Table of Contents for HIV Special Needs Plan Model Contract

Recitals

Section 1 Definitions

Section 2 Agreement Term, Amendments, Extensions, and General Contract Administration Provisions
- 2.1 Term
- 2.2 Amendments
- 2.3 Approvals
- 2.4 Entire Agreement
- 2.5 Renegotiation
- 2.6 Assignment and Subcontracting
- 2.7 Termination
  - a) DOHMH Initiated Termination
  - b) Contractor and DOHMH Initiated Termination
  - c) Contractor Initiated Termination
  - d) Termination Due to Loss of Funding
- 2.8 Close-Out Procedures
- 2.9 Rights and Remedies
- 2.10 Notices
- 2.11 Board of Directors
- 2.12 Severability

Section 3 Compensation
- 3.1 Capitation Payments
- 3.2 Modification of Rates During Contract Period
- 3.3 Rate Setting Methodology
- 3.4 Payment of Capitation
- 3.5 Denial of Capitation Payments
- 3.6 SDOH Right to Recover Premiums
- 3.7 Third Party Health Insurance Determination
- 3.8 Payment for Newborns and Children
- 3.9 Supplemental Maternity Capitation Payment
- 3.10 Contractor Financial Liability
- 3.11 Inpatient Hospital Stop-Loss Insurance
- 3.12 Mental Health and Chemical Dependence Stop-Loss
- 3.13 Aggregate Risk Sharing
- 3.14 Residential Health Care Facility Stop-Loss
- 3.15 Stop-Loss Documentation and Procedures
- 3.16 Tracking Visits Provided by Indian Health Clinics

Section 4 Service Area

Table of Contents for HIV Special Needs Plan Model Contract

Section 5 RESERVED

Section 6 Enrollment
- 6.1 Populations Eligible for Enrollment in an HIV SNP
- 6.2 Enrollment Requirements
- 6.3 Equality of Access to Enrollment
- 6.4 Enrollment Decisions
- 6.5 RESERVED
- 6.6 Prohibition Against Conditions on Enrollment
- 6.7 Newborn Enrollment
- 6.8 Effective Date of Enrollment
- 6.9 Roster
- 6.10 Automatic Re-Enrollment
- 6.11 Verification of HIV SNP Enrollment Eligibility

Section 7 Lock-In Provisions
- 7.1 Lock-In Provisions
- 7.2 RESERVED
- 7.3 RESERVED
- 7.4 RESERVED
- 7.5 RESERVED

Section 8 Disenrollment
- 8.1 Disenrollment Requirements
- 8.2 Disenrollment Prohibitions
- 8.3 Reasons for Voluntary Disenrollment
- 8.4 Disenrollment Requests in HIV SNPs
  - a) Routine Disenrollment Requests in HIV SNPs
  - b) Non-Routine Disenrollment Requests
- 8.5 Contractor Notification of Disenrollments
- 8.6 Contractor's Liability
- 8.7 Enrollee Initiated Disenrollment
- 8.8 Contractor Initiated Disenrollment
- 8.9 LDSS Initiated Disenrollment

Section 9 Guaranteed Eligibility
- 9.1 General Requirements
- 9.2 Right to Guaranteed Eligibility
- 9.3 Covered Services During Guaranteed Eligibility
- 9.4 Disenrollment During Guaranteed Eligibility

Section 10 Benefit Package Requirements
- 10.1 Contractor Responsibilities
- 10.2 Compliance with State Medicaid Plan and Applicable Laws

Table of Contents for HIV Special Needs Plan Model Contract

10.3 Definitions
10.4 Child Teen Health Program/Adolescent Preventive Services
10.5 Foster Care Children
10.6 Child Protective Services
10.7 Welfare Reform
10.8 Adult Protective Services
10.9 Court-Ordered Services
10.10 HIV Counseling, Testing, Referral, and Partner Notification Services
10.11 HIV SNP Care and Benefits Coordination Services
10.12 HIV Primary and Secondary Prevention and Risk Reduction Services
10.13 HIV Treatment Adherence Services
10.14 Family Planning and Reproductive Health Services
10.15 Prenatal Care
10.16 Direct Access
10.17 Emergency Services
10.18 Medicaid Utilization Thresholds (MUTS)
10.19 Services for Which Enrollees Can Self-Refer
- a) Mental Health and Chemical Dependence Services
- b) Vision Services
- c) Diagnosis and Treatment of Tuberculosis
- d) Family Planning and Reproductive Health Services
- e) Article 28 Clinics Operated by Academic Dental Centers

10.20 Second Opinions for Medical or Surgical Care
10.21 Coordination with Local Public Health Agencies
10.22 Public Health Services
- a) Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB/DOT)
- b) Immunizations
- c) Prevention and Treatment of Sexually Transmitted Diseases
- d) Lead Poisoning

10.23 HIV-Infected Women
10.24 HIV-Infected and Uninfected Adolescents
10.25 HIV-Infected Pregnant Women, HIV-Exposed Newborns, and HIV-Infected and Affected Children and Adolescents
10.26 HIV-Infected Adults with Additional Non-HIV Related Chronic Illnesses and Physical or Developmental Disabilities
10.27 Children with Special Health Care Needs
10.28 Persons Requiring Ongoing Mental Health Services
10.29 Persons Requiring Chemical Dependence Services
10.30 Native Americans
10.31 Women, Infants, and Children (WIC)
10.32 Urgently Needed Services
10.33 Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers Not Participating in Contractor's Network

Table of Contents for HIV Special Needs Plan Model Contract

10.34 Hospice Services
10.35 Prospective Benefit Package Change for Retroactive SSI Determinations
10.36 Homeless Persons
10.37 Coordination of Services

Section 11 Marketing
11.1 Information Requirements
11.2 Marketing Plan
11.3 Marketing Activities
11.4 Prior Approval of Marketing Materials and Procedures
11.5 Corrective and Remedial Actions

Section 12 Member Services
12.1 General Functions
12.2 Translation and Oral Interpretation
12.3 Communicating with the Visually, Hearing and Cognitively Impaired

Section 13 Enrollee Rights and Notification
13.1 Information Requirements
13.2 Provider Directories/Office Hours for Participating Providers
13.3 Member ID Cards
13.4 Member Handbooks
13.5 Notification of Effective Date of Enrollment
13.6 Notification of Enrollee Rights
13.7 Post Enrollment Follow-Up
13.8 Enrollee's Rights
13.9 Approval of Written Notices
13.10 Contractor's Duty to Report Lack of Contact
13.11 LDSS Notification of Enrollee's Change in Address
13.12 Contractor Responsibility to Notify Enrollee of Effective Date of Benefit Package Change
13.13 Contractor Responsibility to Notify Enrollee of Termination, Service Area Changes and Network Changes

Section 14 Action and Grievance System
14.1 General Requirements
14.2 Actions
14.3 Grievance System
14.4 Notification of Action and Grievance System Procedures
14.5 Complaint, Complaint Appeal and Action Appeal Investigation Determinations

Table of Contents for HIV Special Needs Plan Model Contract

Section 15 Access Requirements
- 15.1 General Requirements
- 15.2 Appointment Availability Standards
- 15.3 Twenty-Four (24) Hour Access
- 15.4 Unscheduled, Non-urgent Care (Walk-ins)
- 15.5 Appointment Waiting Times
- 15.6 Travel Time Standards
- 15.7 Service Continuation
  - a) New Enrollees
  - b) Enrollees Whose Health Care Provider Leaves Network
- 15.8 Standing Referrals
- 15.9 Specialist as a Coordinator of Primary Care
- 15.10 Specialty Care Centers
- 15.11 Cultural Competence

Section 16 Quality Management
- 16.1 Internal Quality Management (QM) Program
- 16.2 QM Committee
- 16.3 Quality Management Plan (QMP)
- 16.4 QM Procedures
- 16.5 HIV SNP Medical Director Requirements
- 16.6 HIV Education for Staff
- 16.7 Standards of Care
- 16.8 Quality Management and Provider Manuals
  - a) Quality Management Manual
  - b) HIV SNP Provider Manual

Section 17 Monitoring and Evaluation
- 17.1 Right To Monitor Contractor Performance
- 17.2 Cooperation During Monitoring and Evaluation
- 17.3 Cooperation During On-Site Review
- 17.4 Cooperation During Review of Services by External Review Agency

Section 18 Contractor Reporting Requirements
- 18.1 General Requirements
- 18.2 Time Frames for Report Submissions
- 18.3 SDOH Instructions for Report Submissions
- 18.4 Liquidated Damages
- 18.5 Notification of Changes in Report Due Dates, Requirements or Formats
- 18.6 Computer Systems
- 18.7 Reporting Requirements
- 18.8 Ownership and Related Information Disclosure
- 18.9 Public Access to Reports
- 18.10 Professional Discipline

Table of Contents for HIV Special Needs Plan Model Contract

18.11 Certification Regarding Individuals Who Have Been Debarred or Suspended by Federal, State, or Local Government
18.12 Conflict of Interest Disclosure
18.13 Physician Incentive Plan Reporting

Section 19 Records Maintenance and Audit Rights
19.1 Maintenance of Contractor Performance Records
19.2 Maintenance of Financial Records and Statistical Data
19.3 Access to Contractor Records
19.4 Retention Periods

Section 20 Confidentiality
20.1 Confidentiality of Medical Information
20.2 Confidentiality of Identifying Information about Enrollees, Potential Enrollees and Prospective Enrollees
20.3 Medical Records of Foster Children
20.4 Confidentiality of Medical Records
20.5 Length of Confidentiality Requirements

Section 21 Provider Network
21.1 Network Requirements
21.2 Absence of Appropriate Network Provider
21.3 Suspension of Enrollee Assignments to Providers
21.4 Credentialing
a) Credentialing/Recredentialing Process
b) Licensure
c) Minimum Standards
21.5 SDOH Exclusion or Termination of Providers
21.6 Application Procedures
21.7 Evaluation Information
21.8 Choice/Assignment of Primary Care Providers (PCPs)
21.9 Enrollee PCP Changes
21.10 Provider Status Changes
21.11 PCP Responsibilities
21.12 Member to Provider Ratios
21.13 Minimum PCP Office Hours
21.14 Primary Care Practitioners
a) General Limitations
b) PCP Education
c) Pediatric Co-Management Model
d) Specialist and Sub-specialist as PCPs
e) OB/GYN Providers as PCPs
f) Certified Nurse Practitioners as PCPs
21.15 PCP Teams

Table of Contents for HIV Special Needs Plan Model Contract

a) General Requirements
b) Registered Physician Assistants as Physician Extenders
c) Medical Residents

21.16 Hospitals
a) Tertiary Services
b) Emergency Services

21.17 Dental Networks
21.18 Presumptive Eligibility Providers
21.19 Mental Health and Chemical Dependence Service Providers
21.20 Laboratory Procedures
21.21 Federally Qualified Health Centers (FQHCs)
21.22 Case Management Providers
21.23 HIV Comprehensive Medicaid Case Management (CMCM) Providers
21.24 Linkage Agreement Providers
21.25 Provider Services Function

Section 22 Subcontracts and Provider Agreements
22.1 Written Subcontracts
22.2 Permissible Subcontracts
22.3 Provision of Services Through Provider Agreements
22.4 Approvals
22.5 Required Components
22.6 Timely Payment
22.7 Restrictions on Disclosure
22.8 Transfer of Liability
22.9 Termination of Health Care Professional Agreements
22.10 Health Care Professional Hearings
22.11 Non-Renewal of Provider Agreements
22.12 Notice of Participating Provider Termination
22.13 Physician Incentive Plan

Section 23 Fraud and Abuse
23.1 General Requirements
23.2 Prevention Plans and Special Investigation Units

Section 24 Americans With Disabilities Act Compliance Plan

Section 25 Fair Hearings
25.1 Enrollee Access to Fair Hearing Process
25.2 Enrollee Rights to a Fair Hearing
25.3 Contractor Notice to Enrollees
25.4 Aid Continuing
25.5 Responsibilities of SDOH
25.6 Contractor's Obligations

Table of Contents for HIV Special Needs Plan Model Contract

Section 26 External Appeal
- 26.1 Basis for External Appeal
- 26.2 Eligibility For External Appeal
- 26.3 External Appeal Determination
- 26.4 Compliance With External Appeal Laws and Regulations
- 26.5 Member Handbook

Section 27 Intermediate Sanctions
- 27.1 General
- 27.2 Unacceptable Practices
- 27.3 Intermediate Sanctions
- 27.4 Enrollment Limitations
- 27.5 Due Process

Section 28 Environmental Compliance

Section 29 Energy Conservation

Section 30 Independent Capacity of Contractor

Section 31 No Third Party Beneficiaries

Section 32 Indemnification
- 32.1 Indemnification by Contractor
- 32.2 Indemnification by DOHMH

Section 33 Prohibition on Use of Federal Funds for Lobbying
- 33.1 Prohibition of Use of Federal Funds for Lobbying
- 33.2 Disclosure Form to Report Lobbying
- 33.3 Requirements of Subcontractors

Section 34 Non-Discrimination
- 34.1 Equal Access to Benefit Package
- 34.2 Non-Discrimination
- 34.3 Equal Employment Opportunity
- 34.4 Native Americans Access to Services From Tribal or Urban Indian Health Facility

Section 35 Compliance with Applicable Laws
- 35.1 Contractor and DOHMH Compliance With Applicable Laws
- 35.2 Nullification of Illegal, Unenforceable, Ineffective or Void Agreement Provisions
- 35.3 Certificate of Authority Requirements

Table of Contents for HIV Special Needs Plan Model Contract

35.4 Notification of Changes In Certificate of Incorporation
35.5 Contractor's Financial Solvency Requirements
35.6 Compliance With Care For Maternity Patients
35.7 Informed Consent Procedures for Hysterectomy and Sterilization
35.8 Non-Liability of Enrollees For Contractor's Debts
35.9 DOHMH Compliance With Conflict of Interest Laws
35.10 Compliance With PHL Regarding External Appeals

Section 36 New York State Standard Contract Clauses and Local Standard Clauses

Signature Page

Table of Contents for HIV Special Needs Plan Model Contract

APPENDICES

A. New York State Standard Clauses and Local Standard Clauses

B. Certification Regarding Lobbying

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

D. New York State Department of Health Marketing Guidelines for HIV Special Needs Plans

E. New York State Department of Health HIV Special Needs Plans Member Handbook Guidelines

F. New York State Department of Health Action and Grievance System Requirements for HIV SNP Program

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

H. New York State Department of Health Requirements for the Processing of Enrollments and Disenrollments in HIV Special Needs Plan (SNP) Program

I. New York State Department of Health Guidelines for Use of Medical Residents

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

K. HIV Special Needs Plan Prepaid Benefit Package Definitions of Covered and Non-Covered Services

L. Approved Capitation Payment Rates

M. Service Area, Benefit Options, and Enrollment Elections

N. New York City Specific Contracting Requirements for HIV Special Needs Plans

O. Reserved

P. Reserved

Q. Reserved

Table of Contents for HIV Special Needs Plan Model Contract

R. New York City Standard Local Clauses

AGREEMENT BETWEEN

_____

City of New York

And

_____

Contractor Name

This Agreement is made by and between

_____

City of New York ("City")

Acting through,

_____

Department of Social Services ("LDSS") or Health ("DOHMH")

Located at

_____

_____

_____

And

_____

Contractor Name ("the Contractor")

Located At

_____

_____

_____

STATE OF NEW YORK
MEDICAID AND HIV SPECIAL NEEDS PLAN
PARTICIPATING MANAGED CARE PLAN AGREEMENT

This AGREEMENT is hereby made by and between the New York City Department of Health and Mental Hygiene (DOHMH) and _____(Contractor) located at: _____.

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

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 and HIV SNP 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 or working in the geographic area specified in Appendix M of this Agreement (Service Area, Benefit Package Options, and Enrollment Elections); and

WHEREAS, the SDOH and DOHMH have determined that the Contractor meets the qualifications established for participation in the HIV SNP Program to provide the applicable health care coverage to Eligible Persons in the geographic area specified in Appendix M of this Agreement; and

WHEREAS, Chapter 364-j(5)(d) of the SSL authorizes the local department of social services in a city with a population of over two million to contract with managed care providers who meet the qualifications for participation in the MMC Program and since in the City of New York such authority has been delegated to the DOHMH;

NOW THEREFORE, the parties agree as follows:

1. DEFINITIONS

"AIDS" means the Centers for Disease Control and Prevention (CDC) definition of Acquired Immune Deficiency Syndrome as provided in CDC's most currently published Classification System for HIV Infected and Expanded Surveillance Case Definition for AIDS.

"AIDS Institute" is the New York State government entity responsible for directing and coordinating New York State's response to the HIV/AIDS epidemic. Created as a Center within the State Department of Health in 1983 by legislative mandate, the AIDS Institute formulates HIV/AIDS policy; initiates, develops and monitors HIV prevention, health care and supportive service programs; guides regional and statewide HIV/AIDS planning; and educates health care providers and the public.

"Behavioral Health Services" means services to address mental health disorders and/or chemical dependence.

"Benefit Package" means the covered services 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.

"Co-located Substance Abuse Provider" means an OASAS-licensed drug treatment program that also provides an array of HIV services integrated into its drug treatment protocol. These HIV services include at a minimum: HIV primary care; HIV risk reduction education; HIV counseling, testing, referral, and partner notification; supportive counseling; and case management. The OASAS-licensed program may be exclusively methadone maintenance, methadone combined with drug free ambulatory

modalities, or methadone to abstinence co-located with HIV services. Co-located drug treatment programs may be hospital-affiliated or free-standing.

"Community Based Organization" or **"CBO"** means an organization which provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

"Comprehensive HIV Special Needs Plan" 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 is authorized pursuant to Section three hundred sixty-five-a (365-a) of the SSL, also provides or arranges for the provision of comprehensive and specialized HIV care to HIV positive persons eligible to receive benefits under Title XIX of the Federal Social Security Act or other public programs.

"Court-Ordered Services" means those services that the Contractor is required to provide to Enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Contractor's Benefit Package and reimbursable under Title XIX of the Federal Social Security Act (see SSL 364-j(4)(r)).

"Days" means calendar days except as otherwise stated.

"Designated AIDS Center" or "DAC" means State-certified, hospital-based programs that provide a continuum of state-of-the art, multi-disciplinary hospital and community-based care and case management for persons with HIV infection and AIDS. DACs with pediatric and obstetrical departments are required to provide specialized HIV care to infants, children, and pregnant women

"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 plan terminates.

"Effective Date of Disenrollment" means the date on which an Enrollee may no longer receive services from the Contractor, pursuant to Section 8.6 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 and Appendix H of this Agreement.

"Eligible Person" means an HIV SNP Eligible Person as this term is 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.

"Enrollee" means an HIV SNP Enrollee as defined in this Agreement.

"Enrollment" means the process by which an Enrollee's membership in the Contractor's HIV SNP 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 HIV SNPs; and provides other contracted services on behalf of the SDOH and the LDSS.

"Experienced HIV Provider" means an entity grant-funded by the SDOH AIDS Institute to provide clinical and/or supportive services, or an entity licensed or certified by SDOH to provide HIV/AIDS services.

"Fee-For-Service" or "FFS" is a method of Medicaid reimbursement whereby payment is made for specific services rendered to an enrollee according to rates set or approved by the SDOH. Fee-for-service is the traditional method of Medicaid reimbursement used by physicians, medical facilities and other health care providers and almost always occurs retrospectively (i.e., after the service has already been rendered).

"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.

"Grant-Funded Services" means services that are and will continue to be paid for through State, Federal, and private grants.

"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 plan despite the loss of eligibility as set forth in Section 9 of this Agreement.

"Health Provider Network" or "HPN" means a closed communication network dedicated to secure data exchange and distribution of health related information between various health facility providers and the SDOH. HPN 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).

"**HIV COBRA Case Management**" means intensive case management provided by an AIDS Institute-designated entity participating in the Comprehensive Medicaid Case Management (CMCM) program. HIV COBRA Case Management is a non-benefit package service that is available to HIV SNP enrollees on a fee-for-service basis.

"HIV-Experienced Dental Care Provider" means a licensed dentist who has completed the AIDS Institute/HRSA sponsored Oral Health Training, or its equivalent, in the diagnosis and treatment of the conditions associated with HIV disease and education of patients on how to achieve and maintain oral health. An equivalent HIV oral health curriculum must include at least five (5) hours of training and cover the following areas: medical assessment of the HIV dental patient; dental treatment modifications; identification and management of oral lesions and HIV-related conditions; post-exposure prophylaxis; and legal/ethical issues.

"HIV Infected Person" includes individuals who are HIV-positive but asymptomatic, individuals with symptomatic HIV disease, and individuals with CDC-defined AIDS.

"HIV Primary Care Medicaid Program" means a community-based institutional provider licensed under Article 28 of the Public Health Law that has signed agreement(s) with the New York State Department of Health to provide HIV counseling, testing, referral, and partner notification to persons of unknown serostatus and to provide or arrange for continuous, coordinated primary care for persons with HIV infection.

"HIV Primary Prevention" means the reduction or control of causative factors for HIV and also includes reducing risk factors. Primary prevention includes strategies to help prevent uninfected persons from acquiring HIV, i.e., behavior counseling for HIV negative persons with risk behavior, and community behavioral interventions for communities at increased risk for STD/HIV infection. Primary prevention also includes strategies to help prevent infected persons from transmitting a communicable disease, i.e., behavior counseling with an HIV infected person to reduce risky sexual behavior or providing antiviral therapy to a pregnant, HIV infected female to prevent transmission to a newborn.

"HIV Secondary Prevention" means promotion of early detection and treatment of a disease in an asymptomatic person to prevent the development of symptomatic disease. In the case of HIV infection this would include: regular medical assessments; routine

immunization for preventable infections; prophylaxis for opportunistic infections; regular dental, optical, dermatological and gynecological care; optimal diet/nutritional supplementation; and partner notification services which lead to the early detection and treatment of other infected persons.

"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.

"HIV SNP Medical Case Management/Care Coordination" means a process for clinical service planning, service acquisition, service delivery and coordination by a designated medical case manager and/or case management team. HIV SNP medical case management/care coordination is a client-centered service that links and promotes timely, coordinated access to medically appropriate levels of care and services that support adherence to care and wellness. HIV SNP medical case management/care coordination includes treatment adherence services and education; care advocacy; primary and secondary prevention education; health promotion assistance; and partner/spousal notification assistance.

"HIV Specialist PCP" means a Primary Care Provider that meets the qualifications for HIV Specialist as defined by the Medical Care Criteria Committee of the SDOH AIDS Institute.

"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 the mentally retarded is not an Institution for Mental Diseases.

"Linkage Agreement" means a written agreement in the form of either a contractual agreement or memorandum of understanding. At minimum, a linkage agreement includes the following:

- Bilateral referral arrangements, where legally permissible;

- Identification of programmatic responsibility where appropriate for quality assurance, delivery of direct services, transfer of information between sites of care, education, and outreach;

- Written descriptions of methods and systems for monitoring referrals, for documenting the outcome of the referral process, and for the collection and interpretation of data and information from enrollees to determine consumer satisfaction with the referral process;

- Written descriptions of how capacity and access to care will be measured and evaluated to assure appropriate access as measured by time, distance, and appointment availability or other measures as appropriate;

- Clearly defined roles, responsibilities and activities that are consistent with the New York State Public Health Law, SDOH regulations, and local public health ordinances as appropriate; and

- Timely flow of information to both parties consistent with State confidentiality laws.

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

"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.

"**Lock-In Period" --** There is no Lock-In Period for SNP Enrollees.

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

"Marketing" means any activity of the Contractor, subcontractor or individuals or entities affiliated with the Contractor by which information about the Contractor is made known to Eligible Persons or Prospective Enrollees for the purpose of persuading such persons to enroll with the Contractor.

"Marketing Representative" means any individual or entity engaged by the Contractor to market on behalf of the Contractor.

"Maternal/Pediatric HIV Specialized Care Centers" means facilities licensed under Article 28 of the Public Health Law which are: (1) Designated AIDS Centers with Maternal Pediatric HIV Care Centers or (2) recipients of State or Federal grant funding to provide comprehensive care and services for HIV-infected mothers and their children.

"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.

"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 an HIV SNP Enrollee.

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

"Nonconsensual Enrollment" means Enrollment of an Eligible Person, other than through Auto-assignment, newborn Enrollment or case addition, in an HIV SNP 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.

"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.

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

"Pediatric Co-Management Model of Care" means, for purposes of this Agreement, a model of care approved for a particular Contractor on a case-by-case basis by the AIDS Institute for HIV-infected child Enrollees up to the age of thirteen (13) whereby the Enrollee is assigned to a pediatrician or family practice primary care provider and a consulting Pediatric HIV Specialist.

"Permanent Placement Status" means the status of an individual in a Residential Health Care Facility [RHCF] when the LDSS determines that the individual is not expected to return home based on medical evidence affirming the individual's need for permanent RHCF placement.

"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 an MMC Eligible Person who is not yet enrolled in an MCO that is participating in the MMC Program.

"Prenatal Care Assistance Program" or "PCAP" means the program that provides comprehensive ambulatory prenatal care services reimbursed under Medicaid as described in Part 85.40 of Title 10, NYCRR, in facilities operating under Article 28 of the Public Health Law.

"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 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 or working in the Contractor’s Service Area that has not yet enrolled in an HIV SNP.

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

"Quality Improvement" or "QI" means an organizational approach to improve quality of care and services using a specified set of principles and methodologies. Those principles include, but are not limited to, leadership commitment, a multidisciplinary

team approach, consumer orientation, and a continuing cycle of improvement activities and performance measurements.

"Related Child(ren)" includes birth, step, and adopted children under the age of nineteen included in the Enrollee's Medicaid household and children defined by ADC-related child to caretaker relative criteria if the HIV-infected adult Enrollee is the caretaker relative of the child because the birth, step or adoptive parents are absent. The following is a list of relationships included under the caretaker relative criteria: the Enrollee's child, sibling, grandchild, great grandchild, great-great grandchild, niece, great niece, great-great niece, nephew, great nephew, great-great nephew, or first cousin.

"Risk Reduction Education and Counseling" means an interactive process, tailored to the unique life situation of each Enrollee, in which the provider assists the Enrollee in: 1) understanding the specific behaviors associated with transmitting and/or acquiring HIV; 2) understanding the latest methods of preventing the transmission and/or acquisition of HIV; and 3) creating an Enrollee-centered risk reduction plan which includes assessing readiness for behavior change, addressing specific barriers to change and developing the skills needed to reduce or eliminate the risk of HIV infection.

"Ryan White CARE Act Funded Program" means a program providing health care and/or service needs for people living with HIV disease and their families through funding from the Ryan White Comprehensive AIDS Resources Emergency Act.

"School Based Health Centers" or "SBHC" means SDOH approved centers which provide comprehensive primary and mental health services including health assessments, 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 seventeen (17) 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.

- **"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.

“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.

"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 plan, 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.

"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 plan.

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

2.1 Term

a) This Agreement is effective April 1, 2006 and shall remain in effect until March 31, 2008 or until the execution of an extension, renewal or successor Agreement between the Contractor and the DOHMH approved by the SDOH, the US Department of Health and Human Services (DHHS), and any other entities as required by law or regulation, whichever occurs first.

b) This Agreement shall not be automatically renewed at its expiration. The parties to this Agreement shall have the option to renew this Agreement for an additional three (3) year term, subject to the approval of SDOH, DHHS, and any other entities as required by law or regulation.

c) The maximum duration of this Agreement is five (5) years provided; however 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 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 SDOH, 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.

b) DOHMH will make reasonable efforts to provide the Contractor with notice and opportunity to comment with regard to proposed amendment of this Agreement except when provision of advance notice would result in the SDOH and DOHMH being out of compliance with state or federal law.

c) The Contractor will return the signed amendment or notify the DOHMH that it does not agree with the terms of the amendment 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 SDOH, the DHHS, and any other entity as required in law or regulation. SDOH will provide a notice of such approval to the Contractor and the DOHMH upon such approval.

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 DOHMH 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 all New York State Contracts;
ii) Appendix R, Local Standard Clauses for all New York City Contracts;
iii) Appendix N, New York City Specific Requirements;
iv) The body of this Agreement;
v) The appendices attached to the body of this Agreement, other than Appendix A, R, and N;
iv) The Contractor's approved:
   A) Marketing Plan on file with SDOH and DOHMH
   B) Action and Grievance System Procedures on file with SDOH
   C) Quality Management Plan on file with SDOHand DOHMH
   D) ADA Compliance Plan on file with SDOH and DOHMH
   E) Fraud and Abuse Prevention Plan on file with SDOH.

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 SDOH and DHHS.

2.6 Assignment and Subcontracting

a) The Contractor shall not, without DOHMH and 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 and DOHMH agree that they 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. Any assignment, transfer, conveyance, sublease, or other disposition without DOHMH and 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 as defined in 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 regulations are or become effective that pertain to the service or activity delegated under such subcontract. Contractor agrees that it shall remain legally responsible to SDOH and to DOHMH for carrying out all activities under this Agreement and that no subcontract shall limit or terminate Contractor's responsibility.

2.7 Termination

a) DOHMH Initiated Termination

i) DOHMH shall have the right to terminate this Agreement, in whole or in part, or in specified counties of Contractor's service area as identified in Appendix M, 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 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 or DOHMH'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); or

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.

ii) The DOHMH 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 HIV SNP product under this Agreement in any designated geographic areas not affected by such action, and shall terminate its HIV SNP product 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 DOHMH 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 DOHMH Initiated Termination

The Contractor and the DOHMH each shall have the right to terminate this Agreement in its entirety or in specified counties of the Contractor's service area as defined in Appendix M 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 and SDOH written notice specifying the reason for 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.

c) Contractor Initiated Termination

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

iii) The Contractor shall have the right to terminate this Agreement in its entirety or in specified counties of the Contractor's service area as defined in Appendix M 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 and DOHMH 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.

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 DOHMH 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 or in specified counties of the Contractor's service area as defined in Appendix M 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 DOHMH and that the DOHMH 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, DOHMH, 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, DOHMH, and other authorized federal, state or local agencies, within ninety (90) days of termination, a final financial statement, made by a certified public accountant, unless the Contractor requests of DOHMH and receives written approval from SDOH, DOHMH 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 and DOHMH 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 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 DOHMH shall be done by amendment to this Agreement, unless the Agreement is terminated by the DOHMH 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 DOHMH 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 to be given under this Agreement shall be in writing and shall be deemed to have been given when mailed to, or, if personally delivered, when received by the Contractor, DOHMH, and the SDOH at the following addresses:

For DOHMH:

_____

_____

_____

_____
[Insert Name and Address]

For SDOH:
New York State Department of Health
Empire State Plaza
Corning Tower, Room 2074
Albany, NY 12237-0065

For the Contractor:

_____

_____

_____

_____
[Insert Name and Address]

2.11 Board of Directors

In addition to requirements of other applicable laws regarding Enrollee membership of the Contractor's governing authority, the governing authority of the HIV SNP must include at least one person with HIV infection to serve as a consumer representative.

The above requirement applies to all HIV SNPs, whether part of an MCO which operates an HIV SNP as one of its lines of business or a SNP separately incorporated as a sole line of business.

When the Contractor's SNP enrollment reaches 300 or greater, the Contractor shall make best efforts to ensure the governing authority includes an Enrollee of the SNP.

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

3. COMPENSATION

3.1 Capitation Payments

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

b) The monthly Capitation Rates are attached hereto as Appendix L, which is hereby made a part of this Agreement as if set forth fully herein.

c) The monthly capitation payments, the Supplemental Newborn Capitation 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 3.11, 3.12, and 3.14 of this Agreement.

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

3.2 Modification of Rates During Contract Period

a) Any technical modification to Capitation Rates during the term of this Agreement, as agreed to by the Contractor, including but not limited to, changes in reinsurance or the Benefit Package, shall be deemed incorporated into this Agreement, without further action by the parties, upon approval by SDOH and upon written notice by SDOH to the DOHMH.

b) Any other modification to Capitation Rates, as agreed to by SDOH 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 and the State Division of the Budget, and upon written notice by SDOH and DOHMH.

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 and DOHMH of the amount and effective date of the modified Capitation Rates approved by the State Division of the Budget. The Contractor shall have the option of terminating this Agreement if such approved modified Capitation Rates are not acceptable. In such cases, the Contractor shall give written notice to the SDOH and the DOHMH within thirty (30) days of the date of the formal written notice of the modified Capitation Rates from 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 disenrollment can be accomplished in fewer days. During the period commencing with the effective date of the SDOH modified Capitation Rates, through the effective date of termination of the Agreement, the Contractor shall have the option of continuing to receive capitation payments at the expired Capitation Rates or at the modified Capitation Rates approved by SDOH and State Division of the Budget for the rate period.

If the Contractor fails to exercise its right to terminate in accordance with (c) above, then the modified Capitation Rates approved by SDOH and the State Division of the Budget shall be deemed incorporated into this Agreement without further action by the parties as of the effective date of the modified Capitation Rates, as established by SDOH and approved by the State Division of the Budget.

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 in effect as of April 1, 2006 and thereafter, shall be certified to be actuarially sound in accordance with 42 CFR Section 438.6(c).

b) Notwithstanding the provisions set forth in Section 3.3(a) above, the DOHMH reserves the right to terminate this Agreement, in its entirety or in specified counties of the Contractor’s service area as set forth in Appendix M, 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 (State Finance Law), the State and New York City 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

(a) The parties acknowledge and accept that the SDOH has a right to recover premiums paid to the Contractor for Enrollees listed on the monthly Roster who are later determined for the entire applicable payment month, to have been in an institution; to have been incarcerated; to have moved out of the Contractor’s service area subject to any time remaining in the Enrollee’s Guaranteed Eligibility period; or to have died. In any event, the State may only recover premiums paid for Enrollees listed on a Roster if it is determined by the SDOH that the Contractor was not at risk for provisions of Benefit Package services for any portion of the payment period.

(b) For purposes of premium billing, the Contractor agrees to assign each enrolled member to a premium group in accordance with HIV verification criteria as established by the AIDS Institute, and AIDS as defined by the Centers for Disease Control. The SDOH may at its option review the Contractor’s assignment of enrolled members to premium groups and retrospectively adjust the premium paid to the Contractor upward or downward for enrolled members who are determined by SDOH or its

agent in accordance with the agreed upon criteria to have belonged in another premium group for the entire applicable payment month. In the event that such review results in a retrospective reclassification to another premium group, the SDOH shall recover excess premium payments made to the Contractor. The Contractor shall cooperate fully with such reviews and shall be solely responsible for providing documentation necessary to support its assignment of enrolled members to premium groups.

3.7 Third Party Health Insurance Determination

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. The Contractor shall make good faith efforts to coordinate benefits with and collect TPHI recoveries from other insurers, and must inform the LDSS of any known changes in status of TPHI insurance eligibility within thirty (30) days of learning of a change in TPHI. The Contractor may use the Roster as one method to determine TPHI information. The Contractor will be permitted to retain one hundred percent (100%) of any reimbursement for Benefit Package services obtained from TPHI. Capitation Rates are net of TPHI recoveries. In no instances may an Enrollee be held responsible for disputes over these recoveries.

3.8 Payment For Newborns and Children

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

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.

c) Capitation Rate and Supplemental Newborn Capitation 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) 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.

e) Except as described in (d), 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:

i) 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.

ii) 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.

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

g) The Contractor cannot bill for a Supplemental Newborn Capitation Payment unless the newborn hospital or birthing center payment has been paid by the Contractor. The Contractor must maintain on file evidence of payment to the hospital or birthing center of the claim for the newborn stay. Failure to have supporting records may, upon an audit, result in recoupment of the Supplemental Newborn Capitation Payment by SDOH.

3.9 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 HIV SNP 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 HIV SNP for only part of the pregnancy, but was enrolled on the date of delivery of the child, the Contractor shall be entitled to receive the entire Supplemental Maternity Capitation Payment. The Supplemental

Capitation payment shall not be prorated to reflect that the Enrollee was not enrolled in the Contractor's HIV SNP for the entire duration of the pregnancy.

d) In instances where the Enrollee was enrolled in the Contractor's HIV SNP 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 maintain on file evidence of payment 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.

3.10 Contractor Financial Liability

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

3.11 Inpatient Hospital Stop-Loss Insurance

a) The Contractor must obtain stop-loss coverage for inpatient hospital services for 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 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.

c) If the Contractor elects to purchase stop-loss coverage through a private insurer, the private stop-loss reinsurance program will be subject to State review and approval and will need to meet standards related to cost effectiveness, adequacy of coverage, and reporting capabilities. Timely and detailed reports from the private reinsurer to the State regarding reinsurance cases and stop-loss settlement will be required.

❑ The Contractor has elected to have NYS provide stop-loss reinsurance.

OR

❑ The Contractor has not elected to have NYS provide stop-loss reinsurance.

3.12 Mental Health and Chemical Dependence Stop-Loss

a) The Contractor will be compensated for medically necessary and clinically appropriate Medicaid reimbursable mental health treatment outpatient visits in excess of twenty (20) visits during any calendar year at rates set forth in contracted fee schedules. Any Court-Ordered Services for mental health treatment outpatient visits which specify the use of Non-Participating Providers shall be compensated at the Medicaid rate of payment.

b) The Contractor will be compensated for medically necessary and clinically appropriate inpatient mental health services and/or Chemical Dependence Inpatient Rehabilitation and Treatment Services to Enrollees as defined in Appendix K of this Agreement, in excess of a combined total of thirty (30) days during a calendar year at the lower of the Contractor's negotiated inpatient rate or Medicaid rate of payment.

c) Detoxification Services for Enrollees in Article 28 inpatient hospital facilities are subject to the stop-loss provisions specified in Section 3.11 of this Agreement.

3.13 Aggregate Risk-Sharing

For purposes of sharing in Excess Medical Profits or Losses as defined by this Section, the following aggregate risk-sharing provisions shall be in place:

a) A target medical loss ratio of eighty-five percent (85%) of the capitation revenue earned by the Contractor shall be established. The medical loss ratio (MLR) is defined as medical claim costs incurred by the Contractor divided by earned capitation revenue for the same time period. The Contractor shall remain fully at-risk for administrative costs.

b) A risk corridor of two percent (2%) shall be established such that there will be no aggregate risk-sharing if the MLR is at least eighty-three percent (83%) and no greater than eighty-seven percent (87%).

c) In the event that the Contractor experiences a MLR of less than eighty-three percent (83%), the Contractor shall be required to pay to the SDOH fifty percent (50%) of the Excess Medical Profit. The Excess Medical Profit shall be equal to the dollar amount of the difference between an eighty-three percent (83%) MLR and the Contractor's actual MLR.

d) In the event that the Contractor experiences a MLR of greater than eighty-seven percent (87%), the State shall be required to pay to the Contractor fifty percent (50%) of the Excess Medical Loss. The Excess Medical Loss shall be equal to the dollar amount of the difference between an eighty-seven percent (87%) MLR and the Contractor's actual MLR.

e) In calculating the actual MLR, SDOH shall review the Contractor's reimbursement agreements with providers of medical services to determine if they contain unit prices that are reasonable. In making such determination, the Department shall consider such other prevailing reimbursement rates as it deems appropriate, including, but not limited to, Medicaid fee-for-service rates, usual and customary fees paid by managed care plans for similar services and Medicare reimbursement rates. If the SDOH determines that the Contractor's reimbursement agreements are not reasonable**,** the SDOH may opt to re-price the Contractor's encounter data and base any settlement pursuant to this Section on the lesser of the Contractor's reported medical costs or the amount that the SDOH would have paid for the same medical services at the Medicaid fee-for-service payment schedule. Similarly, if the Contractor enters into capitation or other risk-sharing contracts with providers of medical services, the SDOH may opt to base the calculation of the MLR on actual usage of medical services as reported in the Contractor's encounter data, subject to independent validation, priced at the Medicaid fee schedule. Only those medical services covered by Medicaid under the fee-for-service program shall be included in the calculation of the MLR. Case management costs shall be included in the calculation of the MLR only if reimbursed by the Contractor to a provider of medical service. Costs associated with administrative functions performed by the Contractor, or its subcontractor(s), including but not limited to utilization review, case management and care coordination, shall be reported by the Contractor as an administrative expense and shall not be included in the calculation of the MLR.

f) The risk sharing provisions of the Agreement shall be in effect with the first year of operation of the plan. Settlement of the risk-sharing provisions shall be on a calendar year basis ("The Settlement Period")

beginning with the first full calendar year in which the SNP provided at least 4,800 coverage months or has reached financial breakeven (positive net income for the year), whichever comes first. Settlement calculations shall commence fifteen (15) months following the end of the Settlement Period based on claims incurred during the Settlement Period. Incurred But Not Reported (IBNR) estimates used by the Contractor to complete paid claims data for the Settlement Period shall be subject to audit and the Contractor must provide to the SDOH adequate documentation to support IBNR estimates.

The settlement shall be based on a restatement of revenue and medical expenses for the Settlement Period completed twelve (12) months after the end of the Settlement Period. For purposes of calculating the amount of the settlement, if any, SDOH shall assume that medical costs from a given Settlement Period are one hundred percent (100%) complete.

For purposes of determining the amount of the settlement, if any, the Contractor's medical costs shall be determined net of stop-loss recoveries. Individual stop-loss recoveries shall be adjudicated prior to aggregate stop-loss provisions described in this Section. In the event that the Contractor has elected to purchase private stop-loss insurance from a private reinsurer, the SDOH may require the Contractor to provide detailed reports of such recoveries.

g) The risk-sharing provisions contained in this Section shall be in effect for two Settlement Periods as defined in Section 3.13 (f) of this Agreement, after which time the SDOH may continue, revise or terminate the aggregate risk-sharing methodology.

h) Settlement payment from either party shall be made within six (6) weeks following SDOH's written notification to the Contractor of the settlement amount. Interest shall be applied to payments due to the SDOH more than ten (10) weeks following the due date at the rate equal to the overpayment rate set by the Commissioner of Tax and Finance pursuant to § 1096 of the Tax Law.

3.14 Residential Health Care Facility Stop-Loss

The Contractor will be compensated for medically necessary and clinically appropriate Medicaid reimbursable inpatient Residential Health Care Facility services, as defined in Appendix K of this Agreement, provided to Enrollees in excess of sixty (60) days during a calendar year at the lower of the Contractor's negotiated rates or Medicaid rate of payment.

3.15 Stop-Loss Documentation and Procedures

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 Tracking Visits Provided by Indian Health Clinics

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.

4. SERVICE AREA

The Contractor’s service area shall consist of the New York City 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 New York City-specific geographic area within which Eligible Persons must reside or work at the time of enrollment in the Contractor's plan.

5. RESERVED

6. ENROLLMENT

6.1 Populations Eligible for Enrollment in an HIV SNP

Medicaid Managed Care 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 or work 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. Related children up to the age of nineteen 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.

6.2 Enrollment Requirements

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 plan shall be voluntary.

6.5 RESERVED

6.6 Prohibition Against Conditions on Enrollment

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

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. The child may be disenrolled at any time at the mother's request. The Contractor must register unborn children of members with the LDSS and enroll newborn children of members effective from the time of birth.

b) In addition to the responsibilities set forth in Appendix H of this Agreement, the Contractor is responsible for:

i) Coordinating with the LDSS the efforts to ensure that all newborns are enrolled in the Contractor's HIV SNP, if applicable.

ii) Issuing a letter informing parent(s) about newborn child's enrollment or a member identification card within 14 days of the date on which the Contractor becomes aware of the birth;

iii) 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

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

c) The SDOH 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.

6.8 Effective Date of Enrollment

a) The Contractor and the LDSS are responsible for notifying the HIV SNP Enrollee of the expected Effective Date of Enrollment.

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

c) In the event that the actual Effective Date of Enrollment changes, the Contractor and the LDSS must notify the Enrollee of the change.

d) 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 an Enrollee who is admitted to the hospital prior to the Effective Date of Enrollment in the Contractor's plan and who remains hospitalized on the Effective Date of Enrollment; except when the 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) 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) 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.

6.9 Roster

a) The first and second monthly Rosters generated by SDOH in combination shall serve as the official Contractor Enrollment list 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 LDSS is responsible for making data on eligibility determinations available to the Contractor and SDOH to resolve discrepancies that may arise between the Roster and the Contractor's enrollment files in accordance with the provisions in Appendix H of this Agreement.

c) All Contractors must have the ability to receive Rosters electronically.

6.10 Automatic Re-Enrollment

An Enrollee who loses Medicaid eligibility and who regains eligibility for Medicaid within a three (3) month period, will be automatically prospectively re-enrolled in the Contractor's HIV SNP unless:

i) the Contractor does not offer an HIV SNP in the Enrollee's county of fiscal responsibility; or

ii) the Enrollee indicates in writing that he/she wishes to enroll in another MCO, or, if permitted, receive coverage under Medicaid fee-for-service.

6.11 Verification of HIV SNP Enrollment Eligibility

(a) The Contractor shall make best efforts to confirm that Enrollee applicants have HIV infection prior to the submission of the enrollment, except that such prior confirmation is not required for the Enrollee applicant's related children up to the age of nineteen.

(b) The Contractor must obtain verification of HIV infection as defined in (d) within 30 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 SNP Enrollment eligibility, acceptable verification of HIV infection shall include one of the following laboratory test results, or other diagnostic tests approved by the AIDS Institute:

i) HIV antibody screen assay;

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

iii) CD4 Level Measurement of less than 200.

(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.

7. LOCK-IN PROVISIONS

7.1 Lock-In Provisions

There is no lock-in of HIV SNP Enrollees.

7.2 RESERVED

7.3 RESERVED

7.4 RESERVED

7.5 RESERVED

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) LDSSs are responsible for making the final determination concerning Disenrollment requests.

c) 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. With the Enrollee's consent, information will also be provided on and referrals provided to HIV case management resources and primary care providers. 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. For individuals who lose Medicaid eligibility, this plan will include information regarding services offered by the AIDS Drug Assistance Program (ADAP).

8.2 Disenrollment Prohibitions

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

8.3 Reasons for Voluntary Disenrollment

The Contractor shall provide Enrollees who disenroll voluntarily with an opportunity to identify, in writing, their reason(s) for disenrollment.

8.4 Disenrollment Requests in HIV SNPs

a) Routine Disenrollment Requests in HIV SNPs

All Enrollees are categorically eligible for expedited disenrollment. Unless otherwise specified in Appendix H, Section E disenrollment requests will be processed to take effect on the first (1st) day of the next month if the request is made before the date 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 an urgent medical need to disenroll from the Contractor's plan may request an expedited Disenrollment by the LDSS. An Enrollee who requests a return to Medicaid fee-for-service based on his/her HIV, ESRD, or SPMI/SED status is categorically eligible for an expedited Disenrollment on the basis of urgent medical need.

ii) Enrollees with a complaint of Nonconsensual Enrollment may request an expedited Disenrollment by the LDSS.

iii) In districts where homeless individuals are Exempt, as described in Appendices H and M of this Agreement, homeless Enrollees residing in the shelter system may request an expedited Disenrollment by the LDSS.

iv) Retroactive Disenrollments may be warranted in rare instances and may be requested of the LDSS as described in Appendix H of this Agreement.

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

8.5 Contractor Notification of Disenrollments

a) Notwithstanding anything herein to the contrary, the Roster, along with any changes sent by the LDSS 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.

b) In the event that the LDSS intends to retroactively disenroll an Enrollee on a date prior to the first day of the month of the disenrollment request, the LDSS is responsible for consulting with the Contractor prior to disenrollment. Such consultation shall not be required for the retroactive disenrollment of SSI infants or in cases where it is clear that the Contractor was not at risk for the provision of Benefit Package services for any portion of the retroactive period.

c) In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the LDSS is responsible for notifying 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.

8.6 Contractor's Liability

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 an Enrollee who is admitted to the hospital prior to the Effective Date of Disenrollment from the Contractor's plan and who remains hospitalized on the Effective Date of Disenrollment; except when the 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.

b) The Contractor shall notify the LDSS 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.

8.7 Enrollee Initiated Disenrollment

a) An Enrollee may disenroll from the Contractor's plan at any time, for any reason.

b) All Enrollees are entitled to an expedited disenrollment as set forth in Appendix H.

c) In cases where an Enrollee's request for disenrollment may include a complaint of non-consensual enrollment, Enrollees may initiate a request for an expedited disenrollment to the LDSS or the SDOH. Substantiation of such a request by the LDSS or the SDOH may result in an expedited disenrollment as set forth in Appendix H.

8.8 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.

b) The Contractor shall initiate disenrollment when there is clear and consistent documentation that the Enrollee has neither presented for care or treatment for a period of three (3) months from the effective date of enrollment, nor received a Case Management encounter or Enrollee orientation contact during this three month period.

c) The Contractor shall initiate disenrollment when there is clear and consistent documentation that the Enrollee has neither presented for required care or treatment nor received a Case Management encounter for a period of six (6) consecutive months from the time that the Enrollee's initial treatment plan has been established.

d) 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, other than the absence of utilization described in Sections 8.8 (b) and 8.8 (c) above, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs (except where continued enrollment in the Contractor's plan seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees).

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

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

8.9 LDSS Initiated Disenrollment

a) LDSS is responsible for promptly initiating Disenrollment when:

i) An Enrollee is no longer eligible for MMC; or

ii) The Guaranteed Eligibility period ends and an Enrollee is no longer eligible for MMC benefits; or

iii) An Enrollee is no longer the financial responsibility of the LDSS; or

iv) An Enrollee becomes ineligible for enrollment pursuant to Section 6.1 of this Agreement; or

v) An Enrollee has moved outside the Service Area covered by this Agreement, unless Contractor can demonstrate that:

A) The Enrollee has made an informed choice to continue enrollment with Contractor and that Enrollee will have sufficient access to Contractor's provider network; and

B) Fiscal responsibility for Medicaid coverage remains in the county of origin.

9. GUARANTEED ELIGIBILITY

9.1 General Requirements

SDOH, the LDSS and the Contractor will follow the policies in this section subject to state and federal law and regulation.

9.2 Right to Guaranteed Eligibility

a) New Enrollees, other than those identified in Section 9.2 (b) below, who would otherwise lose Medicaid eligibility during the first six (6) months of Enrollment will retain the right to remain enrolled in the Contractor's plan under this Agreement for a period of six (6) months from their Effective Date of Enrollment.

b) Guaranteed Eligibility is not available to the following Enrollees:

   i) Enrollees who lose eligibility due to death, moving out of State or incarceration;

   ii) Female MMC Enrollees with a net available income in excess of medically necessary income but at or below two hundred percent (200%) of the federal poverty level who are only eligible for Medicaid while they are pregnant and then through the end of the month in which the sixtieth (60th) day following the end of the pregnancy occurs.

c) If, during the first six (6) months of enrollment in the Contractor's plan, an Enrollee becomes eligible for Medicaid only as a spend-down, the Enrollee will be eligible to remain enrolled in the Contractor's plan for the remainder of the six (6) month Guaranteed Eligibility period. During the six (6) month Guaranteed Eligibility period, an Enrollee eligible for spend-down and in need of wrap-around services has the option of spending down to gain full Medicaid eligibility for the wrap-around services. In this situation, the LDSS is responsible for monitoring the Enrollee's need for wrap-around services and manually setting coverage codes as appropriate.

d) Enrollees who lose and regain Medicaid eligibility within a three (3) month period will not be entitled to a new period of six (6) months Guaranteed Eligibility.

9.3 Covered Services During Guaranteed Eligibility

The services covered during the Guaranteed Eligibility period shall be those contained in the Benefit Package, as specified in Appendix K of this Agreement.

MMC Enrollees shall also be eligible to receive Free Access to family planning and reproductive health services as set forth in Section 10.14 of this Agreement and pharmacy services on a Medicaid fee-for-service basis during the Guaranteed Eligibility period.

9.4 Disenrollment During Guaranteed Eligibility

a) An Enrollee-initiated disenrollment from the Contractor's plan terminates the Guaranteed Eligibility period.

b) During the Guaranteed Eligibility period, an Enrollee may not change health plans. An Enrollee may choose to disenroll from the Contractor’s Plan during the guaranteed eligibility period but is not eligible to enroll in any other health plan because he/she has lost eligibility for Medicaid.

10. BENEFIT PACKAGE REQUIREMENTS

10.1 Contractor Responsibilities

a) Capitated Benefits

Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for HIV SNP Enrollees subject to any exclusions or limitations imposed by federal or state law during the period of this Agreement. SDOH and LDSS 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 HIV SNP Enrollees.

b) Fee-for-Service Benefits

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.

10.2 Compliance with State Medicaid Plan and Applicable Laws

All services provided under the Benefit Package to Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

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 and Periodic Screening, Diagnostic and Treatment (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:

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.

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 programs 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.

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

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 infected and should be tested.

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 according to the Medicaid fee schedule by the Contractor.

10.7 Welfare Reform

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.

b) The Contractor shall require that the Participating Providers in its HIV SNP, upon 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 Enrollee or a former Enrollee currently receiving public assistance or who is applying for public assistance, the Enrollee's or a former Enrollee's PCP or specialist provider, as appropriate, shall provide medical documentation concerning the Enrollee or former 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 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 Enrollee, who has already undergone, or is scheduled to undergo, an initial LDSS required mental and/or physical examination, the 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 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 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 continue to be responsible for the provision and payment of Chemical Dependence Services in the Benefit Package for Enrollees mandated by the LDSS under Welfare Reform if such services are already under way and the LDSS is satisfied with the level of care and services.

e) The Contractor is not responsible for the provision and payment of Chemical Dependence Inpatient Rehabilitation and Treatment Services for Enrollees mandated by the LDSS as a condition of eligibility for Public Assistance or Medicaid under Welfare Reform (as indicated by Code 83) unless such services are already under way as described in (d) above.

f) The Contractor is not responsible for the provision and payment of Medically Supervised Inpatient and Outpatient Withdrawal Services for Enrollees mandated by the LDSS under Welfare Reform (as indicated by Code 83) unless such services are already under way as described in (d) above.

g) The Contractor is responsible for the provision and payment of Medically Managed Detoxification Services ordered by the LDSS under Welfare Reform.

h) The Contractor is responsible for the provision of services in Sections 10.9, 10.19 and 10.29 of this Agreement for Enrollees requiring LDSS managed 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 benefit package services and covered by the Benefit Package and reimbursable by Medicaid.

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.

10.10 HIV Counseling, Testing, Referral, and Partner Notification Services

a) Enrollees may receive HIV antibody testing and pre- and post-test counseling when performed as part of a family planning or reproductive health visit from any qualified provider which undertakes to provide such services regardless of whether the provider is part of the HIV SNP's provider network. Such testing may be provided without referral and without the HIV SNP's prior approval or notification of the HIV SNP.

b) The Contractor shall comply with the requirements in Title 10 NYCRR which mandate that HIV counseling with testing, presented as a clinical recommendation, be provided to all women in prenatal care and their newborns.

c) The Contractor shall assure that its participating Providers shall report positive HIV test results and diagnoses and known contacts of such

persons to the New York State Commissioner of Health or, for HIV SNPs located in New York City, to the New York City Commissioner of Health and Mental Hygiene. Access to Partner Notification services must be consistent with Chapter 163 of the Laws of 1998.

10.11 HIV SNP Care and Benefits Coordination Services

HIV SNP Care and Benefits Coordination Services include the following:

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

b) Assessment and service plan development that identifies and addresses the Enrollee's medical and psychosocial 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.

a) Medical Case Management /Care Coordination

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

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

iii) 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.

b) Assessment of Case Management Needs

i) 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.

ii) 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 psychosocial crisis. Such reassessment shall consider whether a change in the Enrollee's Medical Case Management/Care Coordination or psychosocial 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.

iii) 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.

iv) 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.

v) 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:

A) through contractual agreements with qualified community-based case management providers who have AIDS Institute-approved case management programs and who are able to provide SNP Enrollees access to case management and other support services; and/or

B) directly by the Contractor if the Contractor can demonstrate the ability to comply with AIDS Institute standards for providing Case Management; and/or

C) with the consent of the Enrollee, by a referral to a qualified external case management provider that has a linkage agreement with the Contractor such as in the case of services provided by a CMCM (HIV COBRA) provider.

c) Service Utilization Monitoring and Care Advocacy

i) The Contractor shall ensure that the provider(s) of case management services have in place a comprehensive case management assessment for each Enrollee and an updated service plan within sixty (60) days of the effective date of SNP enrollment.

ii) 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.

d) Quality Assurance

i) 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.

ii) 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.

10.12 HIV Primary and Secondary Prevention and Risk Reduction Services

a) The Contractor must provide the following services:

i) HIV primary and secondary prevention and risk reduction education and counseling;

ii) Harm reduction education and services;

iii) Sponsorship of or participation in HIV community education, outreach and health promotion activities.

b) 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:

i) Education and counseling regarding reduction of perinatal transmission;

ii) HIV prevention and risk reduction education and counseling;

iii) Education to enrollees regarding STDs and services available for STD treatment and prevention;

iv) Counseling and supportive services for partner/spousal notification (pursuant to Chapter 163 of the Laws of 1998).

10.13 HIV Treatment Adherence Services

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.

10.14 Family Planning and Reproductive Health Services

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. 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 Enrollee's PCP and without approval from the Contractor.

b) The Contractor agrees to permit Enrollees to exercise their right to obtain Family Planning and Reproductive Health Services. The Contractor shall include Family Planning and Reproductive Health services in its Benefit Package and 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.

c) The Contractor agrees to permit Enrollees to obtain pre and post-test HIV counseling and testing when performed as part of a Family Planning encounter from the Contractor, or from any appropriate Medicaid enrolled Non-Participating family planning Provider without a referral from the Enrollee's PCP and without approval by the Contractor.

d) The Contractor will inform Enrollees about the availability of in-plan HIV counseling, testing, referral, and partner notification services, out-of-plan HIV counseling testing, referral, and partner notification services when performed as part of a Family Planning encounter and anonymous HIV counseling, testing, referral, and partner notification services available from SDOH, Local Public Health Agency clinics and other county programs. HIV counseling, testing, referral, and partner notification services rendered outside of a Family Planning encounter, as well as services provided as the result of a diagnosis of HIV infection, will be furnished by the Contractor in accordance with standards of care.

e) Contractor must comply with federal, state, and local laws, regulations and policies regarding informed consent and confidentiality. Providers who are employed by the Contractor may share patient information with appropriate Contractor personnel for the purposes of claims payment, utilization review and quality assurance. Providers who have a contract with the Contractor, with an appropriate enrollee consent, may share patient information with the Contractor for purposes of claims payment, utilization review and quality assurance. Contractor must ensure that an individual's use of family planning services remains confidential and is not disclosed to family members or other unauthorized parties.

f) Contractor must inform its practitioners and administrative personnel about policies concerning free access to family planning services, HIV counseling, testing, referral, and partner notification services,

reimbursement, enrollee education and confidentiality. Contractor must inform its 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, the New York State Child/Teen Health Program, and the AIDS Institute. These standards and laws indicate that family planning counseling is an integral part of primary and preventive care.

g) The Contractor agrees that the Contractor will be charged for the services of out-of-network providers at the applicable Medicaid rate or fee. In such instances, out of network providers will bill Medicaid and the SDOH will issue a confidential charge back to the Contractor. Such a charge back mechanism will comply with all applicable patient confidentiality requirements.

h) The Contractor shall comply with the requirements for informing Enrollees about family planning and reproductive health services set forth in Part C-2 of Appendix C, which is hereby made a part of this Agreement as if set forth herein.

i) SDOH with DHHS approval may issue modifications to Appendix (C) consistent with relevant provisions of federal and state statutes and regulations. Once issued and upon sixty (60) days notice to the LDSS and Contractor, such modifications shall be deemed incorporated into this Agreement without further action by the parties.

10.15 Prenatal Care

The Contractor is responsible for arranging for the provision of comprehensive Prenatal Care Services to all pregnant Enrollees including all services enumerated in Subdivision 1, Section 2522 of the PHL in accordance with 10 NYCRR § 85.40 (Prenatal Care Assistance Program).

10.16 Direct Access

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).

10.17 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 agrees that it will not require prior authorization for services in a medical or behavioral health emergency. 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. 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 must pay for services for Emergency Medical Conditions whether provided by a Participating Provider or a Non-Participating Provider, and may not deny payments for failure of the Emergency Services provider or Enrollee to give notice.

c) Emergency Services rendered by Non-Participating Providers: 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 shall bear the cost of providing Emergency Services through Non-Participating Providers.

d) 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.

10.18 Medicaid Utilization Thresholds (MUTS)

Enrollees may be subject to MUTS for outpatient pharmacy services which are billed to Medicaid fee-for-service and for dental services provided without referral at Article 28 clinics operated by academic dental centers as described in Section 10.33 of this Agreement. Enrollees are not otherwise subject to MUTS for services included in the Benefit Package.

10.19 Services for Which Enrollees Can Self-Refer

a) Mental Health and Chemical Dependence Services

i) The Contractor will allow Enrollees to make a self-referral for one mental health assessment from a Participating Provider and one chemical dependence assessment from a Detoxification or

Chemical Dependence Participating Provider in any calendar year period without requiring pre-authorization or referral from the Enrollee's Primary Care Provider. 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 or similar source.

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

iii) The Contractor also must ensure that formal assessment instruments are used by HIV SNP PCPs during initial and subsequent patient assessments to: (1) identify members who require mental health and Chemical Dependence Services and (2) determine the types of mental health and Chemical Dependence Services that should be furnished. HIV SNPs must offer formal training for network providers in the use of these assessment instruments and in techniques for identifying individuals with unmet behavioral health care needs. HIV SNPs should reference the AIDS Institute's web site for HIV Clinical Resources for guidance regarding Mental Health and Chemical Dependence assessments and clinical care. HIV SNPs should reference the AIDS Institute's web site for HIV Clinical Resources for guidance regarding Mental Health and Chemical Dependence assessments and clinical care, consistent with Sections 15.2(a)(x) and (xi) of this Agreement.

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 Chemical Dependence assessment(s), consistent with Sections 15.2(a)(x) and (xi) of this Agreement.

v) The Contractor must have arrangements to allow any HIV SNP participating PCP, with appropriate enrollee consent, to request that a representative of the HIV SNP or behavioral health provider contact any patient 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 as described in Appendix K 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 10.22(a) of this Agreement.

d) Family Planning and Reproductive Health Services

Enrollees may self-refer for family planning services as described in Section 10.14 and Appendix C of this Agreement.

e) Article 28 Clinics Operated by Academic Dental Centers

Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services as described in Section 10.33 of this Agreement.

10.20 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.

10.21 Coordination with Local Public Health Agencies

The Contractor will coordinate its public health-related activities with the Local Public Health Agency (LPHA) consistent with the SDOH MCO and Public Health Guidelines. Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with the LPHA and be customized to reflect local public health priorities. Negotiations must result in agreements regarding required Contractor activities related to public health as set forth in Appendix N of this Agreement as if set forth fully herein.

10.22 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 as set forth in Appendix K.3 (3) (e) of this Agreement.

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, except for 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 Local Public Health Agency 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 their Enrollees, within the context of TB diagnosis and treatment.

B) The Contractor will make a 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 rates determined by SDOH.

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 10.21 of this Agreement, unless these services are ordered by a court of competent jurisdiction; 2) making reasonable efforts to verify with the Enrollees'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 not included in the Benefit Package as set forth in Appendix K.3 (3)(e) of this Agreement.

A) The Contractor will not be capitated or financially liable for these costs.

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

C) Enrollees may use any Medicaid fee-for-service TB/DOT provider.

iv) HIV counseling and testing provided to a MMC Enrollee during a TB related visit at a public health clinic, directly operated by a LPHA, will be covered by Medicaid fee-for-service at 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.

B) The Contractor will make a 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 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.

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. HIV counseling, testing, referral, and partner notification services provided to an Enrollee during an STD related visit at a public health clinic, directly operated by a LPHA, will be covered by Medicaid fee-for-service at rates established by SDOH.

d) Lead Poisoning

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.

10.23 HIV-Infected Women

The Contractor must assure access to comprehensive care for women enrolled in its plan, and, to the extent geographically available, promote access to HIV Primary Care Medicaid Programs providing the co-location of routine gynecological care and HIV primary care services.

10.24 HIV-Infected and Uninfected Adolescents

The Contractor must facilitate access for its adolescent enrollees to Providers knowledgeable regarding adolescent development, HIV treatment, methods of reducing the risk of transmission, and methods of effective communication with this age group.

10.25 HIV-Infected Pregnant Women, HIV-Exposed Newborns, and HIV-Infected and Affected Children and Adolescents

a) HIV SNPs must provide care that is consistent with State and federal policies regarding methods of reducing HIV transmission and encouraging early entry into care including:

i) Timely exchange of clinical information among prenatal, delivery, and pediatric settings for HIV positive pregnant women, with appropriate enrollee consent;

ii) Initiation of prophylaxis with anti-retroviral therapy as needed;

iii) Provision of anti-retroviral counseling and offering of such therapies to all HIV-infected pregnant women;

iv) Provision of PCR or viral culture testing at recommended intervals to definitively diagnose or rule-out HIV infection in exposed infants;

v) Provision of routine pediatric care to all children enrolled in Contractor's plan in accordance with guidelines established by the American Academy of Pediatrics. Such care must include: immunizations, monitoring of growth and development, routine screening, and guidance to help parents anticipate normal changes and problems with growth, development, and education. The Contractor must provide: adolescent health; child/teen health screenings; and provision of early and periodic screening, diagnosis, treatment, and referral to each participant under the age of twenty-one (21) at regular intervals and as medically appropriate; and

vi) Provision of (1) comprehensive developmental assessments; (2) all child/teen health plan services; (3) early intervention services including physical, speech, and occupational therapies; (4) access to intravenous infusions; (5) oral health services; and (6) linkages to clinical trials for all Enrollees under the age of 21, as appropriate.

b) The Contractor must assure access availability to Maternal/Pediatric HIV Specialized Care Centers for HIV infected mothers with HIV infected- and/or HIV-exposed children up to the age of eighteen months enrolled in its plan.

10.26 HIV-Infected Adults with Additional Non-HIV Related 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) Satisfactory systems for coordinating service delivery with Non-Participating Providers, including behavioral health providers for all Enrollees.

iii) Policies and procedures to allow for the continuation of existing relationships with Non-Participating Providers, consistent with PHL § 4403 (6)(e) and Section 15.7 of this Agreement.

10.27 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. All children who are HIV-infected are by definition children with special health care needs. For all children with special needs, whether or not they are HIV-infected, the Contractor will be responsible for performing all of the same activities for this population as for adults. In addition, the Contractor will implement the following for these children:

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.

10.28 Persons Requiring Ongoing Mental Health Services

a) 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;

ii) Satisfactory methods for identifying Enrollees requiring such services and encouraging self-referral and early entry into treatment. Such methods shall include administration of a mental health assessment using an approved instrument as part of the initial baseline Enrollee assessment;

iii) Satisfactory case management systems or satisfactory case management;

iv) Satisfactory systems for coordinating service delivery between physical health, chemical dependence, and mental health providers, and coordinating services with other available services, including Social Services;

v) Satisfactory systems of care (provider networks and referral processes sufficient to ensure that emergency services can be provided in a timely manner), including crisis services.

vi) The Contractor agrees to participate in the local planning process for serving Enrollees with mental health needs to the extent requested by the DOHMH. At the discretion of DOHMH, the Contractor will develop linkages with local governmental units on coordination, procedures and standards related to mental health services and related activities.

10.29 Persons Requiring Chemical Dependence Services

a) The Contractor will have in place all of the following for its Enrollees requiring Chemical Dependence Services:

i) A Participating Provider network which includes all the required provider types listed in Section 21 of this Agreement;

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). Such methods shall include administration of a chemical dependence assessment using an approved assessment instrument as part of the initial baseline Enrollee assessment;

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;

iv) Satisfactory case management systems;

v) Satisfactory systems for coordinating service delivery between physical health, chemical dependence, and mental health providers, and coordinating services received from Participating Providers with other services, including Social Services;

vi) The Contractor also agrees to participate in the local planning process for serving persons with chemical dependence, to the extent requested by the DOHMH. At the discretion of DOHMH, the Contractor will develop linkages with local governmental units on coordination procedures and standards related to Chemical Dependence Services and related activities.

10.30 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 Packages must develop a referral relationship with the Enrollee's PCP at the tribal health center to coordinate services for said Native American Enrollee.

10.31 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.

10.32 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, the Northern Mariana Islands and Canada.

The Contractor may require the Enrollee or the Enrollee’s designee to coordinate with the Contractor or the Enrollee’s PCP prior to receiving care.

10.33 Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers Not Participating in Contractor’s Network

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.

b) If dental services are part of the Contractor's Benefit Package, the Contractor will reimburse non-participating Article 28 clinics operated by academic dental centers for covered dental services provided to Enrollees at approved Article 28 Medicaid clinic rates in accordance with the protocols issued by the SDOH.

10.34 Hospice Services

HIV SNP Enrollees receive coverage for hospice services through the Medicaid fee-for-service program.

10.35 Prospective Benefit Package Change for Retroactive SSI Determinations

The Benefit Package and associated Capitation Rate for 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.

10.36 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.

10.37 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;

iv) WIC, Head Start, Early Intervention;

v) Programs funded through the Ryan White CARE Act;

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

vii) Prenatal Care Assistance Program (PCAP) Providers;

viii) Local governmental units responsible for public health, mental health, mental retardation or chemical dependence services,

ix) Specialized providers of long-term care for people with developmental disabilities, and

x) School-based health centers.

b) As applicable for Enrollees requiring such services, the Contractor shall make best efforts to ensure coordinated care through the HIV SNP care and benefits coordination process and linkage agreements and/or contracts with the following service providers:

i) HIV/AIDS social service providers, including those funded through the Ryan White CARE Act;

ii) Community-based providers offering HIV case management services including non-intensive psychosocial case management and COBRA;

iii) Providers of individual or group HIV prevention and risk reduction services, education, and counseling services;

iv) Organizations offering treatment education to support and promote adherence to treatment regimens;

v) Organizations providing chemical dependence treatment readiness assessment, counseling and referrals;

vi) Harm reduction and needle exchange providers (where available);

vii) Programs offering counseling and assistance with partner/spousal notification;

viii) Permanency planning and transitional service providers;

ix) Community education providers;

x) HIV clinical education initiative providers;

xi) Providers of housing and supportive services for the homeless;

xii) Shelters and other providers of services for victims of domestic violence;

xiii) Providers of services to migrants;

xiv) Programs offering nutritional services;

xv) Programs offering transportation services to supportive services; and

xvi) Providers of legal services.

11. MARKETING

11.1 Information Requirements

a) The Contractor shall provide Prospective Enrollees, upon request, with pre-enrollment and post-enrollment information pursuant to PHL § 4408 and SSL § 364-j.

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) The Contractor shall provide Potential Enrollees with pre-enrollment and post-enrollment information pursuant to 42 CFR § 438.10 (e).

d) The Contractor must inform Potential Enrollees that oral interpretation service is available for any language and that information is available in alternate formats and how to access these formats.

11.2 Marketing Plan

a) The Contractor shall have a Marketing Plan, that has been prior-approved by the SDOH and the DOHMH that describes the Marketing activities the Contractor will undertake within the service area, as specified in Appendix M of this Agreement, during the term of this Agreement.

b) The Marketing Plan and all Marketing activities must comply with the Marketing Guidelines which are set forth in Appendix D and any New York City Specific marketing requirements as set forth in Appendix N, which are hereby made a part of this Agreement as if set forth fully herein.

c) The Marketing Plan shall be kept on file in the offices of the Contractor, the DOHMH, and the SDOH. The Marketing Plan may be modified by the Contractor subject to prior written approval by the SDOH and DOHMH. The SDOH and the DOHMH must take action on the changes submitted within sixty (60) calendar days of submission or the Contractor may deem the changes approved.

11.3 Marketing Activities

Marketing activities by the Contractor shall conform to the approved Marketing Plan.

11.4 Prior Approval of Marketing Materials and Procedures

The Contractor shall submit all procedures and materials related to Marketing to Prospective Enrollees to the SDOH for prior written approval, as described in Appendix D of this Agreement. The Contractor shall not use any procedures or materials that the SDOH has not approved. Marketing materials shall be made available by the Contractor throughout its entire service area. Marketing materials may be customized for specific counties and populations within the Contractor's service area. All Marketing activities should provide for equitable distribution of materials without bias toward or against any group.

11.5 Corrective and Remedial Actions

a) If the Contractor's Marketing activities do not comply with the Marketing Guidelines set forth in Appendix D of this Agreement or the Contractor's approved Marketing plan, the SDOH and/or the DOHMH, may take the actions described in (i), (ii) and (iii) below to protect the interests of Enrollees and the integrity of the Program. The Contractor shall take the corrective and remedial actions directed by the SDOH and/or the DOHMH within the specified timeframes.

i) If the Contractor or its representative commits a first time infraction of the Marketing Guidelines and/or the Contractor's approved Marketing plan, and the SDOH and/or the DOHMH deem the infraction to be minor or unintentional in nature, the SDOH and/or the DOHMH may issue a warning letter to the Contractor.

ii) If the Contractor engages in Marketing activities that SDOH and/or the DOHMH determines, in its sole discretion, to be an intentional or serious breach of the Marketing Guidelines or the Contractor's approved Marketing plan, or a pattern of minor breaches, SDOH and/or the DOHMH may require the Contractor to, and the Contractor shall, prepare and implement a corrective action plan acceptable to SDOH and/or DOHMH within a specified timeframe. In addition, or alternatively, SDOH and the DOHMH, in consultation with 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, or DOHMH, in consultation with the SDOH, may in addition to any other legal remedy available to SDOH and/or DOHMH in law or equity:

A) Direct the Contractor to suspend its Marketing activities for a period up to the end of the Agreement period;

B) Suspend new Enrollments, other than newborns, for a period up to the remainder of the Agreement period; or

C) Terminate this Agreement pursuant to termination procedures described in Section 2.7 of this Agreement.

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 two thousand (2,000) 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 Enrollee questions and complaints, and advising Enrollees of the prerogative 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 Enrollees current categories of exemptions and/or 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.

12.2 Translation and Oral Interpretation

a) The Contractor must make available written marketing 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.

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.

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.

13.2 Provider Directories/Office Hours for Participating Providers

a) The Contractor shall maintain and update, on a quarterly 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 physicians, information on language capabilities, and wheelchair accessibility of Participating Providers. The list should also identify providers that are not accepting new patients.

b) New Enrollees must receive the most current complete listing in hardcopy, along with any updates to such listing.

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
   v) for ID Cards issued after October 1, 2004, 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) If 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.

13.4 Member Handbooks

The Contractor shall issue to a new Enrollee within fourteen (14) days of the Effective Date of Enrollment a Member Handbook, which is consistent with the SDOH guidelines described in Appendix E, which is hereby made a part of this Agreement as if set forth fully herein.

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 aggressive efforts as necessary to contact new Enrollees, in person, by telephone, or by mail within fifteen (15) days of their Effective Date of Enrollment. Aggressive efforts are defined to mean at least six attempts including a home visit to contact the individual. 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 Benefit Package services, including services for which the Enrollee may self-refer, pursuant to Section 10.19 of this Agreement, 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 15.6 (b) of this Agreement.

ii) Conduct a brief health screening to assess the Enrollee's need for any special health care (e.g., prenatal or behavioral health services) or language/communication needs. 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 on a timely basis.

iii) 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.

iv) Offer assistance in arranging an initial visit to the Enrollee's PCP for a baseline physical and other preventive services, including a comprehensive risk assessment.

v) Inform new Enrollees about their rights for continuation of certain existing services.

vi) 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.

vii) 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.

viii) Advise the 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).

ix) Provide the Enrollee with a complete list of network providers including those that may be accessed directly without referral and those that require a referral from the individual's PCP. The plan must also provide a separate list for those providers with which the Contractor has linkage arrangements including but not limited to community –based psychosocial service providers. The list should group providers by service type and must include addresses and telephone numbers.

x) Assist the Enrollee in selecting an HIV Specialist primary care provider if one has not already been chosen.

13.7 Post Enrollment Follow-Up

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.

13.8 Enrollee's Rights

a) The Contractor shall, in compliance with the requirements of 42 CFR §438.6(i)(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;

   ii) Be treated with respect and due consideration for his or her dignity and privacy;

   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 13.8(b) above.

13.9 Approval of Written Notices

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 in consultation with DOHMH. All written notifications must be written at a fourth (4th) to sixth (6th) grade reading level and in at least ten (10) point print.

13.10 Contractor's Duty to Report Lack of Contact

The Contractor must inform the LDSS of any Enrollee it is unable to contact within ninety (90) days of Enrollment using efforts as defined in Section 13.6 of the Agreement and who has not presented for any health care services through the Contractor or its Participating Providers.

13.11 LDSS Notification of Enrollee's Change in Address

The LDSS is responsible for notifying the Contractor of any known change in address of Enrollees.

13.12 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 and DOHMH 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.

13.13 Contractor Responsibility to Notify Enrollee of Termination, Service Area Changes and Network Changes

a) With prior notice to and approval of the SDOH and DOHMH, the Contractor shall inform each Enrollee in writing of any withdrawal by the Contractor from the HIV SNP 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 in consultation with DOHMH.

14. ACTION AND GRIEVANCE SYSTEM

14.1 General Requirements

a) The Contractor shall establish and maintain written Action procedures and a comprehensive Grievance System that complies with the Managed Care Action and Grievance System Requirements for HIV SNPs described in Appendix F, which is hereby made a part of this Agreement as if set forth fully herein. Nothing herein shall release the Contractor from its responsibilities under PHL § 4408-a or PHL Article 49 and 10 NYCRR Part 98 that is not otherwise expressly established in Appendix F.

b) The Contractor's Action procedure and Grievance 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 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.

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.

b) If the Contractor subcontracts for Service Authorization Determinations and utilization review, the Contractor must ensure that its subcontractors have in place and follow written policies and procedures for delegated activities regarding processing requests for initial and continuing authorization of services consistent with 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.

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.

14.3 Grievance System

a) The Contractor shall ensure that its Grievance 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 System.

14.4 Notification of Action and Grievance 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:

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 a representative to file Complaints, Complaint Appeals and Action Appeals 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 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, Complaint Appeal and Action Appeal Investigation Determinations

The Contractor must adhere to determinations resulting from Complaint, Complaint Appeal and Action Appeal investigations conducted by SDOH.

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 urgent medical or behavioral problems: within twenty-four (24) hours of request.

iii) Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.

iv) Routine non-urgent, preventive appointments: within four (4) weeks of request.

v) Specialist referrals (not urgent): within four (4) to six (6) weeks of request.

vi) 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.

vii) Adult Baseline and routine physicals: within four (4) weeks from enrollment. (Adults >21 years).

viii) Well child care: within four (4) weeks of request.

ix) Initial family planning visits: within two (2) weeks of request.

x) Pursuant to an emergency or hospital discharge, mental health or chemical dependence follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.

xi) Non-urgent mental health or chemical dependence visits with a Participating Provider (as included in the Benefit Package): within two (2) weeks of request.

[1] These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.

xii) Initial PCP office visit for newborns: within forty-eight (48) hours of hospital discharge.

xiii) Provider visits to make health, mental health and chemical dependence 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 Enrollee, in accordance with Section 10.7 of this Agreement.

15.3 Twenty-Four (24) Hour Access

a) The Contractor must provide access to Benefit Package services and coverage to Enrollees, either directly or through their PCPs, or in the case of a pregnant Enrollee, through the Enrollee's OB/GYN provider, 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 an 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 Unscheduled, Non-urgent Care (Walk-ins)

The Contractor shall be responsible for ensuring network providers have policy and procedure addressing Enrollees, and in particular adolescents and substance abusers, who present for unscheduled, non-urgent care.

15.5 Appointment Waiting Times

Enrollees with appointments shall not routinely be made to wait longer than one hour.

15.6 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 HIV specialty primary care sites shall not exceed thirty (30) minutes in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee's residence in non-metropolitan areas. 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 the community standard for accessing HIV specialist care, travel time shall not exceed thirty (30) minutes/thirty (30) miles. Transport time and distance in rural areas to primary care sites may be greater than thirty (30) minutes/thirty (30) miles if based on the community standard for accessing care or if by Enrollee choice.

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.

c) Other Providers

Travel time/distance to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles. Transport time and distance in rural areas to specialty care, hospitals, mental health, lab and X-ray providers may be greater than thirty (30) minutes/thirty (30) miles if based on the community standard for accessing care or if by Enrollee choice.

15.7 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 (1) the Enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition, or (2) the Enrollee has entered the second trimester of pregnancy at the Effective Date of Enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery up until sixty (60) days post partum. 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.

ii) In no event shall this requirement be construed to require the Contractor to provide coverage for benefits not otherwise covered.

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 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.

15.8 Standing Referrals

The Contractor will implement policies and procedures to allow for standing referrals to specialist physicians for Enrollees who have ongoing needs for care from such specialists, consistent with PHL § 4403(6)(b).

15.9 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) If the specialist does not meet the qualifications of an HIV Specialist, 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.

15.10 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).

15.11 Cultural Competence

The Contractor will participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

16. QUALITY MANAGEMENT

16.1 Internal Quality Management (QM) Program

a) Contractor must operate a quality management program which is approved by the AIDS Institute of the 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 approved quality management program must be kept on file by the Contractor. The Contractor shall not modify the quality management program without the prior written approval of the AIDS Institute of the SDOH.

b) The Contractor shall incorporate the findings from reports in Section 18 of this Agreement into its quality management program. Where performance is less than the statewide average or another standard as defined by the AIDS Institute and developed in consultation with DOHMH, HIV SNPs and appropriate clinical experts, the Contractor will be required to develop and implement a plan for improving performance that is approved by the AIDS Institute 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 the AIDS Institute, develop alternative plans to achieve improvement, to be implemented upon AIDS Institute approval. If requested by the AIDS Institute, the Contractor agrees to meet with the AIDS Institute and DOHMH to review improvement plans and quality performance.

16.2 QM Committee

The Contractor will establish a QM Committee charged with implementing 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.

16.3 Quality Management Plan (QMP)

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;

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;

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;

v) a description of how performance data and information from QI activities will be distributed throughout the plan;

vi) a description of how improvement interventions will be developed and implemented in response to findings from QI studies.

16.4 QM Procedures

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.

16.5 HIV SNP Medical Director Requirements

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.

16.6 HIV Education for Staff

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 including Rapid Testing options;

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.

16.7 Standards of Care

a) The Contractor must adopt practice guidelines that are consistent with prevailing standards of medical practice and with any additional standards established and updated by the AIDS Institute or the U.S. Department of Health and Human Services. Practice guidelines must comply 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 U.S. 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 U.S. Department of Health and Human Services Center for Substance Abuse Treatment, the American College of Obstetricians and Gynecologists, the American Diabetes Association, and the AIDS Institute clinical standards for care. Practice guidelines must be found to be acceptable by the AIDS Institute.

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 practices guidelines to its Participating Providers at least annually, or more frequently, as appropriate, with all relevant updates as they are released by the State or Federal government.

d) The Contractor shall be responsible for developing and implementing protocols for measuring individual provider performance and for making efforts to improve performance of Participating Providers.

16.8 Quality Management and Provider Manuals

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 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;

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.

17. MONITORING AND EVALUATION

17.1 Right to Monitor Contractor Performance

The SDOH or its designee, DOHMH 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 or its designee, DOHMH and DHHS in the monitoring and evaluation of the services provided under this Agreement.

17.3 Cooperation During On-Site Review

The Contractor shall cooperate with SDOH and/or its designee, and DOHMH in any on-site review of the Contractor’s operations. SDOH 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 the DOHMH, the 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.

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, Complaints and Appeals, and Disenrollments for other than loss of Medicaid eligibility. The system must be sufficient to provide the data necessary to comply with the requirements of this Agreement.

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.

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, with notice to the DOHMH, will provide Contractor with instructions for submitting the reports required by SDOH in Section 18.7 of this Agreement, including time frames, and requisite formats. The instructions, time frames and formats may be modified by SDOH upon sixty (60) days written notice to the Contractor.

18.4 Liquidated Damages

The Contractor shall pay liquidated damages of $2,500 to SDOH if any report required pursuant to this Section is materially incomplete, contains material misstatements or inaccurate information, or is not submitted in the requested format. The Contractor shall pay liquidated damages of $2,500 to the SDOH if its monthly encounter data submission is not received by the Fiscal Agent by the due date specified in Section 18.7(a)(iv) of this Agreement. The Contractor shall pay liquidated damages of $500 to SDOH for each day other reports required by this Section are late. The SDOH shall not impose liquidated damages for a first time infraction by the Contractor unless the SDOH deems the infraction to be a material misrepresentation of fact or the Contractor fails to cure the first infraction within a reasonable period of time upon notice from the SDOH. Liquidated

damages may be waived at the sole discretion of SDOH. Nothing in this Section shall limit other remedies or rights available to SDOH and DOHMH relating to the timeliness, completeness and/or accuracy of Contractor's reporting submission.

18.5 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.

18.6 Computer Systems

The Contractor must develop and implement SNP-related systems (or system modifications for existing plans seeking SNP certification). The system should easily identify enrollees for maintenance of accounts related to payment of distinct SNP capitation rates and monitor SNP enrollments and transfers on a timely basis. The HIV SNP 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 Provider Network (HPN) and must also have an ability to link with various data bases such as encounter reports and laboratory utilization.

18.7 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:

      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.

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 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 DOHMH.

iv) Encounter Data:

The Contractor shall prepare and submit encounter data on a monthly basis to SDOH through SDOH's designated Fiscal Agent. Each provider is required to have a unique identifier. 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. Monthly submissions must be received by the Fiscal Agent in accordance with the time frames specified in the MEDS II data dictionary on the HPN to assure the submission is included in the Fiscal Agent's monthly production processing.

v) Quality of Care Performance Measures:

A) The Contractor is required to develop MIS capacity to collect and maintain data that can be translated to meet the exact specification of Quality Indicator measures used or adopted by the AIDS Institute. Such measures include but are not limited to Enrollee-specific laboratory data including viral loads and CD-4 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.

B) The Contractor shall prepare and submit reports to SDOH, as specified in the Quality Assurance Reporting Requirements (QARRs) measures as determined and adopted by the AIDS Institute. The AIDS Institute may require the Contractor to arrange for an NCQA-certified entity to audit the QARR data prior to its submission to the SDOH. The AIDS Institute will select the measures which will be audited.

vi) Complaint and Action Appeal Reports:

A) 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 HPN. 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.

B) The Contractor agrees to provide on a quarterly basis, via Summary Complaint Form on the HPN, 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, Complaints and Action Appeals pursuant to Appendix F of this Agreement. These records shall be readily available for review by the SDOH and DOHMH upon request.

C) Nothing in this Section is intended to limit the right of the DOHMH, the SDOH or its designee to obtain information immediately from a Contractor pursuant to investigating a particular Enrollee or provider Complaint, Complaint Appeal or Action Appeal.

vii) Fraud and Abuse Reporting Requirements:

A) The Contractor must submit quarterly, via the HPN Complaint reporting format, the number of Complaints of fraud or abuse made to the Contractor that warrant preliminary investigation by the Contractor.

B) The Contractor also must submit to the SDOH the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through Complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, Enrollees, or any other source:

I) The name of the individual or entity that committed the fraud or abuse;
II) The source that identified the fraud or abuse;
III) The type of provider, entity or organization that committed the fraud or abuse;
IV) A description of the fraud or abuse;
V) The approximate dollar amount of the fraud or abuse;
VI) The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
VII) Other data/information as prescribed by SDOH.

C) Such report shall be submitted when cases of fraud and abuse are confirmed, and shall be reviewed and signed by an executive officer of the Contractor.

viii) Participating Provider Network Reports:

The Contractor shall submit electronically to the HPN 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 the Contractor's Enrollees. 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. This routine reporting requirement in no way relieves the Contractor of the obligation to report material changes in network composition prior to the time they occur.

ix) 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. Results of such surveys must be kept on file and be readily available for review by the SDOH or DOHMH, upon request.

x) Clinical Studies:

A) The Contractor will participate in two (2) AIDS Institute-sponsored focused external 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 approval of the SDOH AIDS Institute. 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 SNP. SDOH will provide guidelines which address study structure and reporting format. Written reports of these projects will be provided to the AIDS Institute and may be validated by the AIDS Institute.

C) The Contractor will collaborate in established research being conducted by the AIDS Institute designed to evaluate patient access to care, patient satisfaction and quality of life, including the "Client Cohort Study" and other specific quality improvement studies developed by or in cooperation with the AIDS Institute. The

Contractor shall obtain appropriate patient consent and IRB consent, if required.

xi) Member Satisfaction Assessments:

A) The Contractor will collaborate with the AIDS Institute and DOHMH to develop and conduct patient satisfaction surveys, focus groups, and other mechanisms to systematically obtain feedback from Contractor's HIV SNP Enrollees.

B) The Contractor must also conduct at least one (1) member satisfaction survey during each twelve (12) month period. At a minimum, this survey is to include questions on the following: member verification; member satisfaction with quality of care and access to care including access to specialists and subspecialists and access to community-based supportive service providers; availability of services from PCPs, family practice specialists and mental health and substance abuse providers; and overall coordination of health and medical care by the enrollee's PCP or PCP team.

C) In conducting the member satisfaction survey the Contractor shall utilize one of the following survey instruments:

(1) an instrument that has been developed by the SDOH;

(2) a validated survey instrument with methodology that ensures adequate and appropriate sampling of the enrolled population that has been approved by the AIDS Institute in collaboration with DOHMH;

(3) the Consumer Assessment of Health Plans (CAHPs), a Medicaid survey instrument sponsored by the Agency for Healthcare Research and Quality (AHRQ), used with additional HIV-specific questions approved by the AIDS Institute.

D) The Contractor shall select for use one of the above survey instruments in consultation with and prior approval of the AIDS Institute.

E) Survey results must be reported to the AIDS Institute and the DOHMH.

xii) Independent Audits:

The Contractor must submit copies of all certified financial statements and, when applicable, 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 thirty (30) days of the close of the quarter showing the percentage of new Enrollees for which the Contractor was able to complete a health screening consistent with Section 13.6 (a) (ii) of this Agreement.

xiv) Additional Reports:

Upon request by the SDOH, or as specified by DOHMH in Appendix N, 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 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.

18.8 Ownership and Related Information Disclosure

The Contractor shall report ownership and related information to SDOH, and upon request to the Secretary of Health and Human Services and the Inspector General of Health and Human Services, in accordance with 42 U.S.C. §§ 1320a-3 and 1396b(m)(4) (Sections 1124 and 1903(m)(4) of the SSA).

18.9 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 Program for which the data and information is collected, reported, prepared and submitted.

18.10 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;

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).

18.11 Certification Regarding Individuals Who Have Been Debarred Or Suspended by Federal, State, or Local 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 who has been debarred or suspended by the federal, state, or local government, or otherwise excluded from participating in procurement activities:

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 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 obligations SNP Program, consistent with requirements of SSA § 1932 (d)(1).

18.12 Conflict of Interest Disclosure

Contractor shall report to SDOH, in a format specified by 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 §§ 455.100–455.104.

18.13 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.

19. RECORDS MAINTENANCE AND AUDIT RIGHTS

19.1 Maintenance of Contractor Performance Records

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 DOHMH, LDSS, SDOH and any other authorized governmental agency may require including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received and expenses incurred under this Agreement;

iii) 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.

b) 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

The Contractor shall provide DOHMH, LDSS, SDOH, the Comptroller of the State of New York, DHHS, the Comptroller General of the United States, and their authorized representatives with access to all records relating to Contractor performance under this Agreement for the purposes of examination, audit, and copying (at reasonable cost to the requesting party) of such records. 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.

19.4 Retention Periods

The Contractor shall preserve and retain all records relating to Contractor performance under this Agreement in readily accessible form during the term of this Agreement and for a period of six (6) years thereafter except that the Contractor shall retain Enrollees' medical records that are in the custody of the Contractor 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 six (6) years after majority. 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 six (6) years after majority. All provisions of this Agreement relating to record maintenance and audit access 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 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 be retained until all litigation, claims, or audit findings involved in the record have been resolved and final action taken.

20. CONFIDENTIALITY

20.1 Confidentiality of Medical Information

a) The Contractor shall obtain consent during the enrollment process to authorize the medical records of the Enrollee and other relevant information (e.g., disclosure of pharmacy records or disclosure of COBRA provider records) to be disclosed to the Contractor for the purposes of reimbursement, quality assurance, utilization review, audit, and other appropriate purposes. Such consent shall be in conformance with State and Federal law and regulations, including but not limited to HIPAA.

b) The Contractor must have in place:

i) initial employee/staff/volunteer education and annual in-service training programs for all HIV SNP employees/staff/volunteers regarding requirements for confidentiality and restricted disclosure of HIV-related information. Initial HIV confidentiality training shall be provided to all HIV SNP staff and authorized agents within seven (7) days of employment and prior to commencement of duties involving contact with confidential Enrollee health information;

ii) a list of job titles or functions of employees who have access to patient records containing HIV-related information;

iii) adequate safeguards (i.e., electronic passwords and firewalls) for maintaining the security of patient information, including both paper and electronic files;

iv) documentation in contracts with health care providers and health facilities that such contractors must be informed of the confidentiality and disclosure restrictions; and

v) policies and procedures for handling requests for confidential HIV information and prohibiting discrimination against persons with HIV infection.

20.2 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 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 42 CFR Part 2 pertaining to Alcohol and Substance Abuse Services.

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 HIV SNP information.

20.3 Medical Records of Foster Children

Medical records of enrolled 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.

20.4 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.

20.5 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.

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 Chemical Dependence Services providers, allied health professionals, ancillary providers, DME providers and home health providers.

   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), being linguistically appropriate, being accessible for the disabled, and access availability as described below to the following HIV-specific program models:

      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.

      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 license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

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 Medicaid Enrollees, comparable to hours for Medicaid fee-for-service patients.

d) The Contractor shall submit its network for SDOH to assess for adequacy through the HPN prior to execution 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 Network Provider

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 care needs of an Enrollee, 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 by the Non-Participating Provider for as long as the Contractor is unable to provide the service through a Participating Provider.

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.

ii) 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 defined by the Medical Criteria Committee of the SDOH AIDS Institute.

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, nurse practitioner, 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

C) Have admitting privileges at one (1) or more hospitals participating in the Contractor's network.

The Contractor agrees that all physicians acting as patient PCPs for Enrollees with HIV infection must possess the qualifications for HIV Specialist as defined by the AIDS Institute.

21.5 SDOH Exclusion or Termination of Providers

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 HIV SNP Medicaid program, 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 HPN. Such information available to the Contractor on the HPN shall be deemed to constitute constructive notice. The HPN should not be the sole basis for identifying current exclusions or termination of previously approved providers. Should the Contractor become aware, through the HPN or any other source, of an SDOH exclusion or termination, the Contractor shall validate this information with the Office of Medicaid Management, Bureau of Enforcement Activities and comply with the provisions of this Section.

21.6 Application Procedures

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, including Clinical Information Systems (CIS), 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.

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 15.6 of this Agreement.

b) The Contractor must establish a system of follow-up contact to new Enrollees who have not made a PCP selection within twenty (20) days of notification of enrollment and encourage such Enrollees to do so.

c) 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 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.

d) 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 or cross-cultural care needs, if known by the Contractor.

e) 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. This "lead" provider will be held accountable for performing the PCP duties.

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.

b) The Contractor must process a without-cause request to change PCPs and advise the Enrollee of the effective date of the change within forty-five (45) 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. Requests to change for good cause must be processed by the Contractor within fifteen (15) days.

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.

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.

f) Whenever initiating a change, the Contractor must offer affected Enrollees 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 five (5) business days 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 five (5) business days 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

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, consultation 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 be responsible for determining the urgency of a consultation with a specialist and shall arrange

for all consultation appointments within appropriate time frames. The PCP shall also be responsible to case conference or otherwise consult with HIV SNP care and benefits coordinators and case management providers in order to facilitate coordination of care efforts.

21.12 Member to Provider Ratios

a) The 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):

   i) No more than 350 Enrollees for each physician or PCP certified nurse practitioner, or

   ii) No more than 500 for a physician practicing in combination with a registered physician assistant or a certified nurse practitioner.

b) The Contractor agrees that these ratios will be prorated for Participating Providers who represent less than an FTE to the Contractor.

c) The above member-to-provider ratio may be waived under the following circumstances:

   i) The HIV SNP can demonstrate that HIV Specialist PCPs are not available in sufficient number to achieve the required ratios, AND

   ii) 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 SNP's Enrollee case-mix characteristics.

d) 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 criteria.

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 AIDS Institute of the SDOH for review and

approval; and the physician must practice at least eight (8) 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

i) The Contractor agrees to limit its PCPs to the following primary care specialties: Family Practice, General Practice, General Pediatrics, General Internal Medicine, and Infectious Diseases except as specified in (c), (d), (e) and (f) of this Section.

ii) In addition, the Contractor agrees to limit its HIV Specialist PCPs to PCPs who meet the HIV Specialist qualifications as defined by the AIDS Institute.

b) PCP Education

i) The Contractor shall require that its PCPs participate annually in at least ten (10) hours Continuing Medical Education that is consistent with guidelines for HIV specialty care as determined by the AIDS Institute.

ii) In addition, the Contractor shall ensure that PCPs attend educational programs as required to ensure understanding of and familiarity with the following areas:

A) New advances in HIV clinical care, including management of antiretroviral therapy;

B) State-of-the-art diagnostic techniques including quantitative viral measures and resistance testing;

C) Strategies to promote treatment adherence;

D) Management of opportunistic infections and diseases;

E) Management of HIV-infected patients with comorbid conditions;

F) Access and referral to clinical trials;

G) Occupational exposure management, post-exposure prophylaxis protocols and infection control issues;

H) Care coordination and medical case management;

I) Patient education needs including primary and secondary prevention, risk reduction and harm reduction;

J) Cross-cultural care issues appropriate to the enrolled populations being served;

K) Family-centered psychosocial issues; and

L) Mental health and chemical dependence issues (to include training in the use of the Contractor's formal mental health and chemical dependence assessment instruments).

iii) Educational programs are to be conducted in coordination with the New York State Clinical Education Initiative or the AIDS Institute when possible.

c) Pediatric Co-Management Model

i) The AIDS Institute Office of the Medical Director may approve a Pediatric Co-Management Model of Care by the Contractor under 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.

ii) 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:

A) At least every three (3) months; and

B) Whenever the Enrollee has a rise in viral load by one (1) log; and

C) Whenever the Enrollee has a downward change in immunologic or clinical classification; and

D) Whenever there is a change to the Enrollee's antiretroviral therapy regimen.

iii) 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:

A) 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

B) 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

C) 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.

d) 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.

e) OB/GYN Providers as PCPs

The Contractor is permitted to use OB/GYN providers as PCPs, subject to SDOH qualifications and subject to the HIV Specialist PCP criteria.

f) 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 subject to the HIV Specialist PCP criteria.

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. All such team practitioners must meet HIV Specialist PCP criteria. 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 and must meet HIV Specialist PCP criteria.

b) Registered Physician Assistants as Physician Extenders

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

The Contractor shall comply with SDOH Guidelines for use of Medical Residents 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 (including Designated AIDS Center hospitals, where geographically appropriate and feasible) 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.

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) If the Contractor includes dental services in its Benefit Package, the Contractor's dental network shall include geographically accessible dentists sufficient to offer each Enrollee a choice of two (2) HIV-experienced dental care providers in their Service Area and to achieve a ratio of at least one (1) HIV-experienced dental care provider for each 500 Enrollees. Dental networks shall include but are not limited to HIV-experienced dental providers. 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 also be available by referral. The dental specialist network should include but is not limited to HIV-experienced dental care providers. The network also should include dentists with expertise in serving other special needs populations (e.g., developmentally disabled Enrollees).

If the Contractor does not include dental services in its benefit package, it must establish formal referral relationships with HIV-experienced dental care providers that accept Medicaid.

b) Dental surgery performed in an ambulatory or inpatient setting is the responsibility of the Contractor whether dental services are a covered benefit or not, as set forth in Appendix K.2(25) Optional Service, Dental Services, of this Agreement.

21.18 Presumptive Eligibility Providers

The Contractor must offer Presumptive Eligibility Providers the opportunity to be Participating Providers in its HIV SNP. 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 county, but must contract with a sufficient number to meet the distance/travel time standards defined for primary care.

21.19 Mental Health and Chemical Dependence Services Providers

a) The Contractor will include a full array of mental health and Chemical Dependence Services providers in its networks, in sufficient numbers to assure accessibility to services for both children and adults, using either individual, appropriately licensed practitioners or New York State Office of Mental Health (OMH) and Office of Alcohol and Substance Abuse Services (OASAS) licensed programs and clinics, or both.

b) The State defines mental health and Chemical Dependence Services providers to include the following: Individual Practitioners, Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Licensed Certified Social Workers, OMH and OASAS Programs and Clinics, and Providers of mental health and/or Chemical Dependence Services certified or licensed pursuant to Article 23 or 31 of Mental Hygiene Law, as appropriate.

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)

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.

21.22 Case Management Providers

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.

21.23 HIV Comprehensive Medicaid Case Management (CMCM) Providers

Case management provided to SNP Enrollees by the HIV CMCM Program (also known as COBRA Case Management and/or the COBRA Community Follow-up Program) will continue to be provided on a fee-for-service basis. COBRA Case Management is a non-covered benefit package service, however, the Contractor shall enter into linkage agreements with COBRA providers (where available) to promote access for Enrollees determined to be in need of such services. If an Enrollee of the Contractor is participating in a CMCM program, the Contractor shall work collaboratively with the Enrollee's CMCM case management provider to coordinate the provision of services covered by the Contractor. Consent for exchange of information between the plan, participating providers and linkage providers shall be obtained as required by law.

21.24 Linkage Agreement Providers

The Contractor is responsible for facilitating Enrollees' access to health and psychosocial service providers that support members' 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 10.37(b) of this Agreement.

21.25 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.

iv) Assisting providers with training regarding cross cultural care issues.

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 or the DOHMH under this Agreement. No contractual relationship shall be deemed to exist between the subcontractor and the State or the DOHMH.

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, marketing, quality assurance and utilization review activities and such other services as are acceptable to the SDOH. The Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

22.3 Provision of Services through Provider Agreements

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 10.19 of this Agreement, shall be provided through Provider Agreements with Participating Providers.

22.4 Approvals

a) Provider Agreements shall require the approval of SDOH as set forth in PHL 4402 and 10 NYCRR Part 98.

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, 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 subcontractor; and provide for revoking the delegation, in whole or in part, and imposing other sanctions if the subcontractor'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 subcontractor must be in accordance with the terms of this Agreement; and

   iii) that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in this Agreement.

b) The Contractor shall impose obligations and duties on its subcontractors, including its Participating Providers, that are consistent with this Agreement, and that do not impair any rights accorded to DOHMH, LDSS, SDOH, or DHHS.

c) No subcontract, including any Provider Agreement shall limit or terminate the Contractor's duties and obligations under this Agreement.

d) Nothing contained in this Agreement shall create any contractual relationship between any subcontractor of the Contractor, including its Participating Providers, and SDOH, DOHMH, or LDSS.

e) Any subcontract entered into by the Contractor shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under such subcontract.

f) The Contractor shall also require that, in the event the Contractor fails to pay any subcontractor, including any Participating Provider in accordance with the subcontract or Provider Agreement, the subcontractor or Participating Provider will not seek payment from the SDOH, LDSS, DOHMH, the Enrollees, or persons acting on an Enrollee's behalf.

g) The Contractor shall include in every Provider Agreement a procedure for the resolution of disputes between the Contractor and its Participating Providers.

h) The Contractor shall ensure that all Provider Agreements entered into with Providers require acceptance of a woman's Enrollment in the Contractor's HIV SNP 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.

i) The Contractor must monitor the subcontractor'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 subcontractor must take corrective action.

22.6 Timely Payment

The 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.

22.7 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 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.

22.8 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.

22.9 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 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 VIII 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.

22.10 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.

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.

22.11 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.

22.12 Notice of Participating Provider Termination

a) The Contractor shall notify DOHMH and 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 (5%) 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 (2) 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.

b) The Contractor shall provide the notification required in (a) above to the DOHMH and the SDOH ninety (90) days prior to the effective date of the termination of the Provider agreement or immediately upon notice from such Participating Provider if less than ninety (90) days.

c) The Contractor shall provide the notification required in (a) above to the DOHMH and the SDOH 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.

d) In addition to the notification required in (a) above, the Contractor shall submit a contingency plan to DOHMH and SDOH, 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 Providers 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.

e) 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 DOHMH and SDOH. DOHMH and 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 13.9 of this Agreement, not less than thirty (30) days prior to the termination or expiration of the Provider Agreement. In the event that Provider Agreements are terminated or are not renewed with less than the notice period required by this Section, the Contractor shall immediately notify DOHMH and SDOH, and develop a transition plan on an expedited basis and provide notice to affected Enrollees upon DOHMH and SDOH consent to the transition plan and Enrollee notice.

f) Upon Contractor notice of failure to renew, or termination of, a Provider Agreement, the DOHMH and the SDOH, in their sole discretion, may waive the requirement of submission of a contingency plan upon a determination by the DOHMH and 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.

g) SDOH and DOHMH reserve 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.

22.13 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 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 Benefit Package 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 protection. Any of these additional requirements that are passed on to the subcontractors must be clearly stated in their Provider Agreement.

23. FRAUD AND ABUSE

23.1 General Requirements

The Contractor shall comply with the Federal fraud and abuse requirements of 42 CFR § 438.608.

23.2 Prevention Plans and Special Investigation Units

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.

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. Said plan must be approved by the SDOH, in collaboration with the DOHMH, and be filed with the SDOH and the DOHMH, 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 clinical treatment or other Benefit Package services by the Contractor. For issues related to disputed services, Enrollees must have received an adverse determination from the Contractor or its 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 time frames established for review of grievances and utilization review in Sections 44 and 49 of the Public Health Law, the grievance system requirements of 42 CFR Part 438 and Appendix F of this Agreement.

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) 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 continuing") if so ordered by the NYS Office of Administrative Hearings (OAH) under the following circumstances:

   i) Contractor has or is seeking to reduce, suspend or terminate a treatment or Benefit Package service currently being provided;

   ii) Enrollee has filed a timely request for a fair hearing with OAH; and

iii) There is a valid order for the treatment or service from a Participating Provider.

b) Contractor shall provide aid continuing until the matter has been resolved to the Enrollee's satisfaction or until the administrative process is completed and there is a determination from OAH that Enrollee is not entitled to receive the service; the Enrollee withdraws the request for aid continuing and/or the fair hearing in writing; or the treatment or service originally ordered by the provider has been completed, whichever occurs first.

c) 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 written material must be submitted to OAH and Enrollee or Enrollee's representative at least three (3) business days prior to the scheduled 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) 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 simultaneously through Contractor's internal process and the State fair hearing process. If Contractor has reversed its initial determination and provided the service to the Enrollee, 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.

c) Contractor shall comply with all determinations rendered by OAH at fair hearings. 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, DOHMH, 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.

d) 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 OAH and Enrollee as required by Section 25.6(b) of this Agreement.

e) 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.

f) 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.

g) 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 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 the Contractor transmitted via e-mail as legally valid.

h) The information describing fair hearing rights, aid continuing, Action, Service Authorization, utilization review, Complaint and Appeal procedures shall be included in all HIV SNP member handbooks and shall comply with Section 14 and Appendices E and F of this Agreement.

i) 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

Enrollees are eligible to request 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 or is experimental or investigational.

26.2 Eligibility for External Appeal

An Enrollee is eligible for an external appeal when the Enrollee has exhausted the Contractor's internal utilization review procedure, has received a final adverse determination from the Contractor, or the Enrollee and the Contractor have agreed to waive internal appeal procedures in accordance with PHL § 4914(2)2(a). A provider is also eligible for an external appeal of retrospective denials.

26.3 External Appeal Determination

The External Appeal determination is binding on the Contractor; however, a fair hearing determination supercedes an External Appeal determination for Enrollees.

26.4 Compliance with External Appeal Laws and Regulations

MCOs must comply with the provisions of Sections 4910-4914 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 right to impose sanctions for unacceptable practices as set forth in 18 NYCRR Part 515 and civil and monetary penalties pursuant to 18 NYCRR Part 516 and 42 CFR § 438.700, 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 changes on Enrollees that are in excess of the premiums or charges permitted under the HIV SNP program.

   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, Marketing 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.

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.

27.4 Enrollment Limitations

a) The DOHMH shall have the right, upon consultation with and notice to the SDOH, to limit, suspend or terminate Enrollment activities by the Contractor and/or Enrollment into the Contractor's HIV SNP 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 to submit additional information that would support the conclusion that limitation, suspension or termination of Enrollment activities or Enrollment in the Contractor's HIV SNP is unnecessary. Nothing in this paragraph limits other remedies available to the DOHMH under this Agreement.

b) The SDOH shall have the right, upon notice to the DOHMH, to limit, suspend or terminate Enrollment activities by the Contractor and/or Enrollment into the Contractor's HIV SNP 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 to submit additional information that would support the conclusion that limitation, suspension or termination of Enrollment activities or Enrollment in the Contractor's HIV SNP is unnecessary. Nothing in this paragraph limits other remedies available to the SDOH or the DOHMH 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, DOHMH, 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

a) The Contractor shall indemnify, defend, and hold harmless the SDOH, DOHMH 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 DOHMH will provide the Contractor with prompt written notice of any claim made against the DOHMH, and the Contractor, at its sole option, shall defend or settle said claim. The DOHMH shall cooperate with the Contractor to the extent necessary for the Contractor to discharge its obligation under Section 32.1 (a).

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 DOHMH, its employees, or agents.

32.2 Indemnification by DOHMH

The DOHMH shall indemnify and hold harmless the Contractor and its officers, agents, and employees from any loss or damage resulting from actions by the DOHMH pursuant to the terms of Appendix R, Section 6.3 herein.

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 HIV SNP Benefit Package to Enrollees 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.

34.2 Non-Discrimination

The Contractor shall not discriminate against Eligible Persons or Enrollees 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 to the 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 Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center.

35. COMPLIANCE WITH APPLICABLE LAWS

35.1 Contractor and DOHMH Compliance With Applicable Laws

Notwithstanding any inconsistent provisions in this Agreement, the Contractor and DOHMH shall comply with all applicable requirements of the State Public Health Law; the State Social Services 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; and the ADA; and Title XIII of the Federal Public Health Services Act, 42 U.S.C. § 300e et seq., and the regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; 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.

35.2 Nullification of Illegal, Unenforceable, Ineffective or Void Agreement 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 and DOHMH 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 participating in the Medicaid Program. 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, LDSS 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, LDSS 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

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 DOHMH Compliance with Conflict of Interest Laws

DOHMH 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.

36. NEW YORK STATE STANDARD CONTRACT CLAUSES AND LOCAL STANDARD CLAUSES

The parties agree to be bound by the standard clauses for all New York State contracts and standard clauses, if any, for local government contracts contained in Appendix A and R, respectively, attached to and incorporated into this Agreement as if set forth fully herein, and any amendment thereto.

[Model Contract Note: Format of signature page(s) may be established by the LDSS, or this page may be used. The Term of the Agreement must be specified on the signature page.]

This Agreement is effective April 1, 2006 and shall remain in effect until March 31, 2008 or until the execution of an extension, renewal or successor agreement as provided for in the Agreement.

In Witness Whereof, the parties have duly executed this Agreement on the dates appearing below their respective signatures.

By _____
Contractor

By _____
County Department of Social Services
(or New York City Department of Health and Mental Hygiene)

Date _____

Date _____

APPENDIX B
Certification Regarding Lobbying

COUNTY NAME _____

PLAN NAME _____

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:_____

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 HIV SNPs Regarding the Provision of Family Planning and Reproductive Health Services

APPENDIX 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, devices such as insertion/removal of an intrauterine device (IUD), or insertion/removal of contraceptive implants, and injection procedures involving Pharmaceuticals such as Depo-Provera;

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 and for New York City recipients, elective 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.

ii) Family Planning and Reproductive Health services include those education and counseling services necessary to render the services effective.

iii) Family Planning and Reproductive Health services include medically necessary ordered contraceptives and pharmaceuticals:

A) 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. Other pharmacy prescriptions, including emergency contraception, medical supplies, and over the counter drugs are not the responsibility of the Contractor and are to be obtained when covered on the New York State list of Medicaid reimbursable drugs by the Enrollee from any appropriate eMedNY-enrolled health care provider of the Enrollee's choice.

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 counseling.

2. Free Access to Services for HIV SNP Enrollees

a) Free Access means HIV SNP Enrollees may obtain Family Planning and Reproductive Health services, and HIV testing and counseling when performed as part of a Family Planning and Reproductive Health encounter, from either the Contractor or from any appropriate eMedNY-enrolled 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.

APPENDIX C.2
Requirements for HIV SNPs Regarding the Provision of Family Planning and Reproductive Health Services

1. Notification to Enrollees

a) 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 from any network or non-network provider 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) HIV SNP Enrollees must receive notification that they also have the right to obtain Family Planning and Reproductive Health services in accordance with the Free Access policy as defined in C.1 of this Appendix.

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 HIV SNP Enrollees with a list of qualified Non-Participating Providers who accept Medicaid and who 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 an HIV SNP Enrollee obtains such services in accordance with the Free Access policy.

2. Billing Policy

a) The Contractor must notify its Participating Providers that all claims for Family Planning and Reproductive Health 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 HIV SNP Enrollees by eMedNY-enrolled Non-Participating Providers at the applicable Medicaid rate or fee. In such instances, Non-Participating Providers will bill Medicaid fee-for-service and the SDOH will issue a confidential 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 that 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 Contractor must ensure that any Enrollee's use 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 disclosure.

4. Informing and Standards

a) The Contractor will inform its Participating Providers and administrative personnel about policies concerning 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.

APPENDIX D

New York State Department of Health
Marketing Guidelines for HIV Special Needs Plans

D.1 Marketing Plans

D.2 Marketing Materials

D.3 Marketing Activities

Appendix D
New York State Department of Health
Marketing Guidelines for HIV Special Needs Plans

1. General

a) The purpose of these guidelines is to provide an operational framework for localities and HIV Special Needs Plans (HIV SNPs) in the development of HIV SNP marketing plans, materials, and activities and to describe SDOH's Marketing rules, HIV SNP Marketing requirements, and prohibited practices.

b) If the Contractor's Marketing activities do not comply with the Marketing Guidelines set forth in this Appendix or the Contractor's approved Marketing plan, the SDOH and the DOHMH may take any actions pursuant to Section 11.5 of this Agreement in its sole discretion deems necessary to protect the interests of Prospective Enrollees, Potential Enrollees and Enrollees and the integrity of the HIV SNP Program.

c) This Appendix contains the following sections:

i) D.1, Marketing Plans;

ii) D.2, Marketing Materials; and

iii) D.3, Marketing Activities.

D.1
Marketing Plans

1. The Contractor shall develop a marketing plan that meets SDOH guidelines and any New York City specific Marketing requirements as set forth in Appendix N.

2. The SDOH, in consultation with DOHMH, is responsible for the review and approval of the Contractor's Marketing plans.

3. Approved Marketing plans set forth the allowable terms and conditions and the proposed activities that the Contractor intends to undertake during the contract period.

4. The Contractor must have on file with the SDOH and the DOHMH, an SDOH- and DOHMH-approved Marketing plan prior to the contract award date or before Marketing and enrollment begin, whichever is sooner. Subsequent changes to the Marketing plan must be submitted to SDOH for approval, in consultation with DOHMH, at least sixty (60) days before implementation.

5. The Marketing plan shall include: a stated Marketing goal and strategies; Marketing activities; a description of the information provided by marketers, including an overview of managed care; and staff training, development and responsibilities. The following must be included in the Contractor's description of materials to be used: distribution methods; primary Marketing locations, and a listing of the kinds of community service events the Contractor anticipates sponsoring and/or participating in for the purposes of providing information and/or distributing Marketing materials.

6. The Contractor shall identify the community based organizations and/or subcontractors which it intends to utilize for Marketing, outreach and education activities, specify the services which they shall perform, describe compensation, describe the training, including a copy of the training curriculum for these organizations, and describe the plan's monitoring and quality control processes for these organizations.

7. The Contractor must describe how it is able to meet the informational needs, related to Marketing, for the physical and cultural diversity of Prospective Enrollees. This may include, but not be limited to: a description of the Contractor's provisions for Non-English speaking Prospective Enrollees, interpreter services, alternate communication mechanisms, including sign language, Braille, audio tapes, and/or use of Telecommunications Device for the Deaf (TDD)/TTY services and how the Contractor will make oral interpretation services available to Potential Enrollees and Enrollees free of charge.

8. The Contractor shall describe measures for monitoring and enforcing compliance with these Guidelines by its Marketing Representatives and its Participating Providers including: the prohibition of door-to-door solicitation and cold-call telephoning; a description of the development of mailing lists of Prospective Enrollees that maintains client confidentiality and that honors the client's express request for direct contact by the Contractor; a description and planned means of distribution of pre-enrollment gifts and incentives to Prospective Enrollees; and a description of the training, compensation and supervision of its Marketing

Representatives.

D.2
Marketing Materials

1. Definitions

a) Marketing materials generally include the concepts of advertising, public service announcements, printed publications, and other broadcast or electronic messages designed to increase awareness and interest in Medicaid managed care and/or the Contractor's HIV SNP. The target audience for HIV SNP Marketing materials is HIV SNP Eligible Persons who are not enrolled in an HIV SNP, and who are living or working in the Contractor's service area.

b) Marketing materials include any information that references the MMC or HIV SNP Program, is intended for general distribution, and is produced in a variety of print, broadcast, and direct Marketing mediums. These generally include: radio, television, billboards, newspapers, leaflets, informational brochures, videos, telephone book yellow page ads, letters, and posters. Additional materials requiring Marketing approval include a listing of items to be provided as nominal gifts or incentives.

2. Marketing Material Requirements

a) Marketing 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.

b) Marketing 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. All Marketing activities should provide for equitable distribution of materials without bias toward or against any group.

c) The Contractor must make available written Marketing 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 Contractor's service area speak that particular language and do not speak English as a first language. SDOH will inform the DOHMH and the DOHMH will inform the Contractor when the five percent (5%) threshold has been reached. Marketing materials to be translated include those key materials, such as informational brochures, that are produced for routine distribution and that are included within the Contractor's Marketing plan. SDOH will determine the need for other-than-English translations based on county-specific census data or other available measures.

d) Alternate forms of communications must be provided for persons with visual, hearing, speech, physical, or developmental disabilities. These alternate forms include Braille or audiotapes for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

e) The Contractor's name, mailing address (and location, if different), and toll-free phone number must be prominently displayed on the cover of all multi-paged Marketing materials.

f) Marketing materials must not contain false, misleading, or ambiguous information--such as "You have been pre-approved for the XYZ Health Plan," or "If you do not choose a plan you will lose your Medicaid coverage," or "You get free, unlimited visits." Materials must not use broad, sweeping statements.

g) The material must accurately reflect general information, which is applicable to the average consumer of the HIV SNP Program.

h) The Contractor may not use logos or wording used by government agencies if such use could imply or cause confusion about a connection between a governmental agency and the Contractor.

i) Marketing materials may not make reference to incentives that may be available to Enrollees after they enroll in the Contractor's HIV SNP, such as "If you join the XYZ Plan, you will receive a free baby carriage after you complete eight prenatal visits."

j) Marketing materials that are prepared for distribution or presentation by the LDSS, Enrollment Broker, or SDOH-approved Enrollment Facilitators must be provided in a manner that is easily understood and appropriate to the target audience. The material covered must include sufficient information to assist the individual in making an informed choice of HIV SNP.

k) 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 HIV SNP and are available to serve the Enrollee.

l) Marketing materials shall not mention other HIV SNPs by name except for materials approved by SDOH and developed to present available HIV SNP choices in an unbiased manner, or as part of a transition of Enrollees from an HIV SNP that withdraws from the HIV SNP Program.

3. Prior Approvals

a) The SDOH, in consultation with DOHMH, will review and approve the Contractor's Marketing plan and all Marketing materials and advertising.

b) The SDOH will coordinate its review and approval of materials that are specific to New York City with the DOHMH.

c) The 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 comment.

4. Dissemination of Outreach Materials

a) Upon request, the Contractor shall provide to the LDSS, Enrollment Broker and/or SDOH-approved Enrollment Facilitators, sufficient quantities of approved Marketing materials or alternative informational materials that describe coverage in the LDSS jurisdiction.

b) The Contractor shall, upon request, submit to the DOHMH, LDSS, Enrollment Broker, or SDOH-approved Enrollment Facilitators, current provider directories, as described in Section 13.2 of this Agreement together with information that describes how to determine whether a provider is presently available.

D.3
Marketing Activities

1. Description and Requirements

a) Marketing includes any occasion during which Marketing information and material regarding MMC and HIV SNP Programs and information about the Contractor's HIV SNP are presented to Prospective Enrollees. Marketing activities include verbal presentations or distribution of written materials, which may or may not be accompanied by the giving away of nominal gifts.

b) With prior DOHMH/LDSS approval, the Contractor may engage in Marketing activities that include community-sponsored social gatherings, provider-hosted informational sessions, or Contractor-sponsored events. Events may include such activities as health fairs, workshops on health promotion, holiday parties, after school programs, raffles, etc. These events must not be restricted to Potential Enrollees.

c) The Contractor may conduct media campaigns (i.e., distribution of information/materials regarding the HIV SNP Program and/or its specific HIV SNP to encourage Prospective Enrollees to enroll in its HIV SNP. All media materials, including television, radio, billboards, subway and bus posters, and electronic messages, must be pre-approved by the SDOH at least thirty (30) days prior to the campaign.

d) The Contractor will be forthright in its presentations to allow Prospective Enrollees to exercise an informed choice.

2. Marketing Sites

a) With prior DOHMH/LDSS approval, the Contractor may distribute approved Marketing material in such places as: an income support maintenance center, community centers, markets, pharmacies, hospitals and other provider sites, schools, health fairs, a resource center established by the LDSS or the Enrollment Broker, and other areas where Prospective Enrollees are likely to gather. The DOHMH/LDSS may require the Contractor to provide a minimum of two weeks notice to the DOHMH/LDSS regarding Marketing at approved locations so that the DOHMH/LDSS may fulfill its role in monitoring Contractor Marketing activities.

b) The Contractor shall comply with the applicable restrictions on Marketing established in SSL § 364-j(4)(e), SSL § 369-ee and the SDOH Marketing Guidelines. The Contractor shall not engage in practices prohibited by law and regulation, including cold call Marketing or door-to-door solicitation. Cold Call Marketing means any unsolicited personal contact by the Contractor with a Prospective Enrollee for the purposes of Marketing. The Contractor shall not market to Prospective Enrollees at their homes without the permission of the Prospective Enrollee.

c) The Contractor shall comply with LDSS written requirements regarding scheduling,

staffing, and on-site procedures when marketing at LDSS sites.

d) The Contractor shall neither conduct Marketing nor distribute Marketing materials in hospital emergency rooms including the emergency room waiting areas, patient rooms or treatment areas (except for waiting areas) or other sites as prohibited by the Commissioner of Health pursuant to SSL § 364-j(4)(e).

e) The Contractor may not require its Participating Providers to distribute Contractor-prepared communications to their patients.

f) The Contractor shall instruct its Participating Providers regarding the following requirements applicable to communications with their patients about the Contractor's HIV SNP and other HIV SNPs with which the Participating Provider may have contracts:

   i) Participating Providers who wish to let their patients know of their affiliations with one or more HIV SNPs must list each HIV SNP with whom they have contracts.

   ii) Participating Providers may display the Contractor's Marketing materials provided that appropriate notice is conspicuously posted for all other HIV SNPs with whom the Provider has a contract.

   iii) Upon termination of a Provider Agreement with the Contractor, a provider that has contracts with other HIV SNPs may notify his/her patients of the change in status and the impact of such change on the patient.

g) Participating Providers are encouraged to communicate with their patients about managed care options and to advise their patients in determining the HIV SNP that best meets the health needs of the patient and his/her family. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one plan over another. Providers who wish to let their patients know of their affiliation with one or more HIV SNPs must list each HIV SNP with whom they hold contracts. In the event Marketing material is included with such communication, the material, together with the intended communication, must be pre-approved by the LDSS before distribution.

3. Marketing Representatives

a) The Contractor shall require its Marketing Representatives, including employees assigned to market its HIV SNP, and employees of Marketing subcontractors, to successfully complete a training program about the basic concepts of managed care and the Enrollee's rights and responsibilities relating to Enrollment in an HIV SNP. The Contractor shall submit a copy of the training curriculum for its Marketing Representatives to SDOH as part of the Marketing plan. The Contractor shall be responsible for the activities of its Marketing Representatives and the Marketing activities of any subcontractor or management entity.

b) The Contractor shall ensure that its Marketing Representatives engage in professional and courteous behavior in their interactions with LDSS staff, staff from other health plans, Eligible Persons and Prospective Enrollees. The Contractor shall neither participate nor encourage nor accept inappropriate behavior by its Marketing Representatives, including but not limited to interference with other MCO presentations, talking negatively about another MCO, or participating in a Medicaid or HIV SNP client's verification interview with LDSS staff.

c) The Contractor shall not offer compensation to Marketing Representatives, including salary increases or bonuses, based solely on the number of individuals they enroll. However, the Contractor may base compensation of Marketing Representatives 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 Marketing Representative's total annual compensation.

d) The Contractor shall keep written documentation, including performance evaluation tools, of the basis it uses for awarding bonuses or increasing the salary of Marketing Representatives and employees involved in Marketing and make such documentation available for inspection by SDOH or the DOHMH.

4. Restricted Marketing Activities

a) The Contractor shall not engage in the following practices:

i) misrepresenting the Medicaid fee-for-service Program, MMC Program or HIV SNP Program, or the program or policy requirements of the LDSS or the SDOH in Marketing encounters or materials;

ii) purchasing or otherwise acquiring or using mailing lists of Eligible Persons from third party vendors, including providers and LDSS offices;

iii) using raffle tickets or event attendance or sign-in sheets to develop mailing lists of Prospective Enrollees;

iv) offering incentives (i.e., any type of inducement whose receipt is contingent upon the individual's Enrollment) of any kind to Prospective Enrollees to enroll in the

Contractor's HIV SNP.

b) The Contractor may not discriminate against Eligible Persons or Enrollees 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 the Capitation Rate the Contractor will receive for such Eligible Person. Health assessments may not be performed by the Contractor prior to Enrollment except to ensure SNP eligibility. The Contractor shall inquire about existing primary care relationships of the applicant and explain whether and how such relationships may be maintained. Upon request, each Prospective Enrollee shall be provided with a listing of all the Contractor's Participating Providers, including PCPs, specialists and facilities in the Contractor's network. The Contractor may respond to a Prospective Enrollee's question about whether a particular PCP, specialist, or facility is a Participating Provider of the Contractor in the network. However, the Contractor shall not inquire about the types of specialists utilized by the Prospective Enrollee.

c) The Contractor may offer nominal gifts of not more than five dollars ($5.00) in fair-market value as part of a health fair or other Marketing activity to stimulate interest in the HIV SNP 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 at Marketing 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.

d) The Contractor may offer its Enrollees rewards for completing a health goal, such as finishing all prenatal visits, participating in a smoking cessation session, attending initial orientation sessions upon enrollment, and timely completion of immunizations or other health related programs. Such rewards may not exceed fifty dollars ($50.00) in fair-market value per Enrollee over a twelve (12) month period, and must be related to a health goal. The Contractor may not make reference to these rewards in its pre-enrollment marketing materials or discussions and all such rewards must be approved by the SDOH.

APPENDIX E

New York State Department of Health
HIV Special Needs Plans
Member Handbook Guidelines

APPENDIX E
HIV Special Needs Plans
Member Handbook Guidelines

1. Purpose

a) This document contains Member Handbook guidelines for use by the Contractor to develop handbooks for HIV SNP Enrollees covered under this Agreement.

b) These guidelines reflect the review criteria used by the SDOH Office of Managed Care and the AIDS Institute in review of all HIV SNP Member Handbooks. Member Handbooks and addenda must be approved by SDOH prior to printing and distribution by the Contractor.

2. HIV SNP Model Member Handbook

a) The SDOH HIV SNP Model Member Handbook includes all required information specified in this Appendix, written at an acceptable reading level. The Contractor may adapt the HIV SNP Model Member Handbook to reflect its specific policies and procedures for its HIV SNP product.

b) SDOH strongly recommends the Contractor use the HIV SNP 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;

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; and

vii) listing of Enrollee entitlements, including benefits, rights and responsibilities, and information available upon request.

c) A copy of the HIV SNP Model Member Handbook is available from the AIDS Institute, Bureau of HIV Program Review and Systems Development.

* HIV SNP-specific requirement

3. General Format

a) It is expected that when a Contractor has other Managed Care products in addition to its HIV SNP, the Contractor will develop a separate handbook for the HIV SNP.

b) The Contractor must write Member handbooks in a style and reading level that will accommodate the reading skills of many HIV SNP 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 a language 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 that particular language and do not speak 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 HIV SNP works)

i) Explanation of the Contractor's HIV SNP, 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 HIV SNP, i.e., location of the Contractor, providers, etc.

iii) Invitation to attend scheduled orientation sessions and other educational and outreach activities.

iv) Overview of HIV SNP services, including access to care networks which specialize in HIV/AIDS care.*

v) Explanation of HIV SNP procedures to maintain confidentiality of a Member's HIV status.*

vi) 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.*

b) Provider Listings

* HIV SNP-specific requirement

i) The Contractor may include the following information in the handbook, or 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 all providers, including case management, and their 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.

c) Voluntary or Fee for Service Enrollment

i) Clear explanation that persons with HIV or AIDS may enroll voluntarily in HIV SNPs, or mainstream managed care or remain in fee for service.*

ii) Explanation that basic managed care involves both mandatory and voluntary enrollment, but different rules apply for HIV SNP Enrollees.

iii) Explanation that children up to age 19 of HIV SNP Enrollee may enroll in parent's HIV SNP or they may enroll in another managed care 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, and the importance of a base line physical, immunizations and well child care, sharing your medical history, and asking questions.

iii) Explanation that PCPs are required to meet HIV Specialist criteria established by the NYS Department of Health, AIDS Institute.*

iv) Notification that the Contractor will assign the Enrollee to a PCP if one is not chosen in thirty (30) days.

v) Initial appointment criteria (differs from mainstream managed care): newborns within 48 hours of hospital discharge; adult baseline physical within 4 weeks; well child visits within 4 weeks.*

vi) OB/GYN choice rules for women.

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

* HIV SNP-specific requirement

after the initial appointment with his or her PCP, and the Contractor may elect to limit the Enrollee to changing PCPs without cause to 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) Regular and HIV Health Care

i) Explanation of the Contractor's role in providing comprehensive HIV and regular health care.*

ii) Explanation that the Contractor will coordinate member's access to combination therapies and pharmacy benefits.*

iii) Explanation that pregnancy requires specialized health care; transmission may occur through pregnancy, childbirth or breast milk; medication is recommended for mother and baby.*

iv) 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.*

v) Explanation of access to clinical trials; experimental treatments will be considered on a case by case basis.*

g) Referrals to Specialists (Participating and 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, 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 and the 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 ongoing medical care and the procedure for obtaining such access; Enrollee's PCP will continue to coordinate HIV care and other treatments; procedure for obtaining such a specialist.*

* HIV SNP-specific requirement

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. PCP will continue to coordinate HIV care.*

h) Covered and Non-Covered Services

i) Benefits and services covered by the Contractor's HIV SNP, including benefit maximums and limits.

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 HIV SNP or are excluded from the HIV SNP Program, and how to access these services.

iv) A description of services not covered by HIV SNP or Medicaid fee-for-service Programs.

v) Prior Authorization and other requirements for obtaining treatments and services.

vi) Access to Family Planning and Reproductive Health services and the Free Access policy for HIV SNP Enrollees, pursuant to Appendix C of this Agreement.

vii) HIV counseling and testing free access policy.

viii) The Contractor's policy relating to emergent and non-emergent transportation, including who to call and what to do if the Contractor's HIV SNP does not cover emergent or non-emergent transportation.

ix) Contractor's toll-free number for Enrollee to call for more information.

x) HIV testing and the Partner Notification Program .*

xi) List of services available which promote healthy living for persons with HIV/AIDS.*

xii) Describe HIV prevention services including access to free needles, syringes and condoms.*

xiii) List of benefits available when using Medicaid card including COBRA case management.*

xiv) Direct access policy for dental services provided at Article 28 clinics operated by academic dental centers when dental is in the Benefit Package.

xv) Any cost-sharing (e.g., co-pays for Contractor covered services).

i) Out of Area Coverage

* HIV SNP-specific requirement

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.

j) 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 the 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.

k) 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 such 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).

l) Enrollment and Disenrollment Procedures

i) Procedures for Disenrollment. HIV SNP Members may disenroll at any time .*

ii) LDSS, or Enrollment Broker as appropriate, phone number for information on Enrollment and Disenrollment.

* HIV SNP-specific requirement

iii) Explanation of AIDS Drug Assistance Program (ADAP) and ADAP Plus programs; may be available if a member loses Medicaid benefits.*

iv) Non-infected children will be disenrolled upon turning age 19.*

m) 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 13.8 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.

n) Language

Description of how the Contractor addresses the needs of non-English speaking Enrollees.

o) Grievance Procedures (Complaints)

i) Right to file a Complaint regarding any dispute between the Contractor and an Enrollee (in accordance with Appendix F of this Agreement).

ii) Right to file a Complaint orally.

iii) The Contractor's toll-free number for filing oral Complaints.

iv) Timeframes and circumstances for expedited and standard Complaints.

v) Right to appeal a Complaint determination and the procedures for filing a Complaint Appeal.

vi) Timeframes 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.

* HIV SNP-specific requirement

x) New York State Insurance Department number for certain Complaints relating to billing.

p) Fair Hearing

i) An 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) A description of situations when the Enrollee may ask for a fair hearing as described in Section 25 of this Agreement including: a SDOH or LDSS decision about the Enrollee staying in or leaving the HIV SNP; a Contractor determination that stops or limits Medicaid benefits; and a Contractor's Complaint determination that upholds a provider's decision not to order Enrollee-requested services.

iii) An explanation of how to request a fair hearing (assistance through member services, LDSS, State fair hearing contact).

q) External Appeals

i) A 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 for an expedited External Appeal.

iv) A description of the expedited External Appeal timeframe.

v) The process for Contractor and Enrollee to agree on waiving the Contractor's internal UR Appeals process.

r) 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.

s) 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.

* HIV SNP-specific requirement

t) 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) 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 SIL.

e) Procedures for protecting the confidentiality of medical records and other Enrollee information.

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.

* HIV SNP-specific requirement

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.

* HIV SNP-specific requirement

APPENDIX F

New York State Department of Health
Action and Grievance System Requirements for HIV SNP Program

F.1 Action Requirements

F.2 Grievance System Requirements

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.

ii) 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.

iii) Concurrent Review Request is a Service Authorization Request by an Enrollee, or a provider on Enrollee's behalf, 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 on the basis that the requested service is not Medically Necessary or an approval of a Service Authorization Request is in an amount, duration, or scope that is less than requested.

d) An Action means an activity of a Contractor or its subcontractor that results in:

i) the denial or limited authorization of a Service Authorization Request, including the type or level of service;

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; or

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.

2. General Requirements

a) The Contractor's policies and procedures for Service Authorization Determinations and utilization review determinations shall comply with 42 CFR Part 438 and Article 49 of the PHL, 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 or 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 determination to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a licensed, certified, or registered health care professional. If such Adverse Determination was based on medical necessity, the determination must be made by a clinical peer reviewer as defined by PHL § 4900(2)(a).

iii) 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 to the provider must contain the same information as the Notice of Action for the Enrollee.

iv) The Contractor is required to provide the Enrollee written notice of any Action other than a Service Authorization Determination within the timeframe specified in Section 4 below.

3. Timeframes for Service Authorization Determinations

a) For Prior Authorization Requests, 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 after receipt of the Service Authorization Request; or

ii) 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.

b) For Concurrent Review Requests, 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 after receipt of the Service Authorization Request; or

ii) 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.

c) Timeframes for Service Authorization Determinations 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.

d) If the Contractor extended its review as provided in paragraph 3(c) 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 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.

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 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;
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) The Contractor must 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.

c) When the Contractor does not reach a determination within the Service Authorization Determination timeframes described above, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

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 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 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;
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 a representative to file Action Appeals on his/her behalf;
D) the process and timeframe for filing an Action Appeal with the Contractor, including an explanation that an expedited review of the Action Appeal can be requested if a delay would significantly increase the risk to an Enrollee's health, a toll-free number for filing an oral Action Appeal and a form, if used by the Contractor, for filing a written Action Appeal;
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 within which the Action Appeal determination must be made;
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; and
H) the notice entitled "Managed Care Action Taken" for denial of benefits or for termination or reduction in benefits, as applicable, containing the Enrollee's fair hearing and aid continuing rights.
I) 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; and
   III) a statement that the Enrollee may be eligible for an External Appeal.

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 HIV SNP 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; or

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.

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;

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 HIV SNP Benefit Package and is provided to an HIV SNP 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.

F.2
Grievance System Requirements

1. Definitions

a) A Grievance 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.

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 42CFR §438.400 (b).

c) An Action Appeal means a request for a review of an Action.

d) A Complaint Appeal means a request for 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 System – General Requirements

a) The Contractor shall describe its Grievance 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 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;

ii) designated staff to receive calls;

iii) "live" phone coverage at least 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 less 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. 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.

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 no less than sixty (60) business days from the date of the notice of Action to file an Action Appeal. An Enrollee filing an Action Appeal within 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 may request "aid continuing" in accordance with Section 25.4 of this 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 in the case of an expedited Action Appeal. The Contractor must 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 or health or ability to attain, maintain, or regain maximum function. 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, make reasonable efforts to provide prompt oral notice of the denial to the Enrollee and send written notice of the denial within two (2) days of the denial 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 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:

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 three (3) business days of the date of the receipt of the Action Appeal.

iii) Timeframes for Action Appeal resolution 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. 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) The 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.

v) The 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.

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 shall include 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.

ii) Notice to the Enrollee regarding an 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 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 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 Determination shall 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;
D) if the determination was not in favor of the Enrollee, a description of Enrollee's fair hearing rights, if applicable;
E) 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) for Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:
   I) a clear statement that the notice constitutes 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) statement that the Enrollee is eligible to file an External Appeal and the timeframe for filing;
   V) a copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form;
   VI) the Contractor's contact person and telephone number;
   VII) the contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent; and
   VIII) 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. 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.

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.

7. 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 written notification to the Enrollee. Such Complaints must be logged by the Contractor and included in the Contractor's quarterly HPN 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 twenty-four (24) 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. Complaint Determination Notices

a) The Contactor's procedures regarding the resolution of Enrollee complaints shall include the following:

i) Complaint 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;
D) and notice of the right of the Enrollee to contact the State Department of Health regarding his/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 within three (3) business days.

9. Complaint Appeals

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) one (1) business day after the receipt of all necessary information when a delay would significantly increase the risk to an Enrollee's health;
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. Records

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) date the complaint was filed;

ii) copy of the complaint, if written;

iii) date of receipt of and copy of the Enrollee's written confirmation, if any;

iv) log of Complaint determination including the date of the determination and the titles of the personnel and credentials of clinical personnel who reviewed the Complaint;

v) date and copy of the Enrollee's Action Appeal or Complaint Appeal;

vi) Enrollee or Provider requests for expedited Action Appeals and Complaint Appeals and the Contractor's determination;

vii) necessary documents to support any extensions;

viii) determination and date of determination of the Action Appeals and Complaint Appeals;

ix) the titles, and credentials of clinical staff who reviewed the Action Appeals and Complaint Appeals;

x) Complaints unresolved for greater than forty-five (45) days.

APPENDIX G

New York State Department of Health
Requirements for the Provision of Emergency Care and Services

APPENDIX G
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 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.

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 must advise Enrollees that they may access Emergency Services at any Emergency Services provider.

c) Prior authorization for treatment of an Emergency Medical Condition is never required.

d) 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.

e) A Contractor may not:

i) limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms; or

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.

f) 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.

g) 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-stabilization Care Services it has not 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;

iii) 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. Triage Fees

For emergency room services that do not meet the definition of Emergency Medical Condition, the Contractor shall pay the hospital a triage fee of $40.00 in the absence of a negotiated rate.

6. Emergency Transportation

When emergency transportation is included in the Contractor's Benefit Package, the Contractor shall reimburse the transportation provider for all emergency ambulance services without regard to final diagnosis or prudent layperson standards.

APPENDIX H

New York State Department of Health Requirements for the Processing of Enrollments and Disenrollments in HIV Special Needs Plan (SNP) Program

APPENDIX H
New York State Department of Health
Requirements for the Processing of Enrollments and Disenrollments
In HIV Special Needs Plan (SNP) Program

1. General

The Contractor's Enrollment and Disenrollment procedures shall be consistent with these requirements, except that to allow LDSS and the Contractor flexibility in developing processes that will meet the needs of both parties, SDOH may allow modifications to timeframes and some procedures. Where an Enrollment Broker exists, the Enrollment Broker may be responsible for some or all of the LDSS responsibilities.

2. Enrollment

a) SDOH Responsibilities:

i) The SDOH is responsible for monitoring LDSS program activities and providing technical assistance to the 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.

b) LDSS Responsibilities:

i) The LDSS has the primary responsibility for the Enrollment process.

ii) Each LDSS determines Medicaid eligibility. To the extent practicable, the LDSS will follow up with Enrollees when the Contractor provides documentation of any change in status which may affect the Enrollee's Medicaid and/or MMC eligibility.

iii) The LDSS is responsible for coordinating the Medicaid application and Enrollment processes.

iv) The 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 LDSS is responsible for informing Eligible Persons of the availability of MCOs and HIV SNPs and the scope of services covered by each.

vi) 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 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 HIV SNP and are available to serve the Enrollee. The 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 HIV SNP and are available to serve the Prospective Enrollee.

ix) The LDSS is responsible for the timely processing of managed care Enrollment applications, Exemptions, and Exclusions.

x) The LDSS will approve the Contractor's phone enrollment process, if applicable.

xi) The LDSS is responsible for determining the status of Enrollment applications. Applications will be enrolled, pended or denied. The LDSS will notify the Contractor of the denial of any Enrollment applications that the Contractor assisted in completing and submitting to the LDSS under the circumstances described in 2(c)(i) of this Appendix.

xii) The LDSS is responsible for determining the Exemption and Exclusion status of individuals determined to be eligible for Medicaid under Title 11 of the SSL.

A) Exempt means an individual eligible for Medicaid under Title 11 of the SSL determined by the LDSS 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 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.

xiii) Individuals eligible for Medicaid under Title 11 of the SSL in the following categories will be eligible for Enrollment in the Contractor's HIV SNP at the LDSS's option, as indicated in Schedule 2 of Appendix M.

A) Foster care children in the direct care of LDSS;

B) Homeless persons living in shelters outside of New York City.

xiv) The LDSS is responsible for entering individual Enrollment form data and transmitting that data to the State's Prepaid Capitation Plan (PCP) Subsystem. The transfer of Enrollment information may be accomplished by any of the following:

A) LDSS directly enters data into PCP Subsystem; or

B) LDSS or Contractor submits a tape to the State, to be edited and entered into PCP Subsystem; or

C) LDSS electronically transfers data, via a dedicated line or Medicaid Eligibility Verification System (MEVS) to the PCP Subsystem.

xv) The LDSS is responsible for sending the following required notices to Eligible Persons:

A) For mandatory program only - Initial Notification Letter: 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 are managed care brochures, an Enrollment form, and information on their rights and responsibilities under this program, including the option for HIV/AIDS infected individuals who are categorically exempt from the mainstream MMC program to enroll in an HIV SNP on a voluntary basis in LDSS jurisdictions where HIV SNPs exist.

B) For mandatory program only - Reminder Letter: A letter to all Eligible Persons in a mandatory category who have not responded by submitting a completed Enrollment form within thirty (30) days of being sent or given an Enrollment packet.

C) 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 case additions and re-enrollments into the same MCO.

D) Notice of Denial of Enrollment: This notice is used when an individual has been determined by LDSS to be ineligible for Enrollment into the HIV SNP. This notice must include fair hearing rights. This notice is not required when Medicaid eligibility is being denied (or closed).

E) 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.

F) 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 LDSS of the 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 voluntary and mandatory MMC Eligible Persons.

c) Contractor Responsibilities:

i) To the extent permitted by law and regulation, the Contractor may accept Enrollment forms from Potential Enrollees for the HIV SNP program, provided that the appropriate education has been provided to the Potential Enrollee by the LDSS pursuant to Section 2(b) of this Appendix. In those instances, the Contractor will submit resulting Enrollments to the LDSS, within a maximum of five (5) business days from the day the Enrollment is received by the Contractor (unless otherwise agreed to by SDOH and LDSS).

ii) Prior to the submission of the enrollment for Potential Enrollees the HIV SNP must make best efforts to confirm that Potential Enrollees have HIV infection with the exception of uninfected children under the age of nineteen (19) years enrolling along with an infected parent and HIV-exposed infants whose HIV status has not yet been confirmed. Enrollments may not be submitted until such time that the HIV SNP attests to the confirmation of HIV seropositivity. In local districts where there is an enrollment broker, HIV SNPs may transmit enrollments through the Electronic Bulletin Board only after confirmation of HIV infection in the potential enrollee. The HIV SNP must obtain verification of an Enrollee's HIV infection as specified in Section 6.11 of this Agreement within thirty (30) days of the effective date of Enrollment. Such verification must be maintained by the HIV SNP for audit purposes.

iii) The Contractor must notify new HIV SNP 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.

iv) The Contractor must report any changes in status for its enrolled members to the LDSS within five (5) business days of such information becoming known to the Contractor. This includes, but is not limited to, factors that may impact Medicaid eligibility such as address changes, verification of pregnancy, incarceration, third party insurance, etc.

v) 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 HIV SNP and are available to serve the Prospective Enrollee.

vi) 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.

3. Newborn Enrollments

a) The Contractor agrees to enroll and provide coverage for eligible newborn children of Enrollees effective from the time of birth.

b) SDOH Responsibilities:

i) The SDOH will update WMS with information on the newborn received from hospitals, consistent with the requirements of Section 366-g of the Social Services Law as amended by Chapter 412 of the Laws of 1999.

ii) Upon notification of the birth by the hospital or birthing center, SDOH will update WMS with the demographic data for the newborn and enroll the newborn in the mother's HIV SNP if not already enrolled and the newborn is not identified as SSI or SSI-related and therefore Excluded from the MMC Program pursuant to Section 2(b)(xi) of this Appendix. The newborn will be retroactively enrolled back to the first (1st) day of the month of birth. Based on the transaction date of the Enrollment of the newborn on the PCP subsystem, the newborn will appear on either the next month's Roster or the subsequent month's Roster. On Rosters for upstate and NYC, the "PCP Effective From Date" will indicate the first day of the month of birth, as described in 01 OMM/ADM 5 "Automatic Medicaid Enrollment for Newborns." If the newborn's Enrollment is not completed by this process, the LDSS is responsible for Enrollment (see (c)(iv) below).

c) LDSS Responsibilities:

i) Grant Medicaid eligibility for newborns for one (1) year if born to a woman eligible for and receiving Medicaid on the date of the newborn's birth.

ii) The LDSS is responsible for adding eligible unborns to all WMS cases that include a pregnant woman as soon as the pregnancy is medically verified.

iii) In the event that the LDSS learns of an Enrollee's pregnancy prior to the Contractor, the LDSS is responsible for establishing Medicaid eligibility and enrolling the unborn in the Contractor's HIV SNP.

iv) The LDSS is responsible for newborn Enrollment if enrollment is not successfully completed under the "SDOH Responsibilities" process as outlined in 2(b)(ii) above.

d) Contractor Responsibilities:

i) The Contractor must notify the LDSS in writing of any Enrollee that is pregnant within thirty (30) days of knowledge of the pregnancy. Notifications should be transmitted to the LDSS at least monthly. The notification 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 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) In districts that use an Enrollment Broker, the Contractor shall not submit electronic Enrollments of newborns to the Enrollment Broker, as this will interfere with the retroactive Enrollment of the newborn back to the first (1st) day of the month of birth. For newborns whose mothers are not enrolled in the HIV SNP and who were not pre-enrolled into HIV SNP as unborns, the Contractor may submit electronic Enrollment of the newborns to the Enrollment Broker. In such cases, the Effective Date of Enrollment will be prospective.

iv) The Contractor will accept Enrollment applications for eligible unborns if that is the mother's intent, even if the mother is not and/or will not be enrolled in the HIV SNP. In all Counties when a mother is ineligible or chooses not to enroll, the HIV SNP will accept applications for enrollment of unborns who are eligible.

v) The Contractor is responsible for provision of services to the 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, unless the newborn is Excluded from the MMC Program pursuant to Section 2(b)(xi).

vi) Within two (2) business 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.

vii) 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 and that the mother makes an appointment with the PCP immediately upon birth.

viii) The Contractor will ensure that the newborn is linked with a PCP within two (2) days and 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. Roster Reconciliation

a) All enrollments are effective the first of the month.

b) SDOH Responsibilities:

i) The SDOH maintains both the PCP subsystem enrollment files and the WMS eligibility files, using data input 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). Notification to the Contractor and LDSS will be accomplished via paper transmission, magnetic media, or the HPN.

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. Notification to the MCOs and LDSSs will be accomplished via paper transmission, magnetic media, or the HPN.

C) The SDOH shall also forward an error report as necessary to the Contractor and LDSS.

D) 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.

c) LDSS Responsibilities:

i) LDSS must notify the Contractor electronically or in writing of changes in the first Roster and error report, no later than the end of the month. (Note: 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.)

ii) Enrollment and eligibility issues are reconciled by the LDSS to the extent possible, through manual adjustments to the PCP Subsystem enrollment and WMS eligibility files, if appropriate.

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 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 sub-capitation does not constitute "provision of Benefit Package services."

5. Disenrollment

All Enrollees shall be allowed to disenroll to Fee-for-Service, or enroll in a mainstream health plan, or (subject to eligibility requirements) enroll in another HIV/SNP at any time. All disenrollments shall be effective the first day of the month following the request, unless there is cause for retroactive disenrollment as described in Section E of this Appendix.

a) LDSS Responsibilities:

i) The LDSS will accept requests for disenrollment directly from Enrollees and may not require Enrollees to approach the Contractor for a disenrollment form. Where an LDSS is authorized to mandate enrollment, all requests for disenrollment must be directed to the LDSS or the enrollment broker. LDSS and the enrollment broker must utilize the State-approved Disenrollment form.

ii) Enrollees may initiate a request for Disenrollment to the LDSS. The LDSS will expedite the Disenrollment process for all HIV SNP Enrollees. The LDSS will manually process the Disenrollment through the PCP Subsystem. Enrollees who request to be disenrolled from managed care based on their documented HIV, ESRD, or SPMI/SED status are categorically eligible for an expedited Disenrollment on the basis of urgent medical need.

iii) The LDSS is responsible for processing routine Disenrollment requests to take effect on the first (1st) day of the following month.

iv) The LDSS is responsible for disenrolling Enrollees automatically upon death or loss of Medicaid eligibility. All such disenrollments will be effective at the end of the month in which the death or loss of eligibility occurs or at the end of the last month of guaranteed eligibility, where applicable.

v) The LDSS is responsible for informing Enrollees of their right to disenroll from the HIV SNP at any time.

vi) The LDSS will promptly disenroll an Enrollee whose managed care eligibility or health status changes such that he/she is deemed by the LDSS to meet the exclusion

criteria. The LDSS will provide Enrollees with a notice of their right to request a fair hearing.

vii) In instances where an Enrollee requests disenrollment due to exclusion, the LDSS must notify the Enrollee of the approval or denial of exclusion/disenrollement status, including fair hearing rights if disenrollment is denied.

viii) The LDSS is responsible for ensuring that retroactive Disenrollments are used only when absolutely necessary. Circumstances warranting a retroactive disenrollment are rare and include when an Enrollee is determined to have been non-consensually enrolled in an HIV SNP; he or she enters or resides in a residential institution under circumstances which render the individual Excluded from the Medicaid managed care program; is incarcerated; is an SSI infant less than six (6) months of age; is simultaneously in receipt of comprehensive health care coverage from a MCO and is Enrolled in the same MCO; it is determined that an Enrollee with more than one Client Identification Number (CIN) is enrolled in a MCO under more than one of the CINs; or he or she died – as long as the Contractor was not at risk for provision of Benefit Package services for any portion of the retroactive period. Payment of subcapitation does not constitute "provision of Benefit Package services." The LDSS is responsible for notifying the Contractor of the retroactive Disenrollment prior to the action. The LDSS is responsible for finding out if the Contractor has made payments to providers on behalf of the Enrollee prior to Disenrollment. After this information is obtained, the LDSS and Contractor will agree on a retroactive Disenrollment or prospective Disenrollment date.

In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the 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 for any full months of retroactive Disenrollment, where the Contractor was not at risk for the provision of Benefit Package services during the month. However, failure by the LDSS to so notify the Contractor does not affect the right of the SDOH to recover the premium payment as authorized by Section 3.6 of this Agreement.

ix) Generally the effective dates of disenrollment are prospective. Effective dates other than routine disenrollments are described below:

Reason for Disenrollment	Effective Date of Disenrollment
A) Infants weighing less than 1200 grams at birth and other infants under six (6) months of age who meet the criteria for the SSI or SSI related category.	First Day of the month of birth or the month of onset of disability, whichever is later.
B) Death of Enrollee	First day of the month after death
C) Incarceration	First day of the month of incarceration. (Note – Contractor is at risk for covered services only to the date of incarceration and is entitled to the capitation payment for the month of incarceration.)
D) Enrollee entered or stayed in a residential institution 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.	First day of the month of entry or first day of the month of classification of the stay as permanent subsequent to entry. (Note – Contractor is at risk for covered services only to the date of entry or classification of the stay as permanent subsequent to entry, and is entitled to the capitation payment for the month of entry or classification of the stay as permanent subsequent to entry.)
E) Individual's effective date of Enrollment or autoassignment into a MMC product occurred while meeting institutional criteria in (D) above.	Effective Date of Enrollment in the Contractor's Plan.
F) Non-consensual Enrollment.	Retroactive to the first day of the month of Enrollment
G) Enrollee moved outside of the District/County of Fiscal Responsibility.	First day of the month after the update of the system with the new address[1]
H) Urgent medical need.	First day of the next month after determination except where medical need requires an earlier Disenrollment
I) Homeless Enrollees in Medicaid Managed Care residing in the shelter system in NYC or in other districts where homeless individuals are exempt.	Retroactive to the first day of the month of the request.
J) Individual is simultaneously in receipt of comprehensive health care coverage from an MCO and is Enrolled in the MMC of the same MCO.	First day of the month after simultaneous coverage began.
K) An Enrollee with more than one Client Identification Number (CIN) is enrolled in an MCO under more than one of the CINs.	First day of the month the duplicate Enrollment began.

[1]In counties outside of New York City, LDSSs should work together to ensure continuity of care through the Contractor if the Contractor's service area includes the county to which the Enrollee has moved and the Enrollee, with continuous eligibility, wishes to stay enrolled in the Contractor's plan. In New York City, Enrollees, not in guaranteed status, who move out of the Contractor's Service Area, but not outside of the City of New York (e.g., move from one borough to another), will not be involuntarily disenrolled, but must request a Disenrollment or transfer. These Disenrollments will be performed on a routine basis unless there is an urgent medical need to expedite the Disenrollment.

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x) The LDSS, to the extent possible, is responsible for processing an HIV SNP Disenrollment within two (2) business days of its determination that a Disenrollment is warranted.

xi) The LDSS is responsible for informing Enrollees of their right to change HIV SNPs.

xii) The 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 LDSS's determination regarding an Enrollee-initiated, 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) Notice of Change to "Guaranteed Coverage": This notice will advise the Enrollee that his or her Medicaid coverage is ending and how this affects his or her enrollment in Medicaid managed care. This notice contains pertinent information regarding "guaranteed eligibility" benefits and dates of coverage. If an Enrollee is not eligible for guarantee, this notice is not necessary.

xiii) The LDSS shall establish procedures whereby the Contractor refers cases which are appropriate for an LDSS-initiated disenrollment and submits supporting documentation to the LDSS.

xiv) After the LDSS receives and, if appropriate, approves the request for disenrollment either from the Enrollee or the Contractor, the LDSS is responsible for updating the PCP subsystem file with an end date. The Enrollee is removed from the Contractor's Roster.

xv) The LDSS may require that an individual that has been disenrolled at the request of the Contractor be returned to the Medicaid fee-for-service program.

xvi) In those instances where the 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 HIV SNP until the disposition of the fair hearing if Aid to Continue is ordered by the New York State Office of Administrative Hearings.

xvii) The LDSS is responsible for reviewing each Contractor-requested Disenrollment in accordance with the provisions of Section 8.8 of this Agreement and this Appendix. Where applicable, the LDSS may consult with local mental health and substance abuse authorities in the district when making the determination to approve or disapprove the request.

xviii) The LDSS is responsible for establishing procedures whereby the Contractor refers cases which are appropriate for an LDSS-initiated Disenrollment and submits supporting documentation to the LDSS.

xix) Eligible persons who are disenrolled from the HIV SNP due to loss of Medicaid eligibility and who regain eligibility within three (3) months will be automatically and prospectively re-enrolled into that HIV SNP, subject to availability of enrollment capacity in the HIV SNP.

xx) LDSS will promptly initiate disenrollment due to eligibility status change, including when:

A) An Enrollee is no longer eligible for any Medicaid benefits; or

B) The Guaranteed Eligibility period ends (See Section 9) and an Enrollee is no longer eligible for any Medicaid benefits; or

C) An Enrollee is no longer the financial responsibility of the LDSS; or

D) An Enrollee becomes ineligible for enrollment pursuant to Section 6 of this Agreement, as appropriate; or

E) An Enrollee resides outside the Service Area covered by this Agreement, unless HIV SNP can demonstrate that the Enrollee has made an informed choice to continue enrollment with HIV SNP and that Enrollee will have sufficient access to HIV SNP's provider network; or

F) In New York City, enrollees, not in guaranteed status, who move out of the HIV SNP's service area but not outside of the City of New York (i.e., move from one borough to another), will not be involuntarily disenrolled, but must request a disenrollment or transfer. These disenrollments will be effective the first day of the month following the request; or

G) An uninfected child enrolled in the HIV SNP through an infected parent reaches his or her nineteenth birthday.

b) Contractor Responsibilities:

i) In those instances where the Contractor directly receives Disenrollment forms, the Contractor will forward these Disenrollments to the LDSS for processing within five (5) business days (or according to Section 5 of this Appendix). During pulldown week these forms may be faxed to the LDSS with the hard copy to follow.

ii) The Contractor must accept and transmit all requests for voluntary disenrollments from its Enrollees to the LDSS, and shall not impose any barriers to disenrollment requests. The Contractor may require that a disenrollment request be in writing,

contain the signature of the Enrollee, and state the Enrollee's correct plan or Medicaid identification number.

iii) Following LDSS procedures, the Contractor will refer cases which are appropriate for an LDSS-initiated disenrollment and will submit supporting documentation to the LDSS. This includes, but is not limited to, changes in status for its Enrollees that may impact eligibility for Enrollment such as address changes, incarceration, death, Exclusion from the MMC program, etc.

iv) Pursuant to Section 8.8 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.

v) The Contractor shall initiate disenrollment when there is clear and consistent documentation that the Enrollee has neither presented for care or treatment for a period of three (3) months from the effective date of enrollment, nor received a Case Management encounter or Enrollee orientation contact during this three month period.

vi) The Contractor shall initiate disenrollment when there is clear and consistent documentation that the Enrollee has neither presented for required care or treatment nor received a Case Management encounter for a period of six (6) consecutive months from the time that the Enrollee's initial treatment plan has been established.

vii) 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, other than the absence of utilization described in Section 8.8 (b) and (c) of this Agreement, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs (except where continued enrollment in the Contractor's plan seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees).

viii) 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.

ix) Prior to requesting disenrollment by the LDSS of an Enrollee for whom an agency other than the LDSS provides oversight, the Contractor must make reasonable efforts to engage the Enrollee directly or by working with such agencies.

x) The Contractor shall give prior written notice to the Enrollee, with a copy to the LDSS, of its intent to request disenrollment. The written notice shall advise the Enrollee that the request has been forwarded to the LDSS for review and approval.

The written notice must include the mailing address and telephone number of the LDSS. The Contractor shall make best efforts to give prior verbal notice to the Enrollee of its intent to disenroll.

xi) The Contractor shall keep the 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.

xii) The Contractor will not consider an Enrollee disenrolled without confirmation from the LDSS or the Roster (as described in Section 5 of this Appendix).

xiii) The 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 HIV 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.

APPENDIX I

New York State Department of Health
Guidelines for the Use of Medical Residents

Guidelines for the Use of Medical Residents

1. Medical Residents for Primary Care

a) The Contractor may utilize medical residents 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 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 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, may be credentialed to the Contractor and may be empaneled with Enrollees. Enrollees must be assigned an attending physician or certified nurse practitioner to act as their PCP, although residents 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 to or instead of being seen by a resident.

iii) Residents 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 and attending PCP relationship and be informed of their rights to be cared for directly by their PCP.

iv) Residents 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) Reserved

vi) In order for a resident to provide continuity of care to an Enrollee, both the resident 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 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 on his/her team. Attendings spending twenty-four (24) hours per week in patient care/supervisory activity at the continuity site may have six (6) residents per team. Attendings spending thirty-two (32) hours per week may have eight (8) residents on his/her team. Two (2) or more attendings may join together to form a larger team as long as the ratio of attending to residents 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 teams must provide adequate continuity of care, twenty-four (24) hour a day, seven (7) day 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 who do not qualify to act as continuity providers as part of an attending and resident 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 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.

2. Medical Residents as Specialty Care Providers

a) Residents 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, may be credentialed by the Contractor. Each attending must be credentialed by each HIV SNP with which he or she will participate. Residents may perform all or many of the clinical services for the Enrollee as long as these clinical services are under the supervision of an appropriately credentialed specialty physician. Even when residents 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 as his or her 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 he/she may contact his/her attending physician or covering physician, if needed. This allows Enrollees to assist in the communication between his/her primary care provider and specialty attending and enables him/her to reach the specialty attending if an emergency arises in the course of their care. Enrollees must be made aware of the resident 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 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 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 HIV SNP Program must be accredited by the appropriate academic accrediting agency.

h) All sites in which residents 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 must 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.

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, HIV SNPs, uninsured and private patients in the same settings.

APPENDIX J
New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans With Disabilities Act

APPENDIX J

Guidelines for Contractor Compliance with the Federal Americans With Disabilities Act (ADA)

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 Medicaid is a government program, health services provided through the HIV SNP Program must be accessible to all who qualify for the program.

Contractor responsibilities for compliance with the ADA are imposed under Title II and Section 504 when, as a Contractor in a Medicaid Program, a Contractor is providing a government service. If an individual provider under Contract with the MCO 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 HIV SNP Program. 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.

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 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, Brailled 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 the 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-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. Pre-enrollment Marketing and Education

Standard for Compliance:

Marketing staff, activities and materials will be made available to persons with disabilities. Marketing materials will be made available in alternative formats (such as Braille, large print, audio tapes) 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. 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. Enrollee health promotion material/activities targeted specifically to persons with disabilities (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
6. Policy statement that Marketing Representatives will offer to read or summarize to blind or vision impaired individuals any written material that is typically distributed to all Enrollees

7. 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 Marketing presentations (materials and communications) are accessible to persons with auditory, visual and cognitive impairments
2. A description of the Contractor's policies and procedures, including Marketing training, to ensure that Marketing Representatives neither screen health status nor ask questions about health status or prior health care services

B. Member 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.

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
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 plan 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

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 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 Contractors 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, the 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

Compliance Plan Submission

1. A description of how the Contractor's Complaint, Complaint Appeal 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 and 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

Compliance Plan Submission

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 networks 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 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.

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, a description of 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, a description of 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 (see attached - county specific/borough specific for NYC) or Contractor statement that data submitted to SDOH on the Health Provider Network (HPN) 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.

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 workups 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 OMRDD 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, preschool services, child protective service agencies, early intervention officials, behavioral health, and disability and advocacy organizations and School Based Health Centers.
3. A description of the sub-specialist network, including contractual relationships with tertiary institutions to meet the health care needs of children 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 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.

APPENDIX K

HIV SPECIAL NEEDS PLAN PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

K.1 **Chart of Prepaid Benefit Package**
- **Special Needs Plan Non-SSI (SNP Non-SSI)**
- **Special Needs Plan SSI (SNP HIV/AIDS SSI)**
- **Medicaid Fee-for-Service (MFFS)**
- **SSI Non HIV/AIDS (SSI uninfected children)**

K.2 **Prepaid Benefit Package Definitions of Covered Services**

K.3 **Medicaid Managed Care Definitions of Non-Covered Services**

APPENDIX K
HIV SPECIAL NEEDS PLAN -- PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

1. General

a) The categories of services in the Special Needs Plan Benefit Package, including optional covered services shall be provided by the Contractor to Enrollees 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.

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 most behavioral health services to non HIV/AIDS SSI or SSI related beneficiaries, and emergency services, emergency transportation, Family Planning and Reproductive Health services, mental health and chemical dependence assessments (one (1) of each per year), court ordered services, and services provided by Local Public Health Agencies as described in Section 10 of this Agreement.

c) This Appendix contains the following sections:

   i) K.1 - "Chart of Prepaid Benefit Package" lists the services provided by the Contractor to all HIV SNP Non-SSI Enrollees, HIV SNP SSI Enrollees, Medicaid fee-for-service coverage for carved out and wraparound benefits, and SSI Non-HIV/AIDS (SSI uninfected children).

   ii) K.2 - "Prepaid Benefit Package Definitions Of Covered Services" describes the covered services, as numbered in K.1.

   iii) K.3 - "Medicaid Managed Care Definitions of Non-Covered Services" describes services that are not covered by the SNP Benefit Package. These services are covered by the Medicaid fee-for-service program unless otherwise noted.

K.1

PREPAID BENEFIT PACKAGE

*	**Covered Services**	**SNP Non-SSI**	**SNP HIV/AIDS SSI**	**SNP Non-HIV/AIDS SSI** (SSI uninfected children)	**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	Covered	Covered	HIV phenotypic, virtual phenotypic and genotypic drug resistance tests
9.	Radiology Services	Covered	Covered	Covered	
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit	Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit	Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit	Covered outpatient drugs from the list of Medicaid reimbursable prescription drugs, subject to any applicable co-payments
11.	Smoking Cessation Products				Covered
12.	Rehabilitation Services	Covered	Covered	Covered	
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered	Covered	
14.	Home Health Services	Covered	Covered	Covered	

* See K.2 for Scope of Benefits

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

*	Covered Services	SNP Non-SSI	SNP HIV/AIDS SSI	SNP Non-HIV/AIDS SSI (SSI uninfected children)	MFFS
15	Private Duty Nursing Services	Covered	Covered	Covered	
16	Hospice				Covered
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered	Covered Covered	
18.	Foot Care Services	Covered	Covered	Covered	
19.	Eye Care and Low Vision Services	Covered	Covered	Covered	
20.	Durable Medical Equipment (DME)	Covered	Covered	Covered	
21.	Audiology, Hearing Aids Services & Products	Covered except for hearing aid batteries	Covered except for hearing aid batteries	Covered except for hearing aid batteries	Hearing aid batteries
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	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement	Covered if not included in Contractor's Benefit Package
24	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement	Covered if not included in Contractor's Benefit Package
25.	Dental Services	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement, except orthodontia	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement, except orthodontia	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement, except orthodontia	Covered if not included in the Contractor's Benefit Package,Orthodontia in all instances

* See K.2 for Scope of Benefits

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

*	Covered Services	SNP Non-SSI	SNP HIV/AIDS SSI	SNP Non-HIV/AIDS SSI (SSI uninfected children)	MFFS
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.	Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered	Covered	
28.	Mental Health Services	Covered subject to stop loss	Covered subject to stop loss		Covered for non-HIV/AIDS SSI SNP Enrollees
29.	Detoxification Services	Covered	Covered	Covered	
30.	Chemical Dependence Inpatient Rehabilitation and Treatment Services	Covered subject to stop loss	Covered subject to stop loss		Covered for non-HIV/AIDS SSI SNP Enrollees
31	Chemical Dependence Outpatient				Covered
32.	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	
33.	Renal Dialysis	Covered	Covered	Covered	
34.	Residential Health Care Facility Services (RHCF)	Covered, subject to stop loss, except for individuals in permanent placement	Covered, subject to stop loss, except for individuals in permanent placement	Covered, subject to stop loss, except for individuals in permanent placement	
35.	HIV SNP Enhanced Services: HIV SNP Care + Benefits Coordination; HIV Prevention + Risk Reduction Services; and HIV Treatment Adherence Services	Covered	Covered	Covered	

* See K.2 for Scope of Benefits

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

K.2

HIV SPECIAL NEEDS PLAN -- PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED SERVICES

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). The 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 8.6 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 pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85.

3. Physician Services

a) "Physician 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.

c) The following are also included without limitations:

   i) pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit;

   ii) physical examinations, including those which are necessary for employment, 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) health assessments for the Infant /Child Assessment Program (ICHAP);

vi) annual preventive health visits for adolescents;

vii) new admission exams for school children if required by the LDSS;

viii) health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms;

ix) 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 10.4 of this Agreement).

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 employment, school and camp.

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 as specified in a written practice agreement 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.

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 and preventing illness:

i) General health education classes.
ii) Pneumonia and influenza immunizations for at risk populations.
iii) 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 counseling and testing.

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) NOTE: coverage for HIV phenotypic, HIV virtual phenotypic and HIV genotypic drug resistance tests are covered by Medicaid fee-for-service when ordered by the Enrollee's PCP.

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 fee-for-service only: Medically necessary prescription and non-prescription (OTC) drugs, medical supplies and enteral formula are covered when ordered by a qualified provider.

b) HIV SNP Enrollees are covered for prescription drugs through the Medicaid fee-for-service program. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered by the MMC Program. Self-administered injectable drugs (including those administered by a family member) and injectable drugs administered during a home care visit are covered by Medicaid fee-for-service if the drug is on the list of Medicaid reimbursable prescription drugs or covered by the Contractor, subject to medical necessity, if the drug is not on the list of Medicaid reimbursable prescription drugs.

11. Smoking Cessation Products

SNP Enrollees are covered for smoking cessation products through the Medicaid fee-for service program.

12. Rehabilitation Services
18 NYCRR 505.11

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, in 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. Rehabilitation services provided in Residential Health Care Facilities are subject to the stop-loss provisions specified in Section 3.14 of this Agreement. Rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider.

13. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services Through the Child Teen Health Program (C/THP) and Adolescent Preventive Services

18 NYCRR § 508.8

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 an 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 must provide up to two (2) post partum home visits for high risk infants and/or high risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery. Visits must be made by a qualified health professional (minimum qualifications being an RN with maternal/child health background), the first visit to occur within forty-eight (48) hours of discharge.

15. Private Duty Nursing Services

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 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 MMC Enrollee's home or in the hospital.

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 provided in accordance with the ordering physicians, or certified nurse practitioner's written treatment plan.

16. Hospice Services

a) Hospice Services means a coordinated hospice program of home and inpatient services which provide non-curative medical and support services for Enrollees certified by a physician to be terminally ill with a life expectancy of six (6) months or less.

b) Hospice services 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. Hospices must be certified under Article 40 of the New York State Public Health Law. 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 Enrollee and the Enrollee's family. Family members are eligible for up to five visits for bereavement counseling.

c) Enrollees receive coverage for hospice services through the Medicaid fee-for-service program.

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 or alcohol. A medical assessment (triage) is covered for non-emergent conditions. See also Appendix G of this Agreement.

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 when the physical condition of any Enrollee (regardless of age) 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.

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) 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.

b) If the Contractor does not provided 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. The Enrollee can choose to purchase the upgraded frames and/or additional features by paying the entire cost of the eyeglasses as a private customer. For example, if the Contractor covers standard bifocal eyeglasses and the Enrollee wants no-line bifocal eyeglasses, the Enrollee must choose between taking the standard bifocal eyeglasses or paying the full price of the no-line bifocal eyeglasses (not just the difference between the cost of bifocal lenses and the no-line lenses). The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

c) 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.

d) 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.

e) 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.

f) 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.

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:

   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 are covered through the Medicaid fee-for-service program.

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.

23. Non-Emergency Transportation

a) Transportation expenses are covered for Enrollees when transportation is essential in order for an 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). Non-emergent transportation guidelines may be developed in conjunction with the LDSS, based on the LDSS' approved transportation plan.

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

c) 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.

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

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. The Contractor shall reimburse the transportation provider for all emergency ambulance services without regard for final diagnosis or prudent layperson standard.

25. Dental 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. Orthodontic services are not covered.

b) Dental surgery performed in an ambulatory or inpatient setting is the responsibility of the Contractor whether dental services are included in the Benefit Package or not. Inpatient claims and referred ambulatory claims for dental services provided in an inpatient or outpatient hospital setting for surgery, anesthesiology, X-rays, etc. are the responsibility of the Contractor. The Contractor shall set up procedures to prior approve dental services provided in inpatient and ambulatory settings.

c) As described in Sections 10.19 and 10.33 of this Agreement, Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services if dental services are included in the Benefit Package.

d) Professional services of a dentist for dental surgery performed in an ambulatory or inpatient setting are billed Medicaid fee-for-service if the Contractor does not include dental services in the benefit package.

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 chemical dependence), or other covered services. The Contractor is responsible for payment of those services included in the benefit package.

27. Prosthetic/Orthotic Orthopedic Footwear

Sections 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) 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.

28. 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.

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, chlozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). Services may be provided in-home, in an office or in the community. Services may be provided by licensed OMH providers or by other providers of mental health services including clinical psychologists and physicians.

29. 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 or by the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

b) Medically Supervised Withdrawal

i) 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.

ii) Medically Supervised Outpatient Withdrawal

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 Title 14 NYCRR § 816.7.

c) All detoxification and withdrawal services are a covered benefit for all Enrollees, including those categorized as SSI or SSI-related. Detoxification Services in Article 28 inpatient hospital facilities are subject to the inpatient hospital stop-loss provisions specified in Section 3.11 of this Agreement.

30. Chemical Dependence Inpatient Rehabilitation and Treatment Services

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.

31. Outpatient Chemical Dependency 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 and provide chemical dependence outpatient treatment to individuals who suffer from chemical abuse or dependence and their family members or significant others.

b) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide full or half-day services to meet the needs of a specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. Programs are licensed by as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR §822.9.

c) Outpatient Chemical Dependence for Youth Programs

Outpatient Chemical Dependence for Youth Programs (OCDY) are licensed under Title 14 NYCRR Part 823. 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.

d) Medicaid Managed Care Enrollees access outpatient chemical dependency services through the Medicaid fee-for-service program.

32. Experimental and/or Investigational Treatment

a) Experimental and/or investigational treatment are covered on a case by case basis.

b) Experimental and/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/or 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 and/or investigational.

33. 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.

34. Residential Health Care Facility (RHCF) Services

a) Residential Health Care Facility (RHCF) 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 Enrollee:

i) Who is diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the 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 Enrollee's physician or a medical team:

A) do not require care or active treatment of the Enrollee in a general or special hospital;

B) cannot be met satisfactorily in the 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 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 Residential Health Care Facility services authorized by the Contractor up to a sixty (60) day calendar year stop-loss for Enrollees who are not in Permanent Placement Status as determined by LDSS.

35. HIV SNP Enhanced Services

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.

K.3
HIV Special Needs Plan -- 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) Personal Care Agency Services

i) Personal care services (PCS) 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 has to be ordered by a physician, and there has to be a medical need for the service. Licensed home care services agencies, as opposed to certified home health agencies, are the primary providers of PCS. Enrollees receiving PCS have to have a stable medical condition and are generally expected to be in receipt of such services for an extended period of time (years).

ii) Services rendered by a personal care agency which are approved by the LDSS are not covered under the Benefit Package. Should it be medically necessary for the PCP to order personal care agency services, the PCP (or the Contractor on the physician's behalf) must first contact the Enrollee's LDSS contact person for personal care. The district will determine the Enrollee's need for personal care agency services and coordinate with the personal care agency to develop a plan of care.

b) Residential Health Care Facilities (RHCF)

Services provided in a Residential Health Care Facility (RHCF) to an individual who is determined by the LDSS to be in Permanent Status are not covered.

c) Hospice Program

i) 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.

ii) Hospices are organizations which must be certified under Article 40 of the PHL. 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.

iii) If an Enrollee becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access the Contractor's Benefit Package while Hospice costs are paid for by Medicaid fee-for-service.

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

Coverage for drugs dispensed by community pharmacies, over the counter drugs, medical/surgical supplies and enteral formula are not included in the Benefit Package and will be paid for by Medicaid fee-for-service. Medical/surgical supplies are items other than drugs, prosthetic or orthotic appliances, or DME which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which are: consumable, non-reusable, disposable, or for a specific rather than incidental purpose, and generally have no salvageable value (e.g. gauze pads, bandages and diapers). Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered.

2. Non-Covered Behavioral Health Services

a) Chemical Dependence Services

i) Outpatient Rehabilitation and Treatment Services

A) Methadone Maintenance Treatment Program (MMTP)

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 OASAS under 14 NYCRR Part 828.

B) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 and provide chemical dependence outpatient treatment to individuals who suffer from chemical abuse or dependence and their family members or significant others.

C) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide full or half-day services to meet the needs of a specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. Programs are licensed by as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR § 822.9.

D) 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.

ii) Chemical Dependence Services Ordered by the LDSS

A) The Contractor is not responsible for the provision and payment of Chemical Dependence Inpatient Rehabilitation and Treatment Services ordered by the LDSS and provided to Enrollees who have:

I) been assessed as unable to work by the LDSS and are mandated to receive Chemical Dependence Inpatient Rehabilitation and Treatment Services as a condition of eligibility for Public Assistance or Medicaid, or

II) been determined to be able to work with limitations (work limited) and are simultaneously mandated by the LDSS into Chemical Dependence Inpatient Rehabilitation and Treatment Services (including alcohol and substance abuse treatment services) pursuant to work activity requirements.

B) The Contractor is not responsible for the provision and payment of Medically Supervised Inpatient and Outpatient Withdrawal Services ordered by the LDSS under Welfare Reform (as indicated by Code 83).

C) The Contractor is responsible for the provision and payment of Medically Managed Detoxification Services in this Agreement.

D) If the Contractor is already providing an Enrollee with Chemical Dependence Inpatient Rehabilitation and Treatment Services and Detoxification Services and the LDSS is satisfied with the level of care and services, then the

Contractor will continue to be responsible for the provision and payment of these services.

b) Mental Health Services

i) Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

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.

ii) Day Treatment

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.

iii) Continuing Day Treatment

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.

iv) Day Treatment Programs Serving Children

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.

v) 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.

vi) Case Management

The target population consists of individuals who are seriously and persistently mentally ill (SPMI), 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.

Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under Item 3 – "Other Non-Covered Services."

vii) Partial Hospitalization

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 NYCRR Part 587.

viii) Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)

These are services provided by designated OMH clinics to children and adolescents with a clinical diagnosis of SED.

ix) Assertive Community Treatment (ACT)

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.

x) Personalized Recovery Oriented Services (PROS)

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.

c) 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 and Parts 594 and 595.

d) Office of Mental Retardation and Developmental Disabilities (OMRDD) Services

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 OMRDD 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 an ICF or a comparable setting. These services are certified by OMRDD under 14 NYCRR Part 690.

iii) Medicaid Service Coordination (MSC)

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OMRDD 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 OMRDD, 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.”

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 (OMRDD)

The OMRDD 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.

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).

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.

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 and informed on the need to contact the Contractor to coordinate service provision.

e) 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 included in the Benefit Package, TB/DOT where applicable, can be billed directly to eMedNY by any SDOH approved Medicaid fee-for-service TB/DOT Provider. The Contractor remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT Provider.

f) 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 chemical dependence 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.

g) HIV COBRA Case Management

The HIV COBRA Case Management Program (also known as the Community Follow-up Program) is a Comprehensive Medicaid Case Management (CMCM) program targeted to the HIV/AIDS population.

The HIV COBRA Case Management Program provides comprehensive, intensive, family-centered case management activities by a team of case managers, case management technicians, and community follow-up workers. This intensive case management program is designed for patients with multiple complex needs who require home visits, active community follow-up, and frequent contacts. Reimbursement is through an hourly rate billable to Medicaid. Reimbursable activities include intake, assessment, reassessment, service plan development and implementation, monitoring, advocacy, crisis intervention, exit planning, and case specific supervision. HIV COBRA Case Management may be carried out only by an entity designated by the SDOH AIDS Institute.

h) Adult Day Health Care

i) 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 individualized health care plan, ongoing implementation and coordination of the health care plan, and transportation.

ii) 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.

i) Personal Emergency Response Services (PERS)

Personal Emergency Response Services (PERS) are not included in the Benefit Package. PERS are covered on a fee-for-service basis through contracts between the LDSS and PERS vendors.

j) 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.

APPENDIX L

Approved Capitation Payment Rates

APPENDIX M

Service Area, Benefit Options, and Enrollment Elections

Schedule 1 of Appendix M
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 below, an entry of "yes" in the subsections of Column B means the Contractor offers the HIV SNP and/or includes the optional service indicated in its Benefit Package.

b) For each county listed in Column A below, an entry of "no" in the subsections of Column B means the Contractor does not include the optional service indicated in its Benefit Package.

3. Effective Date

The effective date of this Schedule is April 1, 2006.

Column A County	Column B HIV SNP		
	Dental	Non-Emergency Transportation	Emergency Transportation

Schedule 2 of Appendix M

LDSS Election of Enrollment in HIV SNPs For Foster Care Children and Homeless Persons

1. Effective April 1, 2006, in the Contractor's service area, HIV SNP Eligible Persons in the following categories will be eligible for Enrollment in the Contractor's HIV SNP product at LDSS's option as described in (a) and (b) as follows, and indicated by an "X" in the chart below:

   a) Options for foster care children in the direct care of LDSS:

      i) Children in LDSS direct care are enrolled on a case by case basis in HIV SNPs (mandatory or voluntary counties);

      ii) All foster children are Excluded from Enrollment in HIV SNPs (mandatory or voluntary counties).

   b) Options for homeless persons living in shelters outside of New York City:

      i) Homeless persons are enrolled on a case by case basis in HIV SNPs (mandatory or voluntary counties);

      ii) All homeless persons are Excluded from Enrollment in HIV SNPs (mandatory or voluntary counties).

   c) In the schedule below, and entry of "NA" means not applicable for the purposes of this Agreement.

County	Foster Care Children			Homeless Persons		
	Mandatory Enrollment	Enrollment on Case by Case Basis	Excluded from Enrollment	Mandatory Enrollment	Enrollment on Case by Case Basis	Excluded from Enrollment
	NA			**NA**		
	NA			**NA**		
	NA			**NA**		
	NA			**NA**		

Appendix N

New York City Specific Contracting Requirements for HIV Special Needs Plans

Appendix N

New York City Specific Contracting Requirements for HIV Special Needs Plans

1. General

a) In New York City, the Contractor will comply with all provisions of the main body and other Appendices of this Agreement, except as otherwise expressly established in this Appendix.

b) This Appendix sets forth New York City Specific Contracting Requirements and contains the following sections:

N.1 Compensation for Public Health Services
N.2 Coordination with DOHMH on Public Health Initiatives
N.3 Benefits
N.4 Additional Reporting Requirements
N.5 Quality Management
N.6 New York City Additional Marketing Guidelines
N.7 Guidelines for Processing Enrollments and Disenrollments in New York City
N.8 New York City Transportation Policy Guidelines

Schedule 1 DOHMH Public Health Services Fee Schedule

N.1

Compensation for Public Health Services

1. The Contractor shall reimburse DOHMH at the rates contained in Schedule 1 of this Appendix for Enrollees who receive the following services from DOHMH facilities, except in those instances where DOHMH may bill Medicaid fee-for-service.

a) Diagnosis and/or treatment of TB
b) HIV counseling and testing that is not part of an STD or TB visit
c) Adult and child immunizations
d) Lead poison screening
e) Dental services

2. Notwithstanding Sections 10.22 (a)(ii)(C) and (b)(ii)(C) of this Agreement, the following requirements concerning Contractor notification and documentation of services shall apply in New York City:

a) DOHMH shall confirm the Enrollee's membership in the Contractor's HIV SNP on the date of service through eMedNY prior to billing for these services.
b) DOHMH must submit claims for services provided to Enrollees no later than one year from the date of the service.
c) The Contractor shall not require pre-authorization, notification to the Contractor or contacts with the PCP for the above mentioned services.
d) DOHMH shall make reasonable efforts to notify the Contractor that it has provided the above mentioned services to an Enrollee.

N.2

Coordination with DOHMH on Public Health Initiatives

1. Coordination with DOHMH

a) The Contractor shall provide the DOHMH with existing information requested by DOHMH to conduct epidemiological investigations.

2. Provider Reporting Obligations

a) The Contractor shall make reasonable efforts to assure timely and accurate compliance by Participating Providers with public health reporting requirements relating to communicable disease and conditions mandated in the New York City Health Code pursuant to 24 RCNY §§ 1103-1107 and Article 21 of the NYS Public Health Law.

b) 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;
iii) Immunization (reporting to immunization registry); and
iv) Additional reporting requirements adopted by the New York City Health Code

c) "Reasonable efforts" shall include:

(i) For mandated reporting requirements described in paragraphs (2)(a) and (2)(b) above:
A) Educating Participating Providers on treatment guidelines and instructions for reporting included in the NYC DOHMH *Compendium of Public Health Requirements and Recommendations.*
B) Including reporting requirements in the Contractor's provider manual or other written instructions or guidelines.

(ii) For mandated reporting requirements described in paragraph (2)(a) above:
A) Letters from the Contractor to Participating Providers who generated claims that suggest that an Enrollee may have a reportable disease or condition, encouraging such providers to report and providing information on how to report.
B) Other methods for follow up with Participating Providers, subject to DOHMH approval, may be employed.

3. Matching to Registries

a) The Contractor shall participate in matches of its Enrollees to the DOHMH immunization and lead registries through submission of files in formats specified by DOHMH Immunization and Lead Poisoning Prevention Programs.

   i) Matches to the Citywide Immunization Registry shall occur, at a minimum, twice a year, in March and October, but may occur more frequently at the Contractor's discretion. The file matches which occur in March and October will include all children aged eighteen (18) through thirty (30) months who are enrolled in the Contractor's HIV SNP at the time of the match, regardless of the children's length of Enrollment in the Contractor's HIV SNP. Additional file matches, done at the discretion of the Contractor, may include any group of children currently enrolled in the Contractor's HIV SNP at the time of the match and may be done at any time of year.

   ii) Matches to the City Lead Registry shall occur at least twice a year, but may occur more frequently as agreed by both the Contractor and the DOHMH Lead Poisoning Prevention Program. Files for these matches shall be submitted in March and October, and will include all children up to thirty-six (36) months of age who are enrolled in the Contractor's HIV SNP at the time of the match, regardless of the children's length of Enrollment in the Contractor's HIV SNP.

b) Formats for reports from the DOHMH to the Contractor based on these matches will be developed through discussion between the Contractor and DOHMH programs.

c) The Contractor will follow up with Participating Providers of Enrollees who have not been appropriately immunized or screened for lead poisoning to facilitate provision of appropriate services.

d) The following provisions regarding confidentiality shall apply:

   i) Consistent with the New York City Health Code §11.07 (c) and (d), the Contractor and DOHMH shall keep confidential all identifying information provided by the DOHMH and not further disclose to any other person or entity such identifying information unless compelled by law to disclose such identifying information, except as provided in paragraph 3(c) above.

   ii) The Contractor shall notify the DOHMH Office of General Counsel for Health in writing, of the receipt of any document seeking disclosure of identifying information that is not accompanied by a written consent from the parent or guardian of an Enrollee authorizing the disclosure of such identifying information as follows:

A) Such notice shall be given not later than five (5) days prior to the date on which a disclosure is required by a subpoena, court order or other document, and shall attach a copy of the document requesting identifying information.

B) If a subpoena, court order or other document requests disclosure to be made within five (5) days or less after its receipt by the Contractor, the Contractor shall provide DOHMH with such notice as far in advance of the disclosure date as possible, but in no circumstances shall the Contractor make such disclosure without prior notice to the DOHMH.

C) The Contractor acknowledges that DOHMH may elect to seek a court order prohibiting the disclosure of identifying information when it deems it appropriate to do so, and consents to DOHMH's intervention in any proceeding, including, but not limited to, any judicial proceeding that seeks the disclosure of identifying information.

4. Enrollee Outreach/Education

a) The Contractor shall provide health education to Enrollees on an on-going basis through methods such as distribution of Enrollee newsletters, health education classes or individual counseling on preventive health and public health topics. Each topic below shall be covered at least once every two years.

i) HIV/AIDS
   A) Encourage Enrollee counseling and testing
   B) Inform Enrollees as to availability of sterile needles and syringes
ii) STDs
   A) Inform members that confidential STD services are available at DOHMH facilities for non-enrolled sexual and needle-sharing partners at no charge
iii) Lead poisoning prevention
iv) Maternal and child health, including importance of developmental screening for children
v) Injury prevention, including age appropriate anticipatory guidance
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

5. Provider Education

a) DOHMH shall prepare a public health compendium ("Compendium") with public health guidelines, protocols, and recommendations which it shall make available directly to providers and to the Contractor.

b) The Contractor shall adapt public health guidance from the Compendium for its internal protocols, practice manuals and guidelines.

c) The Contractor will assist DOHMH in its efforts to disseminate electronic materials to its Participating Providers by providing electronic addresses if known by Contractor (fax and/or e-mail) for its Participating Providers, updated semi-annually.

d) The Contractor shall promote the use of rapid HIV testing among its Participating Providers.

6. MCO Staff Responsibilities and Training

a) Early Intervention Services

i) The Contractor shall ensure that appropriate MCO staff such as member services staff and case managers are knowledgeable about early intervention services and provide technical assistance and consultation to Enrollees concerning early intervention services (including eligibility, referral process and coordination of services).

b) Domestic Violence

i) The Contractor shall designate a domestic violence coordinator who can:

A) Provide technical assistance to Participating Providers in documenting cases of domestic violence;
B) Provide referrals to Enrollees or their Participating Providers, to obtain protective, legal and or supportive social services; and
C) Provide consultative assistance to other staff within the Contractor's organization.

ii) The Contractor shall distribute a directory of resources for victims of domestic violence to appropriate staff, such as member services staff or case managers.

7. Medical Directors

a) The Contractor's Medical Director shall participate in Medical Directors' Meetings with the medical directors of the other HIV SNPs participating in the MMC Program in New York City and representatives of the New York City Department of Health

and Mental Hygiene. The purpose of the Medical Directors' Meetings shall be to share public health information and data; recommend that certain public information be disseminated by the HIV SNPs to their Participating Providers; discuss public health strategies and outreach efforts and potential collaborative projects; encourage the development of HIV SNP policies that support public health strategies; and provide a vehicle for communication between the HIV SNPs participating in the MMC Program and the various bureaus and divisions of the NYC Department of Health and Mental Hygiene

b) The Contractor's Medical Director shall attend all periodic meetings, which shall not exceed one every two months. In the event that the Medical Director is unable to attend a particular meeting, the Contractor will designate an appropriate substitute to attend the meeting.

c) DOHMH, following consultation with the Medical Directors, may create workgroups on particular public health topics. The Contractor's Medical Director may participate in any or all of the workgroups, but shall participate in at least one of the designated workgroups.

8. Take Care New York

a) The Contractor shall:

i) Educate Enrollees regarding prevention and treatment of diseases and conditions included in the Take Care New York initiative (TCNY);

ii) Disseminate TCNY health passports or materials containing similar content approved by DOHMH to Enrollees;

iii) Disseminate reminders to obtain recommended health screenings at age appropriate intervals to Enrollees; and

iv) Educate Participating Providers on recommended clinical guidelines regarding prevention and treatment/management of diseases and conditions described in the TCNY initiative.

b) The Contractor shall select one condition annually from the TCNY initiative and perform the following:

i) Identify Enrollees with the condition using information from multiple sources (e.g., utilization data, including hospitalizations and ER visits; provider referrals; new Enrollee screenings; self-referrals by Enrollees) and maintain such information in a patient registry; and

ii) Develop and submit to DOHMH for approval a proposal to evaluate the effectiveness of Contractor interventions for this condition by tracking service utilization and assessing health outcomes.

c) The Contractor shall, upon request by DOHMH, participate in one or more TCNY workgroups or other activities sponsored by the DOHMH.

N.3

Benefits

1. Transitional Home Health Services Pending Placement in Personal Care Agency Services

a) Transitional home health services are home health services as defined in Appendix K of this Agreement provided by the Contractor to an Enrollee while the Human Resources Administration's determination regarding a request for the provision of personal care agency services to the Enrollee is pending. Transitional home health services are available to Enrollees in addition to the home health care services otherwise covered under the Benefit Package as medically necessary.

b) The Contractor shall be responsible for providing transitional home health services to Enrollees for up to a thirty (30) day period as follows:

i) For Enrollees discharged from a hospital or RHCF and for whom personal care agency services have been requested by the hospital/RHCF discharge planner, the thirty (30) day period shall commence with the day following the Enrollee's discharge from the hospital or RHCF. Transitional home health services shall not be available if the Enrollee: was hospitalized less than thirty (30) days, was in receipt of personal care agency services prior to his/her admission to the hospital or RHCF, and requires the same level and hours of personal care agency services upon discharge.

ii) For Enrollees who have been receiving home health care services in the community and for whom personal care agency services have been ordered by the Enrollee's physician, the thirty (30) day period shall commence with the day following the last day that the Contractor approved home health care services to be medically necessary.

c) The Contractor shall provide reasonable assistance as requested regarding the completion of forms required by the Human Resources Administration to initiate the review of a request for personal care agency services. Such form, commonly referred to as the M11Q, requires physician orders, signed by the licensed physician, to be received by the HRA within thirty (30) calendar days of the physician's examination.

N.4

Additional Reporting Requirements

1. DOHMH will provide Contractor with instructions for submitting the reports required by paragraphs 4(c) and (d) below. These instructions shall include time frames and requisite formats. The instructions, time frames and formats may be modified by DOHMH upon sixty (60) days written notice to the Contractor.

2. The Contractor shall submit reports that are required to be submitted to DOHMH by this Agreement electronically.

3. The Contractor shall pay liquidated damages of $500 to DOHMH for any report required by paragraphs 4(c) and (d) below which is materially incomplete, contains material misstatements or inaccurate information or is not submitted on time in the requested format. The DOHMH shall not impose liquidated damages for a first time infraction by the Contractor unless DOHMH deems the infraction to be a material misrepresentation of fact or the Contractor fails to cure the first infraction within a reasonable period of time upon notice from the DOHMH. Liquidated damages may be waived at the sole discretion of DOHMH.

4. The Contractor shall submit the following reports to DOHMH:

a) The Contractor shall provide DOHMH with all reports submitted to SDOH pursuant to Sections 18.7(a)(i), (ii), (vi), (vii), (xiii), and (xiv) of this Agreement.

b) Upon request by DOHMH, the Contractor shall submit to DOHMH reports submitted to SDOH pursuant to Section 18.7(a)(iii); and Section 18.7(xii) and/or Section 23.2 of this Agreement.

c) To meet the appointment availability review requirements of Section 18.7 (a)(ix), the Contractor shall conduct a service area specific review of appointment availability for two specialist types, to be determined by DOHMH, semi-annually. Reports on the results of such surveys must be kept on file by the Contractor and be readily available for review by SDOH and DOHMH, and submitted to the DOHMH.

d) Upon request by the DOHMH, 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 opportunity to discuss and comment on the proposed requirements before work is begun. However, the DOHMH reserves the right to give thirty (30) days notice in circumstances where time is of the essence.

N.5

Quality Management

1. The Contractor's quality management program, as approved by SDOH, must be kept on file with the DOHMH. The Contractor shall notify the DOHMH when it modifies its quality management program.

N.6

New York City Additional Marketing Guidelines

1. Prior Approvals

a) In addition to the Marketing submission and approval requirements of Section 11 and Appendix D of this Agreement, the Contractor shall submit to DOHMH for review and prior approval, in consultation with SDOH, the following:

i) The Contractor's HIV SNP Marketing plan:

A) The Contractor must have on file with DOHMH an approved Marketing plan prior to the contract award date or before Marketing and Enrollment begin, whichever is sooner. Subsequent changes to the Marketing plan must be submitted to the SDOH and DOHMH for approval at least sixty (60) days before implementation.

B) The Marketing plan shall include a copy of the training curriculum for the Contractor's Marketing Representatives and a description of the minimum qualifications for the Contractor's Marketing staff.

ii) A copy of all Contractor written policies and procedures related to Marketing to Prospective Enrollees in New York City.

iii) A copy of all Marketing material and scripts for Marketing presentations in New York City:

A) Marketing materials sent by Participating Providers to their patients must be pre-approved by DOHMH.

iv) Advertising that is targeted solely to New York City including videos, broadcast material (radio, television, or electronic), billboards, mass transit and print advertising material.

b) The Contractor's HIV SNP marketing plan shall indicate:

i) Whether the Contractor will use dedicated Marketing Representatives for its SNP product;

ii) Whether Marketing Representatives will be used to assist Potential Enrollees to obtain necessary documentation of HIV status, and if so, how such assistance will be provided; and

iii) How the Contractor will communicate to providers, particularly the HIV Specialist PCPs, essential terms and conditions from the contractual marketing guidelines.

2. Marketing Schedules

a) Contractor shall submit to the DOHMH a bi-weekly schedule of all Marketing activities in accordance with instructions for submitting the schedule and requisite formats provided by DOHMH. The instructions, time frames and formats may be modified by DOHMH with thirty (30) days prior notice to the Contractor.

b) Contractor shall submit electronically a schedule of all intended marketing activities within HRA sites to both HRA and DOHMH.

c) DOHMH may, in its sole discretion, waive the reporting of certain activities.

3. Marketing Materials

a) The Contractor shall ensure that Marketing brochures or similar materials that describe Contractor services, benefits and enrollment shall contain the following information:

i) Contractor's name, toll free telephone number, and TTY

ii) A contact telephone number for New York Medicaid CHOICE

iii) General description of the Plan (i.e., identification of Contractor as a Special Needs Plan for persons with HIV/AIDS; service area)

iv) Statement that participation in a HIV Special Needs Plan is voluntary and that persons with HIV/AIDS may choose instead to stay in fee-for-service Medicaid or join or remain in a mainstream Medicaid health plan.

v) The Potential Enrollee has a choice among several alternative HIV SNPs.

vi) The Potential Enrollee will have a choice among at least three Primary Care Providers.

vii) Upon Enrollment in a Special Needs Plan, the Enrollee will be required to use his/her Primary Care Provider and other plan Providers exclusively for medical care, except in certain limited circumstances.

viii) All PCPs in an HIV SNP assigned to or treating persons with HIV/AIDS must be qualified as an HIV Specialist PCP.

ix) Newborns of a mother enrolled in a SNP will automatically be enrolled in the mother's HIV SNP. The infant may be disenrolled at any time at the mother's request.

x) Language advising prospective members to verify with the provider of their choice that the provider participates in the Contractor's network and is available to service the member.

b) Foreign language translations of Marketing materials need not be independently reviewed by DOHMH if the Contractor submits a letter by the translation service attesting that it has used its best efforts to accurately translate the Marketing material into the specified languages. At a minimum, the translation service must perform a reverse translation (translate the foreign language version back into English and compare to original document). Translated materials must meet the readability standards described in Section 13.9 of this Agreement.

4. Marketing Encounters

a) Marketing encounters must clearly inform Potential Enrollees of the Partnership Plan policies described in paragraph (3) (a) (iii) through (x) above, in addition to meeting any other information requirements of Section 11.1 and Appendix D of this Agreement.

b) Marketing Representatives shall ask Prospective Enrollees whether they are currently enrolled in another HIV SNP, and shall not market to persons who are enrolled in another HIV SNP.

c) Marketing Representatives may market to persons enrolled in the mainstream health plan operated by the same organization as the HIV SNP, but must inform the Enrollee that the change is optional subject to the requirements of Section 3 (a) (iv) above. Enrollees who change from a mainstream health plan to an affiliated SNP must sign a new enrollment form.

d) Marketing Representatives must give a copy of the document "Important Facts about HIV SNPs" provided by HCAI to Prospective Enrollees in each marketing encounter.

e) Marketing Representatives shall ask Prospective Enrollees whether they currently have a Provider whom they would like to continue to see, and shall assist him or her in making sure that this Provider participates in the Contractor's network.

f) Marketing Representatives shall give a business card, identifying the name of the representative, the name of the Contractor, and a telephone contact number (which may be the Contractor's Member Services number) to each Prospective Enrollee so that he or she may ask follow-up questions. In the alternative, the Marketing Representative may have this information printed or stamped on the Contractor's Marketing flyers or brochures that are distributed to each Prospective Enrollee.

g) Marketing Representatives shall inform Prospective Enrollees that upon Enrollment they shall receive either a phone call or a welcome package from the Contractor to assess their health care needs and explain how to access Contractor services.

5. Marketing in HRA Facilities

a) Contractor may conduct Marketing activities within HRA facilities with the prior approval of NYC HRA and must adhere to HRA procedures. HRA shall give Contractor an allotted number of allowable Marketing Representatives at each HRA facility, and Contractor shall not exceed this allotment. No other Marketing Representatives for Contractor may market within a two block perimeter of an HRA facility. Additionally, when a Medicaid community office is located in a hospital facility, Contractor may not market within sixty (60) feet of the Medicaid community office. The Contractor is required to adhere to all HRA Marketing guidelines when marketing in HRA facilities. HRA has the right to suspend Marketing privileges within their facilities for failure to adhere to these guidelines.

6. Marketing Sites

a) The Contractor may not market at sites that were not reported on its Marketing schedule to DOHMH.

b) The Contractor shall not market in homeless shelters. DOHMH reserves the right to waive the restrictions.

c) The Contractor shall not market in low income housing projects unless permission is requested by the Contractor for a special event in the public areas of the project, and approval is received in writing from the facility, and a copy sent to DOHMH with the Marketing schedule.

d) The Contractor shall not market within a two block perimeter of an HRA facility (except as authorized by paragraph 5(a) of these guidelines).

e) The Contractor may not market in the same room or immediate proximity of New York Medicaid CHOICE presentations.

7. Marketing Conduct

a) All Marketing activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Prospective Enrollees or the general community.

b) Marketing activities shall be conducted in a manner which does not disclose nor breach the confidentiality of the Potential Enrollee's HIV status. SNPs, including their Participating Providers and /or Subcontractors, shall not perform targeted mailings to persons who are known to have HIV/AIDS, or for whom there is a significant probability of having HIV/AIDS or being at risk for HIV/AIDS, unless

there is expressed written request and consent from such Potential Enrollees for mail contact by the HIV SNP.

8. Marketing Representatives

a) The Contractor's Marketing Representatives must attend Marketing training sessions provided by DOHMH, upon request from DOHMH.

b) Marketing Representatives must wear visible badges with the name of the Contractor and the Marketing Representative's name during all Marketing activities.

c) Marketing Representatives may not wear any additional identification badge from a Participating Provider or facility that is likely to confuse Enrollees or lead them to believe that the Marketing Representative is an employee of such organization. The Contractor shall obtain prior approval from DOHMH to wear identification badges bearing the name of any other organization.

d) Marketing Representatives employed by a subcontractor of the Contractor or affiliated with a community based organization which performs outreach, education, and Enrollment on behalf of the Contractor, shall attend a training session conducted by the Contractor consistent with the training curriculum approved by DOHMH.

9. Marketing Infractions

a) In addition to the corrective action and remedial actions specified in Section 11.5 of this Agreement, if the Contractor or its representative commits a repeat violation or an infraction which is not minor or unintentional, DOHMH may, following consultation with SDOH, impose liquidated damages of $2000.00 for each such infraction. Imposition of liquidated damages shall be taken at the sole discretion of the DOHMH except that the DOHMH shall not impose liquidated damages for any infraction of the Contractor where SDOH has imposed a monetary sanction.

N.7

Guidelines for the Processing of Enrollments and Disenrollments in New York City

1. Notwithstanding any contrary provisions in Appendix H, in New York City, 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 the Roster pulldown. Changes in Enrollee eligibility or Enrollment status that occur prior to production of the monthly Roster are reported by the State to the Contractor with their rosters. Changes in Enrollee eligibility status that occur subsequent to the production of the monthly Roster shall be reported by the Enrollment Broker by means of the electronic bulletin board. Reports of Disenrollments processed by the Enrollment Broker shall be reported to the Contractor as they occur by means of the electronic bulletin board. Reports of Disenrollments processed by HRA shall be reported to the Contractor manually as they occur or through the HPN. In the event that the electronic bulletin board notification process is not available for any reason, the Contractor shall use eMedNY to verify loss of eligibility.

2. Paragraph 5(a)(iv) of Appendix H of this Agreement (LDSS responsibilities) is not applicable in New York City. In the event that an Enrollee loses Medicaid eligibility, the PCP Enrollment is left on the system and removed thereafter by SDOH if no eligibility reinstatement occurs.

3. Paragraph 3(d)(ii) of Appendix H of this Agreement is not applicable in New York City. The Contactor shall not send verification of the infant's demographic data to the HRA unless thirty (30) days has expired since the date of birth and the Contractor has not received confirmation via the HPN of a successful Enrollment through the automated Enrollment system. When the thirty (30) days has expired the Contractor shall, within ten (10) days, send verification of the infant's demographic data to the HRA including: the mother's name and CIN; and the newborn's name, CIN, sex and date of birth. Upon receipt of the data, if the Enrollment does not appear on the system, HRA will process the retroactive Enrollment.

4. In New York City, Enrollees may initiate a request for an expedited Disenrollment to the HRA. The HRA will expedite the Disenrollment process in those cases where: an Enrollee's request for Disenrollment involves urgent medical need; the Enrollee is a homeless individual residing in the shelter system in New York City; the Enrollee has HIV, ESRD, or a SPMI/SED condition; the request involves a complaint of non-consensual Enrollment; or the Enrollee is certified blind or disabled and meets an exemption criteria. If approved, the HRA will manually process the Disenrollment.

5. Notwithstanding paragraph (5)(a)(viii) of Appendix H of this Agreement, in New York City, further notification by HRA is not required prior to retroactive Disenrollment in the following instances:

a) Death or incarceration of an Enrollee;
b) An Enrollee has duplicate CINs and is enrolled in an MCO's MMC or FHPlus product under more than one of the CINs; or
c) Where there has been communication between the Contractor and HRA or the Enrollment Broker regarding the date of disenrollment.

6. Consistent with paragraph 5(a) (viii) of Appendix H of this Agreement, the LDSS remains responsible for sending a 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 for any full months of retroactive Disenrollment where the Contractor was not at risk for the provision of Benefit Package Services. Such notice shall be completed by the LDSS to include: the Disenrollment Effective Date, the reason for the retroactive Disenrollment, and the months for which premiums must be repaid.

The Contractor has ten (10) days to notify the LDSS should it refute the Disenrollment Effective Date, based on a belief that the Contractor was at risk for the provision of Benefit Package Services for any month for which recoupment of premium has been requested. However, failure by the LDSS to so notify the Contractor does not affect the right of SDOH to recover premium payment as authorized by Section 3.6 of this Agreement.

N.8

New York City Transportation Policy Guidelines

1. The Medicaid Managed Care Program contractual Benefit Package in New York City includes transportation to all medical care and services that are covered under the Medicaid program, regardless of whether the specific medical service is included in the Benefit Package or paid for on a fee-for-service basis, except for transportation costs to Methadone Maintenance Treatment Programs. The transportation obligation includes the cost of meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

2. Generally, the Contractor may provide transportation by giving or reimbursing the Enrollee subway/bus tokens for the round trip for their medical care and services, if public transportation is available for such care and services. The Contractor is not required to provide transportation if the distance to the medical appointment is so short that the Enrollee would customarily walk to perform other routine errands. The Contractor may adopt policies requiring a minimum distance between an Enrollee's residence and the medical appointment, which may not be greater than ten blocks; however, the policy must provide transportation for Enrollees living a lesser distance upon a showing of special circumstances such as a physical disability on a case-by-case basis.

3. If the Enrollee has disabilities or medical conditions which prevent him or her from utilizing public transportation, the HIV SNP must provide accessible transportation which is appropriate to the disability or condition such as livery, ambulette, or taxi. The HIV SNP may require pre-authorization of non-public transportation except for emergency transportation.

a) The HIV SNP shall provide livery transportation under the following circumstances, unless the Enrollee requires transportation by ambulette or ambulance:

   i) The Enrollee is able to travel independently but due to a debilitating physical or mental condition, cannot use the mass transit system.
   ii) The Enrollee is traveling to and from a location that is inaccessible by mass transit.
   iii) The Enrollee cannot access the mass transit system due to temporary severe weather, which prohibits use of the normal mode of transportation.

b) The HIV SNP shall provide ambulette transportation under the following circumstances, unless the Enrollee requires transportation by ambulance:

   i) The Enrollee requires personal assistance from the driver in entering/exiting the Enrollee's residence, the ambulette and the medical facility.

ii) The Enrollee is wheelchair-bound (non-collapsible or requires a specially configured vehicle).

iii) The Enrollee has a mental impairment and requires the personal assistance of the ambulette driver.

iv) The Enrollee has a severe, debilitating weakness or is mentally disoriented as a result of medical treatment and requires the personal assistance of the ambulette driver.

v) The Enrollee has a disabling physical condition that requires the use of a walker, cane, crutch or brace and is unable to use livery service or mass transportation.

c) The HIV SNP shall provide non-emergency ambulance transportation when the Enrollee must be transported on a stretcher and/or requires the administration of life support equipment by trained medical personnel. The use of non-emergency ambulance is indicated when the Enrollee's condition would prohibit any other form of transport.

4. Emergency transportation may only be provided by accessing 911 emergency ambulances. Urgent care transportation may be provided by any mode of transportation so long as such a mode is appropriate for the medical condition or disability experienced by the Enrollee.

5. If an attendant is Medically Necessary to accompany the Enrollee to the medical appointment, the Contractor is responsible for the transportation of the attendant. A medically required attendant (authorized by the attending physician) may include a family member, friend, legal guardian or home health worker. When a child travels to medical care and services, and an attendant is required, the parent or guardian of the child may act as an attendant. In these situations, the costs of the transportation, lodging and meals of the parent or guardian may be reimbursable, and authorization of the attending physician is not required.

Schedule 1 of Appendix N

DOHMH Public Health Services Fee Schedule

SERVICE	FEE
TB CLINIC	$125.00
IMMUNIZATION	$50.00
LEAD POISONING SCREENING	$15.00
HIV COUNSELING AND TESTING VISIT	$96.47
HIV COUNSELING AND NO TESTING	$90.12
HIV POST TEST COUNSELING	
Visit Negative Result	$72.54
Visit Positive Result	$90.12
LAB TESTS	
HIV 1 (ELISA Test)	$12.27
HIV Antibody, Confirmatory (Western Blot)	$26.75
DENTAL SERVICES	$108.00

Appendix O

Reserved

APPENDIX P

Reserved

APPENDIX Q

Reserved

APPENDIX R

New York City Standard Local Clauses

R.1 General Provisions Governing Contracts for Consultants, Professional and Technical Services (Not-For-Profit Entities)

R.2 General Provisions Governing Contracts for Consultants, Professional and Technical Services (For-Profit Entities)