

COORDINATION OF BENEFITS AGREEMENT

BETWEEN

[PLAN NAME]

AND

NEW YORK STATE DEPARTMENT OF HEALTH

This AGREEMENT (“Agreement”) is made and entered into as of the 1st day of January 2021 (the “Effective Date”) by and between the New York State Department of Health (“SDOH”) and [PLAN NAME] (“Health Plan”). Health Plan and SDOH collectively are referred to herein as the “Parties,” and each individually as a “Party.”

**RECITALS**

WHEREAS, Health Plan contracts with the Centers for Medicare & Medicaid Services, U.S Department of Health and Human Services (“CMS”) to sponsor a Medicare Advantage (“MA”) Plan under Title XVIII of the Social Security Act, including one or more Dual-Eligible Medicare Advantage Special Needs Plan(s) (“D-SNP”) that arranges for the provision of Medicare services for individuals who are dually-eligible for both Medicare and at least some Medicaid benefits pursuant to Titles XVIII and XIX of the Social Security Act;

WHEREAS, Health Plan sponsors D-SNP(s) in the State of New York and enrolls residents of New York who are eligible for Medicare benefits, eligible for Medicaid pursuant to New York’s Medicaid Plan as administered by SDOH (“Dual Eligible Beneficiaries”), and eligible to enroll in the D-SNP;

WHEREAS, the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS require that Health Plan enter into an agreement with SDOH to coordinate benefits and/or services for members of Health Plan’s D-SNP(s) within the State of New York;

WHEREAS, the Bipartisan Budget Act of 2018 and its implementing regulations issued by CMS further defines a D-SNP to include Fully Integrated D-SNPs (“FIDE D-SNP”) and Highly Integrated D-SNPs (“HIDE D-SNP”) and impose certain rules and requirements to these plan types;

WHEREAS, Health Plan and SDOH desire to enter into an arrangement regarding the provision of such benefits by Health Plan’s D-SNP(s) within the State of New York in an effort to

improve and expand the integration and coordination of such benefits, better educate Dual Eligible Beneficiaries into New York's D-SNP products, and thereby improve the quality of care to Dual Eligible Beneficiaries by coordinating care and reducing the costs and administrative burden.

**NOW THEREFORE**, in consideration of the terms and conditions set forth in this Agreement, the Parties agree as follows:

## **I. DEFINITIONS**

- A. "Coinsurance" is the percentage of the total amount of the cost of medical services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage.
- B. "Co-payment" is that portion of the total cost of covered services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage.
- C. "Cost-Sharing" means the portion of the cost of covered services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage. Cost-Sharing includes: Deductibles, Coinsurance, and Co-payments.
- D. "Cost-Sharing Obligations" mean those financial payment obligations to be paid by SDOH in satisfaction of Deductibles, Coinsurance, and Co-payments for Medicare Part A and Medicare Part B services with respect to certain Dual Eligible Beneficiaries and as defined for certain Dual Eligible Beneficiaries with full Medicaid benefits, as defined in New York's Medicaid Plan. Such financial payment obligations shall not include premiums or Cost-Sharing relating to Medicare Part D benefits.
- E. "Deductible" means the fixed dollar amount for which an individual would normally be financially responsible pursuant to his or her Medicare coverage before the costs of services are covered.
- F. "Dual-Eligible Medicare Advantage Special Needs Plan(s)" or "D-SNP" as defined in 42 CFR § 422.2, means a specialized Medicare Advantage Plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that (1) coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services; (2) may provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services; (3) has a contract with SDOH consistent with 42 CFR § 422.107 that meets the minimum requirements in

paragraph (c) of such section; and (4) beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits: (i) meets the additional requirement specified in 42 CFR § 422.107(d) in its contract with SDOH; (ii) is a Highly Integrated Dual Eligible Special Needs Plan; (iii) is a Fully Integrated Dual Eligible Special Needs Plan.

- G. “Dual Eligible Beneficiary” or “Dual Eligible Beneficiaries” or “Dual Eligibles” are those categories of individuals indicated in Attachment B that are eligible for Medicare benefits as well as for Medicaid under the New York State Medicaid Plan. Medicaid may include coverage of medical services, assistance in paying Medicare Part A and/or Part B premiums, and Cost-Sharing Obligations for Medicare-covered services.
- H. “Exclusively Aligned” shall mean a D-SNP enrolling only full benefit Dually-Eligible Beneficiaries who are also enrolled in an Integrated Medicaid Product offered by SDOH, including but not limited to Medicaid Advantage and Medicaid Advantage Plus, that is offered by the Medicare Advantage Organization, its parent organization (directly or indirectly), or another entity owned and controlled by its parent organization.
- I. “Fully Integrated Dual Eligible Special Needs Plan” or “FIDE SNP” means a D-SNP (1) that provides Dually-Eligible Beneficiaries access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Social Security Act with SDOH; (2) whose capitated contract with SDOH provides coverage, consistent with SDOH policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) that coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) that employs policies and procedures approved by CMS and SDOH to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement; and (5) has received CMS designation as a FIDE SNP.
- J. “Highly Integrated Dual Eligible Special Needs Plan” or “HIDE SNP” means a D-SNP offered by a Medicare Advantage organization that provides coverage, consistent with SDOH policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements: (1) the capitated contract is between the Medicare Advantage organization and SDOH; or (2) the capitated contract is between the Medicare Advantage organization’s parent organization (or another entity that is owned and

controlled by its parent organization) and SDOH; and (3) has received CMS designation as a HIDE SNP.

- K. “Integrated Medicaid Product” means a plan that provides and/or arranges coverage of Medicare and Medicaid services for Dual Eligible Beneficiaries contracted through CMS-approved D-SNP and a companion Medicaid plan offered by SDOH, including but not limited to Medicaid Advantage and Medicaid Advantage Plus.
- L. “MA Contract” means the contract between Health Plan and CMS pursuant to which Health Plan sponsors Medicare Advantage.
- M. “Medicaid Benefits” means those items and services set out in Attachment A that are (i) covered by the New York State Medicaid Plan for certain individuals identified in Attachment B, (ii) not eligible for coverage as basic benefits under the Medicare Program, and (iii) not covered by Health Plan’s D-SNP(s) as a Supplemental Benefit.
- N. “Medicare Laws” means any and all laws, rules, regulations, statutes, orders and standards, instructions and guidance applicable to the Medicare Advantage Program and Medicare Advantage Organizations, as the term is defined in 42 CFR § 422.4, including Health Plan in its capacity as the sponsor of Health Plan’s D-SNP(s).
- O. “Medicare Advantage Premium” means the amount Medicare Advantage plans may charge a Member for mandatory benefits and/or optional Supplemental Benefits beyond basic Medicare services.
- P. “Member” shall mean an individual eligible to enroll in, and who has enrolled in, Health Plan’s D-SNP.
- Q. “Model of Care” shall mean the program designed by Health Plan and approved by CMS to meet the specialized needs of a Dual Eligible population that includes (i) an appropriate network of providers and specialists available through Health Plan’s D-SNP, and (ii) care management services, which include assessment, individualized plan of care and interdisciplinary team.
- R. “Partial Dual Eligible” beneficiary means those categories of individuals indicated in Attachment B that are eligible for Medicare benefits as well as Medicaid coverage of assistance in paying Medicare Part A and/or Part B premiums, and Cost-Sharing Obligations for Medicare-covered services.
- S. “Premium” shall mean the amount SDOH pays for Medicare Part A and/or Part B

on behalf of certain Dual Eligible beneficiaries pursuant to Section 1905 of the Social Security Act.

- T. “Service Area” means the counties identified in Attachment C in which Health Plan’s D-SNP(s) operate(s) pursuant to Health Plan’s MA Contract and certificate of authority issued by SDOH.
- U. “Subcontract” shall mean an agreement between Health Plan and a third-party under which the third-party agrees to accept payment for providing services to Health Plan’s members.
- V. “Subcontractor” shall mean a third party with which Health Plan has an agreement.
- W. “Supplemental Benefit” means Medicare Advantage D-SNP benefits beyond basic Medicare Part A and Part B services described in 42 CFR § 422.101, including limits on out-of-pocket spending, reduction in premiums, or optional healthcare services.

## II. HEALTH PLAN RESPONSIBILITIES

- A. Coordination of Benefits. Health Plan is responsible for coordinating the delivery of all benefits covered by both Medicare and New York’s Medicaid Plan as administered by SDOH. Health Plan is further responsible for coordinating care of all of its Members with other managed care organizations as applicable. In furtherance of these obligations, Health Plan will specifically:
  - 1. Identify for its Members the benefits they may be eligible for under New York’s Medicaid Plan that are not covered by the D-SNP;
  - 2. Assist in the coordination and access to needed Medicaid services, and arrange for the provision of such Medicaid services, to its Members by identifying participating Medicaid providers in the D-SNP’s provider network; and
  - 3. Develop care coordination policies describing services Health Plan will provide or arrange including without limitation, care management, disease management, and discharge planning.
- B. Plan Management.
  - 1. Medicare Benefits. Health Plan shall provide to its Members the benefits set out in Health Plan’s D-SNP benefit package, including basic benefits and Supplemental Benefits, pursuant to Health Plan’s MA Contract and applicable

Medicare Law.

2. Compliance with Medicare Laws. Health Plan's administration of Health Plan's D-SNP(s), including, without limitation, plan benefit package design, provider network adequacy, provider credentialing, utilization management programs, quality improvement programs, and payment processes and procedures (collectively, "Administrative Services"), shall be subject to and in compliance with Medicare Laws.
  3. Care Coordination. In accordance with the Model of Care approved by CMS, Health Plan shall develop individualized care plans that include communication and coordination with providers that render services covered under New York's Medicaid Plan. Health Plan will use its care management process to manage the Member's health status and assist the Member in obtaining or accessing Medicare and/or Medicaid benefits and services.
  4. Comprehensive Written Statement of Benefits. Prior to enrolling any eligible individual into Health Plan's D-SNP, Health Plan shall provide such individual with a comprehensive written statement describing the Medicare and Medicaid benefits and Cost-Sharing protections the individual would receive as a Member of Health Plan's D-SNP. Such written statement shall include such information and be formatted in accordance with the requirements established by CMS. Health Plan and SDOH agree that Attachment A sets forth the Medicaid benefits that SDOH will provide to Members, if applicable, and that Health Plan will document in the comprehensive written statement of benefits.
  5. Summary of Benefits. To the extent required by CMS of Medicare Advantage organizations sponsoring D-SNPs, Health Plan shall integrate into a single Summary of Benefits all Medicare and Medicaid benefits a Member may be eligible to receive upon enrollment in Health Plan's D-SNP(s).
  6. Prompt Pay. Health Plan shall pay all claims for items and services in accordance with applicable federal and state law and regulation, including Section 3224-a of the New York Insurance Law.
- C. Medicare Advantage Supplemental Benefits. Services that are covered as Supplemental Benefits under Health Plan's D-SNP(s) and overlap with benefits under the New York State Medicaid Plan shall be first adjudicated by Health Plan as claims for services under the Supplemental Benefit offered by Health Plan's D-SNP(s) before treating such claims as SDOH responsibility under the State Medicaid Plan.

D. Categories of Dual Eligible Beneficiaries to be Served.

Health Plan shall enroll only the following categories of Dual Eligible Beneficiaries, as defined in **Attachment B**, into a D-SNP with the following companion products:

- Medicaid Advantage Plus (MAP)
  - Full Benefit Dual Eligible (FBDE)
  - QMB-Plus
  - SLMB-Plus
- Medicaid Advantage (MA)
  - Full Benefit Dual Eligible (FBDE)
  - QMB-Plus
  - SLMB-Plus
- MLTC Partial (MLTC-P)
  - QMB
  - SLMB
  - QI
  - QDWI
  - QMB-Plus
  - SLMB-Plus
  - Full Benefit Dual Eligible (FBDE)
- Other D-SNPs (the plan has not received CMS designation as a HIDE or FIDE)
  - QMB
  - SLMB
  - QI
  - QDWI
  - QMB-Plus
  - SLMB-Plus
  - Full Benefit Dual Eligible (FBDE)

E. Eligibility Verification. Health Plan will verify ongoing Medicaid eligibility through the enrollment and disenrollment processes established for its companion Medicaid plan. Health Plan shall verify the Medicare eligibility of all D-SNP Members on a monthly basis and shall also verify Medicare eligibility of individual members when requested by SDOH.

F. Provider Network. Health Plan shall verify a provider's participation in the New York Medicaid Plan before inclusion in its D-SNP Provider Directory. Health Plan shall identify in its provider directory those participating providers that accept both

Medicare and Medicaid.

- G. Claims Crossover Agreement. In accordance with 42 CFR § 438.3(t), Health Plan shall enter into a signed agreement with CMS for the coordination of benefits and participate in the automated Medicare claims crossover process to receive Medicare fee-for-service claims.
- H. Integrated Medicaid Product Offerings. To further SDOH efforts to provide integrated care and benefits for New York’s Dual Eligible Beneficiaries, Health Plan offering D-SNPs in New York must also have submitted a complete application by June 15, 2021 to be authorized by SDOH to offer an Integrated Medicaid Product effective January 1, 2022. Health Plan agrees to work with SDOH in good faith to ensure its Supplemental Benefits will overlap with Medicaid benefits covered by the New York State Medicaid Plan.
- I. Notifications. Health Plan shall provide SDOH with the following notifications within ten business days, unless a different time period is specified for a particular notification requirement:
1. Medicare Advantage Bid Filing. Health Plan will provide SDOH with copy of: (i) its annual bid filing submitted to CMS, and (ii) CMS approval of its bid filing.
  2. Notice of Intent. Health Plan shall provide SDOH with a copy of its Medicare Notice of Intent describing its proposed Medicare product offerings, service area expansions and/or any other changes it intends to apply for to be effective for the upcoming contract year.
  3. Service Area.
    - a. Health Plan shall submit its Service Area, as approved by CMS, to SDOH within 10 business days of such approval. In order for Health Plan to offer benefits in such Service Area, it must also be authorized by SDOH.
    - b. Health Plan shall notify SDOH of any CMS approval of an update to its Service Area.
  4. Summary of Benefits. Health Plan shall submit an annual Summary of Benefits of Health Plan’s D-SNP benefits offered under the plan benefit packages, including Supplemental Benefits, for the counties identified in Attachment C, by January 1 each year, and within 15 calendar days of any

update or modification.

5. Quality Reporting.

- a. Health Plan shall submit to SDOH copies of all quality reports, measures, and findings generated from Health Plan's D-SNP(s) quality management programs as required by and submitted to CMS.
- b. Health Plan shall notify SDOH in the event Health Plan receives less than 3.0 Medicare Star rating on either its Part C or Part D scores for any D-SNP. Health Plan shall provide SDOH with a copy of any document submitted to CMS outlining the steps proposed or implemented to improve the low score.

6. Information Sharing about Hospital and SNF Admissions. In accordance with 42 CFR § 422.107(d), D-SNPs that do not meet a FIDE or HIDE designation, shall be required to provide timely notification of all admissions to a hospital or skilled nursing facility ("SNF") to the Member's Medicaid health plan, or SDOH for fee-for-service Medicaid beneficiaries. Such information must include, but may not be limited to:

- Member Name
- Subscriber ID
- Date of Birth
- Facility Member admitted to
- Attending Physician
- Admission Type/Diagnosis
- Date of Admission
- Primary Care Physician (PCP)

Timely notification is defined as any real-time notification provided by Health Plan or its contracted hospitals and skilled nursing facilities via secure electronic data exchange, via direct communication from Health Plan or its Subcontractor within 48 hours of becoming aware of such admission. In the event Health Plan delegates notifications to a Subcontractor, Health Plan shall retain responsibility for compliance with these requirements.

Health Plans shall enter into business associate agreements and any other agreements governing the legally compliant sharing of data and shall provide SDOH with proof of documentation upon execution of agreements. Where notification must be provided to SDOH, Health Plan

shall submit or transmit such notifications and data pursuant to instructions provided by SDOH.

- J. Marketing. Health Plan shall comply with all applicable state and Medicare Laws relating to marketing of its D-SNP(s). In connection therewith, Health Plan agrees to submit its D-SNP(s) marketing materials to both SDOH and CMS for approval as described in the State model contract and agrees to only use SDOH and CMS approved marketing material in New York.
- K. Product Offerings. For each D-SNP offered by Health Plan and covered under this agreement, Health Plan shall complete all information required by **Attachment C**.
- L. Exclusively Aligned D-SNP Requirements. The following are applicable only to Health Plan's operation of Exclusively Aligned D-SNPs.
1. Service Area. The counties within an Exclusively Aligned D-SNP's Service Area shall be aligned with the service area of its Integrated Medicaid Product.
  2. Integrated Appeals and Grievances
    - a. *Unified Appeals and Grievance Process*. As of the Effective Date, Health Plan's Exclusively Aligned HIDE DSNP shall implement a grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§ 422.629 – 634, 438.210, 438.400 & 438.402. This requirement includes:
      - Grievances and appeals systems that meet the standards described in 42 CFR § 422.629;
      - An integrated grievance process that complies with 42 CFR § 422.630;
      - A process for making integrated organization determinations consistent with 42 CFR § 422.631;
      - Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR § 422.632;
      - A process for making integrated reconsiderations consistent with 42 CFR § 422.633; and
      - A process for effectuation of decisions consistent with 42 CFR § 422.634.

*b. Integrated Appeals and Grievances Process – Medicaid Advantage Plus.*

(i) Health Plan’s D-SNPs that are with a Medicaid Advantage Plus product and have exclusively aligned enrollment shall comply with an integrated appeals and grievance process at both the internal Health Plan and fair hearing levels for Medicare and Medicaid services, consistent with the requirements of both state and Medicare Laws. (ii) *Integrated Appeals and Grievances Process Reporting Requirements.* The following appeals and grievances reporting requirements shall be submitted within 15 business days of the close of each quarter:

A quarterly summary of integrated appeals including:

- The reason for appeal;
- The coverage type of appeals (Medicaid only, Medicare only or Medicaid and Medicare);
- The status of appeals;
- The number of appeals late to OTDA;
- The appeal overturn/reversal rate; and
- The auto-forward rate to OTDA;

3. Default Enrollment. Upon the approval of the use of CMS default enrollment procedures pursuant to 42 CFR § 422.66(c) by SDOH, Health Plan agrees to seek approval from CMS to default enroll into Health Plan’s D-SNP(s) individuals who become newly eligible for Medicare while enrolled in a Medicaid managed care plan Exclusively Aligned with Health Plan’s D-SNP(s). Within ten (10) business days, Health Plan shall notify SDOH of submission of an application to CMS, and upon receipt of approval or denial of such application by CMS.
4. Ownership and/or Affiliation with Medicaid Managed Care Plan. Health Plan shall demonstrate that the entity holding the capitated contract with SDOH is the same legal entity as that which CMS has designated as a FIDE SNP, by providing SDOH with a copy of the notice from CMS attesting to such entity’s status as a FIDE SNP.

**III. SDOH RESPONSIBILITIES**

- A. Financial Responsibilities. Pursuant to New York’s Medicaid Plan, SDOH will remain financially responsible for Cost-Sharing Obligations and Medicaid Benefits for certain Dual Eligible Beneficiaries, as set forth in Attachment B, who are Members of Health Plan’s D-SNP(s). SDOH may have financial responsibility for

Medicare Part A and/or Part B premiums for select categories of Dual Eligible Beneficiaries, as set forth in Attachment B. SDOH is not responsible for payment of Medicare Advantage premiums for mandatory or optional Supplemental Benefits, unless specifically prescribed in the New York's Medicaid Plan.

- B. Claims Processing. SDOH shall receive, process, and adjudicate claims for Cost-Sharing Obligations and Medicaid Benefits from Health Plan providers through the fee-for-service payment system, in accordance with SDOH's processes and procedures for claims administration. Health Plan shall receive, process and adjudicate claims for basic Medicare services and Supplemental Benefits.
- C. Electronic Data Format. SDOH will provide Health Plan with an electronic data file containing Medicaid participating providers in a generally accepted format on or about April 1 and October 1 of each year, or at such other time as determined by SDOH.
- D. Educational and Marketing Materials. SDOH shall retain responsibility for developing and distributing materials and conducting educational activities relating to the New York State Medicaid Plan and benefits and services covered under the New York State Medicaid Plan.

#### **IV. MEMBER PROTECTIONS**

- A. No Balance Billing by Providers. With respect to its Members who are eligible for Medicaid payment of Cost-Sharing, Health Plan agrees that it shall include in its contracts with Health Plan providers that they shall not bill or charge ("balance bill") such individuals the balance for any services such individuals are not liable in accordance with Section 1902(n)(3) of the Social Security Act.
- B. Limitation on Out-of-Pocket Costs. Notwithstanding Paragraph III.C.1., Dual Eligible Beneficiaries enrolled in Health Plan's SNP(s), Health Plan agrees that it may not impose Cost-Sharing that exceeds the amount of Cost-Sharing that would be permitted with respect to such individual pursuant to the State Medicaid Plan if the individual were not enrolled in the Health Plan's SNP(s).
- C. Member /Hold Harmless. Notwithstanding any provision in this Agreement to the contrary, Health Plan shall prohibit providers, under any circumstance including but not limited to non-payment by Health Plan or SDOH, insolvency of Health Plan or breach of Health Plan's agreement with a provider, from billing, charging, collecting a deposit from, seeking compensation or remuneration from or having any recourse against any Member for fees that are the responsibility of Health Plan or SDOH.

D. Program Integrity. Pursuant to 42 CFR §§ 455.436 & 42 CFR 438.610, Health Plan shall:

1. 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 ("SSDM"), the National Plan and Provider Enumeration System ("NPES"), the System of Awards Management ("SAM"), the List of Excluded Individuals and Entities ("LEIE"), the NYS OMIG Exclusion List, and any such other databases as the Secretary of Health & Human Services ("Secretary") or NYS OMIG may prescribe; and
2. 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 databases include the SSDM, NPES, SAM, LEIE, the NYS OMIG Exclusion List, and any such other databases as the Secretary or NYS OMIG may prescribe;
3. check the SSDM and NPES for new providers, re-enrolled providers and any current provider who were not checked upon enrollment into Contractor's Medicaid program;
4. confirm that providers have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These databases include the SSDM, NPES, SAM, LEIE, and any such other databases as the Secretary or NYS OMIG may prescribe; and
5. check the LEIE, the 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.

## V. **PRIVACY AND SECURITY**

The Parties agree that any data or other information transmitted pursuant to this Agreement shall comply with all applicable State and Federal laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA"), Sections 367b(4) and 369 of the New York Social Services Law, Article 27-F of the New York Public Health Law and its implementing

regulations, and 42 USC § 1396a and its implementing regulations.

## **VI. TERM AND TERMINATION**

A. Term. This Agreement commences on the Effective Date and shall be in effect until December 31, 2021.

B. Termination. This Agreement shall automatically terminate upon the termination or expiration of (1) Health Plan's MA Contract with CMS to sponsor Health Plan's D-SNP(s), regardless of the reason for such termination or expiration; or (2) Health Plan's contract with SDOH to provide a companion Medicaid plan.

## **VII. MISCELLANEOUS**

A. Survival. Any provision of this Agreement that requires or reasonably contemplates the performance or existence of obligations by either Party after termination of this Agreement shall survive such termination, regardless of the reason for termination. Additionally, upon termination of this Agreement and regardless of the reason for termination, the defined terms and the following provisions shall survive: §§ IV.(A)-(D), and § V.

B. Attachments.

1. The following attachments are incorporated by reference into this Agreement and attached hereto:
  - a. Attachment A, "Medicaid Benefits"
  - b. Attachment B, "Categories of Dual-Eligible Beneficiaries"
  - c. Attachment C, "Product Offerings"

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

CONTRACTOR SIGNATURE

STATE AGENCY SIGNATURE

By: \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_

Lana Earle

Printed Name

Printed Name

Title: \_\_\_\_\_

Title: Director

Date: \_\_\_\_\_

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.

\_\_\_\_\_  
(Signature and office of the individual taking acknowledgement)

## **ATTACHMENT A MEDICAID BENEFITS**

The following shall be considered Medicaid Benefits associated with a Medicaid product for purposes of this Agreement. For a listing of benefits associated with each product, look to your current model contract with the State.

### **Adult Day Health Care**

Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

### **AIDS Adult Day Health Care**

Adult Day Health Care Programs (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 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 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.

### **Assisted Living Program**

Assisted Living Program provides personal care, housekeeping, supervision, home health aides. Personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting.

## **Buprenorphine Prescribers**

As defined by the model contract.

## **Chronic renal dialysis**

Includes services provided by a renal dialysis center.

## **Comprehensive Medicaid Case Management**

A program which provides "social work" case management referral services to a targeted population (e.g.: 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 should 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 eMedNY and informed on the need to contact the Contractor to coordinate service provision.

## **Care Management**

Care Management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

### **Certain Behavioral Health Services, including:**

- Clinic: Continuing Day Treatment & Partial Hospitalization
- Rehabilitation: Inpatient, Treatment & Residential Addiction Services
- Outpatient Hospital & Personal Emergency Response Services
- Crisis Residence 1115 Waiver Services
- Personalized Recovery Oriented Services & Rehab: ACT Community Residence

### **Certain Mental Health Services, including:**

- Intensive Psychiatric Rehabilitation Treatment Programs
- Day Treatment

- Continuing Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospitalizations
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

### **Consumer Directed Personal Care Services**

As defined by Medicaid products' model contracts.

### **Court-Ordered Services**

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 services), or other Medicare and Medicaid Advantage Plus covered services. The Contractor is responsible for payment of those services as covered by the Contractor's Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package, even when provided by Non-Participating Providers.

### **Crisis Intervention Services**

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 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.

### **Dental Services**

Dental services include, but shall not be limited to, preventive, prophylactic and other dental care, services, supplies, routine exams, prophylaxis, oral surgery (when not covered by Medicare), and dental prosthetic and orthotic appliances required to alleviate a serious health condition, including one which affects employability.

### **Directly Observed Therapy for Tuberculosis Disease**

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen. While the clinical management of tuberculosis is covered in the Benefit Package, TB/DOT where

applicable, can be billed directly to MMIS by any SDOH approved fee-for-service Medicaid TB/DOT Provider. The Contractor remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT Provider.

### **Emergency Services**

Covered services that are needed to treat an Emergency Medical Condition. 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 or alcohol.

### **Emergency Transportation**

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.

### **Family Planning and Reproductive Health Services**

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.

### **Hearing Services (and Audiology)**

Hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts.

### **Home Care Services**

As defined by the product's model contract. Home care includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

## **Home and Community Based Waiver Program Services**

There are a number of Home and Community–Based Waiver Programs that provides services authorized pursuant to SSA Section 1915(c) waivers from DHHS. The programs include the Long Term Home Health Care Program, the Traumatic Brain Injury (TBI) Program, the ICF/MR Waiver, as well as Medicaid Care at Home HCBS Programs and OPWDD Care at Home Programs.

## **Home Delivered and Congregate Meals**

Home delivered and congregate meals are meals provided at home or in congregate settings, e.g. senior centers to individuals unable to prepare meals or have them prepared.

## **Hospice services**

Hospice services provided to Medicare Advantage Enrollees by a Medicare approved hospice providers are directly reimbursed by Medicare. Hospice is a coordinated program of home and inpatient care that provides non–curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less. Hospice programs provide patients and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations which must be certified under Article 40 of the NYS PHL and approved by Medicare. 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 federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family.

## **Inpatient and Outpatient Hospital Services**

Inpatient Hospital Services are those items and services, provided under the direction of a physician, physician’s assistant, nurse practitioner, or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Inpatient hospital services include care, treatment, maintenance and nursing services as may be required on an inpatient hospital basis. Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.

Outpatient hospital services are services which are provided by a hospital division or department primarily engaged in providing services for ambulatory patients, by or under the supervision of a physician, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition.

### **Inpatient Mental Health Over 190-Day Lifetime Limit**

All inpatient mental health services, including voluntary or involuntary admissions for mental health services, over the Medicare 190-Day Lifetime Limit. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the New York State P.H.L.

### **Laboratory Services**

Include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services. Physicians providing laboratory testing may perform specific laboratory testing procedures identified in the Physician's eMedNY Provider Manual.

### **Medicaid Pharmacy Benefits**

As allowed by State Law (select drug categories excluded from the Medicare Part D benefit).

### **Methadone Maintenance Treatment Programs**

Consists of drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management of the patient with methadone. Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services (OASAS) under Title 14 NYCRR, Part 828.

### **Medical and Surgical Supplies, Enteral and Parenteral Formula and Hearing Aid Batteries**

These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for-service Medicaid.

Coverage of enteral formula and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding. Coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and, 3) children who require medical formulas due to mitigating factors in growth and development. 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.

### **Medical Social Services**

Medical social services include assessing the need for, arranging for and providing aid for social

problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care. These services must be provided by a qualified social worker as defined in Section 700.2(b)(24) 10 NYCRR.

### **Medicare Cost Sharing**

Medicare cost sharing for Part A and B Medicare benefits, encompassing deductibles, co-pays and co-insurance amounts.

### **Midwifery Services**

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.

### **Non-Emergency Transportation**

Transportation expenses are covered when transportation is essential in order for a Member to obtain necessary medical care and services which are covered under the Medicaid program.

Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Member's medical condition; and a transportation attendant to accompany the Member, 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 Member's family.

*For Members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.*

### **Non-Medicare Covered Care in Skilled Nursing Facility**

Skilled nursing facility days provided by a licensed facility as specified in Chapter V, 10 NYCRR, in excess of the first 100 days in the Medicare Advantage benefit period.

### **Non-Medicare Covered Home Health Services**

Medicaid covered home health services include the provision of skilled services not covered by

Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care.

### **Non-Medicare Covered Durable Medical Equipment**

Medicare and Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use.

### **Nurse Practitioner Services**

As defined by the model contract.

### **Nursing Home Care**

Nursing Home Care is care provided to Enrollees by a licensed facility as specified in Chapter V, 10 NYCRR.

### **Nutrition**

Nutrition services includes the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist as defined in Part 700.2(b)(5), 10 NYCRR.

### **Observation Services**

As defined by the model contract.

### **Office for People with Developmental Disabilities (OPWDD) Services, including:**

- Long Term Therapy Services Provided by Article 16–Clinic Treatment Facilities or

#### Article 28 Facilities

- Day Treatment
- Medicaid Service Coordination (MSC)

### **Outpatient Rehabilitation**

Medicaid covered Occupational therapy; physical therapy and speech and language therapy are limited to twenty (20) visits per therapy per calendar year except for children under age 21 and the developmentally disabled.

### **Out of Network Family Planning Services**

Out of network family planning services provided by qualified Medicaid providers to plan enrollees will be directly reimbursed by Medicaid fee-for-service at the Medicaid fee schedule. Family Planning and Reproductive Health Care Services means those health services which enable Enrollees, including minors, who may be sexually active to prevent or reduce the incidence of unwanted pregnancy. These include: diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases and screening for disease and pregnancy.

Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally, reproductive health care includes coverage of all medically necessary abortions. Elective induced abortions must be covered for New York City recipients. Fertility services are not covered.

### **Personal Care Services**

Personal care services (“PCS”) are the provision of some or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of the Member’s health and safety in his or her own home. Personal care must be medically necessary, ordered by the Member’s physician and provided by a qualified person as defined in Part 700.2(b)(14) of 10 NYCRR, in accordance with a plan of care.

### **Personal Emergency Response Services**

Personal Emergency Response Services (“PERS”) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient’s phone and signal a response center once a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.

## **Pharmacy Benefits as Permitted by State Law Services**

NYS Medicaid continues to provide coverage for certain drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, and some prescription vitamins, and some non-prescription drugs.

## **Physician Services**

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. Physician services include the services of physician extenders, e.g., physician's assistants, social workers. Physician services may be provided in the office, home and facilities including but not limited to hospitals and diagnostic treatment centers.

## **Podiatry Services**

Medically necessary foot care, including care for medical conditions affecting lower limbs.

## **Prescription and Non-Prescription Drug Services**

Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula.

## **Preventative Health Services**

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.

## **Private Duty Nursing Services**

Private duty nursing services 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 can be provided through an approved certified home health agency, a licensed home care agency, or a private Practitioner. The location of nursing services may be in the Member's home.

Private duty nursing services are covered when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided

in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.

### **Prosthetics**

Medicaid covered prescription footwear is limited to treatment of diabetics, or when shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21. Compression and support stockings are limited to coverage only for pregnancy or treatment for venous stasis ulcers.

### **PT, OT, SP and Other Services**

PT, OT, SP and other therapies provided in a setting other than a home.

### **Radiology and Radioscope 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 are performed upon the order of a qualified practitioner.

### **Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs**

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.

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 Parts 586.3, 594 and 595.

### **Respiratory Therapy**

Respiratory therapy means the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. These services must be provided by a qualified respiratory therapist as defined in 10 NYCRR 700.2(b)(33).

## **Second Medical/Opinion Services**

Obtaining a 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.

## **Smoking Cessation Products**

As defined by the model contract.

## **Social and Environmental Supports**

Social and environmental supports are services and items that support the medical needs of the Members and are included in a Member's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

## **Social Day Care**

Social day care is a structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, care giver assistance and case coordination and assistance.

## **State Directed Services, including:**

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation Services
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Peer Supports
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment

## **SUD Services**

SUD services include Inpatient detoxification services, residential addiction treatment services,

outpatient services, LDSS mandated SUD services, and medically supervised outpatient withdrawal.

### **Vision Services**

Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.

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.

### **Other Services**

All other services listed in the Title XIX State Plan.

**ATTACHMENT B**  
**CATEGORIES OF DUAL ELIGIBLE BENEFICIARIES**

The following categories of Dual Eligible Beneficiaries are recognized within the scope of this Agreement:

- A. Full-benefit Dual Eligible Beneficiaries where the D-SNP is Exclusively Aligned:
1. A “Full Medicaid Only” is an individual who is enrolled in Medicare Part A and/or Part B, and eligible for Medicaid benefits under the New York State Medicaid Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the income or resource criteria for QMB or SLMB.
  2. A “QMB-Plus” is an individual who meets all of the Qualified Medicare Beneficiary (QMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York’s Medicaid Plan.
  3. A “SLMB-Plus” is an individual (i) who meets all the Specified Low-Income Medicare Beneficiary (SLMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York’s Medicaid Plan.
- B. The following categories of Dual Eligible Beneficiaries and/or partial Dual Eligible Beneficiaries are recognized within the scope of this Agreement where the D-SNP is not Exclusively Aligned and enrolls full benefit Dual Eligible Beneficiaries and/or partial Dual Eligible Beneficiaries:
1. “Full Medicaid Only” is an individual who is enrolled in Medicare Part A and/or Part B, and eligible for Medicaid benefits under the New York State Medicaid Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the income or resource criteria for QMB or SLMB.
  2. A “QMB-Plus” is an individual who meets all of the Qualified Medicare Beneficiary (QMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York’s Medicaid Plan.
  3. A “SLMB-Plus” is an individual (i) who meets all the Specified Low-Income Medicare Beneficiary (SLMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York’s Medicaid Plan.

4. Qualified Disabled and Working Individual (QDWI) is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in the purchase of Medicare Part A. The individual must meet federal income and resource criteria and may not be otherwise eligible for Medicaid. A QDWI is eligible only for Medicaid payment of Part A premiums.
5. Qualified Medicare Beneficiary (QMB) Only is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments.
6. Qualifying Individual (QI) is an individual who is entitled to Medicare Part A, meets federal income and resource criteria, and who is not otherwise eligible for Medicaid. A QI is eligible only for Medicaid payment of Medicare Part B premiums.
7. Specified Low Income Medicare Beneficiary (SLMB) Only is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resource do not exceed twice the SSI limit. The only Medicaid benefit a SLMB is eligible for is payment of Medicare Part B premiums.

**Attachment C  
PRODUCT OFFERINGS**

Health Plan shall complete all information below for each D-SNP under this Agreement.

**D-SNP WITH COMPANION MEDICAID ADVANTAGE PLUS (MAP)**

Health Plan shall attach copy of model contract template when submitting to CMS. See the link below.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/hlth\\_plans\\_prov\\_prof.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm)

CMS Contract Code (H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

DSNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- Full Medicaid Only
- QMB-Plus
- SLMB-Plus

**Appeals and Grievances:**

Health Plan verifies that it utilizes the Integrated Appeals and Grievances Process, including its reporting requirements, set forth in section III.L.2.b of this Agreement.

**Ownership and Affiliation:** Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion MAP:

The legal entity offering Health Plan is the same legal entity offering the MAP plan under which SDOH provides capitated payments for provision of the services in Appendix A.

Full name of legal entity offering Health Plan (D-SNP): \_\_\_\_\_

Full name of legal entity offering MAP: \_\_\_\_\_

**D-SNP WITH COMPANION MEDICAID ADVANTAGE (MA)**

Health Plan shall complete all information below for each D-SNP under this Agreement. Health Plan shall attach copy of model contract template when submitting to CMS. See the link below.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/hlth\\_plans\\_prov\\_prof.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm)

CMS Contract Code (H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

DSNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- Full Medicaid Only
- QMB-Plus
- SLMB-Plus

**Ownership and Affiliation:** Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion MA:

- The legal entity offering Health Plan is the same legal entity offering the MA plan under which SDOH provides capitated payments for provision of the services in Appendix A.
- The legal entity offering Health Plan is a separate legal entity under the same parent organization offering the MA plan under which SDOH provides capitated payments for the provision of the services in Appendix A.

Full name of legal entity offering Health Plan (DSNP): \_\_\_\_\_

Full name of legal entity offering MA: \_\_\_\_\_

**D-SNP WITH COMPANION PARTIAL CAPITATION (MLTC-P) PLAN**

Health Plan shall complete all information below for each D-SNP under this Agreement. Health Plan shall attach copy of model contract template when submitting to CMS. See the link below.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/hlth\\_plans\\_prov\\_prof.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm)

CMS Contract Code H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

D-SNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- QMB
- SLMB
- QI
- QDWI
- QMB-Plus
- SLMB-Plus
- Full Medicaid Only

**Ownership and Affiliation:** Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion partial capitation MLTC plan:

The legal entity offering Health Plan is the same legal entity offering the partial capitation MLTC plan under which SDOH provides capitated payments for provision of long term services and supports in Appendix A.

The legal entity offering Health Plan is a separate legal entity under the same parent organization offering the partial capitation MLTC plan under which SDOH provides capitated payments for the provision of long term services and supports in Appendix A.

Full name of legal entity offering Health Plan (D-SNP): \_\_\_\_\_

Full name of legal entity offering partial capitation MLTC plan: \_\_\_\_\_

**OTHER D-SNP (1) –**

CMS Contract Code (H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

D-SNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- QMB
- SLMB
- QI
- QDWI
- QMB-Plus
- SLMB-Plus
- Full Medicaid Only

**OTHER D-SNP (2) –**

CMS Contract Code (H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

D-SNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- QMB
- SLMB
- QI
- QDWI
- QMB-Plus
- SLMB-Plus
- Full Medicaid Only

**OTHER D-SNP (3) –**

CMS Contract Code (H#): \_\_\_\_\_

Contract Name: \_\_\_\_\_

D-SNP Plan Benefit Package: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Service Area – check all that apply:

<input type="checkbox"/> Albany	<input type="checkbox"/> Franklin	<input type="checkbox"/> Oneida	<input type="checkbox"/> Schuyler
<input type="checkbox"/> Allegany	<input type="checkbox"/> Fulton	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Seneca
<input type="checkbox"/> Bronx	<input type="checkbox"/> Genesee	<input type="checkbox"/> Ontario	<input type="checkbox"/> Steuben
<input type="checkbox"/> Broome	<input type="checkbox"/> Greene	<input type="checkbox"/> Orange	<input type="checkbox"/> Suffolk
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Orleans	<input type="checkbox"/> Sullivan
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oswego	<input type="checkbox"/> Tioga
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Otsego	<input type="checkbox"/> Tompkins
<input type="checkbox"/> Chemung	<input type="checkbox"/> Kings	<input type="checkbox"/> Putnam	<input type="checkbox"/> Ulster
<input type="checkbox"/> Chenango	<input type="checkbox"/> Lewis	<input type="checkbox"/> Queens	<input type="checkbox"/> Warren
<input type="checkbox"/> Clinton	<input type="checkbox"/> Livingston	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Washington
<input type="checkbox"/> Columbia	<input type="checkbox"/> Madison	<input type="checkbox"/> Richmond	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cortland	<input type="checkbox"/> Monroe	<input type="checkbox"/> Rockland	<input type="checkbox"/> Westchester
<input type="checkbox"/> Delaware	<input type="checkbox"/> Montgomery	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Dutchess	<input type="checkbox"/> Nassau	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Yates
<input type="checkbox"/> Erie	<input type="checkbox"/> New York	<input type="checkbox"/> Schenectady	
<input type="checkbox"/> Essex	<input type="checkbox"/> Niagara	<input type="checkbox"/> Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan verifies that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment B**, are enrolled in this D-SNP:

- QMB
- SLMB
- QI
- QDWI
- QMB-Plus
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- Full Medicaid Only