right to file a Complaint regarding any dispute between the Contractor and an Enrollee (in accordance with Appendix F of the Agreement).

ii) Right to file a Complaint orally.

iii) The Contractor's toll-free number for filing oral Complaints.

iv) Time frames and circumstances for expedited and standard Complaints.

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v) Right to appeal a Complaint determination and the procedures for filing a Complaint Appeal.

vi) Time frames and circumstances for expedited and standard Complaint Appeals.

vii) Right to designate a representative.

viii) A notice that all determinations involving clinical disputes will be made by qualified clinical personnel and that all notices will include information about the basis of the determination, and further appeal rights (if any).

ix) SDOH's toll-free number for medically related Complaints.

x) New York State Department of Financial Services number for certain complaints relating to billing.

o) Fair Hearing

i) Explanation that the Enrollee has a right to a State fair hearing and aid to continue in some situations and that the Enrollee may be required to repay the Contractor for services received if the fair hearing decision is adverse to the Enrollee.

ii) Describe situations when the Enrollee may ask for a fair hearing as described in Section 25 of this Agreement including: SDOH or LDSS decision about the Enrollee staying in or leaving the Contractor's MMC or FHPlus product; Contractor determination that stops or limits Medicaid benefits; and Contractor's Complaint determination that upholds a provider's decision not to order Enrollee-requested services.

iii) Describe how to request a fair hearing (assistance through member services, LDSS, State fair hearing contact).

p) External Appeals

i) Description of circumstances under which an Enrollee may request an External Appeal.

ii) Timeframes for applying for External Appeal and for decision-making.

iii) How and where to apply.

iv) Describe expedited External Appeal timeframe.

v) Process for Contractor and Enrollee to agree on waiving the Contractor's internal UR Appeals process.

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vi) The Department of Financial Services toll-free telephone number for assistance completing external appeals.

q) Payment Methodologies

Description prepared annually of the types of methodologies the Contractor uses to reimburse providers, specifying the type of methodology used to reimburse particular types of providers or for the provision of particular types of services.

r) Physician Incentive Plan Arrangements

The Member Handbook must contain a statement indicating the Enrollees and Prospective Enrollees are entitled to ask if the Contractor has special financial arrangements with physicians that can affect the use of referrals and other services that they might need and how to obtain this information.

s) How and Where to Get More Information

i) How to access a member services representative through a toll-free number.

ii) How and when to contact LDSS for assistance.

iii) [Applicable to HIV SNP Program only]: List of relevant HIV SNP, State, and City phone numbers for services to persons with HIV/AIDS (see sample member handbook). Reference availability in languages other than English or TDD, where applicable.

**5. Other Information Available Upon Enrollee's Request**

a) Information on the structure and operation of the Contractor's organization. List of the names, business addresses, and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the Contractor.

b) Copy of the most recent annual certified financial statement of the Contractor, including a balance sheet and summary of receipts and disbursements prepared by a CPA.

c) Copy of the most recent individual, direct pay subscriber contracts.

d) Information relating to consumer complaints compiled pursuant to Section 210 of the Insurance Law.

e) Procedures for protecting the confidentiality of medical records and other Enrollee information.

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f) Written description of the organizational arrangements and ongoing procedures of the Contractor's quality assurance program.

g) Description of the procedures followed by the Contractor in making determinations about the experimental or investigational nature of medical devices, or treatments in clinical trials.

h) Individual health practitioner affiliations with Participating hospitals.

i) Specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the Contractor might consider in its Service Authorization or utilization review process.

j) Written application procedures and minimum qualification requirements for health care providers to be considered by the Contractor.

k) Upon request, the Contractor is required to provide the following information on the incentive arrangements affecting Participating Providers to Enrollees, previous Enrollees and Prospective Enrollees:

i) Whether the Contractor's Provider Agreements or subcontracts include Physician Incentive Plans (PIP) that affect the use of referral services.

ii) Information on the type of incentive arrangements used.

iii) Whether stop-loss protection is provided for physicians and physicians groups.

iv) If the Contractor is at substantial financial risk, as defined in the PIP regulations, a summary of the required customer satisfaction survey results.

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# APPENDIX F

## New York State Department of Health
## Action and Grievance and Appeal System Requirements
## for the MMC and FHPlus Programs

**F.1 Action Requirements**

**F.2 Grievance and Appeal System Requirements**

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# F.1

## Action Requirements

### 1. Definitions

a) Service Authorization Request means a request by an Enrollee, or a provider on the Enrollee's behalf, to the Contractor for the provision of a service, including a request for a referral or for a non-covered service.

i) Prior Authorization Request is a Service Authorization Request by the Enrollee, or a provider on the Enrollee's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided to the Enrollee.

ii) Concurrent Review Request is a Service Authorization Request by an Enrollee, or a provider on Enrollee's behalf, for home health care services following an inpatient admission, for inpatient Substance Use Disorder treatment or for continued, extended or more of an authorized service than what is currently authorized by the Contractor.

b) Service Authorization Determination means the Contractor's approval or denial of a Service Authorization Request.

c) Adverse Determination means a denial of a Service Authorization Request by the Contractor or an approval of a Service Authorization Request in an amount, duration, or scope that is less than requested.

d) An Action means the same as an "adverse benefit determination" as defined by 42 CFR §438.400 (b), and also includes an activity of a Contractor or its subcontractor that results in:

i) the denial or limited authorization of a Service Authorization Request, including Adverse Determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

ii) the reduction, suspension, or termination of a previously authorized service;

iii) the denial, in whole or in part, of payment for a service;

iv) failure to provide services in a timely manner as defined by applicable State law and regulation and Section 15 of this Agreement;

v) failure of the Contractor to act within the timeframes for resolution and notification of determinations regarding Complaints, Action Appeals and Complaint Appeals provided in this Appendix;

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vi) in rural areas, ~~as defined by 42 CFR §412.62(f)(a),~~ where enrollment in the MMC program is mandatory and there is only one MCO, the denial of an Enrollee's request to obtain services outside the MCO's network pursuant to 42 CFR §438.52(b)(2)(ii); ~~or~~

vii) the denial of an enrollee's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; or

viii) the restriction of an Enrollee to certain network providers under the Contractor's Recipient Restriction Program as provided for in Appendix Q of this Agreement.

**2. General Requirements**

a) The Contractor's policies and procedures for Service Authorization Determinations and utilization review determinations shall comply with ~~applicable statute and regulations, including but not limited to~~ 42 CFR Part 438, Articles 44 and 49 of the PHL, Article 43 of INSL, SSL § 364-j ~~(25) and (25-a)~~, 18 NYCRR 360-10 and 10 NYCRR Part 98, ~~and~~ including but not limited to the following:

i) Expedited review of a Service Authorization Request must be conducted when the Contractor determines or the provider indicates that a delay would seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function. The Enrollee may request expedited review of a Prior Authorization Request or Concurrent Review Request. If the Contractor denies the Enrollee's request for expedited review, the Contractor must handle the request under standard review timeframes.

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

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

iv) The Contractor is required to provide notice by phone and in writing to the Enrollee and to the provider of Service Authorization Determinations, whether adverse or not, within the timeframe specified in Section 3 below. Notice of an

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adverse Service Authorization Determination to the provider must contain the same information as the Notice of Action for the Enrollee.

A) Written notice to the provider of any Service Authorization Determination may be transmitted electronically in a manner and form agreed upon by the parties.

B) Notwithstanding section 5(a)(iii)(H) of this Appendix, the Contractor is not required to include the SDOH standard Managed Care Decision Fair Hearing Request Form~~form "Managed Care Action Taken – Denial, Reduction or Termination of Benefits"~~ in the written notice to the provider regarding an adverse Service Authorization Determination or the denial, in whole or in part, of payment for a service (denied claim).

v) The Contractor is required to provide the Enrollee written notice of any Action other than a Service Authorization Determinations within the timeframe specified in Section 4 below.

vi) Pursuant to SSL §364-j (25) and (25-a) and Section 10.32 of this Agreement, the Contractor will ensure authorization of a Service Authorization Request for medically necessary prescription medications specified in Section 10.32 (~~g~~h) of this Agreement (including non-formulary drugs), when the prescriber demonstrates, in consultation with the Contractor, that such medication is, in the prescriber's reasonable professional judgment, medically necessary and warranted to treat the Enrollee.

A) The Contractor may require such Service Authorization Request be reviewed in accordance with its authorization policies and procedures. Such procedures will comply with the review timeframes provided in Section 3. a) below. Review of such Service Authorization Request is not subject to review for medical necessity pursuant to PHL Article 49.

B) The prescriber's reasonable professional judgment shall be considered demonstrated upon the Contractor's receipt of information that the requested medication is consistent with U.S. Food and Drug Administration's approved labeling for use or supported in at least one of the Official Compendia as defined in federal law under the Social Security Act §1927 (g)(1)(B)(i).

~~C)~~vii) The Contractor shall accept the standard NYS ~~Medicaid~~ Prior Authorization Request Form for review and approval of pharmacy Service Authorization Requests.

b) Requirements for written notice to Enrollees.

i) The Contractor shall ensure that all written notices provided pursuant to this Appendix are in easily understood language and are accessible to non-English

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speaking and visually impaired Enrollees; include that oral interpretation and alternate formats of written material for Enrollees with special needs are available and how to access the alternate formats; and conform with the language and format requirements of 42 CFR 438.10(d).

ii) ~~.~~Unless the written notice is required to be mailed by applicable federal or state law or regulations, written notice to the Enrollee may be transmitted by electronic means in accordance with 42 CFR §435.918 and 42 CFR §438.10, as applicable.

iii) In a form and format required by SDOH, the Contractor shall submit template notices, along with proposed attachments, to the SDOH for approval prior to use, conforming with the requirements of SDOH model notices, where available. SDOH reserves the right to require revisions to the Contractor's templates, including the Contractor's use of the SDOH model Notice of Action template, to ensure compliance with noticing requirements.

**3. Timeframes for Service Authorization Determinations**

a) For Service Authorization Requests regarding prescription medications specified in Section 10.32 (~~g~~h) of this Agreement, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than ~~three (3) business days~~ seventy-two (72) hours after receipt of the Service Authorization Request.

i) Within the ~~3 business day~~ seventy-two (72) hour timeframe, if the Contractor needs more information to complete its review of such Service Authorization Request, the Contractor must request the information promptly, and inform the prescriber of the deadline to provide the requested information. The Contractor will offer peer to peer consultation with the prescriber as necessary to facilitate prompt resolution of the Service Authorization Request.

ii) In accordance with Section 10.32(d) of this Agreement, the Contractor may provide the Enrollee a temporary (72 hour) supply of the requested medication when medically necessary.

iii) The Contractor's review may result in an Action only under the following circumstances:

A) The Contractor requested information needed to complete the review of the Service Authorization Request, but the information was not provided to the Contractor and the time for review has expired.

B) The prescriber's reasonable professional judgment was not adequately demonstrated, in accordance with Section F.1(2)(a)(vi)(B), and the time for review has expired.

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b) Pursuant to PHL §4903(3-a), for a Service Authorization Requests that is a request for a step therapy protocol override determination, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than seventy-two (72) hours of the receipt of information that includes supporting rationale and documentation from a health care professional as specified in PHL §4903(3-a), but no more than fourteen (14) days after the receipt of the Service Authorization Request.

i) Pursuant to PHL §4903(3-b), if such Service Authorization Request is a request for an expedited step therapy protocol override determination, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than twenty-four (24) hours of receipt of the information that includes supporting rationale and documentation from a health care professional as specified in PHL §4903(3-a), but no more than seventy-two (72) hours after the receipt of the Service Authorization Request.

c) Notwithstanding paragraphs (a) and (b) above, for Service Authorization Requests regarding covered outpatient drugs, as defined in SSA §1927(k), the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone or telecommunication device, and in writing as fast as the Enrollee's condition requires and no more than twenty-four (24) hours after receipt of the Service Authorization Request.

~~b~~d) For Prior Authorization Requests, except as provided in paragraphs (a), (b), and (c) above, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

i) In the case of an expedited review, ~~three (3) business days~~ seventy-two (72) hours after receipt of the Service Authorization Request; or

ii) Seventy-two (72) hours after receipt of the Service Authorization Request, in the case of a prior authorization request meeting the conditions described in PHL 4903 (2)(b), for proposed mental health or substance use disorder service, where the Enrollee, or the Enrollee's designee, has certified the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction. This review cannot override the plan's responsibility to provide court ordered services in accordance with Section 10.9 of this Agreement.

iii) In all other cases, within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt of the Service Authorization request.

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~~c~~e) For Concurrent Review Requests, except as provided in paragraphs (a), (b) and (c) above, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

i) In the case of an expedited review, one (1) business day after receipt of necessary information but no more than ~~three (3) business days~~ seventy-two (72) hours after receipt of the Service Authorization Request; or

ii) the case of a request for home health care services following an inpatient admission, one (1) business day after receipt of necessary information~~; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event,~~ but no more than ~~three (3) business days~~ seventy-two (72) hours after receipt of the Service Authorization Request; or

iii) in the case of a request for inpatient Substance Use Disorder treatment, within twenty-four (24) hours of receipt of the request for services when such request is submitted at least twenty-four (24) hours prior to discharge of an inpatient admission; or

iv) In all other cases, within one (1) business day of receipt of necessary information, but no more than fourteen (14) days after receipt of the Service Authorization Request.

~~d~~f) Timeframes for Service Authorization Determinations in paragraphs (b), (d) (i) and (iii) and (~~c~~e) (i), (ii) and (iv) above may be extended for up to fourteen (14) days if:

i) the Enrollee, the Enrollee's designee, or the Enrollee's provider requests an extension orally or in writing; or

ii) The Contractor can demonstrate or substantiate that there is a need for additional information and how the extension is in the Enrollee's interest. The Contractor must send notice of the extension to the Enrollee. The Contractor must maintain sufficient documentation of extension determinations to demonstrate, upon SDOH's request, that the extension was justified.

~~e~~g) If the Contractor extended its review as provided in paragraph 3(~~d~~f) above, the Contractor must make a Service Authorization Determination and notice the Enrollee by phone and in writing as fast as the Enrollee's condition requires and within the timeframe required by ~~Article 49 of the~~ PHL, ~~three (3) business days after receipt of necessary information for Prior Authorization Requests or within one (1) business day after receipt of necessary information for Concurrent Review Requests,~~ but in no event later than the date the extension expires.

~~f~~h) Benefit specific requirements for review of Service Authorization Requests:

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i) Hospice.

A) The timeframe for review begins when the Contractor receives a request for coverage. Service Authorization Requests are to be reviewed under expedited timeframes as per (~~b~~d), (i) and (~~c~~e), (i) above for Prior Authorization and Concurrent Authorization Requests, respectively;

B) When the need for hospice services presents and/or an urgent referral is made by a provider during non-business hours, and the Contractor cannot be reached to request authorization, if the hospice provider requests authorization with all necessary information by the next business day, the Contractor may not deny hospice services provided while the Contractor Service Authorization Request determination is pending.

C) The Contractor may rely on a physician's verbal confirmation the Enrollee is eligible for hospice services to make a Service Authorization Determination. The Contractor may not deny a Prior Authorization Request for hospice services solely due to delay in receipt of the written physician order and eligibility certification or the comprehensive care plan. The Contractor may require such documentation upon concurrent or retrospective review.

D) If the Contractor determines to approve the Service Authorization Request, hospice services are to be authorized as a "package" including the full array of services available, and not by individual services included in the care plan. The Contractor may require prior authorization of a change in level or location of hospice care.

E) If the Contractor determines to approve a Prior Authorization Request, authorization will be provided for no less than a ninety (90) day period. The Contractor will authorize subsequent medically necessary hospice services for an additional period of no less than ninety (90) days, and then for periods no less than sixty (60) days, thereafter.

ii) Adult Day Health Care and AIDS Adult Day Health Care.

A) Upon receipt of a provider order for ADHC/AIDS ADHC services, the Contractor will arrange for a comprehensive assessment of the Enrollee's needs, in accordance with Section 10.39 of this Agreement. The Contractor may authorize up to five (5) per diem visits with an Adult Day Health Care or AIDS Adult Day Health Care provider within thirty (30) days for the provider to complete the Enrollee's comprehensive assessment and develop a Person Centered Services Plan to be submitted with a Service Authorization Request for ongoing services.

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B) The time for review of a Service Authorization Request for ADHC/AIDS ADHC services begins from the Contractor's receipt of the assessment and proposed plan of care. Service Authorization Requests are to be reviewed under expedited timeframes as per b), i) and c), i) above for Prior Authorization and Concurrent Authorization Requests, respectively.

iii) Pharmaceuticals

A) The Contractor shall develop appropriate mechanisms to ensure providers are aware of the Contractor's coverage policies as a medical and pharmacy benefit and the appropriate billing, handling, and administration of long-acting injectable antipsychotic medications (typical and atypical) in accordance with Appendix K of this Agreement. The Contractor shall not require prior authorization of typical long-acting antipsychotics (e.g., haloperidol decanoate and fluphenazine decanoate).

~~g~~i) The Contractor shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by: OASAS certified Part 822 outpatient clinics (including intensive outpatient services), outpatient rehabilitation and opioid treatment programs, OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs, OMH Part 599 licensed outpatient clinics (including community mental health services), OASAS Part 825 integrated clinics, OMH Part 598 integrated clinics and Title 10 Part 404 Diagnostic and Treatment Centers.

**4. Timeframes for Notices of Actions Other Than Service Authorizations Determinations**

a) When the Contractor intends to reduce, suspend, or terminate a previously authorized service within an authorization period, it must provide the Enrollee with a written notice at least ten (10) days prior to the intended Action, except:

i) the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or

ii) the Contractor may send~~mail~~ notice not later than date of the Action for the following:

A) the death of the Enrollee;

B) a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);

C) the Enrollee's admission to an institution where the Enrollee is ineligible for further services;

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D) the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

E) the Enrollee has been accepted for Medicaid services by another jurisdiction; or

F) the Enrollee's physician prescribes a change in the level of medical care.

b) Notwithstanding 4(a) above, for Long Term Services and Supports, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 4 (a)(i) and (ii).

i) For Long Term Services and Supports, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals as per section F.2 (2)(e)(iv)(B) of this Appendix.

c) Notwithstanding 4(a) above, for Enrollees in Short Term Placement Status, when the Contractor intends to deny a Concurrent Review Request for RHCF services; to reduce, suspend, or terminate previously authorized RHCF services; or to issue an authorization for a new period that is less in level or amount than requested, it must provide the Enrollee with a written Notice of Action, including notice of right to aid continuing, at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 4 (a)(i) and (ii).

i) For Enrollees in need of any LTSS, the Contractor shall ensure all RHCF services are authorized and arranged as per Appendix S of this Agreement, whether or not the Enrollee is expected to need RHCF services for at least 120 days.

d) Notwithstanding 4(a)(ii)(F) above, for Enrollees in receipt of community-based LTSS prior to admission in a hospital or RHCF (where such LTSS is included in the Benefit Package), the Contractor must ensure that the same level and quantity of LTSS is authorized upon discharge to a community setting, unless the provider order has changed, or a new assessment for the community-based LTSS indicates the Enrollee's medical, environmental or social needs have changed. Upon determining to reduce, suspend or terminate the level or quantity of the community-based LTSS from the

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pre-admission authorized level or quantity, the Contractor shall issue a Notice of Action reflecting the corresponding reduction, suspension or termination of the community-based LTSS, including notice of right to Fair Hearing and aid continuing, as provided by section 5(a)(iii) below.

e) The Contractor must send ~~mail~~ written notice to the Enrollee on the date of the Action when the Action is denial of payment, in whole or in part, except as provided in paragraph F.1 6(b) below.

f) When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in sections 3 and 4 above, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

g) The Contractor must send~~mail~~ written notice of intent to restrict an Enrollee under the Contractor's Recipient Restriction Program within the timeframe described in Appendix Q of this Agreement.

**5. Format and Content of Notices**

a) The Contractor shall ensure that all notices are in writing, in easily understood language and are accessible to non-English speaking and visually impaired Enrollees. Notices shall include that oral interpretation and alternate formats of written material for Enrollees with special needs are available and how to access the alternate formats.

i) Notice to the Enrollee that the Enrollee's request for an expedited review has been denied shall include that the request will be reviewed under standard timeframes, including a description of the timeframes.

ii) Notice to the Enrollee regarding a Contractor-initiated extension shall include:

A) the reason for the extension;

B) an explanation of how the delay is in the best interest of the Enrollee;

C) any additional information the Contractor requires from any source to make its determination;

D) the right of the Enrollee to file a Complaint (as defined in Appendix F.2 of this Agreement) regarding the extension;

E) the process for filing a Complaint with the Contractor and the timeframes within which a Complaint determination must be made;

F) the right of an Enrollee to designate a representative, through written consent, to file a Complaint on behalf of the Enrollee; and

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G) the right of the Enrollee to contact the New York State Department of Health regarding his or her Complaint, including the SDOH's toll-free number for Complaints.

iii) Notice to the Enrollee of an Action shall include:

A) the description of the Action the Contractor has taken or intends to take;

B) the reasons for the Action, including the clinical rationale, if any, and;

I) The Enrollee's right to be provided upon request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Action, including medical necessity criteria, and processes, standards or evidentiary standards used by the Contractor to determine coverage limits;

II) For ~~a~~Adverse ~~d~~Determinations and payment denials where the reason for denial, in whole or in part, is that the service is not covered by the prepaid Benefit Package, a statement, as applicable and as known by the Contractor, that the requested services may be a benefit available through fee for service Medicaid, which may include a statement, if applicable, directing the Enrollee to contact a FFS Provider to arrange for such services;

III) For Actions involving personal care services, the content required in iv) below and for Actions involving all other LTSS and RHCF services, the content required in vi) below;

~~III~~IV) For Actions involving prescription medications specified in Section 10.32 (~~g~~h) of this Agreement, the content required in v) below.

C) the Enrollee's right to file an Action Appeal (as defined in Appendix F.2 of this Agreement) , including:

I) The fact that the Contractor will not retaliate or take any discriminatory action against the Enrollee because he/she filed an Action Appeal.

II) The right of the Enrollee to designate, through written consent, a representative to file Action Appeals and/or request a fair hearing on his/her behalf;

D) the process and timeframe for filing an Action Appeal with the Contractor, a toll-free number for filing an oral Action Appeal-, and address for filing a written Action Appeal, and an Action Appeal request form~~, if used by the Contractor~~. The description of the appeal process shall include:

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I) an explanation that an expedited review of the Action Appeal may be requested if a delay would significantly increase the risk to an Enrollee's health, and the Contractor will notify the Enrollee if this request is denied;

II) an explanation that an expedited review of the Action Appeal will be conducted if the Action involves the circumstances described in Appendix F.2(3)(a)(v); and

III) for Actions related to inpatient substance use disorder treatment continued pursuant to PHL §4903(3)(c), a statement that coverage of these services will continue while the appeal reviews are pending, provided the Enrollee or the Enrollee's health care provider requests an expedited Action Appeal and an expedited External Appeal within twenty-four (24) hours of receiving the Notice of Action, as provided by PHL §4904(2)(b). Such statement will include the timeframes for resolution of the expedited Action Appeal (24 hours) and the expedited External Appeal (72 hours).

E) a description of what additional information, if any, must be obtained by the Contractor from any source in order for the Contractor to make an Appeal determination;

F) the timeframes, including possible extensions, within which the Action Appeal determination must be made ~~and a statement that the time to request a State Fair Hearing is sixty (60) days from the date of the notice of Action, and this time may expire if the Enrollee delays requesting a fair hearing while pursuing an Action Appeal~~;

G) the right of the Enrollee to contact the New York State Department of Health with his or her Complaint, including the SDOH's toll-free number for Complaints;

H) ~~a completed SDOH standard "Managed Care Action Taken- Denial, Reduction of Termination of Benefits" containing the Enrollee's fair hearing and aid continuing rights, if applicable;~~the Enrollee's right to request a fair hearing, as follows:

I) For an Action regarding an intent to restrict an Enrollee under the Contractor's Recipient Restriction Program as provided for in Appendix Q of this Agreement, a completed SDOH standard "Managed Care Action Taken- Denial, Reduction of Termination of Benefits" containing the Enrollee's fair hearing and aid continuing rights.

II) For all other Actions, a statement that the Enrollee will have one hundred twenty (120) days from the date of the notice of an adverse Action Appeal determination to request a fair hearing regarding the Contractor's decision,

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and that the Enrollee may request a fair hearing if the Contractor does not adhere to the Action Appeal notice and timing requirements of Section (4) of Part F.2 of this Appendix;

I) Except for an Action regarding an intent to restrict an Enrollee under the Contractor's Recipient Restriction Program as provided for in Appendix Q of this Agreement, and where applicable and in accordance with 42 CFR 438.420 and Section 25.4 of this Agreement, the right of the Enrollee to request aid continuing while the Enrollee's Action Appeal is pending, including:

I) the time frame and process for requesting aid continuing; and

II) the circumstances, consistent with state policy, under which the Enrollee may be required to pay the costs of services provided while the Action Appeal is pending.

~~I~~J) For Actions based on a determination that a requested out-of-network service is not materially different from an alternate service available from a Participating Provider, the notice of Action shall also include:

I) a description of the alternate service that is available in network and how to access the alternate service or obtain authorization for the alternate service, if required by the Contractor;

II) notice of the required information and physician statement that must be submitted when filing an Action Appeal for the Contractor to review the medical necessity of the requested service, as provided for in PHL 4904 (1-a);

III) a statement that if the Action Appeal is upheld as not medically necessary, the Enrollee may be eligible for an External Appeal. If the Contractor will not conduct a utilization review appeal in the absence of the information described in PHL 4904 (1-a), a statement that if the required information in II) above is not provided, the Action Appeal will be reviewed by the Contractor but the Enrollee will not be eligible for an External Appeal;

IV) a statement that if the Action Appeal is upheld as not medically necessary, the Enrollee will have four (4) months from the receipt of the final adverse determination to request an External Appeal;

V) a statement that the Enrollee and the Contractor may agree to waive the internal appeal process, and the Enrollee will have four (4) months to request an External Appeal from receipt of written notice of that agreement; and

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VI) a statement that if Enrollee files an expedited Action Appeal for review of the medical necessity of the requested service, the Enrollee may request an expedited External Appeal at the same time, and a description of how to obtain an External Appeal application.

~~J~~K) For Actions denying a request for a referral to an out-of-network provider on the basis that the Contractor has a Participating Provider with the appropriate training and experience to meet the particular health care needs of the Enrollee and who is able to provide the requested health care service, the notice of Action shall also include:

I) the name(s) of of the Participating Provider(s) with appropriate training and experience to meet the particular health care needs of the Enrollee who is able to provide the requested service;

II) a statement that if the Enrollee believes there is no Participating Provider with the training and experience to provide the requested service, the Enrollee may request an Action Appeal to review the medical necessity of the out-of-network referral, including notice that a physician statement with required information, as provided by PHL §4904 (1-b), must be submitted when filing the Action Appeal;

III) a statement that if the Action Appeal is upheld as not medically necessary, the Enrollee may be eligible for an External Appeal. If the Contractor will not conduct a utilization review appeal in the absence of the information described in PHL §4904 (1-b), a statement that if the required information in II) above is not provided, the Action Appeal will be reviewed by the Contractor but the Enrollee will not be eligible for an External Appeal;

IV) a statement that if the Action Appeal is upheld as not medically necessary, the Enrollee will have four (4) months from the receipt of the final adverse determination to request an External Appeal;

V) a statement that the Enrollee and the Contractor may agree to waive the internal appeal process, and the Enrollee will have four (4) months to request an External Appeal from receipt of written notice of that agreement; and

VI) a statement that if Enrollee files an expedited Action Appeal for review of the medical necessity of the requested service, the Enrollee may request an expedited External Appeal at the same time, and a description of how to obtain an External Appeal application.

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~~K~~L) For Actions based on issues of Medical Necessity or an experimental or investigational treatment, the notice of Action shall also include:

I) a clear statement that the notice constitutes the initial adverse determination and specific use of the terms "medical necessity" or "experimental/investigational";

II) a statement that the specific clinical review criteria relied upon in making the determination is available upon request;

III) a statement that the Enrollee may be eligible for an External Appeal;

IV) a statement that if the denial is upheld on Action Appeal, the Enrollee will have four (4) months from receipt of the final adverse determination to request an External Appeal;

V) a statement that the Enrollee and the Contractor may agree to waive the internal appeal process, and the Enrollee will have four (4) months to request an External Appeal from receipt of written notice of that agreement; and

VI) a statement that if the Enrollee files an expedited Action Appeal, the Enrollee may request an expedited External Appeal at the same time, and a description of how to obtain an External Appeal application.

~~L~~M) For an Action ~~based on intent~~ regarding an intent to restrict an Enrollee under the Contractor's Recipient Restriction Program, all additional information as required by Appendix Q of this Agreement.

iv) For all service authorization determinations involving personal care services, the determination notice, whether adverse or not, shall include the number of hours per day, number of hours per week, and the personal care services function (Level I/Level II):

A) that were previously authorized, if any;

B) that were requested by the Enrollee or their designee, if so specified in the request;

C) that are authorized for the new authorization period; and

D) the original authorization period and the new authorization period, as applicable.

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v) For all Service Authorizations Determinations regarding prescription medications specified in Section 10.32 (g) of this Agreement, the Notice of Action will clearly state:

A) that the requested medication must be provided when the prescriber demonstrates that in their reasonable professional judgment, either by consistency with U.S. Food and Drug Administration approved labeling or use supported in at least one of the Official Compendia as defined in federal law under the Social Security Act §1927 (g)(1)(B)(i), that the medication is medically necessary and warranted to treat the Enrollee; and

B) whether the Action is being taken by the plan because:

I) the necessary information to complete the Service Authorization Request was not provided to the Contractor and the time for review has expired, or

II) the prescriber's reasonable professional judgment has not been adequately demonstrated and the time for review has expired; and

C) what information must be provided during reconsideration or with an appeal to complete the Service Authorization Request.

vi) For all service authorization determinations involving Long Term Services and Supports or RHCF services, the determination notice, whether adverse or not, shall include the type and level of services authorized, and, as applicable:

A) the number of visits, hours per day, and/or number of hours per week;

I) that were previously authorized, if any;

II) that were requested by the Provider, Enrollee or their designee, if so specified in the request;

III) that are authorized for the new authorization period; and

B) the original authorization period and the new authorization period, as applicable.

b) In a form and format required by SDOH, t~~T~~he Contractor shall submit ~~all~~ template n~~N~~otices, ~~of Action,~~ along with proposed attachments, to the SDOH for approval prior to use, conforming with the requirements of SDOH model notices where available~~. Alternatively, the Contractor may attest to SDOH its intent to utilize the SDOH model Notice of Action template, which includes all required information specified by this Appendix~~. SDOH reserves the right to require revisions to the Contractor's templates, including the Contractor's use of the SDOH model Notice of Action template, to ensure compliance with noticing requirements.

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## 6. Contractor Obligation to Notice

a) The Contractor must provide written Notice of Action to Enrollees and providers in accordance with the requirements of this Appendix, including, but not limited to, the following circumstances (except as provided for in paragraph 6(b) below):

i) the Contractor makes a coverage determination or denies a request for a referral, regardless of whether the Enrollee has received the benefit;

ii) the Contractor determines that a service does not have appropriate authorization;

iii) the Contractor denies a claim for services provided by a Non-Participating Provider for any reason;

iv) the Contractor denies a claim or service due to medical necessity;

v) the Contractor rejects a claim or denies payment due to a late claim submission;

vi) the Contractor denies a claim because it has determined that the Enrollee was not eligible for MMC or FHPlus coverage on the date of service;

vii) the Contractor denies a claim for service rendered by a Participating Provider due to lack of a referral;

viii) the Contractor denies a claim because it has determined it is not the appropriate payor;

ix) the Contractor denies a claim due to a Participating Provider billing for Benefit Package services not included in the Provider Agreement between the Contractor and the Participating Provider; or

x) the Contractor intends to restrict the Enrollee under its Recipient Restriction Program as provided by Appendix Q of this Agreement.

b) The Contractor is not required to provide written Notice of Action to Enrollees in the following circumstances:

i) When there is a prepaid capitation arrangement with a Participating Provider and the Participating Provider submits a fee-for-service claim to the Contractor for a service that falls within the capitation payment;

ii) if a Participating Provider of the Contractor itemizes or "unbundles" a claim for services encompassed by a previously negotiated global fee arrangement;

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iii) if a duplicate claim is submitted by the Enrollee or a Participating Provider, no notice is required, provided an initial notice has been issued;

iv) if the claim is for a service that is carved-out of the MMC Benefit Package and is provided to a MMC Enrollee through Medicaid fee-for-service, however, the Contractor should notify the provider to submit the claim to Medicaid;

v) if the Contractor makes a coding adjustment to a claim (up-coding or down-coding) and its Provider Agreement with the Participating Provider includes a provision allowing the Contractor to make such adjustments;

vi) if the Contractor has paid the negotiated amount reflected in the Provider Agreement with a Participating Provider for the services provided to the Enrollee and denies the Participating Provider's request for additional payment; or

vii) if the Contractor has not yet adjudicated the claim. If the Contractor has pended the claim while requesting additional information, a notice is not required until the coverage determination has been made.

viii) if claims payment is denied for a service included in the Benefit Package to an Enrollee who is under age eighteen (18), when:

A) the claim has been denied for a reason other than Utilization Review, pursuant to PHL Article 49;

B) the Enrollee has already received the service;

C) the Enrollee is not liable for the cost of any part of the service;

D) the Enrollee is protected under federal or NYS law or regulation from disclosure of information related to the service; and

E) issuing the Notice of Action may disclose such protected information to unauthorized parties.

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# F.2

## Grievance and Appeal System Requirements

1. **Definitions**

a) A Grievance and Appeal System means the Contractor's Complaint and Appeal process, and includes a Complaint and Complaint Appeal process, a process to appeal Actions, ~~and~~ access to the State's fair hearing system, and to a process to collect and track data about these activities.

b) For the purposes of this Agreement, a Complaint means an Enrollee's expression of dissatisfaction with any aspect of his or her care other than an Action. A "Complaint" means the same as a "grievance" as defined by 42 CFR §438.400 (b).

c) An Action Appeal means a request for a review of an Action.

d) A Complaint Appeal means a request for a review of a Complaint determination.

e) An Inquiry means a written or verbal question or request for information posed to the Contractor with regard to such issues as benefits, contracts, and organization rules. Neither Enrollee Complaints nor disagreements with Contractor determinations are Inquiries.

**2. Grievance and Appeal System – General Requirements**

a) The Contractor shall describe its Grievance and Appeal System in the Member Handbook, and it must be accessible to non-English speaking, visually, and hearing impaired Enrollees. The handbook shall comply with Section 13.4 and The Member Handbook Guidelines (Appendix E) of this Agreement.

b) The Contractor will provide Enrollees with any reasonable assistance in completing forms and other procedural steps for filing a Complaint, Complaint Appeal or Action Appeal, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

c) The Enrollee may designate a representative, through written consent, to file Complaints, Complaint Appeals and Action Appeals on his/her behalf.

d) The Contractor will not retaliate or take any discriminatory action against the Enrollee because he/she filed a Complaint, Complaint Appeal or Action Appeal.

e) The Contractor's procedures for accepting Complaints, Complaint Appeals and Action Appeals shall include:

i) toll-free telephone number;

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ii) designated staff to receive calls;

iii) "live" phone coverage at least forty (40) hours a week during normal business hours;

iv) a mechanism to receive after hours calls, including either:

A) a telephone system available to take calls and a plan to respond to all such calls no later than on the next business day after the calls were recorded; or

B) a mechanism to have available on a twenty-four (24) hour, seven (7) day a week basis designated staff to accept telephone Complaints, whenever a delay would significantly increase the risk to an Enrollee's health.

f) The Contractor must ensure that personnel making determinations regarding Complaints, Complaint Appeals and Action Appeals were not involved in previous levels of review or decision-making, nor subordinate to any such individual. If any of the following applies, determinations must be made by qualified clinical personnel as specified in this Appendix:

i) A denial Action Appeal based on lack of medical necessity.

ii) A Complaint regarding denial of expedited resolution of an Action Appeal.

iii) A Complaint, Complaint Appeal, or Action Appeal that involves clinical issues.

g) The Contractor must ensure that personnel making determinations regarding Complaints, Complaint Appeals and Action Appeals take into account all comments, documents, records, and other information submitted by the Enrollee without regard to whether such information was submitted or considered in the initial Action determination.

h) Requirements for written notice to Enrollees.

i) The Contractor shall ensure that all written notices provided pursuant to this Appendix are in easily understood language and are accessible to non-English speaking and visually impaired Enrollees; include that oral interpretation and alternate formats of written material for Enrollees with special needs are available and how to access the alternate formats; and conform with the language and format requirements of 42 CFR 438.10(d).

ii) Unless the written notice is required to be mailed by applicable federal or state law or regulations, written notice to the Enrollee may be transmitted by electronic means in accordance with 42 CFR §435.918 and 42 CFR §438.10, as applicable.

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iii) In a form and format required by SDOH, the Contractor shall submit template notices, along with proposed attachments, to the SDOH for approval prior to use, conforming with the requirements of SDOH model notices, where available. SDOH reserves the right to require revisions to the Contractor's templates, including the Contractor's use of the SDOH model Notice of Action template, to ensure compliance with noticing requirements.

**3. Action Appeals Process**

a) The Contractor's Action Appeals process shall indicate the following regarding resolution of Appeals of an Action:

i) The Enrollee, or his or her designee, will have ~~a Contractor-specified time that allows at least sixty (60) business days but no more than ninety (90) days~~ sixty (60) days from the date of the notice of Action to file an Action Appeal. An Enrollee requesting an Action Appeal ~~fair hearing~~ within ten (10) days of the notice of Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or termination of previously approved services, or the partial approval, reduction, suspension, or terminaton of a subsequent authorization period for ~~an Enrollee in receipt of~~ LTSS or RHCF services, ~~or the intent of the Contractor to restrict the Enrollee under the Contractor's Recipient Restriction Program,~~ may request "aid continuing" in accordance with Section 6~~25.4~~ of this Appendix~~Agreement~~.

ii) The Enrollee may file a written Action Appeal or an oral Action Appeal. Oral Action Appeals must be followed by a written, signed, Action Appeal. The Contractor may provide a written summary of an oral Action Appeal to the Enrollee (with the acknowledgement or separately) for the Enrollee to review, modify if needed, sign and return to the Contractor. If the Enrollee or provider requests expedited resolution of the Action Appeal, the oral Action Appeal does not need to be confirmed in writing. The date of the oral filing of the Action Appeal will be the date of the Action Appeal for the purposes of the timeframes for resolution of Action Appeals. Action Appeals resulting from a Concurrent Review must be handled as an expedited Action Appeal.

iii) The Contractor must send a written acknowledgement of the Action Appeal within fifteen (15) days of receipt. If a determination is reached before the written acknowledgement is sent, the Contractor may include the written acknowledgement with the notice of Action Appeal determination (one notice).

iv) The Contractor must provide the Enrollee reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor must inform the Enrollee of the limited time to present such evidence sufficiently in advance of the resolution time frame in the case of an expedited Action Appeal. The Contractor must provide the Enrollee and his or her designee copies of information about the Enrollee's case, including medical records, other

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documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Action Appeal, free of charge and sufficiently in advance of Action Appeal resolution timeframes outlined in this Appendix. ~~allow the Enrollee or his or her designee, both before and during the Action Appeals process, to examine the Enrollee's case file, including medical records and any other documents and records considered during the Action Appeals process.~~ The Contractor will consider the Enrollee, his or her designee, or legal estate representative of a deceased Enrollee a party to the Action Appeal.

v) The Contractor must have a process for handling expedited Action Appeals. Expedited resolution of the Action Appeal must be conducted when the Contractor determines or the provider indicates that a delay would seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function, or when the Action involved a Concurrent Review Request or a Prior Authorization Request meeting the conditions described in PHL 4903 (2)(b), for proposed mental health or substance use disorder service, where the Enrollee, or the Enrollee's designee, has certified the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction (subject to the provisions of Section 10.9 of this Agreement). The Enrollee may request an expedited review of an Action Appeal. If the Contractor denies the Enrollee's request for an expedited review, the Contractor must handle the request under standard Action Appeal resolution timeframes. The Contractor must make reasonable efforts to provide prompt oral notice to the Enrollee of the determination to deny the Enrollee's request for expedited review and send written notice as provided by paragraph 5 (a) (i) below to the Enrollee within two (2) days of this determination.

vi) The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

vii) Action Appeals of clinical matters must be decided by personnel qualified to review the Action Appeal, including licensed, certified or registered health care professionals who did not make, and are not subordinate to anyone involved in, the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL §4900(2)(a). Action Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original determination.

**4. Timeframes for Resolution of Action Appeals**

a) The Contractor's Action Appeals process shall indicate the following specific timeframes regarding Action Appeal resolution:

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i) The Contractor will resolve Action Appeals as fast as the Enrollee's condition requires, and no later than thirty (30) days from the date of the receipt of the Action Appeal.

ii) The Contractor will resolve expedited Action Appeals as fast as the Enrollee's condition requires, within two (2) business days of receipt of necessary information and no later than seventy-two (72) hours~~three (3) business days~~ of the date of the receipt of the Action Appeal.

A) as provided by PHL §4904(2), the Contractor will resolve expedited Action Appeals regarding inpatient Substance Use Disorder treatment provided pursuant to PHL §4903(3)(c) within 24 hours of the receipt of the Action Appeal.

iii) Timeframes for Action Appeal resolution, except Action Appeals for 4a)ii)A) above, may be extended for up to fourteen (14) days if:

A) the Enrollee, his or her designee, or the provider requests an extension orally or in writing; or

B) the Contractor can demonstrate or substantiate that there is a need for additional information and the extension is in the Enrollee's interest. Where the Contractor determines to extend the review of the Action Appeal, the Contractor shall:

I) make reasonable efforts to give the Enrollee prompt oral notice of the delay;

II) within two (2) days give the Enrollee written notice of the reason for the decision to extend the timeframe;

III) resolve the Action A~~a~~ppeal as expeditiously as the enrollee's health condition requires, within the time frames required by PHL and no later than the date the extension expires; and

IV) ~~The Contractor must send notice of the extension to the Enrollee. The Contractor must~~ maintain sufficient documentation of extension determinations to demonstrate, upon SDOH's request, that the extension was justified.

iv) For expedited Action Appeals, t~~T~~he Contractor will make a reasonable effort to provide oral notice to the Enrollee, his or her designee, and the provider where appropriate, ~~for expedited Action Appeals~~ at the time the Action Appeal determination is made and send written notice to the Enrollee, and the provider where appropriate, within 24 hours of the Action Appeal determination, and not later than 72 hours from the receipt of the Action Appeal, or, if the review has

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been extended as provided in 4) iii) above, not later than the date the extension expires.

v) For Action Appeals reviewed under the standard timeframe, t~~T~~he Contractor must send written notice to the Enrollee,~~, his or her designee,~~ and the provider where appropriate, within two (2) business days of the Action Appeal determination and not later than 30 days of the receipt of the Action Appeal or, if review has been extended as provided in 4) iii) above, not later than the date the extension expires.

vi) Where the Contractor determines to reverse a decision to deny, limit, or delay services that were not furnished while an Action Appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, within the timeframe required by State law or regulation, and no more than 72 hours from the date of the Action Appeal determination.

**5. Action Appeal Notices**

a) The Contractor shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired Enrollees. Notices shall include that oral interpretation and alternate formats of written material for Enrollees with special needs are available and how to access the alternate formats.

i) Notice to the Enrollee that the Enrollee's request for an expedited Action Appeal has been denied may be combined with the Acknowledgement and shall include:

A) that the request will be reviewed under standard Action Appeal timeframes, including a description of the timeframes~~ This notice may be combined with the acknowledgement~~;

B) the reason for the decision to review under standard timeframes;

C) the right of the Enrollee to file a Complaint regarding the delay:

D) the process for filing a Complaint with the Contractor and the timeframes within which a Complaint determination must be made;

E) the right of an Enrollee to designate a representative, through written consent, to file a Complaint on behalf of the Enrollee; and

F) the right of the Enrollee to contact the New York State Department of Health regarding his or her Complaint, including the SDOH's toll-free number for Complaints.

ii) Notice to the Enrollee regarding an Contractor-initiated extension shall include:

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A) the reason for the extension;

B) an explanation of how the delay is in the best interest of the Enrollee;

C) any additional information the Contractor requires from any source to make its determination;

D) the right of the Enrollee to file a Complaint regarding the extension;

E) the process for filing a Complaint with the Contractor and the timeframes within which a Complaint determination must be made;

F) the right of an Enrollee to designate a representative, through written consent, to file a Complaint on behalf of the Enrollee; and

G) the right of the Enrollee to contact the New York State Department of Health regarding his or her their Complaint, including the SDOH's toll-free number for Complaints.

iii) Notice to the Enrollee of Action Appeal ~~D~~determination shall be dated and include:

A) Date the Action Appeal was filed and a summary of the Action Appeal;

B) Date the Action Appeal process was completed;

C) the results and the reasons for the determination, including the clinical rationale, if any;

I) For Action Appeals regarding prescription medications specified in Section 10.32 (g) of this Agreement where the determination is not in the Enrollee's favor, a clear statement:

*a)* that the requested medication must be provided when the prescriber demonstrates that in their reasonable professional judgment, either by consistency with U.S. Food and Drug Administration approved labeling or use supported in at least one of the Official Compendia as defined in federal law under the Social Security Act §1927 (g)(1)(B)(i), that the medication is medically necessary and warranted to treat the Enrollee; and

*b)* whether the appeal is upheld by the Contractor because:

*i)* the necessary information to complete the Service Authorization Request was not provided to the Contractor (including a

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description of the information needed) and the time for review has expired, or

*ii)* the prescriber's reasonable professional judgment has not been adequately demonstrated and the time for review has expired.

D) For ~~If the~~ Action Appeals regarding~~determination was~~ an intent to restrict under the Contractor's Recipient Restriction Program and where the determination was not wholly in favor of the Enrollee, and:

I) the Contractor upheld its original Action, a statement that reminds the Enrollee of their right to request a fair hearing, including:

*a*) that a request for a fair hearing must be made to the State within 60 days of the initial Action notice;

*b*) the date by which such request must have been made; and

*c*) if time remains for a fair hearing to be requested, instructions on how to request a fair hearing; or a statement that time to request a fair hearing has expired.

II) the Contractor modified its original Action in any way, a statement that the Action Appeal determination constitutes a new Action, and the Enrollee has a right to request a fair hearing, including:

*a*) that a request for a fair hearing must be made to the State within 60 days of the date of the Action Appeal notice; and

*b*) a completed SDOH standard "Managed Care Action Taken – Denial Reduction or Termination of Benefits" notice containing the Enrollee's fair hearing and aid continuing rights.

E) For all Action Appeal determinations other than D) above, where the determination was not wholly in favor of the Enrollee, the Enrollee's right to request a State Fair Hearing, including:

I) that a request for a fair hearing must be made to the State within one hundred twenty (120) days of the date of the Action Appeal notice, including the last date to ask for a fair hearing; and

II) the procedures and instructions for requesting fair hearing including a completed SDOH standard Managed Care Decision Fair Hearing Request Form

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F) Where applicable and in accordance with 42 CFR 438.420 and Section 25.4 of the Agreement, the right of the Enrollee to request aid continuing while the Enrollee's Action Appeal is pending, including:

I the time frame and process for requesting aid continuing; and

II) the circumstances, consistent with state policy, under which the Enrollee may be required to pay the costs of services provided while the Action Appeal is pending.

~~E~~G) the right of the Enrollee to contact the New York State Department of Health regarding his or her Complaint, including the SDOH's toll-free number for Complaints; and

~~F~~H) For Action Appeals involving the restriction of an Enrollee under the Contractor's Recipient Restriction Program where the restriction is upheld:

I) the effective date of the restriction;

II) the scope and type of restriction;

III) the name, address and phone number of the RRP Provider(s) the Enrollee is restricted to; and

IV) the right of the Enrollee to change an RRP Provider as provided by Section 5 (b) of Appendix Q of this Agreement.

~~G~~I) For Action Appeals involving personal care services, the number of hours per day, number of hours per week, and the personal care services function (Level I/Level II); for Action Appeals involving LTSS or RHCF services, the type and level of services authorized; and, as applicable, the services:

I) that were previously authorized, if any;

II) that were requested by the Enrollee or their designee, if so specified in the request;

III) that are authorized for the new authorization period, if any; and

IV) the original authorization period and the new authorization period, as applicable.

~~H~~J) For Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:

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I) a clear statement that the notice constitutes the final adverse determination and specifically use the terms "medical necessity" or "experimental/investigational;"

II) the Enrollee's coverage type;

III) the procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;

IV) where the Action Appeal involved an upheld denial of an out-of-network services or referral as provided by PHL §4904(1-a) or (1-b), the name(s) of the Participating Provider(s) with the training and experience to meet the particular health care needs of the Enrollee and who is able to provide the requested service.

V) statement that the Enrollee is eligible to file an External Appeal and the timeframe for filing, and if the Action Appeal was expedited, a statement that the Enrollee may choose to file a standard Action Appeal with the Contractor or file an External Appeal;

VI) a copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form;

VII) the Contractor's contact person and telephone number; and

VIII) the contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent.~~; and~~

~~IX) if the Contractor has a second level internal review process, the notice shall contain instructions on how to file a second level Action Appeal and a statement in bold text that the timeframe for requesting an External Appeal begins upon receipt of the final adverse determination of the first level Action Appeal, regardless of whether or not a second level of Action Appeal is requested, and that by choosing to request a second level Action Appeal, the time may expire for the Enrollee to request an External Appeal.~~

## 6. State Fair Hearing Process and Aid Continuing

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a) The Enrollee may request a fair hearing regarding a Contractor's Action:

i) For an Action regarding an intent to restrict an Enrollee under the Contractor's Recipient Restriction Program pursuant to Appendix Q of this Agreement, within sixty (60) days of the Contractor's Notice of Intent to Restrict. An Enrollee

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requesting a fair hearing within ten (10) days of the date of the Notice of Intent to Restrict or by the effective date of the restriction, whichever is later, may request aid continuing, in accordance with Section 25.4 of this Agreement.

ii) For all other Actions, within one hundred twenty (120) days of the date of the Contractor's adverse Action Appeal determination. An Enrollee requesting a fair hearing within ten (10) days of the date of the Action Appeal determination or by the effective date of the determination, whichever is later, that involves the reduction, suspension, or termination of previously approved services, or the partial approval, reduction, suspension, or termination of a subsequent authorization period for LTSS or RHCF services, may request aid continuing, in accordance with Section 25.4 of this Agreement.

b) The Enrollee is deemed to have exhausted the Contractor's Action Appeal process and may request a fair hearing if the Contractor does not adhere to the Action Appeal notice and timing requirements of Section (4) of Part F.2 of this Appendix.

c) The Contractor will continue the provision of the Benefit Package services (also known as aid continuing) that are the subject of an Action Appeal, other than an Action Appeal involving a restriction, to an Enrollee:

i) immediately upon receipt of an Action Appeal involving the termination, suspension, reduction, of a previously authorized service filed orally or in writing by the Enrollee, or the Enrollee's designee who is other than a provider, within ten (10) days of the date of the Notice of Action, or the effective date of the Action, whichever is later, unless the Enrollee indicates they do not wish their services to continue pending the resolution of the Action Appeal; or

ii) immediately upon receipt of an Action Appeal involving the partial approval, termination, suspension, or reduction in quantity or level of services authorized for LTSS or an RHCF stay for a subsequent authorization period, filed orally or in writing by the Enrollee, or the Enrollee's designee who is other than a provider, within ten (10) days of the date of the Notice of Action, or the effective date of the Action, whichever is later, unless the Enrollee indicates they do not wish their services to continue pending the resolution of the Action Appeal.

iii) the Contractor shall not cease to provide aid continuing until one of the following occurs:

A) the Enrollee withdraws the request for aid continuing; or

B) the Enrollee withdraws the request for an Action Appeal; or

C) the Enrollee fails to request a fair hearing and aid continuing within ten (10) days of an adverse Action Appeal determination; or

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D) the provider order has expired, except in the case of a home bound Enrollee.

d) Notwithstanding c) above, pursuant to Section 25 of this Agreement, the Contractor will comply with all OAH orders regarding the provision of aid continuing and all determinations rendered by the OAH at fair hearing.

**~~6~~7. Complaint Process**

a) The Contractor' Complaint process shall include the following regarding the handling of Enrollee Complaints:

i) The Enrollee, or his or her designee, may file a Complaint regarding any dispute with the Contractor orally or in writing. The Contractor may have requirements for accepting written Complaints either by letter or Contractor supplied form. The Contractor cannot require an Enrollee to file a Complaint in writing or in English.

ii) The Contractor must provide written acknowledgment of any Complaint not immediately resolved, including the name, address and telephone number of the individual or department handling the Complaint, within fifteen (15) business days of receipt of the Complaint. The acknowledgement must identify any additional information required by the Contractor from any source to make a determination. If a Complaint determination is made before the written acknowledgement is sent, the Contractor may include the acknowledgement with the notice of the determination (one notice).

iii) Complaints shall be reviewed by one or more qualified personnel.

iv) Complaints pertaining to clinical matters shall be reviewed by one or more licensed, certified or registered health care professionals in addition to whichever non-clinical personnel the Contractor designates.

v) If an Enrollee files a Complaint regarding difficulty accessing a needed service or referral from a Participating Provider, and, as part of or in addition to the Complaint, requests the service or referral directly from the Contractor, the Contractor must accept and review such Service Authorization Request and make a Service Authorization Determination, approving the request or confirming the decision of the Participating Provider to deny the service or referral, in the manner and timeframes provided by Appendix F.1 of this Agreement.

**~~7~~8. Timeframes for Complaint Resolution by the Contractor**

a) The Contractor's Complaint process shall indicate the following specific timeframes regarding Complaint resolution:

i) If the Contractor immediately resolves an oral Complaint to the Enrollee's satisfaction, that Complaint may be considered resolved without any additional

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written notification to the Enrollee. Such Complaints must be logged by the Contractor and included in the Contractor's quarterly HCS Complaint report submitted to SDOH in accordance with Section 18 of this Agreement.

ii) Whenever a delay would significantly increase the risk to an Enrollee's health, Complaints shall be resolved within forty-eight (48) hours after receipt of all necessary information and no more than seven (7) days from the receipt of the Complaint.

iii) All other Complaints shall be resolved within forty-five (45) days after the receipt of all necessary information and no more than sixty (60) days from receipt of the Complaint. The Contractor shall maintain reports of Complaints unresolved after forty-five (45) days in accordance with Section 18 of this Agreement.

**~~8~~9. Complaint Determination Notices**

a) The Contractor's procedures regarding the resolution of Enrollee Complaints shall include the following:

i) Complaint ~~D~~determinations by the Contractor shall be made in writing to the Enrollee or his/her designee and include:

A) the detailed reasons for the determination;

B) in cases where the determination has a clinical basis, the clinical rationale for the determination;

C) the procedures for the filing of an appeal of the determination, including a form, if used by the Contractor, for the filing of such a Complaint Appeal; and notice of the right of the Enrollee to contact the State Department of Health regarding his or her Complaint, including SDOH's toll-free number for Complaints.

ii) If the Contractor was unable to make a Complaint determination because insufficient information was presented or available to reach a determination, the Contractor will send a written statement that a determination could not be made to the Enrollee on the date the allowable time to resolve the Complaint has expired.

iii) In cases where delay would significantly increase the risk to an Enrollee's health, the Contractor shall provide notice of a determination by telephone directly to the Enrollee or to the Enrollee's designee, or when no phone is available, some other method of communication, with written notice to follow within three (3) business days.

**~~9~~10. Complaint Appeals**

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a) The Contractor's procedures regarding Enrollee Complaint Appeals shall include the following:

i) The Enrollee or designee has no less than sixty (60) business days after receipt of the notice of the Complaint determination to file a written Complaint Appeal. Complaint Appeals may be submitted by letter or by a form provided by the Contractor.

ii) Within fifteen (15) business days of receipt of the Complaint Appeal, the Contractor shall provide written acknowledgment of the Complaint Appeal, including the name, address and telephone number of the individual designated to respond to the Appeal. The Contractor shall indicate what additional information, if any, must be provided for the Contractor to render a determination.

iii) Complaint Appeals of clinical matters must be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL §4900(2)(a).

iv) Complaint Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original Complaint determination.

v) Complaint Appeals shall be decided and notification provided to the Enrollee no more than:

A) two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an Enrollee's health; or

B) thirty (30) business days after the receipt of all necessary information in all other instances.

vi) The notice of the Contractor's Complaint Appeal determination shall include:

A) the detailed reasons for the determination;

B) the clinical rationale for the determination in cases where the determination has a clinical basis;

C) the notice shall also inform the Enrollee of his/her option to also contact the State Department of Health with his/her Complaint, including the SDOH's toll-free number for Complaints;

D) instructions for any further Appeal, if applicable.

**~~10~~11. Records**

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a) The Contractor shall maintain a file on each Complaint, Action Appeal and Complaint Appeal. These records shall be readily available for review by the SDOH, upon request. The file shall include:

i) For Complaints and Complaint Appeals:

A) name of the covered person for whom the Complaint or Complaint Appeal was filed;

B) the date the Complaint or Complaint Appeal was filed;

C) ii) copy of the Complaint or Complaint Appeal, if written or general description of the reason for the Complaint or Complaint Appeal and ; iii) date of receipt of and copy of the Enrollee's written confirmation, if any;

D) Enrollee or provider requests for expedited review and the Contractor's determination related to such request;

E) date of each review or, if applicable review meeting;

F) iv) log of theComplaint determination at each level of the review, including the date of the determination and the titles of the personnel and credentials of clinical personnel who reviewed the Complaint and Complaint Appeal; and

G) Complaints unresolved for greater than forty-five (45) days.

ii) For Action Appeals:

Av) name of the covered person for whom the Action Appeal was filed;

B) date and copy of the Enrollee's Action Appeal or Complaint Appeallor general description of the reason for the Action Appeal and date of receipt of and copy of the Enrollee's written confirmation, if any;

Cvi) Enrollee or provider requests for expedited Action Appeals and Complaint Appeals and the Contractor's determination related to such request;

Cvii) necessary documentation to support any extensions;

D) -date or each review or, if applicable review meeting:

Eviii) the determination at each level of review, including the and date of the determination of the Action Appeals and Complaint Appeals; and

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F~~ix~~) the titles and credentials of clinical staff who reviewed the Action Appeal~~s and Complaint Appeals; and~~

~~x) Complaints unresolved for greater than forty-five (45) days.~~

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# APPENDIX G

# SDOH Requirements for the Provision of Emergency Care and Services

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# SDOH Requirements for the Provision of Emergency Care and Services

## 1. Definitions

a) **"Emergency Medical Condition"** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

i) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or

ii) serious impairment to such person's bodily functions; or

iii) serious dysfunction of any bodily organ or part of such person; or

iv) serious disfigurement of such person.

b) **"Emergency Services"** means covered inpatient and outpatient health care procedures, treatments or services that are furnished by a provider qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol. Emergency Services also include Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency when rendered in emergency departments.

c) **"Post-stabilization Care Services"** means covered services, related to an emergency medical condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in Section 3 below, to improve or resolve the Enrollee's condition.

## 2. Coverage and Payment of Emergency Services

a) The Contractor must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor.

b) The Contractor shall cover and pay for services as follows:

i) Participating Providers

A) Payment by the Contractor for general hospital emergency department services

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provided to an Enrollee by a Participating Provider shall be at the rate or rates of payment specified in the contract between the Contractor and the hospital. Such contracted rate or rates shall be paid without regard to whether such services meet the definition of Emergency Medical Condition.

B) Payment by the Contractor for physician services provided to an Enrollee by a Participating Provider while the Enrollee is receiving general hospital emergency department services shall be at the rate or rates of payment specified in the contract between the Contractor and the physician. Such contracted rate or rates shall be paid without regard to whether such services meet the definition of Emergency Medical Condition.

ii) Non-Participating Providers

A) Payment by the Contractor for general hospital emergency department services provided to an Enrollee by a Non-Participating Provider shall be at the Medicaid fee-for-service rate, inclusive of the capital component, in effect on the date that the service was rendered without regard to whether such services meet the definition of Emergency Medical Condition.

B) Payment by the Contractor for physician services provided to an Enrollee by a Non-Participating Provider while the Enrollee is receiving general hospital emergency department services shall be at the Medicaid fee-for-service rate in effect on the date the service was rendered without regard to whether such services meet the definition of Emergency Medical Condition.

c) The Contractor must advise Enrollees that they may access Emergency Services at any Emergency Services provider.

d) Prior authorization for treatment of an Emergency Medical Condition is never required.

e) The Contractor may not deny payment for treatment obtained in either of the following circumstances:

i) An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition above.

ii) A representative of the Contractor instructs the Enrollee to seek Emergency Services.

f) A Contractor may not:

i) limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms; or

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ii) refuse to cover emergency room services based on the failure of the provider or the Enrollee to give the Contractor notice of the emergency room visit.

g) An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

h) The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor for payment.

**3. Coverage and Payment of Post-stabilization Care Services**

a) The Contractor is financially responsible for Post-stabilization Care Services furnished by a provider within or outside the Contractor's network when:

i) they are pre-approved by a Participating Provider, as authorized by the Contractor, or other authorized Contractor representative;

ii) they are not pre-approved by a Participating Provider, as authorized by the Contractor, or other authorized Contractor representative, but administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-stabilization Care Services;

iii) they are not pre-approved by a Participating Provider, as authorized by the Contractor, or other authorized Contractor representative, but administered to maintain, improve or resolve the Enrollee's stabilized condition if:

A) The Contractor does not respond to a request for pre-approval within one (1) hour;

B) The Contractor cannot be contacted; or

C) The Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 3(b) is met.

iv) The Contractor must limit charges to Enrollees for Post-stabilization Care Services to an amount no greater than what the organization would charge the Enrollee if he or she had obtained the services through the Contractor.

b) The Contractor's financial responsibility to the treating emergency provider for Post-

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stabilization Care Services it has not pre-approved ends when:

i) A plan physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

ii) A plan physician assumes responsibility for the Enrollee's care through transfer;

ii) A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care or

iv) The Enrollee is discharged.

**4. Protocol for Acceptable Transfer Between Facilities**

a) All relevant COBRA requirements must be met.

b) The Contractor must provide for an appropriate (as determined by the emergency department physician) transfer method/level with personnel as needed.

c) The Contractor must contact/arrange for an available, accepting physician and patient bed at the receiving institution.

d) If a patient is not transferred within eight (8) hours to an appropriate inpatient setting after the decision to admit has been made, then admission at the original facility is deemed authorized.

**5. Emergency Transportation**

When emergency transportation is included in the Contractor's Benefit Package, the Contractor shall reimburse the transportation provider for all emergency transportation services, without regard to final diagnosis or prudent layperson standards. Payment by the Contractor for emergency transportation services provided to an Enrollee by a Participating Provider shall be at the rate or rates of payment specified in the contract between the Contractor and the transportation provider. Payment by the Contractor for emergency transportation services provided to an Enrollee by a Non-Participating Provider shall be at the Medicaid fee-for-service rate in effect on the date the service was rendered.

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# APPENDIX H

# New York State Department of Health Requirements for the Processing of Enrollments and Disenrollments in the MMC and FHPlus Programs

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# SDOH Requirements
# for the Processing of Enrollments and Disenrollments
# in the MMC and FHPlus Programs

## 1. General

The Contractor's Enrollment and Disenrollment procedures shall be consistent with these requirements, except that to allow the NYSoH, LDSS and the Contractor flexibility in developing processes that will meet the needs of all parties, SDOH, upon receipt of a written request from the NYSoH, the LDSS, or the Contractor, may allow modifications to timeframes and some procedures. Where an Enrollment Broker exists, the Enrollment Broker will be responsible for some or all of the LDSS responsibilities as set forth in the Enrollment Broker Contract.

## 2. Enrollment

a) SDOH Responsibilities:

i) The SDOH is responsible for monitoring Medicaid Managed Care program activities and providing technical assistance to the NYSoH, LDSS and the Contractor to ensure compliance with the State's policies and procedures.

ii) SDOH reviews and approves proposed Enrollment materials prior to the Contractor publishing and disseminating or otherwise using the materials.

iii) The SDOH is responsible for notifying HARP Eligible Persons already enrolled in an MMC plan, or who are otherwise HARP eligible. Such notification may include some or all of the following, as appropriate:

A) information about the HARP program;

B) timeframes for passive enrollment into the Contractor's HARP, the opportunity to decline enrollment and/or the timeframe for active enrollment; and

C) information necessary for the HARP Eligible Person to choose between available Managed Care products.

b) NYSoH/LDSS Responsibilities:

i) The NYSoH or LDSS has the primary responsibility for the Enrollment process.

ii) The NYSoH or LDSS determines Medicaid and FHPlus eligibility. To the extent practicable, the NYSoH or LDSS will follow up with Enrollees when the Contractor provides documentation of any change in status which may affect the Enrollee's Medicaid, FHPlus, or MMC eligibility, including disability or

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exclusion status of a current Enrollee. The NYSoH or LDSS must conduct timely review and take appropriate action when the Contractor notifies the NYSoH or LDSS of the existence of duplicate Client Identification Numbers (CINs). The NYSoH or LDSS must work with the Contractor regarding the appropriate forms and documentation required to process a disability review. Individuals not enrolled in an MCO or who are newly eligible for Medicaid, and in need of Nursing Home care shall obtain a long term care eligibility determination from the LDSS prior to enrollment into a Medicaid managed care plan.

iii) The NYSoH or LDSS is responsible for coordinating the Medicaid and FHPlus application and Enrollment processes.

iv) The NYSoH or LDSS is responsible for providing pre-enrollment information to Eligible Persons, consistent with Sections 364-j(4)(e)(iv) and 369-ee of the SSL, and the training of persons providing Enrollment counseling to Eligible Persons.

v) The NYSoH or LDSS is responsible for informing Eligible Persons of the availability of MCOs, Managed Long Term Care Plans, and HIV SNPs and HARPs offering MMC and/or FHPlus products and the scope of services covered by each as appropriate.

vi) The NYSoH or LDSS is responsible for informing Eligible Persons of the right to confidential face-to-face Enrollment counseling and will make confidential face-to-face sessions available upon request.

vii) The NYSoH or LDSS is responsible for instructing Eligible Persons to verify with the medical services providers they prefer, or have an existing relationship with, that such medical services providers are Participating Providers of the selected MCO and are available to serve the Enrollee. The NYSoH or LDSS includes such instructions to Eligible Persons in its written materials related to Enrollment.

viii) For Enrollments made during face-to-face counseling, if the Prospective Enrollee has a preference for particular medical services providers, Enrollment counselors shall verify with the medical services providers that such medical services providers whom the Prospective Enrollee prefers are Participating Providers of the selected MCO and are available to serve the Prospective Enrollee.

ix) The NYSoH or LDSS is responsible for the timely processing of managed care Enrollment applications, Exemptions, and Exclusions.

x) The NYSoH or LDSS is responsible for determining the status of Enrollment applications. Applications will be enrolled, pended or denied.

xi) The NYSoH or LDSS is responsible for determining the Exemption and Exclusion status of individuals determined to be eligible for Medicaid under Title 11 of the SSL.



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A) Exempt means an individual eligible for Medicaid under Title 11 of the SSL determined by the LDSS, NYSoH or the SDOH to be in a category of persons, as specified in Section 364-j of the SSL and/or New York State's Operational Protocol for the Partnership Plan, that are not required to participate in the MMC Program; however, individuals designated as Exempt may elect to voluntarily enroll.

B) Excluded means an individual eligible for Medicaid under Title 11 of the SSL determined by the LDSS, NYSoH or the SDOH to be in a category of persons, as specified in Section 364-j of the SSL and/or New York State's Operational Protocol for the Partnership Plan, that are precluded from participating in the MMC Program.

xii) The NYSoH or LDSS is responsible for entering individual Enrollment form data and transmitting that data to the SDOH enrollment system.

xiii) The NYSoH or LDSS is responsible for sending the following required notices to Eligible Persons:

A) For MMC program - Initial Notification Letter for populations required to enroll: This letter informs Eligible Persons about the mandatory MMC program and the timeframes for choosing a MCO offering a MMC product. Included with the letter is information necessary for the individual to choose an MCO or request an exemption. New applicants are required to choose a plan at application.

B) For MMC program - Enrollment Confirmation Notice for MMC Enrollees: This notice indicates the Effective Date of Enrollment, the name of the MCO and all individuals who are being enrolled. This notice should also be used for auto-assignments, case additions and re-enrollments into the same MCO. There is no requirement that an Enrollment Confirmation Notice be sent to FHPlus Enrollees.

C) Notice of Denial of Enrollment: This notice is used when an individual has been determined by the NYSoH or LDSS to be ineligible for Enrollment into the MMC or FHPlus program. This notice must include fair hearing rights. This notice is not required when Medicaid or FHPlus eligibility is being denied (or closed).

D) For MMC program only - Exemption Request Forms: Exemption forms are provided to MMC Eligible Persons upon request if they wish to apply for an Exemption. Individuals precoded on the system as meeting Exemption or Exclusion criteria do not need to complete an Exemption request form. This notice is required for mandatory MMC Eligible Persons.

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E) For MMC program only - Exemption and Exclusion Request Approval or Denial: This notice is designed to inform a recipient who applied for an exemption or who failed to provide documentation of exclusion criteria when requested by the NYSoH or LDSS of the NYSoH or LDSS's disposition of the request, including the right to a fair hearing if the request for exemption or exclusion is denied. This notice is required for MMC Eligible Persons.

c) Contractor Responsibilities:

i) The Contractor must notify new MMC and FHPlus Enrollees of their Effective Date of Enrollment. In the event that the actual Effective Date of Enrollment is different from that previously given to the Enrollee, the Contractor must notify the Enrollee of the actual date of Enrollment. This may be accomplished through a Welcome Letter. To the extent practicable, such notification must precede the Effective Date of Enrollment.

ii) The Contractor must report any changes (including appropriate documentation if available) that affect or may affect the eligibility or disability status or capitation rate category of its enrolled members to the NYSoH or LDSS, as appropriate, within five (5) business days of such information becoming known to the Contractor. This includes, but is not limited to, address changes, verification of pregnancy, incarceration, death, third party insurance, etc., as well as the disability or exclusion status of MMC members.

iii) The Contractor, within five (5) business days of identifying cases where a person may be enrolled in the Contractor's MMC or FHPlus product under more than one Client Identification Number (CIN), or has knowledge of an Enrollee with more than one active CIN, must convey that information in writing to the NYSoH or LDSS as appropriate.

iv) The Contractor shall advise Prospective Enrollees, in written materials related to Enrollment, to verify with the medical services providers they prefer, or have an existing relationship with, that such medical services providers are Participating Providers of the selected MCO and are available to serve the Prospective Enrollee.

v) The Contractor shall accept all Enrollments as ordered by the Office of Temporary and Disability Assistance's Office of Administrative Hearings due to fair hearing requests or decisions.

vi) [Applicable to HIV SNP Program only]: Eligibility for enrollment in HIV SNPs is verified by the Contractor through confirmation of HIV infection or homeless status.

A) The Contractor must confirm that Enrollees have HIV infection with the exception of uninfected related children enrolling along with an infected parent and HIV-exposed infants whose HIV status has not yet been confirmed.



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The Contractor must obtain verification of an Enrollee's HIV infection as specified in Section 6.11 d) of this Agreement within ninety (90) days of the Effective Date of Enrollment. Such documentation and verification must be maintained by the Contractor for audit purposes.

B) The Contractor must verify that homeless Enrollees are included on NYC Department of Homeless Services (DHS) reports provided to the Contractor. The Contractor must have a process to address and monitor homeless Enrollee's housing status and must transition Enrollees who obtain permanent housing and are no longer considered homeless to other health plans. Documentation of Contractor verification and monitoring efforts must be maintained by the Contractor for audit purposes.

**3. Newborn Enrollments**

a) The Contractor agrees to enroll and provide coverage for eligible newborn children effective from the time of birth.

b) SDOH Responsibilities:

i) The SDOH will update appropriate state systems with information on the newborn received from hospitals, consistent with the requirements of Section 366-g of the SSL as amended by Chapter 412 of the Laws of 1999.

ii) Upon notification of the birth by the hospital or birthing center, the SDOH will notify NYSoH or update appropriate state systems with the demographic data for the newborn and enroll the newborn in the mother's MCO if the newborn is not already enrolled, the mother's MCO offers a MMC product, and the newborn is not identified as Excluded from the MMC Program pursuant to Section 2(b)(xi) of this Appendix. Based on the transaction date of the Enrollment of the newborn, the newborn will appear on either the next month's Roster, the subsequent month's Roster or the 834 file. If the newborn's Enrollment is not completed by this process, the LDSS is responsible for entering the Enrollment on the appropriate state systems (see (c)(iv) below). The NYSoH shall update the demographic data for the newborn and enroll the newborn in the mother's MCO if the newborn is not already enrolled, and send the Contractor an 834 electronic enrollment file.

c) NYSoH and LDSS Responsibilities:

i) The NYSoH or LDSS shall grant Medicaid eligibility for newborns for one (1) year when born to a woman eligible for and receiving Medicaid or FHPlus on the date of the newborn's birth.

ii) The NYSoH or LDSS is responsible for adding eligible unborns to all cases that include a pregnant woman as soon as the pregnancy is medically verified.

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iii) In the event that the NYSoH or LDSS learns of an Enrollee's pregnancy prior to the Contractor, the NYSoH or LDSS is responsible for establishing Medicaid eligibility and enrolling the unborn in the Contractor's MMC product. If the Contractor does not offer a MMC product, the pregnant woman will be asked to select a MCO offering a MMC product for the unborn. If an MCO is not chosen by the mother, the newborn will be eligible for Medicaid fee-for-service coverage, and such information will be entered on the appropriate state system, and any MCO enrollment for the newborn shall be prospective.

iv) The NYSoH or LDSS is responsible for newborn Enrollment if enrollment is not successfully completed under the "SDOH Responsibilities" process as outlined in 3(b)(ii) above.

d) Contractor Responsibilities:

i) The Contractor must notify the NYSoH or LDSS in writing of any Enrollee that is pregnant within five (5) days of knowledge of the pregnancy. The notifications should contain the pregnant woman's name, Client ID Number (CIN), and the expected date of confinement (EDC).

ii) The Contractor must send verifications of infant's demographic data to the NYSoH or LDSS, within five (5) days after knowledge of the birth. The demographic data must include: the mother's name and CIN, the newborn's name and CIN (if newborn has a CIN), sex and the date of birth.

iii) The Contractor will accept Enrollment applications for unborns if that is the mothers' intent, even if the mothers are not and/or will not be enrolled in the Contractor's MMC or FHPlus product. When a mother is ineligible for Enrollment or chooses not to enroll, the Contractor will accept Enrollment applications for pre-enrollment of unborns who are eligible.

iv) The Contractor is responsible for provision of services to a newborn and payment of the hospital or birthing center bill if the mother is an Enrollee at the time of the newborn's birth, even if the newborn is not yet on the Roster or the Contractor has not yet been notified by NYSoH via a 834 file, unless the Contractor does not offer a MMC product in the mother's county of fiscal responsibility or the newborn is Excluded from the MMC Program pursuant to Section 2(b)(xi) of this Appendix.

v) Within fourteen (14) days of the date on which the Contractor becomes aware of the birth, the Contractor will issue a letter, informing parent(s) about the newborn's Enrollment and how to access care, or a member identification card.

vi) In those cases in which the Contractor is aware of the pregnancy, the Contractor will ensure that enrolled pregnant women select a PCP for their infants prior to birth.

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vii) The Contractor will ensure that the newborn is linked with a PCP prior to discharge from the hospital or birthing center, in those instances in which the Contractor has received appropriate notification of birth prior to discharge.

**4. Auto-Assignment Process (Applies to MMC Program):**

a) This section only applies to a County where CMS has given approval and the County has begun mandatory Enrollment into the Medicaid Managed Care Program. The details of the auto-assignment process are contained in Section 12 of New York State's Operational Protocol for the Partnership Plan.

b) SDOH Responsibilities:

i) The SDOH, NYSoH, LDSS or Enrollment Broker will assign MMC Eligible Persons not pre-coded in state systems as Exempt or Excluded, who have not chosen a MCO offering a MMC product in the required time period, to a MCO offering a MMC product using an algorithm as specified in §364-j(4)(d) of the SSL.

ii) SDOH will ensure the auto-assignment process automatically updates the state enrollment system, and will notify MCOs offering MMC products of auto-assigned individuals electronically.

iii) SDOH will notify the LDSS electronically on a daily basis of those individuals for whom SDOH has selected a MCO offering a MMC product through the Automated PCP Update Report. This does not apply for NYSoH Medicaid enrollees.

c) NYSoH or LDSS Responsibilities:

i) The NYSoH or LDSS is responsible for tracking an individual's choice period.

ii) As with Eligible Persons who voluntarily choose a MCO's MMC product, the NYSoH or LDSS is responsible for providing notification to assigned individuals regarding their Enrollment status as specified in Section 2 of this Appendix.

d) Contractor Responsibilities:

i) The Contractor is responsible for providing notification to assigned individuals regarding their Enrollment status as specified in Section 2 of this Appendix.

**5. Roster Reconciliation**:

a) All Enrollments are effective the first of the month.

b) SDOH Responsibilities:

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i) The SDOH maintains both the PCP subsystem Enrollment files and the WMS eligibility files, using data entered by the LDSS. SDOH uses data contained in both these files to generate the Roster.

A) SDOH shall send the Contractor and LDSS monthly (according to a schedule established by SDOH), a complete list of all Enrollees for which the Contractor is expected to assume medical risk beginning on the 1st of the following month (First Monthly Roster).

B) SDOH shall send the Contractor and LDSS monthly, at the time of the first monthly roster production, a Disenrollment Report listing those Enrollees from the previous month's roster who were disenrolled, transferred to another MCO, or whose Enrollments were deleted from the file.

C) The SDOH shall also forward an error report as necessary to the Contractor and LDSS.

D) In LDSSs where the Enrollment Broker services are utilized, Enrollment error reports are generated by the Enrollment Broker to the Contractor generally within 24-48 hours of Contractor Enrollment submissions, and the Contractor is able to resubmit corrections via the Enrollment Broker before Roster pulldown. Changes in Enrollee eligibility status and reports of Disenrollments processed by the Enrollment Broker that occur subsequent to production of the monthly roster shall be reported by the Enrollment Broker through electronic file transfer.

E) On the first (1st) weekend after the first (1st) day of the month following the generation of the first (1st) Roster, SDOH shall send the Contractor and LDSS a second Roster which contains any additional Enrollees that the LDSS has added for Enrollment for the current month. The SDOH will also include any additions to the error report that have occurred since the initial error report was generated. The Contractor must accept this second roster information as well as any other state-designated official enrollment report as an official adjustment to the first roster.

c) LDSS Responsibilities:

i) The LDSS is responsible for notifying the Contractor electronically or in writing of changes to the first Roster that will not show up on the second Roster and error report, no later than the end of the month. To the extent practicable the date specified must allow for timely notice to Enrollees regarding their Enrollment status. The Contractor and the LDSS may develop protocols for the purpose of resolving Roster discrepancies that remain unresolved beyond the end of the month.

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ii) Enrollment and eligibility issues shall be reconciled by the LDSS to the extent possible, through manual adjustments to the PCP subsystem Enrollment and WMS eligibility files, if appropriate.

iii) The LDSS is responsible for promptly notifying the Contractor electronically or in writing of those individuals entering foster care that the LDSS has enrolled in the Contractor's MMC plan. The LDSS is also responsible for notifying the Contractor of the PCP selected for the individual.

d) Contractor Responsibilities:

i) The Contractor is at risk for providing Benefit Package services for those Enrollees listed on the 1st and 2nd Rosters for the month in which the 2nd Roster is generated. Contractor is not at risk for providing services to Enrollees who appear on the monthly Disenrollment report.

ii) The Contractor must submit claims to the State's Fiscal Agent for all Eligible Persons that are on the 1st and 2nd Rosters, adjusted to add Eligible Persons enrolled by the LDSS or the Enrollment Broker after Roster production and to remove individuals disenrolled by LDSS after Roster production (as notified to the Contractor). In the cases of retroactive Disenrollments, the Contractor is responsible for submitting an adjustment to void any previously paid premiums for the period of retroactive Disenrollment, where the Contractor was not at risk for the provision of Benefit Package services. Payment of subcapitation does not constitute "provision of Benefit Package services."

**6. 834 Enrollment Process**

a) The Contractor shall be notified of Enrollments into its Medicaid managed care plan via 834 files listing individuals who are determined to be eligible for Medicaid and have selected the Contractor's plan for Enrollment through the NYSoH Marketplace. All Enrollments are effective the first day of the month.

b) NYSoH Responsibilities

i) The NYSoH is responsible for notifying the Contractor of Medicaid Managed Care Enrollments via 834 files. The 834 files will be transmitted multiple times each month.

ii) Enrollments listed on 834 files transmitted to the Contractor on or before the 15th of the month are effective the first day of the following month.

iii) Enrollments listed on 834 files transmitted to the Contractor after the 15th of the month are effective the first day of the second following month.

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iv) Enrollment and eligibility issues shall be reconciled by the NYSoH to the extent possible through 834 files transmitted to the Contractor and appropriate State systems.

c) Contractor Responsibilities

i) The Contractor, upon receipt of the 834 file, is at risk for providing Benefit Package services for valid Enrollments included in the file, as determined by Section 6 c) ii) of this Appendix. The effective date shall be the Enrollment Date designated in the file.

ii) The Contractor must respond within five (5) business days to the NYSoH via an electronic 834 response file and either effectuate coverage beginning on the Enrollment Date indicated on the 834 file generated by the NYSoH, or deny Enrollment in accordance with the "834 - Benefit Enrollment and Maintenance Companion Guide."

**7. Disenrollment:**

a) NYSoH or LDSS Responsibilities:

i) The NYSoH, Enrollment Broker or LDSS is responsible for accepting requests for Disenrollment directly from Enrollees and may not require Enrollees to approach the Contractor for a Disenrollment form. All requests for Disenrollment must be directed to the NYSoH, LDSS or the Enrollment Broker as appropriate.

ii) Enrollees may initiate a request for an expedited Disenrollment to the NYSoH, Enrollment Broker or LDSS. The NYSoH or LDSS will expedite the Disenrollment process for HIV SNP Enrollees and when an Enrollee's request for Disenrollment involves an urgent medical need or a complaint of non-consensual Enrollment. If approved, the NYSoH or LDSS will process the Disenrollment through the appropriate state system.

iii) The NYSoH, Enrollment Broker or LDSS is responsible for processing routine Disenrollment requests to take effect on the first (1st) day of the following month if the request is made **before** the fifteenth (15th) day of the month. In no event shall the Effective Date of Disenrollment be later than the first (1st) day of the second month after the month in which an Enrollee requests a Disenrollment.

iv) The NYSoH, Enrollment Broker or LDSS is responsible for disenrolling Enrollees automatically upon death or loss of Medicaid or FHPlus eligibility. All such Disenrollments will be effective at the end of the month in which the death or loss of eligibility occurs.

v) The NYSoH, Enrollment Broker or LDSS is responsible for informing Enrollees of their rights relative to changing MCOs. Individuals who are eligible for HIV SNP enrollment may request transfer from an MCO to an HIV SNP, or from an HIV

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SNP to another HIV SNP at any time. Enrollees subject to Lock-In may disenroll from their current MCO and transfer to another MCO after the grace period for Good Cause as defined below. The NYSoH, LDSS, or Enrollment Broker is responsible for determining if the Enrollee has Good Cause and processing the transfer request in accordance with the procedures outlined in this Appendix. The NYSoH or LDSS is responsible for providing Enrollees with notice of their right to request a fair hearing if their Disenrollment request is denied. Such notice must include the reason(s) for the denial. An Enrollee has Good Cause to disenroll from their current MCO if:

A) The Contractor has failed to furnish accessible and appropriate medical care services or supplies to which the Enrollee is entitled under the terms of the contract under which the Contractor has agreed to provide services. This includes, but is not limited to the failure to:

I) provide primary care services;

II) arrange for in-patient care, consultation with specialists, or laboratory and radiological services when reasonably necessary;

III) arrange for consultation appointments;

IV) coordinate and interpret any consultation findings with emphasis on continuity of medical care;

V) arrange for services with qualified licensed or certified providers;

VI) coordinate the Enrollee's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury; or

B) The Contractor fails to adhere to the standards prescribed by SDOH and such failure negatively and specifically impacts the Enrollee; or

C) The Enrollee meets the criteria for an Exemption or Exclusion as set forth in 2(b)(xi) of this Appendix; or

D) It is determined by the NYSoH, the LDSS, the SDOH, or its agent that the Enrollment was not consensual; or

E) The Enrollee, the Contractor and the NYSoH or LDSS agree that a change of MCOs would be in the best interest of the Enrollee; or

F) The Enrollee's medical condition requires related services to be performed at the same time but all such related services cannot be arranged by the Contractor because the Contractor has elected not to cover one of the services the Enrollee seeks, and the Enrollee's Primary Care Provider or another

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provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or

G) An FHPlus Enrollee is pregnant; or

H) The Contractor does not contract with an FQHC and one or more other MCOs in the Enrollee's county of fiscal responsibility provide the service.

I) [Applicable to HIV SNP Program only]: The HIV+ Enrollee is a child who is an SSI recipient with serious emotional disturbances whose behavioral health benefits are provided through the Medicaid fee-for-service program.;or

J) The Enrollee moves out of the Contractor's service area, as designated in Appendix M of this Agreement; or

K) The Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks; or

L) The Enrollee is in receipt of LTSS, as defined in Appendix S of this Agreement, and such Enrollee would have to change their residential, institutional, or employment supports provider based on such provider no longer being a Participating Provider and as a result such Enrollee would experience a disruption in their residence or employment.

vi) An Enrollee subject to Lock-In may initiate Disenrollment for Good Cause by filing an oral or written request with the NYSoH, LDSS, or Enrollment Broker.

vii) The NYSoH or LDSS is responsible for promptly disenrolling an MMC Enrollee whose MMC eligibility or health status changes such that he/she is deemed by the NYSoH or LDSS to meet the Exclusion criteria. The NYSoH or LDSS will provide the MMC Enrollee with a notice of his or her right to request a fair hearing.

viii) In instances where an MMC Enrollee requests Disenrollment due to MMC exclusion, the NYSoH or LDSS must notify the MMC Enrollee of the approval or denial of exclusion/Disenrollment status, including fair hearing rights if Disenrollment is denied.

ix) The NYSoH, Enrollment Broker or LDSS is responsible for ensuring that retroactive Disenrollments are used only when absolutely necessary. Circumstances warranting a retroactive Disenrollment are rare and include when comprehensive third party health insurance has provided coverage or agrees to provide coverage for an infant OR the infant and mother effective on the infant's date of birth; an Enrollee is determined to have been non-consensually enrolled in a MCO; he or she enters or resides in a residential institution under circumstances which render the individual excluded from the MMC program; is incarcerated; he or she is in a psychiatric hospital under circumstances which render the individual

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excluded from managed care; is simultaneously in receipt of comprehensive health care coverage from an MCO and is enrolled in either the MMC or FHPlus product of the same MCO; or he or she has died

x) The SDOH may recover premiums paid for Medicaid or FHPlus Enrollees whose eligibility for those programs was based on false information, when such false information was provided as a result of intentional actions or failures to act on the part of an employee of the Contractor; and the Contractor shall have no right of recourse against the Enrollee or a provider of service for the cost of services provided to the Enrollee for the period covered by such premiums.

xi) The NYSoH or LDSS is responsible for notifying the Contractor of the retroactive Disenrollment prior to the action. Once this information is obtained, the NYSoH or LDSS and Contractor will agree on a retroactive Disenrollment or prospective Disenrollment date.

xii) In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the NYSoH, Enrollment Broker or LDSS is responsible for sending notice to the Contractor at the time of Disenrollment, of the Contractor's responsibility to submit to the SDOH's Fiscal Agent voided premium claims within thirty (30) business days of notification from the NYSoH, Enrollment Broker, or LDSS for any full months of retroactive Disenrollment.

xiii) The NYSoH, Enrollment Broker or LDSS is responsible for promptly notifying the Contractor electronically or in writing of a MMC Enrollee in foster care whose eligibility or placement status changes such that he/she is disenrolled by the NYSoH, Enrollment Broker or LDSS, or is transferred to another MCO.

xiv) Failure by the NYSoH, Enrollment Broker, or LDSS to notify the Contractor of a disenrollment does not affect the right of the SDOH to withhold or recover capitation payment(s) as authorized by Section 3.6 of this Agreement or for the State Attorney General to bring legal action to recover any overpayment.

xv) Generally the effective dates of Disenrollment are prospective. Effective dates for other than routine Disenrollments are described below:

| Reason for Disenrollment | Effective Date of Disenrollment |
|---|---|
| A) Death of Enrollee | First day of the month after death |
| B) Incarceration | First day of the first full month of incarceration<br>• Contractor is responsible for all covered services before incarceration;<br>• Contractor is responsible for the full duration of any hospitalization that commences during a month in which the Contractor is eligible to receive a capitation payment for the incarcerated Enrollee;<br>• Contractor is entitled to the capitation payment |

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|---|---|
| | for the month prior to the first full month of incarceration. |
| C) MMC Enrollee entered or stayed in a residential institution or institutional care facility under circumstances which rendered the individual excluded from managed care, or is in receipt of waivered services through the Long Term Home Health Care Program (LTHHCP), including when an Enrollee is admitted to a hospital that 1) is certified by Medicare as a long-term care hospital and 2) has an average length of stay for all patients greater than ninety-five (95) days as reported in the Statewide Planning and Research Cooperative System (SPARCS) Annual Report 2002. Effective upon DHHS approval, this exclusion will no longer be applicable to individuals receiving waivered services through the LTHHCP. | First day of the first full month in an institution while having Permanent Placement Status<br><br>• Contractor is responsible for all covered services until Enrollee has entered an institution and been assigned Permanent Placement Status; and<br>• Contractor is entitled to the capitation payment for the month prior to the first full month in an institution while having Permanent Placement Status. |
| D) Individual's effective date of Enrollment or autoassignment into a MMC product occurred while meeting institutional criteria in (C) above | Effective Date of Enrollment in the Contractor's Plan |
| E) Non-consensual Enrollment | First day of the month of Enrollment |
| F) MMC Enrollee is simultaneously enrolled or in receipt of ~~c~~Comprehensive Third Party ~~h~~Health ~~care~~Insurance coverage ~~through another product offered by the Contractor (or a parent, subsidiary, or sister entity)~~ | First day of the first full month of simultaneous coverage |
| G) MMC Enrollee is simultaneously enrolled or in receipt of comprehensive health care coverage through any government health insurance program | First day of the first full month of simultaneous coverage |
| H) When third party commercial health insurance provided comprehensive health care coverage or agrees to provide coverage for an infant, or the infant and mother effective on the infant's date of birth | First day of the month of the infant's birth<br><br>Except if the mother was enrolled prior to the month of the infant's birth, then (just for the mother) the first day of the month following the month of the infant's birth |
| I) When an MMC Enrollee is a child whose status or placement in foster care is changing, such that the MMC Enrollee is no longer eligible to be enrolled in the MMC program, either entering or being discharged, or changing placement arrangements | The earlier of the first day of the month after the receipt of foster care services begins or after the Enrollee's status or placement in foster care is indicated in the applicable system |
| J) When an Enrollee no longer resides in Contractor's service area | First day of the first full month after Enrollee moved out of the Contractor's service area |
| K) When an Enrollee no longer resides in New York State | First day of the first full month after residency is established outside of New York State or effective date of other health insurance coverage outside of New York State |
| L) When an MMC Enrollee is otherwise ineligible to be enrolled pursuant to this Agreement or State or federal law | First day of the first full month after the individual became ineligible |

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xvi) The NYSoH, Enrollment Broker or LDSS is responsible for rendering a determination and responding within thirty (30) days of the receipt of a fully documented request for Disenrollment, except for Contractor-initiated Disenrollments where the NYSoH or LDSS decision must be made within fifteen (15) days. The NYSoH or LDSS, to the extent possible, is responsible for processing an expedited Disenrollment within two (2) business days of its determination that an expedited Disenrollment is warranted. To the extent possible, the NYSoH or LDSS is responsible for processing Disenrollment from the HIV SNP Program within two (2) business days of its determination that a Disenrollment is warranted.

xvii) The Contractor must respond timely to NYSoH, Enrollment Broker or LDSS inquiries regarding Good Cause Disenrollment requests to enable the NYSoH, LDSS or Enrollment Broker to make a determination within thirty (30) days of the receipt of the request from the Enrollee.

xviii) The NYSoH, Enrollment Broker or LDSS is responsible for sending the following notices to Enrollees regarding their Disenrollment status. Where practicable, the process will allow for timely notification to Enrollees unless there is Good Cause to disenroll more expeditiously.

A) Notice of Disenrollment: This notice will advise the Enrollee of the NYSoH, Enrollment Broker or LDSS's determination regarding an Enrollee-initiated, NYSoH or LDSS-initiated or Contractor-initiated Disenrollment and will include the Effective Date of Disenrollment. In cases where the Enrollee is being involuntarily disenrolled, the notice must contain fair hearing rights.

B) When the NYSoH, Enrollment Broker or LDSS denies any Enrollee's request for Disenrollment pursuant to Section 8 of this Agreement, the NYSoH, Enrollment Broker or LDSS is responsible for informing the Enrollee in writing, explaining the reason for the denial, stating the facts upon which the denial is based, citing the statutory and regulatory authority and advising the Enrollee of his/her right to a fair hearing pursuant to 18NYCRR Part 358.

C) End of Lock-In Notice: Where Lock-In provisions are applicable, Enrollees must be notified sixty (60) days before the end of their Lock-In Period. The SDOH or its designee is responsible for notifying Enrollees of this provision.

xix) In the FHPlus program, a FHPlus Enrollee disenrolled at the request of the Contractor, may choose another MCO offering a FHPlus product. If the FHPlus Enrollee does not choose, or there is not another MCO offering FHPlus in the LDSS jurisdiction, the case will be closed.

xx) In those instances where the NYSoH or LDSS approves the Contractor's request to disenroll an Enrollee, and the Enrollee requests a fair hearing, the Enrollee will remain enrolled in the Contractor's MMC or FHPlus product until the disposition

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of the fair hearing if Aid to Continue is ordered by the New York State Office of Administrative Hearings.

xxi) The NYSoH or LDSS is responsible for reviewing each Contractor-requested Disenrollment in accordance with the provisions of Section 8.7 of this Agreement and this Appendix. Where applicable, the NYSoH or LDSS may consult with local mental health and Substance Use Disorder authorities in the district when making the determination to approve or disapprove the request.

xxii) The SDOH, NYSoH or LDSS is responsible for establishing procedures whereby the Contractor refers cases which are appropriate for an SDOH, NYSoH or LDSS-initiated Disenrollment and submits supporting documentation to the SDOH, NYSoH or LDSS.

xxiii) After the NYSoH, Enrollment Broker or LDSS receives and, if appropriate, approves the request for Disenrollment either from the Enrollee or the Contractor, the NYSoH, Enrollment Broker or LDSS is responsible for updating the appropriate state systems with an end date. The Enrollee is removed from the Contractor's Roster or NYSoH sends the Contractor a 834 file indicating the Enrollee's disenrollment. If the Enrollee is not otherwise exempt or excluded, he/she will be required to enroll in another MMC product.

xxiv) In the event that the NYSoH, Enrollment Broker, or LDSS determination of the request for Disenrollment is not within timeframes specified in Appendix H of this Agreement, the disenrollment is considered approved for the effective date that would have been established had the NYSoH, Enrollment Broker, or LDSS made the determination within timeframes specified in Appendix H of this Agreement.

xxv) The NYSoH Enrollment Broker, or LDSS is responsible for promptly disenrolling an MMC Enrollee who has requested disenrollment without cause for circumstances described in Section 8.6(d) of this Agreement.

b) Contractor Responsibilities:

i) The Contractor must accept and transmit all requests for transfers from its Enrollees to the NYSoH, LDSS or Enrollment Broker, and shall not impose any barriers to Disenrollment requests.

ii) The Contractor will make a good faith effort to identify cases which may be appropriate for an NYSoH or LDSS-initiated Disenrollment. Within five (5) business days of identifying such cases and following NYSoH or LDSS procedures, the Contractor will, in writing or electronically, refer cases which are appropriate for an NYSoH or LDSS-initiated Disenrollment and will submit supporting documentation to the NYSoH or LDSS. This includes changes in status for its Enrollees that may impact eligibility for Enrollment, including, but not limited to address changes, incarceration, death, exclusion from the MMC

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program, the apparent enrollment of a member in the Contractor's MMC or FHPlus product under more than one CIN, or the availability of Third Party Health Insurance (TPHI) to the Enrollee.

iii) Pursuant to Section 8.7 of this Agreement, the Contractor may initiate an involuntary Disenrollment if the Enrollee engages in conduct or behavior that seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees, provided that the Contractor has made and documented reasonable efforts to resolve the problems presented by the Enrollee.

iv) The Contractor may not request Disenrollment because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs (except where continued Enrollment in the Contractor's MMC or FHPlus product seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees).

v) The Contractor must make a reasonable effort to identify for the Enrollee, both verbally and in writing, those actions of the Enrollee that have interfered with the effective provision of covered services as well as explain what actions or procedures are acceptable.

vi) The Contractor shall give prior verbal and written notice to the Enrollee, with a copy to the NYSoH or LDSS, of its intent to request Disenrollment. The copy of the notice to the NYSoH or LDSS must include the documentation of reasonable efforts. The written notice shall advise the Enrollee that the request has been forwarded to the NYSoH or LDSS for review and approval. The written notice must include the mailing address and telephone number of the NYSoH or LDSS.

vii) The Contractor shall keep the NYSoH or LDSS informed of decisions related to all complaints filed by an Enrollee as a result of, or subsequent to, the notice of intent to disenroll.

viii) The Contractor will not consider an Enrollee disenrolled without confirmation from the NYSoH or LDSS as described in Section 5 of this Appendix.

ix) [Applicable to HIV SNP Program only]: The HIV SNP Contractor will prepare a written discharge plan to assure continuity of care at the time of Disenrollment. With the Enrollee's consent, information will also be provided on and referrals provided to case management resources and primary care providers. The Contractor will provide the discharge plan to the Enrollee within fifteen (15) days of the notice of or request for Disenrollment and, with the Enrollee's consent, to his or her designated provider.

x) [Applicable to children in foster care only]: The Contractor will prepare a written discharge plan to assure continuity of care at the time of Disenrollment. Information will also be provided on and referrals provided to case management



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resources and primary care providers. The discharge plan should be provided to the Enrollee or his/her legal guardian, his/her designated care provider, and the NYSoH or LDSS within fifteen (15) days of the notice of or request for Disenrollment.

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# APPENDIX I

## New York State Department of Health
## Guidelines for Use of Medical Residents and Fellows

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# Medical Residents and Fellows

**1. Medical Residents and Fellows for Primary Care**.

a) The Contractor may utilize medical residents and fellows as participants (but not designated as 'primary care providers') in the care of Enrollees as long as all of the following conditions are met:

i) Residents/fellows are a part of patient care teams headed by fully licensed and Contractor credentialed attending physicians serving patients in one or more training sites in an "up weighted" or "designated priority" residency program. Residents/fellows in a training program which was disapproved as a designated priority program solely due to the outcome measurement requirement for graduates may be eligible to participate in such patient care teams.

ii) Only the attending physicians and certified nurse practitioners on the training team, not residents/fellows, may be credentialed to the Contractor and may be empanelled with Enrollees. Enrollees must be assigned an attending physician or certified nurse practitioner to act as their PCP, though residents/fellows on the team may provide care during all or many of the visits to the Enrollee as long as the majority of these visits are under the direct supervision of the Enrollee's designated PCP. Enrollees have the right to request and receive care by their PCP in addition or instead of being seen by a resident or fellow.

iii) Residents/fellows may work with attending physicians and certified nurse practitioners to provide continuity of care to patients under the supervision of the patient's PCP. Patients must be made aware of the resident/fellow and attending PCP relationship and be informed of their rights to be cared for directly by their PCP.

iv) Residents/fellows eligible to be involved in a continuity relationship with patients must be available at least twenty percent (20%) of the total training time in the continuity of care setting and no less than ten percent (10%) of training time in any training year must be in the continuity of care setting and no fewer than nine (9) months a year must be spent in the continuity of care setting.

v) Residents/fellows meeting these criteria provide increased capacity for Enrollment to their team according to the formula below. Only hours spent routinely scheduled for patient care in the continuity of care training site may count as providing capacity and are based on 1.0 FTE=40 hours.

| | |
|---|---|
| PGY-1 | 300 per FTE |
| PGY-2 | 750 per FTE |
| PGY-3 | 1125 per FTE |
| PGY-4 and above | 1500 per FTE |



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vi) In order for a resident/fellow to provide continuity of care to an Enrollee, both the resident/fellow and the attending PCP must have regular hours in the continuity site and must be scheduled to be in the site together the majority of the time.

vii) A preceptor/attending is required to be present a minimum of sixteen (16) hours of combined precepting and direct patient care in the primary care setting to be counted as a team supervising PCP and accept an increased number of Enrollees based upon the residents/fellows working on his/her team. Time spent in patient care activities at other clinical sites or in other activities off-site is not counted towards this requirement.

viii) A sixteen (16) hour per week attending may have no more than four (4) residents/fellows on their team. Attendings spending twenty-four (24) hours per week in patient care/supervisory activity at the continuity site may have six (6) residents/fellows per team. Attendings spending thirty-two (32) hours per week may have eight (8) residents/fellows on their team. Two (2) or more attendings may join together to form a larger team as long as the ratio of attending to residents/fellows does not exceed 1:4 and all attendings comply with the sixteen (16) hour minimum.

ix) Responsibility for the care of the Enrollee remains with the attending physician. All attending and resident/fellow teams must provide adequate continuity of care, twenty-four (24) hour a day, seven (7) days a week coverage, and appointment and availability access. Enrollees must be given the name of the responsible primary care physician (attending) in writing and be told how he or she may contact the attending physician or covering physician, if needed.

x) Residents/fellows who do not qualify to act as continuity providers as part of an attending and resident/fellow team may still participate in the episodic care of Enrollees as long as that care is under the supervision of an attending physician credentialed to the Contractor. Such residents/fellows do not add to the capacity of that attending to empanel Enrollees.

xi) Certified nurse practitioners and registered physician's assistants may not act as attending preceptors for resident physicians or fellows.

**2. Medical Residents and Fellows as Specialty Care Providers**

a) Residents/fellows may participate in the specialty care of Enrollees in all settings supervised by fully licensed and Contractor credentialed specialty attending physicians.

b) Only the attending physicians, not residents or fellows, may be credentialed by the Contractor. Each attending must be credentialed by each MCO with which he or she will participate. Residents/fellows may perform all or many of the clinical services

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for the Enrollee as long as these clinical services are under the supervision of an appropriately credentialed specialty physician. Even when residents/fellows are credentialed by their program in particular procedures, certifying their competence to perform and teach those procedures, the overall care of each Enrollee remains the responsibility of the supervising Contractor credentialed attending.

c) The Contractor agrees that although many Enrollees will identify a resident or fellow as their specialty provider, the responsibility for all clinical decision-making remains ultimately with the attending physician of record.

d) Enrollees must be given the name of the responsible attending physician in writing and be told how they may contact their attending physician or covering physician, if needed. This allows Enrollees to assist in the communication between their primary care provider and specialty attending and enables them to reach the specialty attending if an emergency arises in the course of their care. Enrollees must be made aware of the resident/fellow and attending relationship and must have a right to be cared for directly by the responsible attending physician, if requested.

e) Enrollees requiring ongoing specialty care must be cared for in a continuity of care setting. This requires the ability to make follow-up appointments with a particular resident/fellow and attending physician team, or if that provider team is not available, with a member of the provider's coverage group in order to insure ongoing responsibility for the patient by his/her Contractor credentialed specialist. The responsible specialist and his/her specialty coverage group must be identifiable to the patient as well as to the referring primary care provider.

f) Attending specialists must be available for emergency consultation and care during non-clinic hours. Emergency coverage may be provided by residents/fellows under adequate supervision. The attending or a member of the attending's coverage group must be available for telephone and/or in-person consultation when necessary.

g) All training programs participating in the MMC or FHPlus Program must be accredited by the appropriate academic accrediting agency.

h) All sites in which residents/fellows train must produce legible (preferably typewritten) consultation reports. Reports must be transmitted such that they are received in a time frame consistent with the clinical condition of the patient, the urgency of the problem and the need for follow-up by the primary care physician. At a minimum, reports should be transmitted so that they are received no later than two (2) weeks from the date of the specialty visit.

i) Written reports are required at the time of initial consultation and again with the receipt of all major significant diagnostic information or changes in therapy. In addition, specialists must promptly report to the referring primary care physician any significant findings or urgent changes in therapy which result from the specialty consultation.

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## 3. Training Sites

All training sites must deliver the same standard of care to all patients irrespective of payor. Training sites must integrate the care of Medicaid, FHPlus, uninsured and private patients in the same settings.

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# APPENDIX J

# New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act

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## I. OBJECTIVES

Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include State and local government and ADA and Section 504 requirements extend to all programs and services provided by State and local government. Since MMC and FHPlus are government programs, health services provided through MMC and FHPlus Programs must be accessible to all that qualify for them.

Contractor responsibilities for compliance with the ADA are imposed under Title II and Section 504 when, as a Contractor in a MMC or FHPlus Program, a Contractor is providing a government service. If an individual provider under contract with the Contractor is not accessible, it is the responsibility of the Contractor to make arrangements to assure that alternative services are provided. The Contractor may determine it is expedient to make arrangements with other providers, or to describe reasonable alternative means and methods to make these services accessible through its existing Participating Providers. The goals of compliance with ADA Title II requirements are to offer a level of services that allows people with disabilities access to the program in its entirety, and the ability to achieve the same health care results as any Enrollee.

Contractor responsibilities for compliance with the ADA are also imposed under Title III when the Contractor functions as a public accommodation providing services to individuals (e.g. program areas and sites such as Marketing, education, member services, orientation, Complaints and Appeals). The goals of compliance with ADA Title III requirements are to offer a level of services that allows people with disabilities full and equal enjoyment of the goods, services, facilities or accommodations that the entity provides for its customers or clients. New and altered areas and facilities must be as accessible as possible. Whenever Contractors engage in new construction or renovation, compliance is also required with accessible design and construction standards promulgated pursuant to the ADA as well as State and local laws. Title III also requires that public accommodations undertake “readily achievable barrier removal” in existing facilities where architectural and communications barriers can be removed easily and without much difficulty or expense.

The State uses MCO Qualification Standards to qualify MCOs for participation in the MMC and FHPlus Programs. Pursuant to the State’s responsibility to assure program access to all Enrollees, the Plan Qualification Standards require each MCO to submit an ADA Compliance Plan that describes in detail how the MCO will make services, programs and activities readily accessible and useable by individuals with disabilities. In the event that certain program sites are not readily accessible, the MCO must describe reasonable alternative methods for making the services or activities accessible and usable.

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The objectives of these guidelines are threefold:

- To ensure that Contractors take appropriate steps to measure access and assure program accessibility for persons with disabilities;
- To provide a framework for Contractors as they develop a plan to assure compliance with the Americans with Disabilities Act (ADA); and
- To provide standards for the review of the Contractor Compliance Plans.

These guidelines include a general standard followed by a discussion of specific considerations and suggestions of methods for assuring compliance. Please be advised that, although these guidelines and any subsequent reviews by State and local governments can give the Contractor guidance, it is ultimately the Contractor's obligation to ensure that it complies with its Contractual obligations, as well as with the requirements of the ADA, Section 504, and other federal, state and local laws. Other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and may impose requirements in addition to those established under ADA. For example, while the ADA covers those impairments that "substantially" limit one or more of the major life activities of an individual, New York City Human Rights Law deletes the modifier "substantially".

## II. DEFINITIONS

A. "Auxiliary aids and services" may include qualified interpreters, note takers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for Enrollees who are deaf or hard of hearing (TTY/TDD), video test displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments; qualified readers, taped texts, audio recordings, Braille materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.

B. "Disability" means a mental or physical impairment that substantially limits one or more of the major life activities of an individual; a record of such impairment; or being regarded as having such an impairment.

## III. SCOPE OF CONTRACTOR COMPLIANCE PLAN

The Contractor Compliance Plan must address accessibility to services at Contractor's program sites, including both Participating Provider sites and Contractor facilities intended for use by Enrollees.

## IV. PROGRAM ACCESSIBILITY

Public programs and services, when viewed in their entirety must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-

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discrimination in policies and procedures and communication. Communications with individuals with disabilities are required to be as effective as communications with others. The Contractor Compliance Plan must include a detailed description of how Contractor services, programs, and activities are readily accessible and usable by individuals with disabilities. In the event that full physical accessibility is not readily available for people with disabilities, the Contractor Compliance Plan will describe the steps or actions the Contractor will take to assure accessibility to services equivalent to those offered at the inaccessible facilities.

## A. OUTREACH/ADVERTISING AND EDUCATION

### STANDARD FOR COMPLIANCE

Enrollment staff and outreach/advertising materials will be made available to persons with disabilities. Outreach/advertising materials will be made available in alternative formats (such as Braille, large print, and audiotapes) so that they are readily usable by people with disabilities.

### SUGGESTED METHODS FOR COMPLIANCE

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes training and information regarding attitudinal barriers related to disability
4. Enrollee health promotion material/activities targeted specifically to persons with disabilities (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
5. Policy statement that enrollment staff will offer to read or summarize to blind or vision impaired individuals any written material that is typically distributed to all Enrollees
6. Staff/resources available to assist individuals with cognitive impairments in understanding materials

### COMPLIANCE PLAN SUBMISSION

1. A description of methods to ensure that the Contractor's outreach/advertising presentations (materials and communications) are accessible to persons with auditory, visual and cognitive impairments

## B. MEMVER SERVICES DEPARTMENT

Member services functions include the provision to Enrollees of information necessary to make informed choices about treatment options, to effectively utilize the health care resources, to assist Enrollees in making appointments, and to field questions and Complaints, to assist Enrollees with the Complaint process.

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## B1. ACCESSIBILITY

### STANDARD FOR COMPLIANCE

Member Services sites and functions will be made accessible to and usable by, people with disabilities.

**SUGGESTED METHODS FOR COMPLIANCE** (include, but are not limited to those identified below):

1. Exterior routes of travel, at least 36" wide, from parking areas or public transportation stops into the Contractor's facility
2. If parking is provided, spaces reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs
3. Routes of travel into the facility are stable, slip-resistant, with all steps > ½" ramped, doorways with minimum 32" opening
4. Interior halls and passageways providing a clear and unobstructed path or travel at least 36" wide to bathrooms and other rooms commonly used by Enrollees
5. Waiting rooms, restrooms, and other rooms used by Enrollees are accessible to people with disabilities
6. Sign language interpreters and other auxiliary aids and services provided in appropriate circumstances
7. Materials available in alternative formats, such as Braille, large print, audio tapes
8. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
9. Availability of activities and educational materials tailored to specific conditions/illnesses and secondary conditions that affect these populations (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
10. Contractor staff trained in the use of telecommunication devices for Enrollees who are deaf or hard of hearing (TTY/TDD) as well as in the use of NY Relay for phone communication
11. New Enrollee orientation available in audio or by interpreter services
12. Policy that when member services staff receive calls through the NY Relay, they will offer to return the call utilizing a direct TTY/TDD connection

### COMPLIANCE PLAN SUBMISSION

1. A description of accessibility to the Contractor's member services department or reasonable alternative means to access member services for Enrollees using wheelchairs (or other mobility aids)
2. A description of the methods the Contractor's member services department will use to communicate with Enrollees who have visual or hearing impairments, including any necessary auxiliary aid/services for Enrollees who are deaf or hard of hearing, and TTY/TDD technology or NY Relay service available through a toll-free telephone number

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3. A description of the training provided to the Contractor's member services staff to assure that staff adequately understands how to implement the requirements of the program, and of these guidelines, and are sensitive to the needs of persons with disabilities

## B2. IDENTIFICATION OF ENROLLEES WITH DISABILITIES

### STANDARD FOR COMPLIANCE

The Contractor must have in place satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services etc. The Contractor may not discriminate against a Prospective Enrollee based on his/her current health status or anticipated need for future health care. The Contractor may not discriminate on the basis of disability, or perceived disability of an Enrollee or their family member. Health assessment forms may not be used by the Contractor prior to Enrollment. Once a MCO has been chosen, a health assessment form may be used to assess the person's health care needs.

### SUGGESTED METHODS FOR COMPLIANCE

1. Appropriate post Enrollment health screening for each Enrollee, using an appropriate health screening tool
2. Patient profiles by condition/disease for comparative analysis to national norms, with appropriate outreach and education
3. Process for follow-up of needs identified by initial screening; e.g. referrals, assignment of case manager, assistance with scheduling/keeping appointments
4. Enrolled population disability assessment survey
5. Process for Enrollees who acquire a disability subsequent to Enrollment to access appropriate services

### COMPLIANCE PLAN SUBMISSION

A description of how the Contractor will identify special health care, physical access or communication needs of Enrollees on a timely basis, including but not limited to the health care needs of Enrollees who:

- are blind or have visual impairments, including the type of auxiliary aids and services required by the Enrollee
- are deaf or hard of hearing, including the type of auxiliary aids and services required by the Enrollee
- have mobility impairments, including the extent, if any, to which they can ambulate
- have other physical or mental impairments or disabilities, including cognitive impairments
- have conditions which may require more intensive case management

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## B3. NEW ENROLLEE ORIENTATION

### STANDARD FOR COMPLIANCE

Enrollees will be given information sufficient to ensure that they understand how to access medical care through the Contractor. This information will be made accessible to and usable by people with disabilities.

### SUGGESTED METHODS FOR COMPLIANCE

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
4. Activities and fairs that include sign language interpreters or the distribution of a written summary of the Marketing script used by Contractor marketing representatives
5. Include in written/audio materials available to all Enrollees information regarding how and where people with disabilities can access help in getting services, for example help with making appointments or for arranging special transportation, an interpreter or assistive communication devices
6. Staff/resources available to assist individuals with cognitive impairments in understanding materials

### COMPLIANCE PLAN SUBMISSION

1. A description of how the Contractor will advise Enrollees with disabilities, during the new Enrollee orientation on how to access care
2. A description of how the Contractor will assist new Enrollees with disabilities (as well as current Enrollees who acquire a disability) in selecting or arranging an appointment with a Primary Care Practitioner (PCP)
   - This should include a description of how the Contractor will assure and provide notice to Enrollees who are deaf or hard of hearing, blind or who have visual impairments, of their right to obtain necessary auxiliary aids and services during appointments and in scheduling appointments and follow-up treatment with Participating Providers
   - In the event that certain provider sites are not physically accessible to Enrollees with mobility impairments, the Contractor will assure that reasonable alternative site and services are available
3. A description of how the Contractor will determine the specific needs of an Enrollee with or at risk of having a disability/chronic disease, in terms of specialist physician referrals, durable medical equipment (including assistive technology and adaptive

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equipment), medical supplies and home health services and will assure that such contractual services are provided

4. A description of how the Contractor will identify if an Enrollee with a disability requires on-going mental health services and how the Contractor will encourage early entry into treatment
5. A description of how the Contractor will notify Enrollees with disabilities as to how to access transportation, where applicable

## B4. COMPLAINTS, COMPLAINT APPEALS AND ACTION APPEALS

### STANDARD FOR COMPLIANCE

The Contractor will establish and maintain a procedure to protect the rights and interests of both Enrollees and the Contractor by receiving, processing, and resolving Complaints, Complaint Appeals and Action Appeals in an expeditious manner, with the goal of ensuring resolution of Complaints, Complaint Appeals, and Action Appeals and access to appropriate services as rapidly as possible.

All Enrollees must be informed about the Grievance System within their Contractor and the procedure for filing Complaints, Complaint Appeals and Action Appeals. This information will be made available through the Member Handbook, SDOH toll-free Complaint line [1-(800) 206-8125] and the Contractor's Complaint process annually, as well as when the Contractor denies a benefit or referral. The Contractor will inform Enrollees of the Contractor's Grievance System; Enrollees' right to contact the LDSS or SDOH with a Complaint, and to file a Complaint Appeal, Action Appeal or request a fair hearing; the right to appoint a designee to handle a Complaint, Complaint Appeal or Action Appeal; and the toll free Complaint line. The Contractor will maintain designated staff to take and process Complaints, Complaint Appeals and Action Appeals, and be responsible for assisting Enrollees in Complaint, Complaint Appeal or Action Appeal resolution.

The Contractor will make all information regarding the Grievance System available to and usable by people with disabilities, and will assure that people with disabilities have access to sites where Enrollees typically file Complaints and requests for Complaint Appeals and Action Appeals.

### SUGGESTED METHODS FOR COMPLIANCE

1. Toll-free Complaint phone line with TDD/TTY capability
2. Staff trained in Complaint process, and able to provide interpretive or assistive support to Enrollee during the Complaint process
3. Notification materials and Complaint forms in alternative formats for Enrollees with visual or hearing impairments
4. Availability of physically accessible sites, e.g. member services department sites
5. Assistance for individuals with cognitive impairments

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**COMPLIANCE PLAN SUBMISSION**

1. A description of how the Contractor's Complaint, Complaint Appeals and Action Appeal procedures shall be accessible for persons with disabilities, including:
   - procedures for Complaints, Complaint Appeals and Action Appeals to be made in person at sites accessible to persons with mobility impairments
   - procedures accessible to persons with sensory or other impairments who wish to make verbal Complaints, Complaint Appeals or Action Appeals, and to communicate with such persons on an ongoing basis as to the status or their Complaints and rights to further appeals
   - description of methods to ensure notification material is available in alternative formats for Enrollees with vision and hearing impairments
2. A description of how the Contractor monitors Complaints, Complaint Appeals and Action Appeals related to people with disabilities. Also, as part of the Compliance Plan, the Contractor must submit a summary report based on the Contractor's most recent year's Complaints, Complaint Appeals and Action Appeals data.

## C. CASE MANAGEMENT

**STANDARD FOR COMPLIANCE**

The Contractor must have in place adequate case management systems to identify the service needs of all Enrollees, including Enrollees with chronic illness and Enrollees with disabilities, and ensure that medically necessary covered benefits are delivered on a timely basis. These systems must include procedures for standing referrals, specialists as PCPs, and referrals to specialty centers for Enrollees who require specialized medical care over a prolonged period of time (as determined by a treatment plan approved by the Contractor in consultation with the primary care provider, the designated specialist and the Enrollee or his/her designee), out-of-network referrals and continuation of existing treatment relationships with out-of-network providers (during transitional period).

**SUGGESTED METHODS FOR COMPLIANCE**

1. Procedures for requesting specialist physicians to function as PCP
2. Procedures for requesting standing referrals to specialists and/or specialty centers, out-of-network referrals, and continuation of existing treatment relationships
3. Procedures to meet Enrollee needs for, durable medical equipment, medical supplies, home visits as appropriate
4. Appropriately trained Contractor staff to function as case managers for special needs populations, or sub-contract arrangements for case management
5. Procedures for informing Enrollees about the availability of case management services, including Health Home care management services.

**COMPLIANCE PLAN SUBMISSION**

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1. A description of the Contractor case management program for people with disabilities, including case management functions, procedures for qualifying for and being assigned a case manager, and description of case management staff qualifications
2. A description of the Contractor's model protocol to enable Participating Providers, at their point of service, to identify Enrollees who require a case manager
3. A description of the Contractor's protocol for assignment of specialists as PCP, and for standing referrals to specialists and specialty centers, out-of-network referrals and continuing treatment relationships
4. A description of the Contractor's notice procedures to Enrollees regarding the availability of case management services, specialists as PCPs, standing referrals to specialists and specialty centers, out-of-network referrals and continuing treatment relationships

## D. PARTICIPATING PROVIDERS

### STANDARD FOR COMPLIANCE

The Contractor's network will include all the provider types necessary to furnish the Benefit Package, to assure appropriate and timely health care to all Enrollees, including those with chronic illness and/or disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, e.g. exam tables and medical equipment.

### SUGGESTED METHODS FOR COMPLIANCE

1. Process for the Contractor to evaluate provider network to ascertain the degree of provider accessibility to persons with disabilities, to identify barriers to access and required modifications to policies/procedures
2. Model protocol to assist Participating Providers, at their point of service, to identify Enrollees who require case manager, audio, visual, mobility aids, or other accommodations
3. Model protocol for determining needs of Enrollees with mental disabilities
4. Use of Wheelchair Accessibility Certification Form (see attached)
5. Submission of map of physically accessible sites
6. Training for providers re: compliance with Title III of ADA, e.g. site access requirements for door widths, wheelchair ramps, accessible diagnostic/treatment rooms and equipment; communication issues; attitudinal barriers related to disability, etc. [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities -V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212) 788-2838].
7. Use of NYS Office of Persons with Disabilities (OAPD) ADA Accessibility Checklist for Existing Facilities and NYC Addendum to OAPD ADA Accessibility Checklist as guides for evaluating existing facilities and for new construction and/or alteration.

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**COMPLIANCE PLAN SUBMISSION**

1. A description of how the Contractor will ensure that its Participating Provider network is accessible to persons with disabilities. This includes the following:
   - Policies and procedures to prevent discrimination on the basis of disability or type of illness or condition
   - Identification of Participating Provider sites which are accessible by people with mobility impairments, including people using mobility devices. If certain provider sites are not physically accessible to persons with disabilities, the Contractor shall describe reasonable, alternative means that result in making the provider services readily accessible.
   - Identification of Participating Provider sites which do not have access to sign language interpreters or reasonable alternative means to communicate with Enrollees who are deaf or hard of hearing; and for those sites describe reasonable alternative methods to ensure that services will be made accessible
   - Identification of Participating Providers which do not have adequate communication systems for Enrollees who are blind or have vision impairments (e.g. raised symbol and lettering or visual signal appliances), and for those sites describe reasonable alternative methods to ensure that services will be made accessible
2. A description of how the Contractor's specialty network is sufficient to meet the needs of Enrollees with disabilities
3. A description of methods to ensure the coordination of out-of-network providers to meet the needs of the Enrollees with disabilities
   - This may include the implementation of a referral system to ensure that the health care needs of Enrollees with disabilities are met appropriately
   - The Contractor shall describe policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when in the best interest of the Enrollee with a disability
4. Submission of the ADA Compliance Summary Report or Contractor statement that data submitted to SDOH on the Health Commerce System (HCS) files is an accurate reflection of each network's physical accessibility

## E. POPULATIONS WITH SPECIAL HEALTH CARE NEEDS

**STANDARD FOR COMPLIANCE**

The Contractor will have satisfactory methods for identifying persons at risk of, or having, chronic disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. The Contractor will have satisfactory systems for coordinating service delivery and, if necessary, procedures to allow continuation of existing relationships with out-of-network provider for course of treatment.

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**SUGGESTED METHODS FOR COMPLIANCE**

1. Procedures for requesting standing referrals to specialists and/or specialty centers, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships with out-of-network providers for course of treatment
2. Linkages with behavioral health agencies, disability and advocacy organizations, etc.
3. Adequate network of providers and sub-specialists (including pediatric providers and sub-specialists) and contractual relationships with tertiary institutions
4. Procedures for assuring that these populations receive appropriate diagnostic work-ups on a timely basis
5. Procedures for assuring that these populations receive appropriate access to durable medical equipment on a timely basis
6. Procedures for assuring that these populations receive appropriate allied health professionals (Physical, Occupational and Speech Therapists, Audiologists) on a timely basis
7. State designation as a Well Qualified Plan to serve the OPWDD population and look-alikes

**COMPLIANCE PLAN SUBMISSION**

1. A description of arrangements to ensure access to specialty care providers and centers in and out of New York State, standing referrals, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships (out-of-network) for diagnosis and treatment of rare disorders
2. A description of appropriate service delivery for children with disabilities. This may include a description of methods for interacting with school districts, child protective service agencies, early intervention officials, behavioral health, and disability and advocacy organizations.
3. A description of the sub-specialist network, including contractual relationships with tertiary institutions to meet the health care needs of people with disabilities

## F. ADDITIONAL ADA RESPONSIBILITIES FOR PUBLIC ACCOMMODATIONS

Please note that Title III of the ADA applies to all non-governmental providers of health care. Title III of the Americans with Disabilities Act prohibits discrimination on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation. A public accommodation is a private entity that owns, leases or leases to, or operates a place of public accommodation. Places of public accommodation identified by the ADA include, but are not limited to, stores (including pharmacies) offices (including doctors' offices), hospitals, health care providers, and social service centers.

New and altered areas and facilities must be as accessible as possible. Barriers must be removed from existing facilities when it is readily achievable, defined by the ADA as easily accomplishable without much difficulty or expense. Factors to be considered when determining if barrier removal is readily achievable include the cost of the action, the financial resources of

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the site involved, and, if applicable, the overall financial resources of any parent corporation or entity. If barrier removal is not readily achievable, the ADA requires alternate methods of making goods and services available. New facilities must be accessible unless structurally impracticable.

Title III also requires places of public accommodation to provide any auxiliary aids and services that are needed to ensure equal access to the services it offers, unless a fundamental alteration in the nature of services or an undue burden would result. Auxiliary aids include but are not limited to qualified sign interpreters, assistive listening systems, readers, large print materials, etc. Undue burden is defined as "significant difficulty or expense". The factors to be considered in determining "undue burden" include, but are not limited to, the nature and cost of the action required and the overall financial resources of the provider. "Undue burden" is a higher standard than "readily achievable" in that it requires a greater level of effort on the part of the public accommodation.

Please note also that the ADA is not the only law applicable for people with disabilities. In some cases, State or local laws require more than the ADA. For example, New York City's Human Rights Law, which also prohibits discrimination against people with disabilities, includes people whose impairments are not as "substantial" as the narrower ADA and uses the higher "undue burden" ("reasonable") standard where the ADA requires only that which is "readily achievable". New York City's Building Code does not permit access waivers for newly constructed facilities and requires incorporation of access features as existing facilities are renovated. Finally, the State Hospital code sets a higher standard than the ADA for provision of communication (such as sign language interpreters) for services provided at most hospitals, even on an outpatient basis.

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# APPENDIX K

# PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

**K.1** **Chart of Prepaid Benefit Package**
**- Medicaid Managed Care Non-SSI (MMC Non-SSI)**
**- Medicaid Managed Care SSI (MMC SSI/SSI-Related)**
**- Medicaid Fee-for-Service (MFFS)**
**- Family Health Plus (FHPlus)**
**- Health and Recovery Plan (HARP)**

**K.1 HIV** **Chart of Prepaid Benefit Package**
**- HIV SNP Non-SSI**
**- HIV SNP HIV/AIDS SSI**
**- HIV SNP Uninfected SSI Children and Homeless Adults**
**- Medicaid Fee-for-Service (MFFS)**

**K.2** **Prepaid Benefit Package Definitions of Covered Services**

**K.3** **Medicaid Managed Care Definitions of Non-Covered Services**

**K.4** **Family Health Plus Non-Covered Services**

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# APPENDIX K
# PREPAID BENEFIT PACKAGE
# DEFINITIONS OF COVERED AND NON-COVERED SERVICES

## 1. General

a) The categories of services in the Medicaid Managed Care and Family Health Plus Benefit Packages, including optional covered services, shall be provided by the Contractor to MMC Enrollees and FHPlus Enrollees, respectively, when medically necessary under the terms of this Agreement. The definitions of covered and non-covered services herein are in summary form; the full description and scope of each covered service as established by the New York Medical Assistance Program are set forth in the applicable NYS Medicaid Provider Manual, except for the Eye Care and Vision benefit for FHPlus Enrollees which is described in Section 19 of Appendix K.2.

b) All care provided by the Contractor, pursuant to this Agreement, must be provided, arranged, or authorized by the Contractor or its Participating Providers with the exception of emergency transportation, Family Planning and Reproductive Health services, court ordered services, and services provided by Local Public Health Agencies as described in Section 10 of this Agreement. HIV SNP and HARP covered benefits may vary.

c) This Appendix contains the following sections:

i) K.1 - "Chart of Prepaid Benefit Package" lists the services provided by the Contractor to all Medicaid Managed Care Non-SSI/Non-SSI Related Enrollees, Medicaid Managed Care SSI/SSI-related Enrollees, Medicaid fee-for-service coverage for carved out and wraparound benefits, Family Health Plus Enrollees and HARP enrollees.

K.1 HIV - "Chart of HIV Special Needs Plan Prepaid Benefit Package" lists the services provided by the Contractor to all HIV SNP Non-SSI Enrollees, HIV SNP HIV/AIDS SSI Enrollees, HIV SNP Uninfected SSI Children and Homeless Adults, and Medicaid fee-for-service coverage for carved out and wraparound benefits.

ii) K.2 - "Prepaid Benefit Package Definitions Of Covered Services" describes the covered services, as numbered in K.1. Each service description applies to both MMC and FHPlus Benefit Package unless otherwise noted.

iii) K.3 - "Medicaid Managed Care Definitions of Non-Covered Services" describes services that are not covered by the MMC Benefit Package. These services are covered by the Medicaid fee-for-service program unless otherwise noted.

iv) K.4 - "Family Health Plus Non-Covered Services" lists the services that are not covered by the FHPlus Benefit Package.



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# K.1

# PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits
** No Medicaid fee-for-service wrap-around is available
Note: If cell is blank, there is no coverage.

| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | 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] | Stay covered only when 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 | Covered |
| 3. | Physician Services | Covered | Covered | | | Covered | Covered |
| 4. | Nurse Practitioner Services | Covered | Covered | | | Covered | Covered |
| 5. | Midwifery Services | Covered | Covered | | | Covered | Covered |
| 6. | Preventive Health Services | Covered | Covered | | | Covered | Covered |
| 7. | Second Medical/Surgical Opinion | Covered | Covered | | | Covered | Covered |
| 8. | Laboratory Services | Covered.<br><br>Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing | Covered.<br><br>Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing | Covered through 3/31/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing | | Covered | Covered,<br><br>Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing |
| 9. | Radiology Services | Covered | Covered | | | Covered | Covered |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 10. | Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula | Covered. Coverage excludes hemophilia blood factors. | Covered. Coverage excludes hemophilia blood factors | Hemophilia blood factors covered through MA FFS | | Covered. Coverage includes prescription drugs, insulin and diabetic supplies, smoking cessation agents, select OTCs, vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formulae. Hemophilia blood factors covered through MA FFS. | Covered, Coverage excludes hemophilia blood factors. |
| 11. | Smoking Cessation Products | Covered | Covered | | | Covered | Covered |
| 12. | Rehabilitation Services (not including Psychosocial Rehabilitation (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 for short term inpatient, and limited to 20 visits each per calendar year for outpatient PT, OT, and speech therapy. | 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 | | | Covered | |
| 14. | Home Health Services | Covered | Covered | | | Covered for 40 visits in lieu of a skilled nursing facility stay or | Covered |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| | | | | | | hospitalization, plus 2 post partum home visits for high risk women | |
| 15. | Private Duty Nursing Services | Covered | Covered | | | Not covered | Covered |
| 16. | Hospice | Covered | Covered | | | Covered | Covered |
| 17. | Emergency Services<br><br>Post-Stabilization Care Services (see also Appendix G of this Agreement) | Covered<br><br>Covered | Covered<br><br>Covered | | | Covered<br><br>Covered | Covered<br><br>Covered |
| 18. | Foot Care Services | Covered | Covered | | | Covered | Covered |
| 19. | Eye Care and Low Vision Services | Covered | Covered | | | Covered | Covered |
| 20. | Durable Medical Equipment (DME) | Covered | Covered | | | Covered | Covered |
| 21. | Audiology, Hearing Aids Services & Products | Covered | 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 pursuant to Appendix C of Agreement. | | Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement or through the DTP Contractor. | 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 not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule. | | Not covered, except for transportation to C/THP services for 19 and 20 year olds. Benefit to be covered by 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 |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 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 not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule. | | Covered | 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. | For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention. | | Covered, if included in Contractor's Benefit Package as per Appendix M of this Agreement, excluding orthodontia. | Covered |
| 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). | 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, except for orthopedic shoes | Covered |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 29. | Mental Health Services | Covered | Covered on the effective date of the Behavioral Health Benefit Inclusion. | Covered | | Covered subject to calendar year benefit limit of 30 days inpatient, 60 visits outpatient, combined with chemical dependency services. | Covered |
| 30. | SUD Inpatient Detoxification Services | Covered | Covered | | | Covered | Covered |
| 31. | SUD Inpatient Rehabilitation and Treatment Services | Covered | Covered on the effective date of Behavioral Health Benefit Inclusion | | | Covered subject to calendar year benefit limit of 30 days combined with mental health services | Covered |
| 32. | SUD Residential Addiction Treatment Services | Covered | Covered | | | | Covered |
| 33. | SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment) | Covered | Covered | | | Covered subject to calendar year benefit limits of 60 visits combined with mental health services | 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 on a case by case basis |
| 37. | Renal Dialysis | Covered | 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. | | | Covers only non-permanent rehabilitative stays. | |
| 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. | | | Not covered | Covered. When only Level I services provided, limited to 8 hours per week. |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 40. | Personal Emergency Response System (PERS) | Covered | Covered | | | Not covered | Covered |
| 41. | Consumer Directed Personal Assistance Services | Covered | Covered | | | Not covered | Covered |
| 42. | Observation Services | Covered | 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 | | | Not covered | 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 | | | Not covered | 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 | | | Not Covered | Covered |
| 46. | AIDS Adult Day Health Care | Covered | Covered | | | Not Covered | Covered |
| 47. | Tuberculosis Directly Observed Therapy | Covered | Covered | | | Not Covered | Covered |
| 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). |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 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). |
| 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). |

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| * | Covered Services | MMC Non-SSI/Non-SSI Related | MMC SSI/SSI-related | MFFS | | FHPlus ** | HARP |
|---|---|---|---|---|---|---|---|
| 61. | Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program | | | | | | Covered. (see § 10.41 of this Agreement.) |

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# K.1 HIV
# HIV SNP PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits

**Benefit is only covered for HIV SNP Enrollees who also meet HARP-eligibility criteria as determined by the State.

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

| * | **Covered Services** | **HIV SNP Non-SSI** | **HIV SNP HIV/AIDS SSI** | **HIV SNP Uninfected SSI Children and Homeless Adults** | **MFFS** |
|---|---|---|---|---|---|
| 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) | Stay covered only when 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<br><br>Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing. | Covered<br><br>Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing. | Covered<br><br>Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing. | Covered through 3/31/14. HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing. |
| 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. | Hemophilia blood factors covered through MA FFS |
| 11. | Smoking Cessation Products | Covered | Covered | Covered | |

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| * | Covered Services | HIV SNP Non-SSI | HIV SNP HIV/AIDS SSI | HIV SNP Uninfected SSI Children and Homeless Adults | MFFS |
|---|---|---|---|---|---|
| 12. | Rehabilitation Services (not including Psychosocial Rehabilitation (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 under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury. | |
| 13. | EPSDT Services/Child Teen Health Program (C/THP) | Covered | Covered | Covered | |
| 14. | Home Health Services | Covered | Covered | Covered | |
| 15. | Private Duty Nursing Services | Covered | Covered | Covered | |
| 16. | Hospice | Covered | Covered | Covered | Covered |
| 17. | Emergency Services<br><br>Post-Stabilization Care Services (see also Appendix G of this Agreement) | Covered<br><br>Covered | Covered<br><br>Covered | Covered<br><br>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 and Products | Covered | Covered | Covered | |
| 22. | Family Planning and Reproductive Health Services | Covered | Covered | Covered | Covered pursuant to Appendix C of 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 a phase-in schedule. | Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule. |

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| * | Covered Services | HIV SNP Non-SSI | HIV SNP HIV/AIDS SSI | HIV SNP Uninfected SSI Children and Homeless Adults | MFFS |
|---|---|---|---|---|---|
| 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. | Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule |
| 25. | Dental and Orthodontic Services | Covered. | Covered. | Covered. | For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention. |
| 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 (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 | Covered | Covered for HIV SNP uninfected SSI Enrollees |
| 30. | SUD Inpatient Detoxification Services | Covered | Covered | Covered | |
| 31. | SUD Inpatient Rehabilitation and Treatment Services | Covered | Covered | 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 | |

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| * | Covered Services | HIV SNP Non-SSI | HIV SNP HIV/AIDS SSI | HIV SNP Uninfected SSI Children and Homeless Adults | MFFS |
|---|---|---|---|---|---|
| 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. | Covered, except for Enrollees under age 21 in Long Term Placement Status. | |
| 39. | Personal Care Services (PCS) | 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 | Not Covered |
| 46. | AIDS Adult Day Health Care | Covered | Covered | Covered | Not Covered |
| 47. | Tuberculosis Directly Observed Therapy | Covered | Covered | Covered | Not Covered |
| 48. | Crisis Intervention Services | Covered | Covered | Covered | |
| 49. | Psychosocial Rehabilitation (PSR)** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | |
| 50. | Community Psychiatric Support and Treatment (CPST)** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | |

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| * | Covered Services | HIV SNP Non-SSI | HIV SNP HIV/AIDS SSI | HIV SNP Uninfected SSI Children and Homeless Adults | MFFS |
|---|---|---|---|---|---|
| 51. | Habilitation Services** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | |
| 52. | Family Support and Training** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also 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). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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 on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | |
| 57. | Pre-vocational Services** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | |

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| * | **Covered Services** | **HIV SNP Non-SSI** | **HIV SNP HIV/AIDS SSI** | **HIV SNP Uninfected SSI Children and Homeless Adults** | **MFFS** |
|---|---|---|---|---|---|
| 60. | Ongoing Supported Employment** | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement). | 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.) | Covered. (see § 10.41 of this Agreement.) | Covered. (see § 10.41 of this Agreement.) | |
| 62. | HIV SNP Enhanced Services: HIV SNP Care and Benefits Coordination; HIV Treatment Adherence Services; HIV Prevention and Risk Reduction Services | Covered | Covered | Covered | |

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# K.2

# PREPAID BENEFIT PACKAGE
# DEFINITIONS OF COVERED SERVICES

**Service definitions in this Section pertain to both MMC and FHPlus unless otherwise indicated.**

## 1. Inpatient Hospital Services

Inpatient hospital services, as medically necessary, shall include, except as otherwise specified, the care, treatment, maintenance and nursing services as may be required, on an inpatient hospital basis, up to 365 days per year (366 days in leap year). Contractor will not be responsible for hospital stays that commence prior to the Effective Date of Enrollment (see Section 6.8 of this Agreement), but will be responsible for stays that commence prior to the Effective Date of Disenrollment (see Section 8.5 of this Agreement). Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.

## 2. Inpatient Stay Pending Alternate Level of Medical Care

Inpatient stay pending alternate level of medical care, or continued care in a hospital, Article 31 mental health facility, Article 32 OASAS Program, or skilled nursing facility pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85. Continued care in an Article 31 mental health facility shall also be covered in a manner consistent with guidelines issued by the Office of Mental Health.

## 3. Physician Services

a) "Physicians' services," whether furnished in the office, the Enrollee's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician:

   i) within the scope of practice of medicine as defined in law by the New York State Education Department; and

   ii) by or under the personal supervision of an individual licensed and currently registered by the New York State Education Department to practice medicine.

b) Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under New York State law.

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c) The following are also included in accordance with the State Medicaid Plan and Section 10.32 of this Agreement:

i) pharmaceuticals, including long-acting antipsychotic injectables and medical supplies routinely furnished or administered as part of a clinic or office visit;

ii) physical examinations, including those which are necessary for school and camp;

iii) physical and/or mental health, or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care;

iv) health and mental health assessments for the purpose of making recommendations regarding a Enrollee's disability status for Federal SSI applications;

v) annual preventive health visits for adolescents;

vi) new admission exams for school children if required by the LDSS;

vii) health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms;

viii) Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) years of age (see Section 10 of this Agreement).

d) Smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

**4. Certified Nurse Practitioner Services**

a) Certified nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the certified nurse practitioner's licensure and collaborative practice agreement with a licensed physician in accordance with the requirements of the NYS Education Department.

b) The following services are also included in the certified nurse practitioner's scope of services, without limitation:

i) Child/Teen Health Program(C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) (see Item 13 of this Appendix and Section 10.4 of this Agreement);

ii) Physical examinations, including those which are necessary for school and camp.

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**5. Midwifery Services**

SSA § 1905 (a)(17), Education Law § 6951(i).

Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Enrollee's home as appropriate. The midwife must be licensed by the NYS Education Department and have a collaborative relationship with a physician or hospital that provides obstetric services, as described in Education Law § 6951.1, that provides for consultation, collaborative management and referral to address the health status and risks of patients and includes plans for emergency medical OB/GYN coverage.

**6. Preventive Health Services**

a) Preventive health services means care and services to avert disease/illness and/or its consequences. There are three (3) levels of preventive health services: 1) primary, such as immunizations, aimed at preventing disease; 2) secondary, such as disease screening programs aimed at early detection of disease; and 3) tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than restorative programs.

b) The Contractor must offer the following preventive health services essential for promoting health and preventing illness:

i) General health education classes.

ii) Pneumonia and influenza immunizations for at risk populations.

iii) Smoking cessation counseling for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year. Effective July 1, 2014, up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner. Smoking cessation classes, with targeted outreach for adolescents and pregnant women.

iv) Childbirth education classes.

v) Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.

vi) Nutrition counseling, with targeted outreach for diabetics and pregnant women.

vii) Extended care coordination, as needed, for pregnant women.

viii) HIV testing.

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ix) Hepatitis C screening for individuals born between 1945 and 1965.

x) Asthma Self-Management Training (ASMT).

1. Enrollees, including pregnant women, with newly diagnosed asthma or with asthma and a medically complex condition (such as an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to ten (10) hours of ASMT during a continuous six-month period.

2. Enrollees with asthma who are medically stable may receive up to one (1) hour of ASMT during a continuous six-month period.

3. Asthma self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xi) Diabetes Self-Management Training

1. Enrollees, including pregnant women, with newly diagnosed diabetes or with diabetes and a medically complex condition (such as poor diabetes control [A1c>8], diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription for new equipment such as an insulin pump, etc.) will be allowed up to ten (10) hours of DSMT during a continuous six-month period.

2. Enrollees with diabetes who are medically stable may receive up to one (1) hour of DSMT during a continuous six-month period.

3. Diabetes self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xii) Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency provided in: hospital outpatient departments; free-standing diagnostic and treatment centers; physician offices (including primary care and specialist physician offices); School Based Health Centers; School Based Mental Health Centers; and OMH licensed and OASAS certified outpatient programs. SBIRT is provided in in accordance with protocols issued by the SDOH, to identify individuals with or at risk of substance use-related problems, assess the severity of substance use and the appropriate level of intervention required and provide brief intervention or brief treatment. Referrals are initiated to chemical dependence providers for evaluation and treatment, when appropriate.

xiii) All United States Preventive Services Task Force (USPSTF) grade A and B preventive services.

xiv) All approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and the administration of such vaccines.

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**7. Second Medical/Surgical Opinions**

The Contractor will allow Enrollees to obtain second opinions for diagnosis of a condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. In the event that the Contractor determines that it does not have a Participating Provider in its network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the Contractor shall make a referral to an appropriate Non-Participating Provider. The Contractor shall pay for the cost of the services associated with obtaining a second opinion regarding medical or surgical care, including diagnostic and evaluation services, provided by the Non-Participating Provider.

**8. Laboratory Services**
18 NYCRR § 505.7(a)

a) Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

b) All laboratory testing sites providing services under this Agreement must have a permit issued by the New York State Department of Health and a Clinical Laboratory Improvement Act (CLIA) certificate of waiver, a physician performed microscopy procedures (PPMP) certificate, or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver or a PPMP certificate may perform only those specific tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the Physician's NYS Medicaid Provider Manual.

c) For MMC only: Until April 1, 2014, coverage for HIV phenotypic, HIV virtual phenotypic and HIV genotypic drug resistance tests and viral tropism testing are covered by Medicaid fee-for-service. Effective April 1, 2014, these tests are covered as other laboratory services.

**9. Radiology Services**
18 NYCRR § 505.17(c)(7)(d)

Radiology services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.

**10. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas**

a) For Medicaid managed care only: Medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula

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are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor.

b) For Family Health Plus only: Medically necessary prescription drugs, insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets, alcohol swabs), smoking cessation agents, including over-the-counter (OTC) smoking cessation products, select OTC medications covered on the Medicaid Preferred Drug List (e.g., Prilosec OTC, Loratadine, Zyrtec and emergency contraception), vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor. Medical supplies (except for diabetic supplies and smoking cessation agents) are not covered.

c) For Medicaid Managed Care and Family Health Plus:

i) Prescription drugs may be limited to generic medications when medically acceptable. All drug classes containing drugs used for preventive and therapeutic purposes are covered, as well as family planning and contraceptive medications and devices, if Family Planning is included in the Contractor's Benefit Package.

ii) Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered by the Contractor. Self-administered injectable drugs (including those administered by a family member) and injectable drugs administered during a home care visit are also covered by the Contractor. Long-acting injectable medications shall be covered by the Contractor as a medical and pharmacy benefit. The Contractor's clinical criteria for coverage for long acting antipsychotic injectable medication quantity/dose/age limits shall be consistent with FDA approved labeling and Official Compendia. Hemophilia blood factors, whether furnished or administered as part of a clinic or office visit or administered during a home care visit are covered by Medicaid fee-for-service. Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™) when administered to SSI and SSI-related Enrollees in mainstream Medicaid managed care plans, are covered by Medicaid fee-for-service until the date of Behavioral Health Benefit Inclusion.

iii) Coverage of enteral formula is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) Individuals who are fed via nasogastric, gastronomy or jejunostomy tube; 2) Individuals with inborn metabolic disorders; and, 3) Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or

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metabolized. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

iv) Fluoride supplements are covered for children up to age 17.

v) Experimental and investigational drugs are generally excluded, except where included in the course of Contractor-authorized experimental/investigational treatment or ordered under the External Appeal program authorized under Article 49 of the Public Health Law.

vi) The following drugs are not covered:

1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy;

2. Drugs prescribed for cosmetic purposes;

3. Drugs prescribed for anorexia, for weight loss or weight gain;

4. Drugs prescribed to promote fertility;

5. Drugs used for the treatment of sexual or erectile dysfunction unless used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and

6. Covered outpatient drugs when the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

vii) The Contractor may establish a prescription formulary, including a therapeutic category formulary, as long as the formulary includes all categories of drugs as listed on the New York State Medicaid formulary, and as long as the Contractor has in place a brand name and therapeutic category exception process for providers to use when the provider deems medically necessary.

viii) Drugs used for the treatment of Substance Use Disorder are covered by the Contractor.

1. The Contractor's clinical criteria for coverage for all Substance Use Disorder agent's quantity/dose/duration/age limits shall be consistent with FDA labeling and Official Compendia.

2. The Contractor shall include medications for the treatment of Alcohol Use Disorder (AUD) in the Contractor's formulary, as indicated by the FDA. The Contractor shall not cover these drugs solely through a medical exception process.

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3. The Contractor shall include medications for the treatment of SUD in the Contractor's formulary, including drugs for the treatment of AUD and/or opioid dependency, as indicated by Official Compendia. The Contractor shall not cover these drugs solely through a medical exception process.

4. The Contractor's formulary shall include at least one formulation of buprenorphine and buprenorphine/naloxone. The Contractor's clinical criteria shall include lengths of therapy with oral buprenorphine appropriate for Enrollees transitioning from long-acting opioids, or who are pregnant or breast feeding, consistent with the U.S. Department of Health and Human Services Center for Substance Abuse Treatment's "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Substance Abuse and Mental Health Services Administration."

5. Naloxone is available in vials/prefilled syringes, and auto-injector and/or atomizer. Naloxone vials/prefilled syringes or the auto-injector and/or atomizer shall be covered by the Contractor as a medical and pharmacy benefit.

6. Extended-release naltrexone injectable (Vivitrol®) shall be covered by the Contractor as a medical and pharmacy benefit.

**11. Smoking Cessation Products**

a) Smoking cessation products are covered by the Contractor. The Contractor may not require prior authorization for smoking cessation products that are included in the Contractor's formulary and ordered by a qualified provider. Except as provided in subsection (b), below the Contractor is responsible for up to two courses of smoking cessation therapy per year. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30-day supply is dispensed on any fill).

b) For Enrollees with one or more substance use disorder(s) or diagnosis of mental illness:

i) The Contractor shall cover all smoking cessation products included in the list of Medicaid reimbursable drugs;

ii) The Contractor is responsible for unlimited courses of smoking cessation therapy;

iii) The Contractor may not require prior authorization for smoking cessation products that are ordered by a qualified provider; and

iv) The Contractor must permit concomitant utilization of two (2) agents which is defined as: two (2) nicotine replacement therapies (NRTs); a NRT and bupropion substance release (SR); or a NRT and Chantix

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v) Notwithstanding the provisions of this Section, the Contractor is not required to cover a brand name smoking cessation product when a generic equivalent of the product is available.

c) Contractor's age restrictions and quantity limits for smoking cessation products must comply with the U.S. Food and Drug Administration's approved labeling for use, or as supported in at least one of the Official Compendia as defined in federal law under the Social Security Act §1927(g)(1)(B)(i).

**12. Rehabilitation Services**
18 NYCRR § 505.11

a) Rehabilitation services are provided for the maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists. Rehabilitation services may be provided in an Article 28 inpatient or outpatient facility, an Enrollee's home, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist, or for a child in a school, pre-school or community setting, or in a Residential Health Care Facility (RHCF) as long as the Enrollee's stay is classified as a rehabilitative stay and meets the requirements for covered RHCF services as defined herein.

b) For the MMC Program, rehabilitation services provided in Residential Health Care Facilities are subject to the stop-loss provisions specified in Section 3.13 of this Agreement. Rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider. Outpatient visits for physical, occupational and speech therapy are limited to twenty (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.

c) For Family Health Plus only: Outpatient visits for physical and occupational therapy are limited to twenty (20) visits each per calendar year. Coverage for speech therapy services is limited to those required for a condition amenable to significant clinical improvement within a two month period. Outpatient visits for speech therapy are also limited to twenty (20) visits each per calendar year.

d) For both Medicaid Managed Care and Family Health Plus, cardiac rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider, and rendered in physician offices, Article 28 hospital outpatient departments, freestanding diagnostic and treatment centers, and Federally Qualified Health Centers.

**13. Early Periodic Screening Diagnosis and Treatment (EPSDT) Services Through the Child Teen Health Program (C/THP) and Adolescent Preventive Services**
18 NYCRR § 508.8

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Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

**14. Home Health Services**
18 NYCRR § 505.23(a)(3)

a) Home health care services are provided to Enrollees in their homes by a home health agency certified under Article 36 of the PHL (Certified Home Health Agency - CHHA). Home health services mean the following services when prescribed by a Provider and provided to a Enrollee in his or her home:

   i) nursing services provided on a part-time or intermittent basis by a CHHA or, if there is no CHHA that services the county/district, by a registered professional nurse or a licensed practical nurse acting under the direction of the Enrollee's PCP;

   ii) physical therapy, occupational therapy, or speech pathology and audiology services; and

   iii) home health services provided by a person who meets the training requirements of the SDOH, is assigned by a registered professional nurse to provide home health aid services in accordance with the Enrollee's plan of care, and is supervised by a registered professional nurse from a CHHA or if the Contractor has no CHHA available, a registered nurse, or therapist.

b) Personal care tasks performed by a home health aide incidental to a certified home health care agency visit, and pursuant to an established care plan, are covered.

c) Services include care rendered directly to the Enrollee and instructions to his/her family or caretaker such as teacher or day care provider in the procedures necessary for the Enrollee's treatment or maintenance.

d) The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment,

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counseling, referral, instructions or clinical monitoring. Criteria for medical necessity are as follows:

i) High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or

ii) Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or

iii) Woman otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or

iv) Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance abuse, unsafe housing and nutritional risk.

Home health service visits may be provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician.

All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above.

The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records:

i) A comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit;

ii) Timely notification to treating providers and case manager concerning significant changes in the woman or infant's condition;

iii) Referral and coordination with appropriate health, mental health and social services and other providers;

iv) Review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and

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v) An appropriate discharge plan.

e) For Medicaid Managed Care only, home telehealth services are covered, pursuant to Section 3614.3-c. of the Public Health Law, when provided by agencies approved by the SDOH for Enrollees who have conditions or clinical circumstances requiring frequent monitoring and when the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admission. To be eligible for reimbursement, approved agencies must obtain any necessary prior approvals and services must be deemed medically necessary by the Contractor. Approved agencies must assess the Enrollee in person, prior to providing telehealth services, using a SDOH approved patient risk assessment tool.

f) For Family Health Plus only: coverage is limited to forty (40) home health care visits per calendar year in lieu of a skilled nursing facility stay or hospitalization, plus two post partum home visits for high risk mothers. For the purposes of this Section, visit is defined as the delivery of a discreet service (e.g. nursing, OT, PT, ST, audiology or home health aide). Four (4) hours of home health aide services equals one visit.

**15. Private Duty Nursing Services – For MMC Program Only**

a) Private duty nursing services shall be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services must be provided in the MMC Enrollee's home. Enrollees authorized to receive private duty nursing services in the home may also use approved hours outside the home when the Enrollee's normal life activities take him or her outside of the home. Private duty nursing services can be provided through a licensed home care agency or a private Practitioner. For a child, full time private duty nursing is also covered in a school, an approved pre-school, or a natural environment, including home and community settings, where such child would otherwise be found, pursuant to an Individualized Education Program under the School Supportive Health Services Program or an Individualized Family Services Plan under the Early Intervention Program.

b) Private duty nursing services are covered only when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and must be provided in an Enrollee's home in accordance with the ordering physician's or certified nurse practitioner's written treatment plan.

**16. Hospice Services**

a) Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. Hospice provides four levels of care: 1) routine home care, 2) respite care, 3) continuous care, and 4) general inpatient care. The program is available to persons with a medical prognosis of six months or less to live for FHPlus or one (1) year or less to live for MMC, if the terminal illness runs its normal course.

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b) Hospice services are provided following an interdisciplinary model, and include palliative and supportive care provided to an Enrollee to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement.

c) The Hospice provider all-inclusive per diem reimbursement rate includes all services, durable medical equipment and medicine related to the hospice diagnosis.

d) For children under age 21 who are receiving Hospice services, medically necessary curative services are covered, in addition to palliative care.

e) Hospice services are provided consistent with licensure requirements, and State and Federal regulations. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by state and federal requirements. All services must be provided pursuant to a written plan of care which reflects the changing needs of the Enrollee and the Enrollee's family.

f) The Contractor's Enrollees must receive hospice services through Participating Providers.

g) Medicaid recipients in receipt of Hospice services prior to October 1, 2013, regardless of enrollment status, shall remain covered under the fee for service (FFS) Medicaid Program (per diem reimbursement) for the duration of the approved Hospice services.

h) The Contractor shall be responsible for Hospice services provided to MMC Enrollees new to Hospice care on and after October 1, 2013.

**17. Emergency Services**

a) Emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person are covered. Emergency services include health care procedures, treatments or services, needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs and/or alcohol. Emergency Services also include hospital emergency room observation services provide in a SDOH approved hospital emergency room observation unit that meets New York State regulatory operating standards and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Use Disorder, provided in accordance with protocols issued by the SDOH, when rendered in emergency departments. See also Appendix G of this Agreement.



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b) Post Stabilization Care Services means **s**ervices related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition. These services are covered pursuant to Appendix G of this Agreement.

**18. Foot Care Services**

a) Covered services must include routine foot care provided by qualified provider types when any Enrollee's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.

b) Services provided by a podiatrist for persons under twenty-one (21) must be covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife. Services provided by a podiatrist for adults with diabetes mellitus are covered.

c) Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

**19. Eye Care and Low Vision Services**
18 NYCRR §505.6(b)(1-3)
SSL §369-ee (1)(e)(xii)

a) For Medicaid Managed Care only:

i) Emergency, preventive and routine eye care services are covered. Eye care includes the services of ophthalmologists, optometrists and ophthalmic dispensers, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses must duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

ii) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line

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bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

iii) Examinations for diagnosis and treatment for visual defects and/or eye disease are provided only as necessary and as required by the Enrollee's particular condition. Examinations which include refraction are limited to once every twenty four (24) months unless otherwise justified as medically necessary.

iv) Eyeglasses do not require changing more frequently than once every twenty four (24) months unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.

v) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

vi) MMC Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty four (24) months, or if otherwise justified as medically necessary or if eyeglasses are lost, damaged or destroyed as described above. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.

vii) As described in Sections 10.15 and 10.28 of this Agreement, Enrollees may self-refer to Article 28 clinics affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.

b) For Family Health Plus only:

i) Covered Services include emergency vision care and the following preventive and routine vision care provided once in any twenty four (24) month period:

A) one eye examination;

B) either: one pair of prescription eyeglass lenses and a frame, or prescription contact lenses when medically necessary; and

C) one pair of medically necessary occupational eyeglasses.

ii) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

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iii) FHPlus Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty-four (24) months. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.

iv) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

v) Contact lenses are covered only when medically necessary. Contact lenses shall not be covered solely because the FHPlus Enrollee selects contact lenses in lieu of receiving eyeglasses.

vi) Coverage does not include the replacement of lost, damaged or destroyed eyeglasses.

vii) The occupational vision benefit for FHPlus Enrollees covers the cost of job-related eyeglasses if that need is determined by a Participating Provider through special testing done in conjunction with a regular vision examination. Such examination shall determine whether a special pair of eyeglasses would improve the performance of job-related activities. Occupational eyeglasses can be provided in addition to regular glasses but are available only in conjunction with a regular vision benefit once in any twenty-four (24) month period. FHPlus Enrollees may purchase an upgraded frame or lenses for occupational eyeglasses by paying the entire cost of the frame or lenses as a private customer (See Section 19. b) iv) above). Sun-sensitive and polarized lens options are not available for occupational eyeglasses.

**20. Durable Medical Equipment (DME)**

18 NYCRR §505.5(a)(1) and Section 4.4 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

a) Durable Medical Equipment (DME) are devices and equipment, other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances, and have the following characteristics:



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i) can withstand repeated use for a protracted period of time;

ii) are primarily and customarily used for medical purposes;

iii) are generally not useful to a person in the absence of illness or injury; and

iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one (1) person, it may be either custom made or customized.

b) Coverage includes equipment servicing but excludes disposable medical supplies.

**21. Audiology, Hearing Aid Services and Products**

18 NYCRR §505.31 (a)(1)(2) and Section 4.7 of the NYS Medicaid Hearing Aid Provider Manual

a) Hearing aid services and products are provided in compliance with Article 37-A of the General Business Law when medically necessary to alleviate disability caused by the loss or impairment of hearing. Hearing aid services include: selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluation, and hearing aid repairs.

b) Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.

c) Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts.

d) Hearing aid batteries

Hearing aid batteries are covered by the Contractor for all Enrollees as part of the prescription drug benefit.

**22. Family Planning and Reproductive Health Care**

a) Family Planning and Reproductive Health Care services means the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy, as specified in Appendix C of this Agreement.

b) HIV counseling and testing is included in coverage when provided as part of a Family Planning and Reproductive Health visit.

c) All medically necessary abortions are covered, as specified in Appendix C of this Agreement.

d) Fertility services are not covered.



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e) If the Contractor excludes Family Planning and Reproductive Health services from its Benefit Package, as specified in Appendix M of this Agreement, the Contractor is required to comply with the requirements of Appendix C.3 of this Agreement and still provide the following services:

i) screening, related diagnosis, ambulatory treatment, and referral to Participating Provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormality/pathology;

ii) screening, related diagnosis, and referral to Participating Provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.

**23. Non-Emergency Transportation**

a) Transportation expenses are covered for MMC Enrollees when transportation is essential in order for a MMC Enrollee to obtain necessary medical care and services which are covered under the Medicaid program (either as part of the Contractor's Benefit Package or by Medicaid fee-for-service). The non-emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.

b) Transportation services means transportation by ambulance, ambulette (invalid coach), fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the MMC Enrollee's medical condition; and a transportation attendant to accompany the MMC Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the MMC Enrollee's family.

c) The Contractor is required to use only approved Medicaid ambulette vendors to provide transportation services to MMC Enrollees.

d) When the Contractor is capitated for non-emergency transportation, the Contractor is also responsible for providing transportation to Medicaid covered services that are not part of the Contractor's Benefit Package.

e) Non-emergency transportation is covered for FHPlus Enrollees that are nineteen (19) or twenty (20) years old and are receiving C/THP services. Subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

f) For MMC Enrollees with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.



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g) For MMC plans that cover non-emergency transportation only, subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

**24. Emergency Transportation**

a) Emergency transportation can only be provided by an ambulance service including air ambulance service. Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an Enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of Emergency Services while the Enrollee is being transported.

b) Emergency Services means the health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.

c) Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency. Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed. When the Contractor is capitated for this benefit, emergency transportation via 911 or any other emergency call system is a covered benefit and the Contractor is responsible for payment. Contractor shall reimburse the transportation provider for all emergency ambulance services without regard for final diagnosis or prudent layperson standard.

d) The emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.

e) For MMC plans that cover emergency transportation only, according to a county-by-county phase in schedule to be determined by SDOH, and concomitantly with the assumption of the MMC non-emergency benefit by a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be removed from the Contractor's benefit package. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

**25. Dental and Orthodontic Services**

a) Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability.

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b) For Medicaid Managed Care only:

i) As described in Sections 10.15 and 10.27 of this Agreement, Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services.

ii) The dental benefit includes up to four annual fluoride varnish treatments for children from birth until age 7 years when applied by a dentist, physician or nurse practitioner.

c) Orthodontia (for Medicaid Managed Care only)

i) Effective October 1, 2012, orthodontia is a plan-covered benefit, consistent with 18 NYCRR 506.4, for Enrollees:

A) under twenty-one (21) years of age for up to three years of active orthodontic care, plus one year of retention care, to treat a severe physically handicapping malocclusion. Part of such care could be provided after the Enrollee reaches the age of 21, provided that the treatment was approved and active therapy began prior to the Enrollee's 21st birthday.

B) 21 years and over in connection with necessary surgical treatment (e.g. approved orthognathic surgery, reconstructive surgery or cleft palate treatment).

ii) Effective October 1, 2012, for cases prior approved by the Contractor, orthodontic services are covered by the Contractor. The Contractor will be responsible for prior approval of all such cases, monitoring treatment progress and quality of care, and reimbursing orthodontists for services provided to Enrollees whose treatment was prior approved by the Contractor. The Contractor must use the same guidelines for approval of orthodontic services that are used by the Medicaid fee-for-service program.

iii) The Contractor's provider network must include a sufficient array of orthodontic providers. The Contractor will assist Enrollees in identifying participating orthodontia providers.

iv) Transitional Care: When an Enrollee changes MCOs after orthodontic appliances are in place and active treatment has begun, transitional care policies will apply if the orthodontist is not a Participating Provider in the provider network of the Enrollee's new MCO. Under the transitional care policy, the Contractor must permit a new Enrollee to continue an ongoing course of treatment with an out-of-network orthodontist during a transitional period of up to sixty (60) days. If the out-of-network orthodontist wishes to continue treating the Enrollee during the transition period, the orthodontist must agree to accept the new MCO's reimbursement as payment in full and adhere to that MCO's policies and

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procedures. The Enrollee must be transferred to an orthodontist in the new MCO's provider network by the end of the transitional care period.

d) Effective July 1, 2014, dental practitioners can provide smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner within any calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

**26. Court Ordered Services**

Court ordered services are those services ordered by a court of competent jurisdiction which are performed by or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including treatment for mental health and/or alcohol and/or substance abuse or dependence), or other covered services. The Contractor is responsible for payment of those services included in the benefit package.

**27. LDSS Mandated Services**

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. LDSS Mandated services are those services mandated by an Enrollees local department of social services after a determination that such Enrollee has a mental, SUD or physical impairment that limits his/her ability to engage in work. Such services are performed by or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including treatment for mental health and/or alcohol and/or substance abuse or dependence), or other covered services. The Contractor is responsible for payment of mandated services included in the benefit package.

**28. Prosthetic/Orthotic Orthopedic Footwear**

Section 4.5, 4.6 and 4.7 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

a) Prosthetics are those appliances or devices which replace or perform the function of any missing part of the body. Artificial eyes are covered as part of the eye care benefit.

b) Orthotics are those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.

c) Medicaid Managed Care: Orthopedic Footwear means shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.

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## 29. Mental Health Services

a) Inpatient Services

All inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the PHL. Inpatient mental health services also includes treatment in a Comprehensive Psychiatric Emergency Program (CPEP) licensed pursuant to Article 31 of the MHL, including Extended Observation Beds in a CPEP.

b) Outpatient Services

Outpatient services including but not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, education, symptom management, case management services, crisis intervention and outreach services, clozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). Services may be provided in-home, office or the community. Services may be provided by licensed OMH providers or by other providers of mental health services including clinical psychologists and physicians.

The Contractor must make available in an accessible manner all services required by OMH regulations 14 NYCRR Part 599. When contracting with mental health clinics licensed under Article 31 of the Mental Hygiene Law, the Contractor is required to contract for each Part 599 service at every clinic with which it has a contract.

c) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.

d) Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. A time limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR Part 587.

e) Day Treatment

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. A combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Services are expected to be of six (6) months duration. These services are certified by OMH under 14 NYCRR Part 587.

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f) Continuing Day Treatment

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self- esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. These services are certified by OMH under 14 NYCRR Part 587.

g) Case Management

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. The target population consists of individuals who suffer from serious mental illness, require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system. Three case management models are currently operated pursuant to an agreement with OMH or a local governmental unit, and receive Medicaid reimbursement pursuant to 14 NYCRR Part 506.

h) Partial Hospitalization

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention. These services are certified by OMH under 14 NYCRR Part 587.

i) Assertive Community Treatment (ACT)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting. ACT programs deliver integrated services to recipients and adjust services over time to meet the recipient's goals and changing needs; are operated pursuant to approval or certification by OMH; and receive Medicaid reimbursement pursuant to 14 NYCRR Part 508.

j) Personalized Recovery Oriented Services (PROS)

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The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. PROS, licensed and reimbursed pursuant to 14 NYCRR Part 512, are designed to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. Specific components of PROS include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation and Support and Clinical Treatment.

k) Community Mental Health/Licensed Behavioral Health Practitioner Waiver Services:

i) The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Community Mental Health/Licensed Behavioral Health Practitioner Waiver Services are community-based mental health services provided pursuant to the New York State Section 1115 Behavioral health Partnership Plan Waiver Amendment by otherwise eligible Medicaid mental health providers, including licensed behavioral health practitioners (LBHP). A LBHP is an individual who is licensed in the State of New York to prescribe, diagnose and/or treat individuals with mental illness or substance abuse operating within the scope of practice defined in State law and in any setting permissible under State practice law. A LBHP includes individuals licensed as a:

1) Licensed Psychiatrist or Advanced Nurse Practitioner;

2) Licensed Psychologist;

3) Licensed Psychoanalyst;

4) Licensed Social worker (LMSW or LCSW);

5) Licensed Marriage & Family Therapist, or

6) Licensed Mental Health Counselor.

ii) Any practitioner providing behavioral health services must operate within an agency licensed by New York State. Licensed LMSW, LCSW, PsyD, Phd and MDs may supervise unlicensed professionals in licensed agencies who have at least Bachelor's level such as a Registered Nurse or a peer with state training and certification.

iii) In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health, state law and OASAS regulations at 14 NYCRR § 853.2.

iv) The Contractor shall reimburse providers for such services at no less than the State-provided rate schedule.

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## 30. SUD Inpatient Detoxification Services

a) Medically Managed Inpatient Detoxification

These programs provide medically directed twenty-four (24) hour care on an inpatient basis to individuals who are at risk of severe alcohol or substance abuse withdrawal, incapacitated, a risk to self or others, or diagnosed with an acute physical or mental co-morbidity. Specific services include, but are not limited to: medical management, bio-psychosocial assessments, stabilization of medical psychiatric / psychological problems, individual and group counseling, level of care determinations and referral and linkages to other services as necessary. Medically Managed Detoxification Services are provided by facilities licensed by OASAS under Title 14 NYCRR § 816.6 and the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

b) Medically Supervised Inpatient Withdrawal

These programs offer treatment for moderate withdrawal on an inpatient basis. Services must include medical supervision and direction under the care of a physician in the treatment for moderate withdrawal. Specific services must include, but are not limited to: medical assessment within twenty four (24) hours of admission; medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling and linkages to other services as necessary. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Inpatient Withdrawal services are provided by facilities licensed under Title 14 NYCRR § 816.7.

## 31. SUD Inpatient Rehabilitation and Treatment Services

a) Services provided include intensive management of chemical dependence symptoms and medical management of physical or mental complications from chemical dependence to clients who cannot be effectively served on an outpatient basis and who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free–standing facility. Specific services can include, but are not limited to: comprehensive admission evaluation and treatment planning; individual group, and family counseling; awareness and relapse prevention; education about self-help groups; assessment and referral services; vocational and educational assessment; medical and psychiatric consultation; food and housing; and HIV and AIDS education. These services may be provided by facilities licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to provide Chemical Dependence Inpatient Rehabilitation and Treatment Services under Title 14 NYCRR Part 818. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized.

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b) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.

## 32. SUD Residential Addiction Services

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Residential addiction services include individual centered residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help individuals achieve changes in their substance use disorder behaviors. Services also address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. These programs are certified under 14 NYCRR Part 820.

## 33. SUD Outpatient Services

a) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 to deliver service to individuals who suffer from chemical abuse or dependence and/or their family members or significant others. Such services may be provided at the certified site or in the community include and provide chemical dependence outpatient treatment (including intensive outpatient services) and continuing care treatment.

b) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide outpatient rehabilitation services for individuals with more chronic SUD conditions and emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. The individual must have an adequate support system and either substantial deficits in interpersonal and functional skills or health care needs requiring attention or monitoring by health care staff. These services are provided in combination with all other clinical services provided by CD-OPs. Programs are certified by OASAS as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR § 822.

c) Outpatient Chemical Dependence for Youth Programs

Outpatient Chemical Dependence for Youth Programs (OCDY) licensed under Title 14 NYCRR Part 823, establishes programs and service regulations for OCDY programs. OCDY programs offer discrete, ambulatory clinic services to chemically-dependent youth in a treatment setting that supports abstinence from chemical dependence (including alcohol and substance abuse) services.

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d) Opioid Treatment Program (OTP)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Opioid Treatment Program (OTP) means one or more OASAS certified sites where methadone or other approved medications are administered to treat opioid dependency, following one or more medical treatment protocols as defined by 14 NYCRR Part 822. OTPs may provide patients with any or all of the following: Opioid detoxification; Opioid medical maintenance; and Opioid taper. The term "OTP" encompasses medical and support services at the certified site or in the community including counseling, educational and vocational rehabilitation. OTP also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 1301. Facilities that provide opioid treatment do so as their principal mission and are certified by OASAS under 14 NYCRR Part 822.

e) Buprenorphine and Buprenorphine Management:

i) Management of buprenorphine in all settings certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 for maintenance or detoxification of patients with Substance Use Disorders.

ii) FHPlus only: Management of buprenorphine in settings other than outpatient clinics and opioid treatment programs certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 by Primary Care Providers and Mental Health Providers for maintenance or detoxification of patients with chemical dependence. Buprenorphine is a covered benefit except when furnished and administered as part of a Part 822 outpatient clinic or opioid treatment program visit. Buprenorphine management services provided by Mental Health Providers, or in a Part 822 outpatient clinic or opioid treatment program, are subject to the combined mental health/chemical dependency benefit limit of sixty (60) outpatient visits per calendar year.

**34. SUD Medically Supervised Outpatient Withdrawal**

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. These programs offer treatment for moderate withdrawal on an outpatient basis. Required services include, but are not limited to: medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling; level of care determinations; discharge planning; and referrals to appropriate services. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Outpatient Withdrawal services are provided by facilities licensed under 14 NYCRR §816.7.

**35. Buprenorphine Prescribers**

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The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Management and/or Prescription of buprenorphine by Primary Care Providers and Mental Health Providers for maintenance or detoxification of patients with Substance Use Disorder.

**36. Experimental or Investigational Treatment**

a) Experimental and investigational treatment is covered on a case by case basis.

b) Experimental or investigational treatment for life-threatening and/or disabling illnesses may also be considered for coverage under the external appeal process pursuant to the requirements of Section 4910 of the PHL under the following conditions:

i) The Enrollee has had coverage of a health care service denied on the basis that such service is experimental and investigational, and

ii) The Enrollee's attending physician has certified that the Enrollee has a life-threatening or disabling condition or disease:

A) for which standard health 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 the Contractor, or

C) for which there exists a clinical trial, and

iii) The Enrollee's provider, who must be a licensed, board-certified or board-eligible physician, qualified to practice in the area of practice appropriate to treat the Enrollee's life-threatening or disabling condition or disease, must have recommended either:

A) a health service or procedure that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the Enrollee than any covered standard health service or procedure; or

B) a clinical trial for which the Enrollee is eligible; and

iv) The specific health service or procedure recommended by the attending physician would otherwise be covered except for the Contractor's determination that the health service or procedure is experimental or investigational.

**37. Renal Dialysis**

Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.

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## 38. Nursing Home Services – [Not Applicable to the HARP Program]

a) Nursing Home Services means inpatient nursing home services provided by facilities licensed under Article 28 of the New York State Public Health Law, including AIDS nursing facilities. Covered services includes the following health care services: medical supervision, twenty-four (24) hour per day nursing care, assistance with the activities of daily living, physical therapy, occupational therapy, and speech/language pathology services and other services as specified in the New York State Health Law and Regulations for residential health care facilities and AIDS nursing facilities. These services should be provided to an MMC Enrollee:

   i) Who is diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the MMC Enrollee to be so incapacitated, sick, invalid, infirm, disabled, or convalescent as to require at least medical and nursing care; and

   ii) Whose assessed health care needs, in the professional judgment of the MMC Enrollee's physician or a medical team:

      A) do not require care or active treatment of the MMC Enrollee in a general or special hospital;

      B) cannot be met satisfactorily in the MMC Enrollee's own home or home substitute through provision of such home health services, including medical and other health and health-related services as are available in or near his or her community; and

      C) cannot be met satisfactorily in the physician's office, a hospital clinic, or other ambulatory care setting because of the unavailability of medical or other health and health-related services for the MMC Enrollee in such setting in or near his or her community.

b) The Contractor is also responsible for respite days and bed hold days authorized by the Contractor.

c) The Contractor is responsible for all medically necessary and clinically appropriate inpatient nursing home services authorized by the Contractor for MMC Enrollees age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay.

## 39. Personal Care Services (MMC only)

a) Personal care services (PCS), as defined by 18 NYCRR §505.14(a) and as further described in the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care," are the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in his or her own home. The service must be ordered

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by a physician or nurse practitioner, and there must be a medical need for the service. Enrollees receiving PCS must have a stable medical condition that is not expected to exhibit sudden deterioration or improvement; does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; is such that a physically disabled individual in need of routine supportive assistance does not need skilled professional care in the home; or the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. Enrollees receiving PCS must be self-directing, which shall mean that the Enrollee is capable of making choices about his or her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choices. Enrollees who are non self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive PCS, except under the following conditions:

i) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household;

ii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

iii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The LDSS may be the outside agency.

b) Personal care services are authorized as Level I (environmental and nutritional functions) or Level II (personal care, environmental and nutritional functions) with specific number of hours per day and days per week the PCS are to be provided. Authorization for solely Level I services may not exceed eight (8) hours per week.

**40. Personal Emergency Response System (PERS)**

a) Personal Emergency Response System (PERS) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.

b) Assessment of need for PERS services must be made in accordance with and in coordination with authorization procedures for home care services, including personal care services. Authorization for PERS services is based on a physician or nurse practitioner's order and a comprehensive assessment which must include an evaluation of the client's physical disability status, the degree that they would be at

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risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation. PERS is not provided in the absence of personal care or home care services. Authorization of PERS is not a substitute for or in lieu of assistance with PCS tasks such as transferring, toileting or walking.

c) The Contractor will be responsible for authorizing and arranging for PERS services through network providers, as described in this Appendix and the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care."

**41. Consumer Directed Personal Assistance Services (MMC Program Only)**

a) Consumer Directed Personal Assistance Services (CDPAS), as defined by 18 NYCRR §§505.28(a) and (b), means the provision to a chronically ill and/or disabled Consumer of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a Consumer or the Consumer's designated representative. A Consumer must acknowledge in writing that they are willing and able to fulfill their responsibilities as provided by 10 NYCRR §505.28(g)(1)-(7).

b) For the MMC program, these terms shall have the following meanings:

i) "Consumer" means an Enrollee who the Contractor has determined to be eligible to receive CDPAS, pursuant to a nursing and social assessment process consistent with 18 NYCRR §§505.28(c) and (d).

ii) "Fiscal Intermediary" means an entity that has an agreement with the Contractor to provide wage and benefit processing for consumer directed personal assistants and other Fiscal Intermediary responsibilities as provided by 18 NYCRR 505.28 (i)(1)(i)-(v), (vii).

**42. Observation Services**

Observation Services in an Article 28 hospital are post-stabilization services covered by the Contractor for observation, short-term treatment, assessment and re-assessment of an Enrollee for whom diagnosis and a determination concerning inpatient admission, discharge, or transfer cannot be accomplished within eight hours but can reasonably be expected within forty-eight (48) hours. Observation services may be provided in distinct units approved by the Department, inpatient beds, or in the emergency department ONLY for hospitals designated as critical access hospitals or sole community hospitals. An Enrollee shall be assigned to the observation service through a hospital Emergency Department by order of a physician, nurse practitioner, or other medical professional within his/her scope of practice. Observation services may be subject to prior approval and/or notification requirements, as well as retrospective review procedures, established by the Contractor. The Enrollee must be admitted to the inpatient service, transferred to another hospital, or discharged to self-care or the care of a physician or other appropriate follow-up service within forty-eight (48) hours of assignment to the observation unit. Notwithstanding the requirements of this section, the Contractor shall provide the Observation Services benefit consistent with regulations at 10 NYCRR Part 405.32.

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## 43. Medical Social Services

a) Medical Social Services are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Medical Social Services while in the LTHHCP. Medical Social Services is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to, home visits to the individual, family or both; visits preparatory to the transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services.

b) Medical Social Services must be provided by a qualified social worker licensed by the Education Department to practice social work in the State of New York.

## 44. Home Delivered Meals

Home Delivered Meals are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Home Delivered Meals while in the LTHHCP. Home Delivered Meals must be provided when the Enrollee's needs cannot be met by existing support services, including family and approved personal care aides. The Home Delivered Meals benefit includes up to two meals per day on week days and/or weekends.

## 45. Adult Day Health Care

a) Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the Adult Day Health Care program in accordance with a comprehensive assessment of care needs and the PCSP, ongoing implementation and coordination of the PCSP, and transportation.

b) Registrant means a person who is a nonresident of the Residential Health Care Facility who is functionally impaired and not homebound and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided by a general hospital, or Residential Health Care Facility; and whose assessed social and health care needs, in the professional judgment of the physician of record, nursing staff, Social Services and other professional personnel of the Adult Day Health Care program can be met in whole or in part satisfactorily by delivery of appropriate services in such program.

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## 46. AIDS Adult Day Health Care

AIDS Adult Day Health Care Programs (AIDS ADHCP) are programs designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services. Registrants in AIDS ADHCP require a greater range of comprehensive health care services than can be provided in any single setting, but do not require the level of services provided in a residential health care setting. Regulations require that a person enrolled in an AIDS ADHCP must require at least three (3) hours of health care delivered on the basis of at least one (1) visit per week. While health care services are broadly defined in this setting to include general medical care, nursing care, medication management, nutritional services, rehabilitative services, and substance abuse and mental health services, the latter two (2) cannot be the sole reason for admission to the program. Admission criteria must include, at a minimum, the need for general medical care and nursing services.

## 47. Directly Observed Therapy (DOT) of Tuberculosis Disease

Tuberculosis Directly Observed Therapy (TB/DOT) is the direct observation of oral ingestion, or the administration of injectable/infused medication, to assure patient compliance with the physician's prescribed medication regimen. DOT is the standard of care for every individual with active TB. Clinical management of TB, including TB/DOT and all TB medications, is included in the benefit package.

## 48. Crisis Intervention Services

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Crisis Intervention Services are provided to an Enrollee who is experiencing or is at imminent risk of having a psychiatric crisis. Such services are designed to interrupt and/or ameliorate a crisis, and include preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the Enrollee as connected as possible with the person's environment and activities. The goals of Crisis Intervention Services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

## 49. Psychosocial Rehabilitation (PSR) [Applicable to HARP and HIV SNP Programs Only]

Psychosocial Rehabilitation (PSR) is a face-to-face intervention designed to assist the Enrollee with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with a behavioral health condition. PSR may be provided in any setting best suited for desired outcomes and may include rehabilitation counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use or the negative effects of psychiatric or emotional symptoms. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive

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member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

**50. Community Psychiatric Support and Treatment (CPST) – [Applicable to HARP and HIV SNP Programs]**

Community Psychiatric Support and Treatment (CPST) is a face-to-face intervention with the Enrollee, family or other collaterals designed to help Enrollees with serious mental illness achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST includes time-limited goal-**directed supports** and solution-focused interventions intended to achieve identified person-centered goals or objectives. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

**51. Habilitation Services– [Applicable to HARP and HIV SNP Programs Only]**

Habilitation Services are typically provided on a 1:1 basis and are designed to assist Enrollees with a behavioral health diagnosis in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist Enrollees with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable Enrollees to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the Enrollee.

**52. Family Support and Training– [Applicable to HARP and HIV SNP Programs Only]**

Family Support and Training is available only at the request of the Enrollee. Family Support and Training is designed to facilitate engagement and active participation of the Enrollee's family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Family Support and Training involves partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder or mental illness. For purposes of this service, "family" is defined as the persons who live with or provide care to an Enrollee served and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the Enrollee.

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Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery **Plan and** shall include updates, as necessary, to safely maintain the Enrollee at home and in the community.

**53. Short-Term Crisis Respite– [Applicable to HARP and HIV SNP Programs Only]**

Short-term Crisis Respite is a short-term, site-based care and intervention strategy for Enrollees who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports. Components offered may include peer support, either on-site or as a wrap-around service during the respite stay, health and wellness coaching, WRAP (Wellness Recovery Action Plan) planning, wellness activities, family support, conflict resolution, and other services as needed.

Referrals to Short-Term Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

**54. Intensive Crisis Respite–[Applicable to HARP and HIV SNP Programs Only]**

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms and cannot be managed in a short-term crisis respite. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

**55. Education Support Services– [Applicable to HARP and HIV SNP Programs Only]**

Education Support Services are provided to assist Enrollees with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 codified at 20 U.S.C. § 1401 et seq. to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career & Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the Enrollee to

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participate in an apprenticeship program. Ongoing Supported Education is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the Enrollee to maintain their status as a registered student.

**56. Peer Supports– [Applicable to HARP and HIV SNP Programs Only]**

Peer Support services are peer-delivered rehabilitation and recovery services designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer supports may be provided in a variety of settings, including inpatient, outpatient, community, and respite programs. Peer support providers must be certified as either an OMH-established Certified Peer Specialist or a OASAS-established Peer Advocate. Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from behavioral health issues. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

**57. Pre-Vocational Services– [Applicable to HARP and HIV SNP Programs Only]**

Pre-vocational services are time-limited, face-to-face services that prepare an Enrollee for participation in competitive employment. The services provide learning and work experiences in order to develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environments or a self-employment arrangement. Service components include teaching concepts such as work compliance, attendance, task completion, problem solving, safety, and, if applicable, how to identify obstacles to or accommodations needed for employment, how to obtain paperwork necessary for employment applications and interpersonal skills. Services may also include providing scheduled activities outside of an individual's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, socialization, daily living skills, communication, community living, social and cognitive skills, including opening and maintaining a bank account.

Pre-vocational services may only be provided by State-designated HCBS providers. Pre-vocational Services may be provided at the program site, in the community or at a work location where the individual may acquire work-related experience.

**58. Transitional Employment– [Applicable to HARP and HIV SNP Programs Only]**

Transitional Employment is a time-limited, face to face intervention designed to strengthen the Enrollee's work record and work skills toward the goal of achieving assisted or unassisted competitive employment. Transitional Employment provides Enrollees with on-the-job training in an integrated employment setting in order to develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environments. This service is provided instead of

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Intensive Supported Employment and only when the Enrollee specifically chooses this service.

Transitional Employment Services may only be provided by State-designated HCBS providers. Settings where this service may be provided include State-designated Clubhouses, psychosocial clubs and OASAS Recovery Centers.

**59. Intensive Supported Employment– [Applicable to HARP and HIV SNP Programs Only]**

Intensive Supported Employment services are individualized, person-centered services providing supports to Enrollees in order to obtain and/or maintain competitive employment or self-employment. Intensive Supported Employment services provide job placement, systematic job development, job coaching, negotiation with prospective employers, including regarding appropriate behavioral health accommodations, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by a supported individual), benefits counseling support, training and planning transportation navigation, asset development, career advancement services, and other workforce support services such as Employee Assistance Program services.

Intensive Supported Employment may only be provided by State-designated HCBS providers, including providers designated for Individualized Employment Support services. This service may be provided in any community location, including the program site or the workplace.

**60. Ongoing Supported Employment– [Applicable to HARP and HIV SNP Programs Only]**

Ongoing Supported Employment services are provided to Enrollees who have successfully obtained and are oriented to competitive and integrated employment. The services include assistance identifying reasonable accommodations necessary to manage mental health symptoms that may emerge after obtaining employment, assistance in establishing positive workplace relationships, interactions with supervisors and co-workers. Support services also include job retention training and ongoing follow-along support as needed by the Enrollee to maintain their paid position.

Ongoing Supported Employment may only be provided by State-designated HCBS providers and may be provided in any community location, including the program site or the workplace.

**61. Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program – Applicable to the HARP and HIV SNP Program Only**

The HARP Benefit package includes enhanced services that are essential for promoting wellness and recovery. HARP Care Coordination includes arranging for the provision of Behavioral Health Home and Community Based Services through ensuring eligible

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Enrollees receive appropriate assessments, developing and approving plans of care, and providing comprehensive care management services through State-designated Health Homes or other entities, pursuant to Section 10.41 of this Agreement.

**62. HIV SNP Enhanced Services - Applicable to HIV SNP Program Only**

The HIV SNP Benefit package includes enhanced services that are essential for promoting wellness and preventing illness. HIV SNP Enhanced Services include the following:

a) HIV SNP Care and Benefits Coordination Services

HIV SNP Care and Benefits Coordination Services include medical case management/care coordination services in consultation with the PCP; assessment and service plan development that identifies and addresses the Enrollee's medical and psychosocial needs; service utilization monitoring and care advocacy services that promote Enrollee access to needed care and services; case manager provider participation in quality assurance and quality improvement activities.

b) HIV Treatment Adherence Services

HIV treatment adherence services include treatment education policies and programs to promote adherence to prescribed treatment regimens for all Enrollees, facilitate access to treatment adherence services including treatment readiness and supportive services integrated into the continuum of HIV care services, and the development of a structural network among providers that facilitates the coordination of treatment adherence services as well as promotes, reinforces and supports adherence services for Enrollees while ensuring collaboration between the provider and Enrollee. Treatment adherence services include development and regular reassessment of an individualized treatment adherence plan for each Enrollee consistent with guidelines as developed by the AIDS Institute and assessment of the overall health and psychosocial needs of the Enrollee in order to identify potential barriers that may impact upon the level of adherence and the overall treatment plan.

c) HIV Primary and Secondary Prevention and Risk-Reduction Services

HIV primary and secondary prevention and risk-reduction services include HIV primary and secondary prevention and risk- reduction education and counseling; education and counseling regarding reduction of perinatal transmission; harm reduction education and services; education to Enrollees regarding STDs and services available for STD treatment and prevention; counseling and supportive services for partner/spousal notification (pursuant to Chapter 163 of the Laws of 1998); and HIV community education, outreach and health promotion activities.

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# K.3

## Medicaid Managed Care Prepaid Benefit Package
## Definitions of Non-Covered Services

The following services are excluded from the Contractor's Benefit Package, but are covered, in most instances, by Medicaid fee-for-service:

**1. Medical Non-Covered Services**

a) Nursing Home Services

Services provided in a nursing home to an Enrollee under age 21 who is determined by the LDSS to be in Long Term Placement Status are not covered for Medicaid Managed Care (MMC) or Family Health Plus Enrollees. Family Health Plus covers only non-permanent rehabilitation stays in nursing homes. Enrollees under age 21 in Long Term Placement Status in nursing home are excluded from MMC and must be disenrolled. Once disenrolled, the beneficiary will receive these services through Medicaid fee-for-service.

b) Emergency and Non-Emergency Transportation (MMC only)

According to a county-by-county phase-in schedule to be determined by SDOH, and subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be covered under Medicaid fee-for-service.

c) Orthodontic Services

i) All existing orthodontic cases that have begun treatment or have been reviewed and approved for treatment prior to October 1, 2012 through Medicaid fee-for-service and issued an eMedNY prior approval number will continue being paid through Medicaid fee-for-service until the completion of the approved course of treatment. Monitoring of such cases will be conducted by SDOH as needed.

ii) If an Enrollee loses eligibility for Medicaid services after appliances are in place and active treatment has begun, the Enrollee will be disenrolled from Medicaid managed care and will be entitled to a maximum of six (6) months of treatment reimbursed by Medicaid fee-for-service.

**2. Non-Covered Behavioral Health Services**

a) Mental Health Services

i) Day Treatment Programs Serving Children

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Day treatment programs are characterized by a blend of mental health and special education services provided in a fully integrated program. Typically these programs include: special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, support and education, crisis intervention, interpersonal skill development, behavior modification, art and music therapy.

ii) Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children

This waiver is in select counties for children and adolescents who would otherwise be admitted to an institutional setting if waiver services were not provided. The services include individualized care coordination, respite, family support, intensive in-home skill building, and crisis response.

iii) Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)

Services provided by designated OMH clinics to children and adolescents through age eighteen (18) with a clinical diagnosis of SED are covered by Medicaid fee-for-service.

b) Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs, as follows:

i) OMH Licensed CRs*

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior defects associated with the person's mental illness.

ii) Family-Based Treatment*

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

*These services are certified by OMH under 14 NYCRR § 586.3, Part 594 and Part 595.

c) Office for People With Developmental Disabilities (OPWDD) Services

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i) Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities

These services are provided to persons with developmental disabilities including medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in or move to, the least restrictive residential and/or day setting. These services are certified by OPWDD under 14 NYCRR Part 679 (or they are provided by Article 28 Diagnostic and Treatment Centers that are explicitly designated by the SDOH as serving primarily persons with developmental disabilities). If care of this nature is provided in facilities other than Article 28 or Article 16 centers, it is a covered service.

ii) Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive twenty-four (24) hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation, self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in ICF or a comparable setting. These services are certified by OPWDD under 14 NYCRR Part 690.

iii) Medicaid Service Coordination (MSC)

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OPWDD which assists persons with developmental disabilities and mental retardation to gain access to necessary services and supports appropriate to the needs of the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities and mental retardation. MSC promotes the concepts of a choice, individualized services and consumer satisfaction. MSC is provided by authorized vendors who have a contract with OPWDD, and who are paid monthly pursuant to such contract. Persons who receive MSC must not permanently reside in an ICF for persons with developmental disabilities, a developmental center, a skilled nursing facility or any other hospital or Medical Assistance institutional setting that provides service coordination. They must also not concurrently be enrolled in any other comprehensive Medicaid long term service coordination program/service including the Care at Home Waiver. Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under Item 3 “Other Non-Covered Services.”

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iv) Home And Community Based Services Waivers (HCBS)

The Home and Community-Based Services Waiver serves persons with developmental disabilities who would otherwise be admitted to an ICF/MR if waiver services were not provided. HCBS waivers services include residential habilitation, day habilitation, prevocational, supported work, respite, adaptive devices, consolidated supports and services, environmental modifications, family education and training, live-in caregiver, and plan of care support services. These services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

v) Services Provided Through the Care At Home Program (OPWDD)

The OPWDD Care at Home III, Care at Home IV, and Care at Home VI waivers, serve children who would otherwise not be eligible for Medicaid because of their parents' income and resources, and who would otherwise be eligible for an ICF/MR level of care. Care at Home waiver services include service coordination, respite and assistive technologies. Care at Home waiver services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

d) Non-Medical Transportation – [Applicable to HARP and HIV SNP Programs Only]

This benefit is covered under Medicaid fee-for-service. Non-medical Transportation services are offered, in addition to any medical transportation furnished pursuant to 42 CFR 440.17(a) and incorporated in the State Plan. Non-Medical Transportation will only be available for non-routine, time-limited services, not for ongoing treatment or services and all other options for transportation, such as informal supports and community services must be explored and utilized prior to requesting waiver transportation. Non-medical Transportation services are necessary, as specified by the plan of care, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the Enrollee. Transportation may consist of either private or public modes of transportation.

**3. Other Non-Covered Services**

a) The Early Intervention Program (EIP) – Children Birth to Two (2) Years of Age

i) This program provides early intervention services to certain children, from birth through two (2) years of age, who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. All managed care providers **must** refer infants and toddlers suspected of having a delay to the local designated Early Intervention agency in their area. (In most municipalities, the County Health Department is the designated agency, except: New York City - the Department of Health and Mental Hygiene; Erie County - The Department of Youth Services; Jefferson County - the Office of Community Services; and Ulster County - the Department of Social Services).

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ii) Early intervention services provided to this eligible population are categorized as Non-Covered. These services, which are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, will be identified on eMedNY by unique rate codes by which only the designated early intervention agency can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor. Consequently, the Contractor, through its Participating Providers, will be expected to refer any enrolled child suspected of having a developmental delay to the locally designated early intervention agency in their area and participate in the development of the Child's Individualized Family Services Plan (IFSP). Contractor's participation in the development of the IFSP is necessary in order to coordinate the provision of early intervention services and services covered by the Contractor.

iii) SDOH will instruct the locally designated early intervention agencies on how to identify an Enrollee and the need to contact the Contractor or the Participating Provider to coordinate service provision.

b) Preschool Supportive Health Services–Children Three (3) Through Four (4) Years of Age

i) The Preschool Supportive Health Services Program (PSHSP) enables counties and New York City to obtain Medicaid reimbursement for certain educationally related medical services provided by approved preschool special education programs for young children with disabilities. The Committee on Preschool Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related health services.

ii) PSHSP services rendered to children three (3) through four (4) years of age in conjunction with an approved IEP are categorized as Non-Covered.

iii) The PSHSP services will be identified on eMedNY by unique rate codes through which only counties and New York City can claim reimbursement. In addition, a limited number of Article 28 clinics associated with approved pre-school programs are allowed to directly bill Medicaid fee-for-service for these services. Contractor covered and authorized services will continue to be provided by the Contractor.

c) School Supportive Health Services–Children Five (5) Through Twenty-One (21) Years of Age

i) The School Supportive Health Services Program (SSHSP) enables school districts to obtain Medicaid reimbursement for certain educationally related medical services provided by approved special education programs for children with disabilities. The Committee on Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related services.



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ii) SSHSP services rendered to children five (5) through twenty-one (21) years of age in conjunction with an approved IEP are categorized as Non-Covered.

iii) The SSHSP services are identified on eMedNY by unique rate codes through which only school districts can claim Medicaid reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.

d) Comprehensive Medicaid Case Management (CMCM)

A program which provides "social work" case management referral services to a targeted population (e.g.: pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but refer to a wide range of service Providers. Some of these services are: medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical providers. Consequently, if an Enrollee of the Contractor is participating in a CMCM program, the Contractor must work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care Enrollee on EMEVS and informed on the need to contact the Contractor to coordinate service provision.

e) School-Based Health Centers

A School-Based Health Center (SBHC) is an Article 28 extension clinic that is located in a school and provides students with primary and preventive physical and mental health care services, acute or first contact care, chronic care, and referral as needed. SBHC services include comprehensive physical and mental health histories and assessments, diagnosis and treatment of acute and chronic illnesses, screenings (e.g., vision, hearing, dental, nutrition, TB), routine management of chronic diseases (e.g., asthma, diabetes), health education, mental health counseling and/or referral, immunizations and physicals for working papers and sports.

f) Conversion or Reparative Therapy

Conversion Therapy is any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to

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prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

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# K.4

## Family Health Plus
## Non-Covered Services

1. Non-emergency Transportation Services (except for 19 and 20 year olds receiving C/THP Services per K.2, Section 23. e) of this Appendix, in counties that have not implemented the Medicaid Managed Care transportation carve-out)
2. Personal Care Services
3. Private Duty Nursing Services
4. Long Term Care – Residential Health Care Facility Services
5. Medical Supplies
6. Alcohol and Substance Abuse (ASA) Services Ordered by the LDSS
7. Office of Mental Health/ Office for People With Developmental Disabilities
8. School Supportive Health Services
9. Comprehensive Medicaid Case Management (CMCM)
10. Directly Observed Therapy for Tuberculosis Disease
11. AIDS Adult Day Health Care
12. Home and Community Based Services Waiver
13. Opioid Treatment Program (OTP)
14. Day Treatment
15. IPRT
16. Infertility Services
17. Adult Day Health Care
18. School Based Health Care Services
19. Personal Emergency Response System
20. Consumer Directed Personal Assistance Services
21. Orthodontia

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# APPENDIX L

# Approved Capitation Payment Rates

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# APPENDIX M

# Service Area and Benefit Package Options

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**Service Area, Program Participation and**
**Prepaid Benefit Package Optional Covered Services**

## 1. Service Area

The Contractor's service area is comprised of the counties listed in Column A of this schedule in their entirety.

## 2. Program Participation and Optional Benefit Package Covered Services

a) For each county listed in Column A of Section 3 below, an entry of "yes" in the subsections of Columns B, C and D means the Contractor offers the MMC, HIV SNP, and/or HARP product and/or includes the optional service indicated in its Benefit Package.

b) For each county listed in Column A of Section 3 below, an entry of "no" in the subsections of Columns B, C and D means the Contractor does not offer the MMC, HIV SNP and/or HARP product and/or does not include the optional service indicated in its Benefit Package.

c) For each county listed in Column A below, the Contractor shall commence covering Behavioral Health Services in the Benefit Package on such county's effective date of Behavioral Health Benefit Inclusion.

d) The Contractor is authorized to offer the cost-effective alternative service listed in Column A of Section 4 below.

## 3. Effective Date

The effective date of this Schedule is March 1, 2019.

| **Contractor:** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Column A County** | **Column B Medicaid Managed Care** | | | | **Column C HIV SNP** | | | | **Column D HARP** | | | |
| | Contractor Participates | Family Planning | Non-Emergency Transportation | Emergency Transportation | Contractor Participates | Family Planning | Non-Emergency Transportation | Emergency Transportation | Contractor Participates | Family Planning | Non-Emergency Transportation | Emergency Transportation |
| | | | | | | | | | | | | |
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## 4. Cost-Effective Alternative Services

The effective date of this Schedule is March 1, 2019.

| **Contractor:** | |
|---|---|
| Column A: Service | Column B: NYS Authorization Number |
| | |
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# APPENDIX N

Reserved

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# Appendix O

# Requirements for Proof of Workers' Compensation and Disability Benefits Coverage

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# Requirements for Proof of Coverage

Unless the Contractor is a political sub-division of New York State, the Contractor shall provide proof, completed by the Contractor's insurance carrier and/or the Workers' Compensation Board, of coverage for:

**1.** **Workers' Compensation**, for which one of the following is incorporated into this Agreement herein as an attachment to Appendix O:

a) **CE-200** – Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; **OR**

b) **C-105.2** – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; **OR**

c) **SI-12** – Certificate of Workers' Compensation Self-Insurance, or **GSI-105.2** – Certificate of Participation in Workers' Compensation Group Self-Insurance.

**2.** **Disability Benefits Coverage**, for which one of the following is incorporated into this Agreement herein as an attachment to Appendix O:

a) **CE-200** – Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; **OR**

b) **DB-120.1** – Certificate of Disability Benefits Insurance; **OR**

c) **DB-155** – Certificate of Disability Benefits Self-Insurance.

**NOTE: ACORD forms are <u>NOT</u> acceptable proof of coverage.**

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# APPENDIX P

## Facilitated Enrollment and Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreements

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**P.1**

**Facilitated Enrollment Agreement**

## 1. Effective Date of Agreement

a) This Appendix shall become effective on the date specified in the written notice from SDOH to the Contractor to initiate Facilitated Enrollment services for the MMC and FHPlus Programs.

b) This Appendix shall be effective subject to statutory authority to conduct Facilitated Enrollment for the MMC and/or FHPlus Program.

## 2. Compensation

a) The Contractor shall not offer compensation to facilitators, including salary increases or bonuses, based solely on the number of individuals they enroll. However, the Contractor may base compensation of facilitators on periodic performance evaluations which consider enrollment productivity as one of several performance factors during a performance period, subject to the following requirements:

i) "Compensation" shall mean any remuneration required to be reported as income or compensation for federal tax purposes;

ii) The Contractor may not pay a "commission" or fixed amount per enrollment;

iii) The Contractor may not award bonuses more frequently than quarterly, or for an annual amount that exceeds ten percent (10%) of a facilitator's total annual compensation;

iv) Sign-on bonuses for facilitators are prohibited;

v) Where productivity is a factor in the bonus determination, bonuses must be structured in such a way that productivity carries a weight of no more than 30% of the total bonus and that application quality/accuracy must carry a weight equal to or greater than the productivity component;

vi) The Contractor must limit salary adjustments for facilitators to annual adjustments except where the adjustment occurs during the first year of employment after a traditional trainee/probationary period or in the event of a company wide adjustment;

vii) The Contractor is prohibited from reducing base salaries for facilitators for failure to meet productivity targets;

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viii) The Contractor is prohibited from offering non-monetary compensation such as gifts and trips to facilitators;

ix) The Contractor shall have human resources policies and procedures for the earning and payment of overtime and must be able to provide documentation (such as time sheets) to support overtime compensation.

b) The Contractor shall keep written documentation, including performance evaluation tools, of the basis it uses for awarding bonuses or increasing the salary of facilitators and employees involved in the facilitated enrollment program and make such documentation available for inspection by SDOH or the LDSS.

**3. Confidentiality**

a) The Contractor shall maintain confidentiality of applicant and Enrollee information in accordance with protocols developed by the Contractor and approved by SDOH.

b) Information concerning the determination of eligibility for MMC, CHPlus, and FHPlus may be shared by the Contractor (including its employees and/or subcontractors) and the SDOH, LDSS, and the Enrollment Broker, provided that the applicant has given appropriate written authorization on the application and that the release of information is being provided solely for purposes of determining eligibility or evaluating the success of the program.

c) Contractor acknowledges that any other disclosure of Medicaid Confidential Data ("MCD") without prior, written approval of the SDOH MCD Review Committee ("MCDRC") is prohibited. Accordingly, the Contractor will require and ensure that any approved agreement or contract pertaining to the above programs contains a statement that the subcontractor or other contracting party may not further disclose the MCD without such approval.

d) Contractor assures that all persons performing Facilitated Enrollment activities will receive appropriate training regarding the confidentiality of MCD and provide SDOH with a copy of the procedures that Contractor has developed to sanction such persons for any violation of MCD confidentiality.

e) Upon termination of this Agreement for any reason, Contractor shall ensure that program data reporting is complete and shall certify that any electronic or paper copies of MCD collected or maintained in connection with this Agreement have been removed and destroyed.

**4. Outreach and Information Dissemination**

a) The Contractor shall provide prospective enrollees, upon request, with pre-enrollment and post enrollment information pursuant to PHL§4408 and SSL §364-j.



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b) The Contractor shall provide prospective enrollees, upon request, with the most current and complete listing of participating providers, as described in Section 13.2(a) of this Agreement, in hardcopy, along with any updates to that listing.

c) Contractor agrees to comply with the following restrictions regarding Facilitated Enrollment:

i) No Facilitated Enrollment will be permitted in emergency rooms or treatment areas; Facilitated Enrollment may be permitted in patient rooms only upon request by the patient or their representative.

ii) No telephone cold-calling and no door-to-door solicitations at the homes of prospective Enrollees.

iii) No facilitated enrollment may occur at homeless shelters unless a shelter specifically makes a request to an MCO. MCOs are required to submit requests along with the request from the shelter to the LDSS and SDOH for approval. Once the MCO receives approval, the MCO must include the location(s) on their monthly facilitated enrollment report.

iv) No incentives to Prospective Enrollees to enroll in an MCO are allowed. The Contractor may offer nominal gifts of not more than five ($5.00) in fair-market value as part of a health fair or facilitated enrollment activity to stimulate interest in the MMC or FHPlus program and/or the Contractor. Such gifts must be pre-approved by the SDOH and offered without regard to enrollment. The Contractor must submit a listing and description of intended items to be distributed during facilitated enrollment activities as nominal gifts, including a listing of item donors or co-sponsors for approval. The submission of actual samples or photographs of intended nominal gifts will not be routinely required, but must be made available upon request by the SDOH reviewer.

v) No facilitated enrollment may occur within a two block perimeter of an HRA facility.

vi) No facilitated enrollment may occur in locations that are not conducive to confidential and personal discussion between the Facilitated Enroller and the uninsured individual. Locations include but are not limited to, banks, fast food restaurants and nail salons unless prior arrangements have been made to meet an uninsured individual at one of these specified locations and privacy can be assured.

vii) The Contractor is not allowed to set up tables throughout the City unless a facilitated enroller is present to communicate with prospective enrollees. The Contractor must obtain permission from the proprietor when using a card display rack or similar type of product.

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d) The Contractor is responsible for local publicity regarding locations and hours of operation of Facilitated Enrollment sites.

e) The Contractor may use only SDOH approved information in conducting Facilitated Enrollment; but the Contractor can tailor materials to the needs of individual communities, subject to SDOH approval of any such modifications.

**5. Sanctions for Non-Compliance**

If the Contractor is found to be out of compliance with the terms and conditions required under Facilitated Enrollment, SDOH may suspend facilitated enrollment activities to protect the interest of potential enrollees and the integrity of the facilitated enrollment program.

The SDOH, in consultation with the LDSS, may terminate the Contractor's responsibilities relating to Facilitated Enrollment if the Contractor commits further infractions, fails to implement a corrective action plan in a timely manner or commits an egregious first-time infraction, in addition to any other legal remedy available to SDOH in law or equity. SDOH will give the Contractor sixty (60) days written notice if it determines that the Contractor's Facilitated Enrollment responsibilities must be terminated.

**6. Contractor Termination of Facilitated Enrollment**

The Contractor may terminate its Facilitated Enrollment responsibilities under this Agreement upon sixty (60) day written notice to the SDOH.

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**P.2**

**Federal Health Insurance Portability and Accountability Act ("HIPAA")**
**Business Associate Agreement (Agreement)**

With respect to its performance of Facilitated Enrollment services for Family Health Plus and Medicaid, the Contractor shall comply with the following:

**1. Definitions**

a) Business Associate shall mean the Contractor.

b) Covered Program shall mean the State.

c) Other terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing regulations, including those at 45 CFR Parts 160 and 164.

**2. Obligations and Activities of the Business Associate**

a) The Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law.

b) The Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to implement administrative, physical, and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c) The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Agreement.

d) The Business Associate agrees to report to the Covered Program as soon as reasonably practicable, any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware. The Business Associate also agrees to report to the Covered Entity any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:

i) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

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ii) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

iii) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

iv) A description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and

v) Contact procedures for the Covered Program to ask questions or learn additional information.

e) The Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by the Business Associate on behalf of the Covered Program agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.

f) The Business Associate agrees to provide access, at the request of the Covered Program, and in the time and manner designated by the Covered Program, to Protected Health Information in a Designated Record Set, to the Covered Program in order for the Covered Program to comply with 45 CFR § 164.524.

g) The Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Program directs in order for the Covered Program to comply with 45 CFR § 164.524.

h) The Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Covered Program available to the Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by the Covered Program or the Secretary, for purposes of the Secretary determining the Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.

i) The Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.

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j) The Business Associate agrees to provide to the Covered Program, in a time and manner designated by the Covered Program, information collected in accordance with this Agreement, to permit the Covered Program to comply with 45 CFR §164.528.

k) The Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.

**3. Permitted Uses and Disclosures by Business Associate**

a) General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, the Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, the Covered Program as specified in this Agreement.

b) Specific Use and Disclosure Provisions

i) Except as otherwise limited in this Agreement, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

ii) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out its legal responsibilities and to provide Data Aggregation services to Covered Program as permitted by 45 CFR § 164.504(e)(2)(i)(B). Data Aggregation includes the combining of protected information created or received by a Business Associate through its activities under this Agreement with other information gained from other sources.

iii) The Business Associate may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

**4. Obligations of Covered Program**

a) Provisions for the Covered Program to Inform the Business Associate of Privacy Practices and Restrictions

i) The Covered Program shall notify the Business Associate of any limitation(s) in its notice of privacy practices of the Covered Program in accordance with 45 CFR

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§ 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.

ii) The Covered Program shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.

iii) The Covered Program shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Program has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.

**5. Permissible Requests by Covered Program**

The Covered Program shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Program, except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate.

**6. Term and Termination**

a) This Agreement shall be effective as of the date noted in Section P.1 (1) of this Appendix.

b) Termination for Cause. Upon the Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for the Business Associate to cure the breach and end the violation or may terminate this Agreement and the master Agreement if the Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or the Covered Program may immediately terminate this Agreement and the master Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible. If the Covered Program terminates this Agreement for cause under this paragraph, all Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to the Covered Program in accordance with paragraph (c) of this section.

c) Effect of Termination.

i) Upon termination of this Agreement for any reason all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program in accordance with the following:

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A) Protected Health Information provided to Business Associate on either the *Growing Up Healthy* or *Access New York Health Care* applications that have been fully processed by Business Associate shall be destroyed by Business Associate, or, if it is infeasible for Business Associate to destroy such information, Business Associate shall provide to the Covered Program notification of the conditions that make destruction infeasible and, upon mutual agreement of the Parties, return Protected Health Information to the Covered Program.

B) Upon termination of this Agreement for any reason, Protected Health Information provided to Business Associate on either the *Growing Up Healthy* or *Access New York Health Care* applications that have not been fully processed by Business Associate shall be returned to the Covered Program.

C) No copies of the Protected Health Information shall be retained by the Business Associate once this Agreement has been terminated.

**7. Violations**

a) It is further agreed that any violation of this Agreement may cause irreparable harm to the State; therefore, the State may seek any other remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.

b) The Business Associate shall indemnify and hold the State harmless against all claims and costs resulting from acts/omissions of the Business Associate in connection with the Business Associate's obligations under this Agreement. The Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the State from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law Section 208, caused by any intentional act or negligence of the Business Associate, its agents, employees, partners or subcontrators, without limitation; provided however, that the Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.

**8. Miscellaneous**

a) Regulatory References. A reference in this Agreement to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.

b) Amendment. The Business Associate and the Covered Program agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR



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Parts 160 and 164.

c) Survival. The respective rights and obligations of the Business Associate under Section 6 of this Appendix shall survive the termination of this Agreement.

d) Interpretation. Any ambiguity in this Appendix shall be resolved in favor of a meaning that permits the Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.

e) If anything in this Agreement conflicts with a provision of any other agreement on this matter, this Agreement is controlling.

f) HIV/AIDS. If HIV/AIDS information is to be disclosed under this Agreement, the Business Associate acknowledges that it has been informed of the confidentiality requirements of Article 27-F of the Public Health Law.

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# APPENDIX Q

## New York State Department of Health
## Recipient Restriction Program Requirements
## for MMC and FHPlus Programs

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## SDOH Recipient Restriction Program Requirements

The Recipient Restriction Program is intended to reduce the cost of inappropriate utilization of Medicaid and FHPlus covered services by identifying and managing Enrollees exhibiting abusive or fraudulent behavior. Through increased coordination of medical services that control the number of providers the Enrollee may select for care and the referrals to services, medications, and equipment, Enrollees in the Recipient Restriction Program are ensured access to medically necessary quality health care, and unnecessary costs to the Medicaid program are prevented.

### 1. Definitions

a) Recipient Restriction Program (RRP) means the Contractor's program whereby selected Enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more RRP Providers for receipt of medically necessary services included in the Benefit Package.

b) FFS Recipient Restriction Program (FRRP) means a medical review and administrative mechanism performed by the Office of the Medicaid Inspector General (OMIG) whereby selected Medicaid recipients with a demonstrated pattern of abusing or misusing Medicaid benefits or who have engaged in abusive practices may be restricted to one or more health care providers.

c) Restricted Enrollee means an Enrollee who has engaged in Abusive Practices or demonstrated a pattern of misuse of a category of Medicaid or FHPlus benefits and has been restricted by either the Contractor or OMIG to receive certain services only from an assigned RRP Provider, or if required to effect the restriction, only as referred by an assigned RRP Provider. The amount, duration and scope of the Medicaid or FHPlus benefit is not reduced.

d) RRP Provider means a Participating Provider who is:

i) an inpatient hospital responsible for all covered non-emergency inpatient services or arranging referrals for specialty care to the Restricted Enrollee; or

ii) a pharmacy responsible for providing all covered and authorized drugs and pharmaceutical supplies to the Restricted Enrollee; or

iii) a dentist or dental clinic/group responsible for providing or arranging referrals for all dental care for the Restricted Enrollee; or

iv) a PCP, specialty provider acting as the PCP, or a primary care clinic responsible for managing the healthcare of the Restricted Enrollee, including referrals to specialty services, as specified by Section 21 of this Agreement; or

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v) a podiatrist responsible for providing or arranging referrals for all podiatric care for the Restricted Enrollee; or

vi) any other type of provider, including a provider of ancillary services, responsible for delivery of services included in the Benefit Package, as may be required to ensure access and coordination of medically necessary covered services for the Restricted Enrollee.

e) Abusive Practice means an Enrollee who(se):

i) Medicaid Benefits or MCO identification card is used or attempted to be used to obtain services for an unauthorized person;

ii) Medicaid Benefits or MCO identification card is used or attempted to be used to present a forged or altered prescription or fiscal order to a FFS provider or Participating Provider to obtain supplies, drugs or services under the Medicaid program;

iii) presents a forged or altered prescription or fiscal order to a FFS provider or Participating Provider to obtain supplies, drugs or services;

iv) is in possession of more than one Medicaid Benefits identification card or more than one MCO identification card which represent more than one Medicaid active cases;

v) sells or trades, or attempts to sell or trade, drugs or supplies acquired with a Medicaid Benefits or MCO identification card or whose Medicaid Benefits or MCO identification card is used or attempted to be used to sell or trade, drugs or supplies acquired with a Medicaid Benefits or MCO identification card;

vi) leaves an emergency department or urgent care clinic against medical advice after receiving controlled substances on three or more occasions within a one-month period;

vii) obtains or attempts to obtain early overlapping supplies of the same controlled substance from three or more pharmacies in a single month; or

viii) obtains or attempts to obtain the same type of durable medical equipment from three or more different durable medical equipment dealers in a three-month period.

f) RRP Review Team (RRPRT) means a Contractor identified professional team comprised of, at a minimum, a physician, registered professional nurse and a pharmacist. The RRPRT shall review and determine whether the enrollee has demonstrated a pattern of over utilization, inappropriate under utilization or mis-utilization of services included in the Benefit Package and whether such behavior

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meets the Contractor's criteria for restriction and should be managed by the Contractor's Recipient Restriction Program.

## 2. Enrollees Subject to the Restriction Program

a) Enrollees to be restricted are:

i) New Enrollees restricted under the FRRP prior to the effective date of enrollment, where the restriction period for services included in the Benefit Package has not yet expired;

ii) New Enrollees restricted under another MCO's RRP, where the restriction period has not yet expired;

iii) Enrollees whose utilization or abuse of services included in the Benefit Package meets the criteria for restriction under the Contractor's Restricted Recipient Program and this Appendix;

iv) Enrollees who are found by the OMIG to have engaged in Abusive Practices;

v) Enrollees who are restricted by the FRRP for Medicaid services not included in the Benefit Package and OMIG determines a restriction on services included in the Benefit Package is required by the Contractor's RRP to ensure misuse of Medicaid services is prevented; or

vi) Enrollees who meet the criteria for continued restriction under the FRRP and/or the Contractor's RRP, or who are non-compliant with restriction requirements as provided by 18 NYCRR 360-6.4 or the Contractor's approved criteria.

## 3. Contractor Responsibilities

a) The Contractor must have effective mechanisms to ensure an Enrollee is restricted to an RRP Provider upon enrollment for Enrollees meeting the condition of Section (2)(a)(i) or (ii) of this Appendix if the restriction is indicated on the Contractor's roster on the Effective Date of Enrollment, and within 45 days of confirming an Enrollee has met the conditions in Section (2)(a)(iii), (iv) or (v) of this Appendix.

b) The Contractor must have effective mechanisms to monitor Benefit Package services provided to the Restricted Enrollee and identify when a Restricted Enrollee attempts to access restricted services from other than their RRP Provider. When a restriction is in place, the Enrollee may only access the restricted service through the RRP Provider(s), except where the Enrollee is referred to an alternate provider authorized by the Contractor or the RRP Provider.

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c) The Contractor must have effective mechanisms for identifying Participating Providers who are able to function as RRP Providers and meet the requirements for providing necessary health care services and referrals for Restricted Enrollees.

i) The Contractor must inform the RRP Provider of their responsibilities for providing care and referrals for the Restricted Enrollee.

ii) The Contractor shall institute and maintain a current patient profile for each Enrollee restricted for pharmacy services. Such profile must contain, at a minimum: the identity of the prescriber of the drugs and supplies; the strength, quantity and dosage regimen of any drugs; and the dates of service for all drugs and supplies dispensed. The profile may be maintained by the Contractor, by its pharmacy network subcontractor, or by the RRP Pharmacy. The profile must be available/accessible upon request by the SDOH, OMIG and the Contractor.

iii) The Contractor shall send written notice confirming an Enrollee's restriction to the RRP Provider, including: the date of the restriction; the scope, type, and length of restriction; and any other Enrollee restrictions and associated RRP Providers. Such notice shall be made when the Contractor imposes, modifies, or continues a restriction or when the Contractor changes the Restricted Enrollee's RRP Provider. Such notice is not required when the Contractor administers an existing restriction for a new Enrollee as provided by Section 4(c)(i) and (ii) of this Appendix.

d) The Contractor must have effective mechanisms to review utilization data and other information as may be necessary to, at a minimum, identify Enrollee behaviors, as described in Section 4(i) of this Appendix, that may indicate Abusive Practices or pattern of misuse of services.

e) The Contractor shall establish criteria for determining an Enrollee has engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services that is in accordance with 18 NYCRR 360-6.4 where appropriate, and consistent with criteria established by OMIG. Prior to the Contractor implementing criteria which exceeds the current restriction criteria, the Contractor must obtain approval of such criteria from OMIG.

**4. Protocols for Restrictions**

a) Restriction for Misuse of Benefit Package Services.

i) The Contractor shall routinely review utilization data, such as encounter data, to assess and identify whether any Enrollee appears to have a pattern of over utilization, under utilization or mis-utilization of Medicaid or FHPlus services and restrict Enrollees where misuse of services meets the Contractor's criteria for restriction. See Section 4(i) below for indicators of suspected misuse of services.

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ii) The RRPRT will perform an analysis of Enrollee-specific data and/or conduct a complete review of the Enrollee's medical records and any other information the RRPRT deems appropriate to make a determination about the medical appropriateness of such services.

iii) The RRPRT may determine whether the Enrollee's pattern of care is appropriate, that the Enrollee is to be referred to the Contractor's case management services to improve coordination of care, that the Enrollee has demonstrated a pattern of misuse and is to be restricted to an RRP provider(s) with appropriate notice as required in Section 6 of this Appendix, or that, where the misuse of care was due to provider actions, other appropriate corrective actions are to be taken. All determinations will be in writing and signed by a licensed, certified or registered health care professional who is a member of the RRPRT.

A) The Contractor will not restrict an Enrollee where the pattern of care under review is found to be the result of an adverse change in the Enrollee's health status, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs, prior to making reasonable efforts to improve the Enrollee's coordination of services through case management or other appropriate methods.

iv) The RRPRT may determine, upon information provided by the Enrollee through an Action Appeal, fair hearing or other credible source, that the pattern of care does not meet the Contractor's criteria for restriction, and will subsequently promptly remove any such restriction of services, if previously implemented.

v) The RRPRT will coordinate findings of both Contractor and OMIG initiated restrictions with the Contractor's SIU and/or Quality assurance program, as appropriate.

vi) The Contractor shall restrict Enrollees, with appropriate notice as required in Section 6 of this Appendix, where OMIG has determined a restriction on Benefit Package services is required to effectively implement a restriction on Medicaid services that are not part of the Benefit Package. OMIG will be responsible for providing documented evidence and other supporting documentation as needed to support the restriction and complete the Recipient Information Packet.

A) Upon notice of a Fair Hearing to be held in relation to such restriction, the Contractor will be responsible for notifying OMIG of the Fair Hearing and OMIG will be responsible for assisting the Contractor in presenting evidence and appearing at the hearing in support of the restriction as provided by Section 25.6 of this Agreement. Such assistance may include, upon request by the Enrollee to the Contractor, providing records which can identify services paid for by FFS on behalf of the Enrollee.

b) Restriction for Abusive Practice.

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i) The Contractor shall restrict Enrollees, with appropriate notice as required in Section 6 of this Appendix, confirmed by the Contractor, SDOH or OMIG to have engaged in an Abusive Practice, as defined by Section 1 (e) of this Appendix. Restriction for a confirmed Abusive Practice does not require a review by the RRPRT.

ii) When the Contractor is to impose a restriction on an Enrollee for Abusive Practices confirmed by OMIG, OMIG is responsible for providing documented evidence and other supporting documentation as needed to support the restriction and complete the Recipient Information Packet.

A) Upon notice of a Fair Hearing to be held in relation to such restriction, the Contractor will be responsible for notifying OMIG of the Fair Hearing and OMIG will be responsible for assisting the Contractor in presenting evidence and appearing at the hearing in support of the restriction as provided by Section 25.6 of this Agreement. Such assistance may include, upon request by the Enrollee to the Contractor, providing records which can identify services paid for by FFS on behalf of the Enrollee.

c) Recipient Restriction Prior to Enrollment.

i) For Enrollees who were restricted prior to the effective date of enrollment, whether by the FRRP or another MCO's RRP, restricted information will be included in the Contractor's monthly enrollment Roster or other State issued notification. OMIG is responsible for providing the date that the restriction ends to the Contractor, as well as the recipient information packet (or similar documentation with the reason for restriction) and the name of current restricted provider.

ii) The Contractor will implement and administer the restriction until the end of the restricted period. Such administration of an existing restriction is not a new restriction, is not an Action under Appendix F of this Agreement, and does not require a Notice of Intent to Restrict. However, the Contractor will inform a new Enrollee in writing, which may be combined with the welcome letter or other notice, that the existing restriction will continue to be implemented for the same purpose and time period as previously imposed by an LDSS or MCO. The Contractor shall monitor the Enrollee to determine if the Enrollee's actions meet the Contractor's criteria for additional restrictions, in accordance with (a) or (b) above, and if so determined, the Contractor will restrict with appropriate notice as required by Section 6 of this Appendix and notify OMIG of their action within ten (10) business days.

iii) Except for Court Ordered Restrictions, if the Enrollee is restricted to an RRP Provider that is not participating in the Contractor's Network, the Contractor shall provide transitional care as required by Section 15.6 of this Agreement and shall

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require the Restricted Enrollee to change the RRP Provider as specified in Section 5 of this Appendix.

d) Court Ordered Restrictions. The Contractor shall comply with restrictions ordered by, and the associated RRP provider selected by, a court of competent jurisdiction, in accordance with Section 10.9 of this Agreement. The Contractor will initiate restrictions to Enrollees in local districts where the RRP is a part of the Drug Treatment Court contract.

e) Continued Restriction.

i) The Contractor shall monitor the Enrollee's compliance with a restriction. Sixty (60) days prior to the end of the restriction period, the Contractor will assess the Enrollee's compliance with the restriction and determine whether an additional restriction period is appropriate.

A) The Contractor will continue the restriction when it is determined by the Contractor that the Enrollee's actions continue to meet criteria for restriction, as provided by Section (a) above, or there is evidence of non-compliance with a restriction.

B) The Contractor will continue restriction when it is confirmed that during the previous restriction period, an Enrollee engaged in Abusive Practices; received or attempted to receive services inappropriately from non-RRP providers; or was placed in additional restriction by the FRRP.

ii) The Contractor's determination not to continue a restriction will in no way preclude any subsequent decisions to restrict as provided by (a) or (b) above.

iii) An Enrollee restricted for an additional period will have the same rights and is entitled to all appropriate notices informing his/her of the proposed action, as required in Section 6 of this Appendix.

f) Emergency Services. At no time will the Contractor restrict an Enrollee's access to Emergency Services or to a specific provider of Emergency Services or deny coverage of Emergency Services for a Restricted Enrollee, except as provided by Appendix G of this Agreement.

g) Length of a Restriction.

i) Restriction time periods shall be consistent with the lengths identified in 18 NYCRR § 360-6.4(h).

ii) All restriction periods continue for the specified time without regard to eligibility for, or receipt of, Medicaid or FHPlus benefits.

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iii) For a Restricted Enrollee who disenrolls from the Contractor's plan for any reason, and subsequently re-enrolls in the Contractor's plan, the restriction will continue until its scheduled expiration date, as if the Enrollee did not have a gap in coverage.

h) Reporting Enrollee Restrictions.

i) The Contractor shall report new, continued, and modified Enrollee Restrictions in accordance with Section 18.5(~~xvi~~a)(viii)(A) of this Agreement. OMIG, LDSS, and the NYSoH when program features allow, will be responsible for ensuring Medicaid eligibility systems are updated with restriction information.

ii) The Contractor shall send Restriction Notifications with supporting documentation to the OMIG. OMIG will be responsible for sending the previous plan's Restriction Notification to the new Contractor within thirty (30) days.

i) Abusive Practice or Pattern of Misuse of Services. The following behaviors may be indicative of aberrant utilization activity or Abusive Practices by an Enrollee:

i) Excessive drugs, supplies or appliances. The Enrollee has received more of a drug, medical supply or appliances in a specified time period than is necessary, according to acceptable medical practice.

ii) Duplicative drugs, supplies or appliances. The Enrollee has received two or more similarly acting drugs in an overlapping time frame or has received duplicative supplies or appliances. The drugs, if taken together, may result in harmful drug interactions or adverse reactions. Duplicative supplies and appliances, while not harmful, have no medical indication and are therefore unwarranted.

iii) Duplicative health care services. The recipient has received health care services from two or more providers for the same or similar conditions in an overlapping time frame. Health care services include, but are not limited to, physician, clinic pharmacy, dental, podiatry, and DME services.

iv) Contraindicated or conflicting care. The Enrollee has received drugs, supplies or appliances and/or health care services which may be inadvisable in the presence of certain medical conditions or which conflict with care being provided or ordered by another provider.

v) Unnecessary hospital emergency room services. The Enrollee has received services in a hospital emergency room for a condition which does not require emergency care or treatment.

vi) Excessive inpatient hospital services. The Enrollee has received multiple inpatient hospital discharges for the same or similar conditions which are more than necessary, according to acceptable medical practice, including but not limited to:

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multiple inpatient hospital discharges against medical advice. For purposes of this paragraph, discharge against medical advice means discontinuance by a recipient of inpatient hospital services contrary to the advice of the attending physician.

**5. Enrollee Right to Change RRP Provider**

a) Upon imposing, modifying, continuing or administering a restriction, the Contractor may assign an RRP Provider or afford the Enrollee a choice of RRP Providers.

b) Upon request, the Contractor will allow a Restricted Enrollee to change RRP Providers without cause in accordance with 18 NYCRR § 360-6.4(e) or at any time with good cause as determined by the Contractor.

c) The Contractor will allow changes to PCPs as provided in Section 5 b) above. The Contractor will process a request to change a PCP in accordance with Section 21.9 b) of this Agreement. The Contractor will assign a new PCP in accordance with Section 21.9 c), d), and e) i) – v) of this Agreement.

d) The Contractor will provide transitional care to a Restricted Enrollee if the RRP Provider leaves the Contractor's network, in accordance with Section 15.6 of this Agreement.

e) Good cause for a Restricted Enrollee to change an RRP provider means one or more of the following circumstances exist:

i) the RRP Provider no longer wishes to be a provider for the Enrollee;

ii) the RRP Provider has closed the servicing location or moved to a location that is not convenient for the Restricted Enrollee;

iii) the RRP Provider has been suspended, terminated, excluded or otherwise disqualified from participation in the Medicaid program;

iv) the Restricted Enrollee's place of residence has changed such that he/she has moved beyond time and distance standards as described in Section 15.5 of this Agreement; or

v) other circumstances exist that make it necessary to change RRP providers, including but not limited to, good cause reasons for changing PCPs as provided by applicable statute and regulations.

**6. Notice Requirements When Contractor Determines to Initiate a New, Modified or Continued Restriction**

a) The Contractor shall prepare a written summary of the specific reason(s) for a restriction known as the Recipient Information Packet, including, but not limited to, a

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summary of any review conducted by and determination of the RRPRT, and evidence confirming the Enrollee engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services.

b) The Contractor must send a Notice of Intent to Restrict to the Enrollee at least 10 days prior to the effective date of the restriction. The period of advance notice is shortened to five (5) days in cases of confirmed enrollee fraud. The Notice of Intent to Restrict is a Notice of Action as provided by Appendix F of this Agreement. The Notice of Intent to Restrict is not a medical necessity coverage determination as defined by PHL Article 49.

c) The Contractor shall ensure that the Notice of Intent to Restrict is in writing, is in easily understood language, and is accessible to non-English speaking and visually impaired Enrollees. The notice shall include that oral interpretation and alternate formats of written materials for Enrollees with special needs are available and how to access the alternate formats.

d) Notice of Intent to Restrict shall also include:

i) All information as required for a Notice of Action as provided by Appendix F of this Agreement in Section F.1(5)(a)(iii)(A) through (G), and (~~K~~M);

ii) the date the restriction will begin;

iii) the effect, scope and type of the restriction, including:

A) the right of the Contractor to designate an RRP Provider(s) for the Enrollee;

B) the services to be restricted;

C) the time period of the restriction and indicate if re-restriction;

D) the name, address and phone number of the RRP Provider(s) the Enrollee will be restricted to, or name of the RRP Providers offered for the Enrollee's selection;

E) instructions on how to access Medicaid or FHPlus covered services while the restriction is in place, including that emergency services are available without restriction;

F) a statement that the restriction will remain in place for the full time period regardless if the Enrollee changes MCOs, returns to FFS, or loses MMC or FHPlus eligibility; and

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G) a statement that if the Enrollee attempts to receive a restricted services from a provider other than the RRP provider, the Contractor will not approve or pay for the services;

iv) the Recipient Information Packet, as described in 6(a) above;

v) if the Contractor affords the Enrollee a choice of RRP Providers, the right of the Enrollee to select an RRP Provider within two weeks of the date of the Notice of Intent to Restrict and a statement that if an RRP Provider is not selected, an RRP Provider will be assigned by the Contractor;

vi) the Enrollee's right to request a change of RRP Provider without cause in accordance with Section 5 b) of the Appendix, or at any time for good cause;

vii) the Enrollee's right to a fair hearing and the notice entitled "Managed Care Action Taken," containing the full description of the Enrollee's fair hearing rights, instructions for requesting a fair hearing, and aid continuing rights;

viii) a statement that requesting an Action Appeal does not suspend the effective date listed on the Notice of Intent to Restrict;

ix) a statement that an Action Appeal does not take the place of or abridge the Enrollee's right to a fair hearing; and

x) the Enrollee's right to present evidence in person or in writing to support his or her Action Appeal and to examine his or her case record, including records maintained by the Contractor which identifies Benefit Package services paid for by the Contractor on behalf of the Enrollee, or if the Contractor initiated restriction is required by OMIG, records which identify services paid for by FFS on behalf of the Enrollee.

**7. Records**

a) The Contractor shall maintain a file on each review conducted by the RRPRT and for each Restricted Recipient. These records shall be readily available for review, on-site or off-site, by SDOH and/or OMIG, upon request. The file shall include:

i) Relevant data collected during review activity in Section 4(a) of this Appendix supporting a restriction;

ii) summary of all the RRPRT reviews and determinations, including Contractor staff involved;

iii) evidence of Abusive Practices or other documentation supporting administrative restriction for other than medical reasons;

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iv) the Recipient Information Packet;

v) the Notice of Intent to Restrict;

vi) a copy of any Action Appeal filed, if written, and any additional information presented during Action Appeal or a fair hearing, and results of such Action Appeals and fair hearings; and

vii) if applicable, the specific rationale for the RRPRT's determination to not apply a restriction, the Contractor's determination not to continue a restriction or the Contractor's determination to remove a restriction prior to the expiration date.

b) Upon request, the Contractor shall make all policies and procedures related to the administration of the RRP available to the OMIG. The Contractor shall modify these policies and procedures as directed by OMIG in consultation with the SDOH.

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# APPENDIX R

# Additional Specifications for the MMC and FHPlus Agreement

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## Additional Specifications for the MMC and FHPlus Agreement

1. Contractor will give continuous attention to performance of its obligations herein for the duration of this Agreement and with the intent that the contracted services shall be provided and reports submitted in a timely manner as SDOH may prescribe.

2. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this Agreement will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Work for Hire Contract

   If pursuant to this Agreement the Contractor will provide the SDOH with software or other copyrightable materials, this Agreement shall be considered a "Work for Hire Contract." The SDOH will be the sole owner of all source code and any software which is developed or included in the application software provided to the SDOH as a part of this Agreement.

4. Technology Purchases Notification -- The following provisions apply if this Agreement procures only "Technology"

   a) For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

   b) If this Agreement is for procurement of software over $20,000, or other technology over $50,000, or where the SDOH determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO APPROVAL by OSC, this Agreement is subject to review by the Governor's Task Force on Information Resource Management.

   c) The terms and conditions of this Agreement may be extended to any other State agency in New York.

5. Subcontracting

   The Contractor agrees not to enter into any agreements with third party organizations for the performance of its obligations, in whole or in part, under this Agreement without the State's prior written approval of such third parties and the scope of the work to be

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performed by them. The State's approval of the scope of work and the subcontractor does not relieve the Contractor of its obligation to perform fully under this Agreement.

6. Sufficiency of Personnel and Equipment

If SDOH is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, SDOH shall have the authority to require the Contractor to use such additional personnel to take such steps necessary to perform the services satisfactorily at no additional cost to the State.

7. Provisions Upon Default

a) The services to be performed by the Contractor shall be at all times subject to the direction and control of the SDOH as to all matters arising in connection with or relating to this Agreement.

b) In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this Agreement, the SDOH acting for and on behalf of the State, shall thereupon have the right to terminate this Agreement by giving notice in writing of the fact and date of such termination to the Contractor, pursuant to Section 2 of this Agreement.

c) If, in the judgment of the SDOH, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the SDOH acting for and on behalf of the State, shall thereupon have the right to terminate this Agreement by giving notice in writing of the fact and date of such termination to the Contractor, pursuant to Section 2 of this Agreement.

8. Minority And Women Owned Business Policy Statement

The SDOH recognizes the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the SDOH's contracting program. This opportunity for full participation in our free enterprise system by traditionally socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the SDOH to provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

9. Insurance Requirements

a) The Contractor must without expense to the State procure and maintain, until final acceptance by the SDOH of the work covered by this Agreement, insurance of the kinds and in the amounts hereinafter provided, by insurance companies authorized to

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do such business in the State of New York covering all operations under this Agreement, whether performed by it or by subcontractors. Before commencing the work, the Contractor shall furnish to the SDOH a certificate or certificates, in a form satisfactory to SDOH, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or cancelled until thirty days written notice has been given to SDOH. The kinds and amounts of required insurance are:

i) A policy covering the obligations of the Contractor in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the Agreement shall be void and of no effect unless the Contractor procures such policy and maintains it until acceptance of the work.

ii) Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than $500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than $1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than $500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than $1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

A) Contractor's Liability Insurance issued to and covering the liability of the Contractor with respect to all work performed by it under this Agreement.

B) Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Agreement, by the Contractor or by its subcontractors, including omissions and supervisory acts of the State.

10. Certification Regarding Debarment and Suspension

a) Regulations of the U.S. Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in Federal program and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the Federal Government. A person who is debarred or suspended by a Federal agency is excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one Federal agency has government wide effect.

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b) Pursuant to the above cited regulations, the SDOH (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government wide exclusion (including an exclusion from Medicare and State health care program participation on or after August 25, 1995), and the SDOH must require its contractors, as lower tier participants, to provide the certification as set forth below:

i) CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

**Instructions for Certification**

A) By signing this Agreement, the Contractor, as a lower tier participant, is providing the certification set out below.

B) The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

C) The lower tier participant shall provide immediate written notice to the SDOH if at any time the lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

D) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. The Contractor may contact the SDOH for assistance in obtaining a copy of those regulations.

E) The lower tier participant agrees that it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR Subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

F) The lower tier participant further agrees that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions," without modification, in all lower tier covered transactions.

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G) A participant in a covered transaction may rely upon a certification of a participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR Subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Excluded Parties List System.

H) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

I) Except for transactions authorized under paragraph E of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR Subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

ii) Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

A) The lower tier participant certifies, by signing this Agreement, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department agency.

B) Where the lower tier participant is unable to certify to any of the statements in this certification, such participant shall attach an explanation to this Agreement.

11. Reports and Publications

a) Any materials, articles, papers, etc., developed by the Contractor pertaining to the MMC Program or FHPlus Program must be reviewed and approved by the SDOH for conformity with the policies and guidelines of the SDOH prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the Contractor shall be free to publish in scholarly journals along with a disclaimer

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that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health.

b) Any publishable or otherwise reproducible material developed under or in the course of performing this Agreement, dealing with any aspect of performance under this Agreement, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the State, and shall not be published or otherwise disseminated by the Contractor to any other party unless prior written approval is secured from the SDOH or under circumstances as indicated in paragraph (a) above. Any and all net proceeds obtained by the Contractor resulting from any such publication shall belong to and be paid over to the State. The State shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

c) No report, document or other data produced in whole or in part with the funds provided under this Agreement may be copyrighted by the Contractor or any of its employees, nor shall any notice of copyright be registered by the Contractor or any of its employees in connection with any report, document or other data developed pursuant to this Agreement.

d) All reports, data sheets, documents, etc. generated under this Agreement shall be the sole and exclusive property of the SDOH. Upon completion or termination of this Agreement the Contractor shall deliver to the SDOH upon its demand all copies of materials relating to or pertaining to this Agreement. The Contractor shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the SDOH or its authorized agents.

e) The Contractor, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this Agreement, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

12. Payment

Payment for claims/invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-6019. The Contractor acknowledges that it will not receive payment on any claims/invoices submitted under this Agreement if it does not comply with the State Comptroller's electronic payment procedures, except

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where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/epay.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

13. Provisions Related to New York State Procurement Lobbying Law

The State reserves the right to terminate this Agreement in the event it is found that the certification filed by the Contractor in accordance with New York State Finance Law § 139-k was intentionally false or intentionally incomplete. Upon such finding, the State may exercise its termination right by providing written notice to the Contractor in accordance with the written notification terms of this Agreement.

14. Provisions Related to New York State Information Security Breach and Notification Act

Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with such breach if caused by the Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or subcontractors.

15. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08005, *Accessibility of Web-Based Information and Applications*, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005, as determined by quality assurance testing. Such quality assurance testing will be conducted by NYSDOH and the awarded contractor and the results of such testing must be satisfactory to NYSDOH before web content will be considered a qualified deliverable under the contract or procurement.

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16. New York State Tax Law Section 5-a

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than $100,000 to certify to the New York State Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

17. M/WBE Utilization Plan for Subcontracting and Purchasing

The Department of Health (DOH) encourages the use of Minority and/or Women Owned Business Enterprises (M/WBEs) for any subcontracting or purchasing related to this contract. Contractors who are not currently a New York State certified M/WBE must define the portion of all consumable products and personnel required for this proposal that will be sourced from a M/WBE. The amount must be stated in total dollars and as a percent of the total cost necessary to fulfill the Agreement requirements. Supportive documentation must include a detailed description of work that is required including products and services.

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The goal for usage of M/WBEs is at least 10% of monies used for contract activities. In order to assure a good-faith effort to attain this goal, the STATE requires that Contractors complete the M/WBE Utilization Plan and submit this Plan.

Contractors that are New York State certified MBEs or WBEs are not required to complete this form. Instead, such Contractors must simply provide evidence of their certified status.

Failure to submit the above referenced Plan (or evidence of certified M/WBE status) will result in disqualification of the vendor from consideration for award.

18. On-going Responsibility

a) General Responsibility Language

The Contractor shall at all times during the Contract term remain responsible. The Contractor agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

b) Suspension of Work (for Non-Responsibility)

The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under the Contract.

c) Termination (for Non-Responsibility)

Upon written notice to the Contractor, and a reasonable opportunity to be heard with appropriate Department of Health officials or staff, the Contract may be terminated by the Commissioner of Health or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

19. Provisions Related to the Use of Funds Provided Through This Agreement

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Funds provided pursuant to this Agreement shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

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# APPENDIX S

## New York State Department of Health
## Requirements for Long Term Services and Supports
## for MMC and FHPlus Programs

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## Requirements for Long-Term Services and Supports

Long Term Services and Supports (LTSS) include the services and supports used by Enrollees with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. Such services may be home or community based or provided in institutional settings. If LTSS are delivered in a community based setting, such setting must comply with requirements at 42 CFR 441.301, consistent with the State-issued "Home and Community Based Services Transition Plan." An effective system of LTSS is essential for Enrollees in need of these services to live safely in the most integrated and least restrictive setting.

### 1. Long Term Services and Supports

a) Community Based Long Term Services and Supports mean the following services provided in the home or community setting (any place of residence, either permanent or temporary, other than a hospital, skilled nursing home, or health related facility) as included in the Benefit Package and provided by the Contractor when medically necessary:

i) Private Duty Nursing

ii) Skilled Nursing

iii) Home Health Services

iv) Personal Care Services

v) Consumer Directed Personal Assistance Services

vi) Adult Day Health Care

vii) AIDS Adult Day Health Care

b) Institutional Long Term Services and Supports mean the following services as included in the Benefit Package and provided by the Contractor when medically necessary:

i) Residential Health Care Facility services

ii) Non-residential inpatient acute care services where it is anticipated that upon discharge, the Enrollee will be in need of RHCF services or Community Based LTSS.

c) When the Contractor determines an Enrollee is in need of LTSS, the Contractor shall provide additional services, as included in the Benefit Package and as medically necessary, to maintain the Enrollee's safety in the most integrated and least restrictive setting and/or for the Enrollee to obtain, maintain, or regain functional capacity. The Contractor shall provide such additional services in accordance with this Appendix

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and pursuant to a Person Centered Services Plan (PCSP) as provided by Section 10.35 of this Agreement.

**2. Identifying Enrollees in Need of LTSS**

a) The requirements of this Agreement for the arrangement and authorization of LTSS apply when the Contractor determines, pursuant to assessment or provider order, an Enrollee is in receipt of or is expected to require LTSS for at least 120 days.

i) When the Contractor identifies an Enrollee who is expected, as demonstrated by an assessment or provider order, to be in receipt of LTSS for less than 120 days, the Contractor shall:

A) Arrange for all medically necessary covered services as required by this Agreement, however, the Contractor shall not be required to meet the provisions of this Agreement solely applicable to the arrangement and authorization of LTSS; and

B) Provide care management services where the Contractor determines, or the Enrollee's provider states, care management services are necessary due to the Enrollee's condition.

b) The Contractor will have appropriate mechanisms to identify new Enrollees in receipt of LTSS to ensure these Enrollees are referred or otherwise engaged by the Contractor's care management process. Such mechanisms may include, but are not limited to: use of welcome letters and initial health screenings to encourage Enrollees in receipt of LTSS to contact the Contractor; outreach to auto-assigned Enrollees; establishing a Contractor liaison for communication with the LDSS and other Medicaid managed care plans regarding the Enrollee's PCSP; communication with Participating Providers to encourage prompt notification to the Contractor of new Enrollees in receipt of LTSS; and identification of Service Authorization Requests for LTSS absent a PCSP.

c) The Contractor will have appropriate mechanisms to ensure Enrollees newly in need of LTSS are referred or otherwise engaged by the Contractor's care management process. Such mechanisms may include but are not limited to: coordination with discharge planners; establishing Contractor liaison with key Participating Providers; developing linkages with member services and/or complaint staff; and protocols linking review of Service Authorization Requests for LTSS to the care management process.

**3. Care Management for LTSS**

a) Care management means a process that assists the Enrollee to access necessary covered services as identified in the PCSP. Care management services include referral, assistance in or coordination of services for the Enrollee to obtain needed medical, social, educational, psychosocial, financial and other services in support of

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the PCSP, irrespective of whether the needed services are included in the Benefit Package.

b) The Contractor shall have appropriate organizational structure and mechanisms, which may take the form of dedicated units or staff, to provide care management services to Enrollees in receipt of LTSS.

i) Through its care management process, the Contractor will ensure:

A) structural linkages with member services, complaint, and service authorization functions to ensure prompt response to Enrollee's request for assistance in accessing LTSS, in accordance with Appendix F of this Agreement;

B) maintenance of a record or list of Enrollees currently in receipt of LTSS;

C) coordination of PCSP development in accordance with Section 10.35 of this Agreement, including reassessment and update of the PCSP as warranted by the Enrollee's condition but in any event at least once every six (6) months;

D) coordination with health care professionals, discharge planners and provider care teams to facilitate Enrollee transitions between levels of care;

E) structural linkages with utilization review functions to authorize medically necessary covered services in accordance with an approved PCSP and Appendix F of this Agreement;

F) referral of Enrollees in receipt of LTSS to case management and coordination with case management to implement approved PCSP, as needed;

G) Enrollees are informed regarding the CDPAS option and are referred to New York State Home and Community Based Services waiver programs and other community resources, as needed;

H) routine contact with Enrollees in receipt of LTSS commensurate with the needs of the Enrollee, which may be satisfied by one care management telephone contact per month. However, the Contractor shall conduct at least one facility or home visit every 6 months, which may be combined with scheduled assessments; and

I) In a manner and form determined by SDOH, notification to the LDSS when an Enrollee in receipt of LTSS no longer appears on the Contractor's roster and transmittal of the PCSP and other needed documentation to the LDSS and to the Enrollee's new Medicaid managed care plan, if known, to minimize disruption of LTSS.

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ii) The Contractor shall ensure that the level and degree of care management provided and the PCSP addresses the needs of the Enrollee and are based upon the acuity and severity of the Enrollee's physical and mental condition. The potential that an Enrollee may require intermittent acute hospital inpatient services shall not be taken into consideration by the Contractor when assessing an Enrollee's need for care management of LTSS.

iii) The Contractor shall develop written operational policies and procedures and automated systems in support of care management functions.

iv) The Contractor shall ensure staff responsible for care management have appropriate experience (as determined by the Contractor) in health care, social work, nursing and/or long term care; are trained in the Contractor's procedures; and the Contractor has sufficient staff capacity to carry out care management functions for the enrolled population utilizing LTSS. If care management is provided via a team approach, the Contractor must ensure its policies and procedures describe responsibilities of team members and how the team is to carry out care management functions.

**4. LTSS Transitional Care**

a) New Enrollees previously in FFS. Notwithstanding any benefit- or population-specific FFS to MMC transitional care policy described in this Agreement, the Contractor shall authorize and cover LTSS at the same level, scope and amount as the Enrollee received under the FFS Program for 90 days following Enrollment or until the Contractor's PCSP is in place, whichever is later.

i) Except where a Participating Provider Agreement describes an alternate arrangement for authorization of transitional care, the Contractor may not deny payment to providers of transitional care LTSS solely on the basis that the provider failed to request prior authorization.

ii) Where an existing medical order has or is about to expire, and a new medical order is required for the continued provision of LTSS during the transitional period but cannot be obtained after reasonable effort, the Contractor shall work with the LTSS provider to arrange a safe transition for the Enrollee, which may be to higher level of care.

b) Enrollees previously in a Medicaid managed care plan. The Contractor will provide transitional care services pursuant to Section 15.6(a)(i) of this Agreement and the SDOH "Medicaid Managed Care and Family Health Plus Coverage Policy: New Managed Care Enrollees in Receipt of an On-going Course of Treatment."

**5. LTSS Authorization Standards**

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a) The Contractor will ensure covered LTSS services are authorized in an amount, duration, and scope to meet the needs of the Enrollee pursuant to the PCSP, and shall not reduce or terminate LTSS unless:

   i) there has been, as demonstrated by an assessment or provider's order, a change in the Enrollee's medical condition, environment, assistive technology, or informal supports;

   ii) the Enrollee no longer meets the statutory or regulatory criteria for provision of the service;

   iii) the Enrollee requests a reduction or change in service;

   iv) there was a documented error in the information the Contractor relied upon for the initial authorization; or

   v) the conditions of INSL §3238 or 10 NYCRR §98-1.13(n) have been met.

b) If the Contractor determines to reduce the level or amount of LTSS, the Contractor must ensure that all needs identified in the PCSP are still appropriately addressed, including authorization for assistance with activities of daily living that may have been previously provided to the Enrollee incidentally under a higher or more intense level of service.

   i) In accordance with section F.1(4)(b) of Appendix F of this Agreement, the Contractor shall ensure the Notice of Action is sent to the Enrollee and provider at least ten (10) days prior to the effective date of an Action that reduces, suspends or terminates LTSS, and that such effective date does not fall on a non-working day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals, in a manner that considers the safety of the Enrollee.

   ii) Consistent with Section 10.37 and Appendix K of this Agreement, if services at an alternate level of care are not immediately available, the Contractor shall ensure continued authorization of LTSS as needed until safe discharge/transition can be effectuated.

c) The Contractor will make reasonable efforts to effectively communicate with providers and Enrollees during the PCSP development process regarding the need to obtain authorization for the services included in the PCSP, the timing of such reviews and when the Contractor has made its determination, so as to facilitate understanding of when any disagreements among the care planning team are to be resolved through the Contractor's Grievance System.

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d) Pursuant to Appendix F of this Agreement, the Contractor will provide timely notice of all Actions to the Enrollee and their provider, including notice of the Enrollee's right to appeal the Contractor's Action, and right to request a State fair hearing and right to aid continuing as per Section 25 of this Agreement.

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# APPENDIX T

# Additional Requirements for the HARP and HIV SNP Programs

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# Additional Requirements for the HARP and HIV SNP Programs

Health and Recovery Plans (HARPs) provide an integrated, enhanced benefit package to adults with Serious Mental Illness and/or Substance Use Disorders to improve health outcomes and promote recovery. The goals of the HARP Program are to reduce unnecessary emergency and inpatient care, increase network capacity to deliver community-based recovery-oriented services and supports, and provide Enrollees with access to an enhanced benefit package, including Care Coordination and Behavioral Health Home and Community Based Services, which will help support Enrollees' well-being and recovery. The HARP, contracting with Health Homes, will also provide care management for all services and assessments for Behavioral Health Home and Community Based Services in compliance with federal and state standards and assurances. Behavioral Health Home and Community Based Services will be available effective January 1, 2016.

1. **Applicability**

This Appendix applies to the HARP and/or HIV SNP program, as indicated. For the HIV SNP, the State will identify HARP-eligible enrollees currently enrolled in the HIV SNP Program and notify Contractors operating a HIV-SNP of their Enrollees eligible for Behavioral Health Home and Community Based Services. Such identified HARP-eligible enrollees will not be required to enroll in a HARP in order to receive Behavioral Health Home and Community Based Services.

**2. Contractor Staffing Requirements**

The Contractor shall not reduce staffing levels by more than 5% from the staffing levels approved by the State during the behavioral health qualification process without prior approval from DOH, OMH and OASAS. The Contractor shall provide written notice to the State within seven days after the date of a qualifying reduction. The State reserves the right to modify minimum staffing standards during the term of the Agreement.

**3. Identifying Enrollees in Need of Behavioral Health Home and Community Based Services**

a) Where an Enrollee is a Health Home participant, the Contractor shall ensure that each Enrollee receives a brief assessment in accordance with Section 10.41 of this Agreement.

b) Where an Enrollee elects to not enroll in a Health Home, and is not receiving care management from an alternative care management entity or ACT program, the Contractor must arrange for completion of the assessment process and development

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of plans of care for BHHCBS, as provided by Section 10.41 of this Agreement, through subcontracts with Health Homes or other entities designated by the State for this purpose. The Contractor will reimburse the Health Home or other State-designated entity no less than the rate established by the State for assessments and development of plans of care for BHHCBS.

**4. Behavioral Health Home and Community Based Services (effective January 1, 2016)**

a) Behavioral Health Home and Community Based Services mean the following services as defined in Appendix K and provided by the Contractor when specified in the Enrollee's plan of care:

i) Psychosocial Rehabilitation (PSR)

ii) Community Psychiatric Support and Treatment (CPST)

iii) Habilitation Services

iv) Family Support and Training

v) Short-term Crisis Respite

vi) Intensive Crisis Respite

vii) Education Support Services

viii) Empowerment Services- Peer Supports

ix) Non-Medical Transportation

x) Pre-vocational Services

xi) Transitional Employment

xii) Intensive Supported Employment (ISE)

xiii) Ongoing Supported Employment

b) Terms and Conditions of Payment:

i) The Contractor shall be responsible for monitoring Enrollee utilization of Behavioral Health Home and Community Based Services.

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ii) The cost of Behavioral Health Home and Community Based Services shall not be included in the Contractor's capitated payment for a period of not less than 24 months from inclusion of BHHCBS in the Benefit Package in a geographic area. The Contractor will be provided with not less than 90 days' notice prior to the inclusion of the cost of such services in the capitation.

iii) Prior to the inclusion of Behavioral Health Home and Community Based Services in the capitation:

A) The Contractor shall process and pay clean provider claims for approved services contained in an Enrollee's plan of care at the State-provided rate schedule, up to the State-determined maximum benefit limits, as described in the State issued Behavioral Health Guidelines. Such benefit limits are subject to change upon reasonable notice to the Contractor and CMS approval.

B) The State shall reimburse the Contractor for such services at the State-provided rate schedule via supplemental rate codes outlined in the applicable billing manual.

C) The State shall not be financially responsible for services provided to an Enrollee beyond the maximum benefit limits except where the Contractor has obtained prior written approval from the Medical Directors of both OMH and OASAS or their designees. In the request for prior approval, the Contractor must establish that the Enrollee is likely to suffer harm or require inpatient hospitalization without the provision of the proposed Behavioral Health Home and Community Based Services.

iv) Nothing in this Agreement is intended to prohibit the Contractor from authorizing payment from the Contractor's prepaid capitation rate for Behavioral Health Home and Community Based Services in excess of the State-determined benefit limits.

c) Behavioral Health Home and Community Based Services Appointment Availability Standards:

The Contractor shall comply with the following minimum appointment availability standards for Behavioral Health Home and Community Based Services contained in an Enrollee's approved plan of care:

i) For Short Term and Intensive Crisis Respite: within twenty-four (24) hours of request.

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ii) For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training: within two (2) weeks of request, unless the appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard shall be within five (5) days of request, or as clinically indicated.

iii) Educational and Employment Support Services, including Pre-Vocational Services: within two (2) weeks of request.

iv) Peer Supports Services: within one (1) week of request, unless the appointment is pursuant to an emergency or hospital discharge, in which case the standard shall be within five (5) days, or if the Peer Support Services are needed urgently for symptom management, in which case an appointment must be available within twenty-four (24) hours.

d) Utilization Management:

i) The Contractor shall use medical necessity criteria and level of care determination criteria for Behavioral Health Home and Community Based Services established by the State.

ii) As Enrollees achieve recovery goals, the Plan shall ensure that person-centered planning focuses on adjusting services to meet individualized needs so that improvements in functional impairments can be maintained when there is a reasonable expectation that withdrawal or premature reduction of services may result in loss of rehabilitation gains or goals attained by the Enrollee.

Medical necessity criteria for BHHCBS shall be no more restrictive than criteria for other covered services.

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# APPENDIX U

## Intellectual/Developmental Disabilities (I/DD)

## Specialized I/DD Plan (SIP)

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# Specialized I/DD Plan (SIP)

## 1. Definitions

**Specialized I/DD Plan (SIP):** A specialized MMC product that includes MMC Benefit Package services and additional specialized I/DD services, as defined in the New York State Medicaid Managed Care Organization I/DD System Transformation Requirements and Standards to Serve Individuals with Intellectual and/or Developmental Disabilities in Specialized I/DD Plans -Provider Led (SIPs-PL) document. Contingent on SDOH approval pursuant to Article 44 of the Public Health Law, a qualified HMO will be authorized to operate a SIP upon receipt of an amended Certificate of Authority or the initial issuance of its Certificate of Authority wherein SDOH specifies such approval and the counties in which the SIP may operate.

**"SIP Enrollee"** means an individual who has enrolled in the Contractor's SIP.

**"New York State Office for People with Developmental Disabilities (OPWDD)"** means the New York State agency responsible for coordinating services for New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. OPWDD provides services directly and certifies a network of not for profit service agencies. Supports and services, including Medicaid funded long-term care services, such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the State. In addition to these Medicaid services, OPWDD also provides New York State-funded family support services. https://www.opwdd.ny.gov

## 2. SIP Requirements

Pending appropriate waiver request and federal approval thereof, the Contractor may not operate a SIP. Upon receipt of appropriate federal approval, and applicable amendment to the Contractor's Certificate of Authority, the Contractor may commence SIP operation. In applying for and operating a SIP, the Contractor shall comply, in the following order, with:

a) all applicable federal and state laws and regulations;

b) all conditions, restrictions, or other requirements for the SIP program identified in the appropriate waiver application or terms and conditions approved by CMS;

c) application and operational standards and policy guidance for the provision of covered services to SIP Enrollees issued by SDOH and OPWDD;

d) the requirements of this Agreement for the provision of the MMC Benefit Package; and

e) SDOH guidance regarding the implementation or operation of the SIP product.

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**3.** In accordance with the provisions of Section 2.7 of this Agreement, the Contractor and/or SDOH shall have the right to terminate the Contractor's SIP product.

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# APPENDIX X

# Modification Agreement Form

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**APPENDIX X**

Agency Code _____ Contract No. _____
Period _____ Funding Amount for Period _____

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through The New York State Department of Health, having its principal office at One Commerce Plaza, Room 1609, Albany, NY 12260, (hereinafter referred to as the STATE), and _____, (hereinafter referred to as the CONTRACTOR), to modify Contract Number _____ as set forth below.

All other provisions of said AGREEMENT shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE

By: _____

_____
Printed Name

Title: _____

Date: _____

STATE AGENCY SIGNATURE

By: _____

_____
Printed Name

Title: _____

Date: _____

State Agency Certification:
In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK )
) SS.:
County of _____ )

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Notary)

Approved:

ATTORNEY GENERAL

_____

Title: _____

Date: _____

Approved:

Thomas P. DiNapoli
STATE COMPTROLLER

_____

Title: _____

Date: _____

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