Draft Three-Way Contract for Capitated Model

Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

State of New York
Department of Health

and

[Insert Entity]

Issued: _____

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This Contract, made on _____, 2014, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of New York, acting by and through the New York State Department of Health (NYSDOH) and _____ (the FIDA Plan). The FIDA Plan's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, pursuant to Article 44 of the New York State Public Health Law (PHL), the New York State Department of Health (NYSDOH) is authorized to issue Certificates of Authority to establish Health Maintenance Organizations (HMOs), PHL §4400 et seq., Managed Long Term Care Plans (MLTCPs), PHL §4403-f, and Article Seven, Section 364j(27) of the Social Services Law;

WHEREAS, the FIDA Plan is in the business of providing medical services, and CMS and NYSDOH desire to purchase such services from the FIDA Plan;

WHEREAS, the FIDA Plan agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all Federal and State laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

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1. **Section 1. Definition of Terms**

1.1 820 Payment File — The electronic HIPAA transaction that the FIDA Plan retrieves from NYSDOH that identifies each Participant for whom payment was made by the NYSDOH to the FIDA Plan.

1.2 834 Daily File — The electronic HIPAA transaction that the FIDA Plan retrieves from the NYSDOH or its designated entity each day that reflects changes in enrollment subsequent to the previous 834 Enrollment File.

1.3 834 Enrollment File — The electronic HIPAA transaction that the FIDA Plan retrieves monthly from the NYSDOH or its designated entity that reflects its Participants for the following calendar month.

1.4 Abuse — (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. § 488.301), generally used in conjunction with Neglect. Abuse includes Physical Abuse, Sexual Abuse, and Emotional Abuse, defined as follows:

(a) "Physical Abuse" — The non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised, or improperly physically restrained.
(b) "Sexual Abuse" — Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact, or forcing sex with a third party.
(c) "Emotional Abuse" — Willful infliction of mental or emotional anguish by threat, humiliation, intimidation or other abusive conduct, including but not limited to, frightening, or isolating an adult.

1.5 Action(s) — A denial or a limited authorization of a requested item or service or a reduction, suspension, or termination of a previously authorized item or service; denial, in whole or in part, of payment for an item or service; failure to provide items or services in a timely manner; determination that a requested service is not a covered benefit

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(does not include requests for items or services that are paid for fee-for-service outside the FIDA Plan); or failure to make a grievance determination within required timeframes.

1.6 Activities of Daily Living (ADL) — Activities such as eating, bathing, grooming, dressing, ambulating, transferring, and continence.

1.7 Administrative Allowance — The portion of the Capitation, paid and allocated by the NYSDOH, for the administrative cost of the Contract attributable to the Medicaid component of the Contract.

1.8 ADA Accessibility Attestation Form — A form created by NYSDOH with questions about a providers' ADA Accessibility that all FIDA Plan providers are required to complete and attest to the veracity of the responses provided.

1.9 Administrative Hearing — For purposes of this Contract, an Administrative Hearing serves as a fair hearing under Medicaid and is conducted by the FIDA Administrative Hearing Unit within the New York State Office of Temporary and Disability Assistance.

1.10 Advance Directive — An individual's written directive or instruction, such as a power of attorney for health care, a living will, or another document made before the individual loses decision-making capacity, for the provision of that individual's health care treatment in the event that the individual loses decision-making capacity and is unable to make his or her health care wishes known.

1.11 Alternative Formats — Formats for presenting information other than English or the written word such that information can be understood by individuals with disabilities and those with limited English proficiency.

1.12 Annual Reassignment — As described in 40.1.5 of Chapter 5 of the Medicare Prescription Drug Benefit Manual, CMS has the discretion to re-assign LIS beneficiaries enrolled in Medicare Prescription Drug Plans that will have a premium above the low-income premium subsidy amount (i.e., benchmark) in the following year, unless the plan volunteers to waive the de minimis amount of the premium above the benchmark. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified.

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1.13 Appeal — A Participant's request for review of an Action taken by the FIDA Plan related to items or services in accordance with Section 2.13 of the Contract.

1.14 Applicant — An individual who has expressed a desire to pursue enrollment in a FIDA Plan.

1.15 Authorized Representative — An adult to whom a Participant with capacity has granted authority to act on behalf of the Participant in Grievances and Appeals or other dealings with the FIDA Plan. For a Participant without capacity, the legal representative (guardian, agent under power of attorney, health care proxy, etc.) is the authorized representative with authority to act on behalf of the Participant in Grievances and Appeals or other dealings with the FIDA Plan.

1.16 Behavioral Health Service — Service for the treatment of a mental illness or a substance use disorder.

1.17 Business Day — Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Time except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

1.18 Capitation — The reimbursement arrangement in which a fixed rate of payment per Participant per month is made, regardless of whether the Participant receives Covered Items and Services in that month, to the FIDA Plan for the performance of all of the FIDA Plan's duties and responsibilities pursuant to the Contract.

1.19 Capitated Financial Alignment Initiative ("the Demonstration" or "Medicare-Medicaid Alignment Initiative") — A model where a State, CMS, and a health plan enter into a Three-way Contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated care.

1.20 Capitation Rate — The sum of the monthly Capitation payments for (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2.4; and 2) any payment adjustments as a result of the reconciliation described in Section 4.5.

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Total Capitation Rate Revenue will be calculated as if all FIDA Plans had received the full quality withhold payment.

1.21 Care Manager — An appropriately qualified professional who is the FIDA Plan's designated accountable point of contact for each Participant's care coordination and care management services. The Care Manager is the primary individual responsible for conducting, directing, or delegating care management duties, as needed. Responsibilities include: facilitating Interdisciplinary Team (IDT) activities and communication; facilitating assessment of needs; ensuring and assisting in developing, implementing and monitoring the Person-Centered Service Plan; and serving as the lead of the IDT.

1.22 Care Management — A collaborative process that assists each Participant in accessing services as identified in the Participant's Person-Centered Service Plan. The Care Management process assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet a Participant's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, and positive outcomes. The Care Management process also provides referral and coordination of other services in support of the Patient-Centered Service Plan. Care Management services will assist Participants to obtain needed medical, Behavioral Health Services, prescription and non-prescription drugs, Community-based or Facility-based Long-Term Services and Supports (LTSS), social, educational, psychosocial, financial and other services in support of the Person-Centered Service Plan irrespective of whether the needed services are covered under the capitation payment of the Three-way Contract.

1.23 Centers for Medicare & Medicaid Services (CMS) — The Federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.24 Change of Control — Any transaction or combination of transactions resulting in: (i) the change in ownership of a FIDA Plan; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a FIDA Plan; or (iii) the divestiture, in whole or in part, of the business unit or division of a Party that is obligated to provide the products and services set forth in this Contract.

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1.25 Chronic Health Condition — A health condition or disease that is persistent or otherwise long-lasting in its effects.

1.26 Cognitive Disabilities — A range of disabilities that may manifest in a cognitive impairment and prompt a wide range of needs and abilities that vary for each specific individual. Conditions range from individuals having a serious mental impairment caused by Alzheimer's disease, bipolar disorder or medications to non-organic disorders such as dyslexia, attention deficit disorder, poor literacy, or problems understanding information. At a basic level, these disabilities affect the mental process of knowledge, including aspects such as awareness, perception, reasoning, and judgment.

1.27 Community-based Long-Term Services and Supports (LTSS) — Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health which are provided in the person's home or community-based setting such as assisted-living facilities. These home and community-based services are designed to meet an individual's needs as an alternative to long-term nursing facility care and to enable a person to live as independently as possible.

1.28 Complaint — See "Grievance."

1.29 Comprehensive Assessment — A systematic evaluation of the Participant's care and service needs as further described herein. The systematic evaluation will be conducted using the Uniform Assessment System – New York (UAS-NY), or State-approved equivalent, which is also referred to as the NYSDOH Approved Assessment.

1.30 Comprehensive Reassessment — A systematic evaluation of the Participant's care and service needs, as further described herein, that takes into consideration the last Comprehensive Assessment completed for the Participant. The systematic evaluation will be conducted using the UAS-NY or State-approved equivalent.

1.31 Computer Aided Real-time Translation (CART) — The instant translation of spoken word into text performed by a CART reporter using a stenotype machine, notebook computer, and real-time software.

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1.32 Confidential Information — Any material, data, or information disclosed by any Party to another Party that, pursuant to agreement of the Parties or a Party's grant of a proper request for confidentiality, is not generally known by or disclosed to the public or to Third Parties including, without limitation: (i) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by CMS, the State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (ii) all information and materials relating to Third Party contractor of CMS or the State that have provided any part of CMS' or the State's information or communications infrastructure to CMS or the State; (iii) software; and (iv) any other information that the Parties agree should be kept confidential.

1.33 Consistently Low Performing Icon — A Medicare Health or Drug Plan that has a rating of less than 3 stars on its Part C and/or Part D summary rating for the current year and the previous two years, or as defined in the most recent Medicare Part C and D Star Rating Technical Notes.

1.34 Consolidated Laws of New York — Contains all New York statutes of a general and permanent nature passed by the New York State Legislature and signed by the governor.

1.35 Consumer Assessment of Healthcare Providers and Systems (CAHPS) — The survey developed by the program funded by the U.S. Agency for Healthcare Research and Quality that works closely with a consortium of public and private organizations. The CAHPS program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experience with ambulatory and facility level care.

1.36 Consumer Directed Personal Assistance Program — The State program under which Consumer Directed Personal Assistance Services are provided.

1.37 Consumer Directed Personal Assistance Services (CDPAS) — CDPAS provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide,

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or nurse. Recipients have flexibility and freedom in choosing their caregivers. The Participant or the person acting on the Participant's behalf (such as the parent of a disabled or chronically ill child) assumes full responsibility for hiring, training, supervising, and – if need be – terminating the employment of persons providing the services.

1.38 Continuity of Operations Plan (COOP) (also called a Disaster Recovery Plan) — A plan developed by the FIDA Plan to ensure business continuity in the event of a catastrophic incident.

1.39 Contract — Also referred to as the Three-way Contract, this is the participation agreement that CMS and the State have with a FIDA Plan specifying the terms and conditions pursuant to which a participating FIDA Plan may participate in this Demonstration.

1.40 Contract Management Team (CMT) — A group of CMS and NYSDOH representatives responsible for overseeing the contract management functions outlined in Section 2.2.2 of the Contract.

1.41 Contract Operational Start Date — The first date on which any enrollment into the FIDA Plan's Demonstration Plan is effective.

1.42 Court-Ordered Services — Those services that the FIDA Plan is required to provide to Participants pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the FIDA Plan's Covered Items and Services.

1.43 Covered Items and Services — The set of items and services required to be offered by the FIDA Plans, as defined in Appendix A.

1.44 Cultural Competence (also Cultural Competency) — Understanding those values, beliefs, and needs that are associated with a Participant's age, gender, sexual orientation, cultural, linguistic, racial, ethnic, and religious backgrounds, and congenital or acquired disabilities.

1.45 Demonstration (also FIDA Demonstration) — Medicare-Medicaid Alignment Initiative to better serve individuals eligible for both Medicare and Medicaid ("Medicare-Medicaid Participants").

1.46 Designee — An adult that a Participant with capacity has invited to participate in decision making about the Participant's enrollment and

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services from the FIDA Plan or may refer to an Authorized Representative as defined at Section 1.15.

1.47 DHHS — The United States Department of Health and Human Services.

1.48 Disease Management Program — A program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. Disease Management Program services include: (i) a population identification process; (ii) use and promotion of evidence-based guidelines; (iii) use of collaborative practice models to include Physician and support service providers; (iv) Participant self-management education (includes primary prevention, behavioral modification, and compliance surveillance); (v) Care Management; (vi) process and outcome measurement, evaluation, and management; and (vii) routine reporting/feedback loop (includes communication with the Participant, Physician, ancillary providers and practice profiling). A Disease Management Program may be a part of a Care Management program.

1.49 Disenrollment — The process by which a Participant's enrollment in the FIDA Plan terminates.

1.50 Effective Date of Disenrollment — The date on which a Participant is no longer a member of the FIDA Plan.

1.51 Effective Date of Enrollment (also Enrollment Effective Date) — The date on which a Participant is a member of the FIDA Plan.

1.52 Eligible Individual — An individual whom the Local Department of Social Services (LDSS), State, an entity designated by the State, or Federal government determines to be eligible for full Medicaid benefits; entitled to benefits under Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Part D; and who meets all the other conditions for enrollment in the FIDA Demonstration as set forth in this Contract.

1.53 eMedNY — The electronic Medicaid system of New York State for eligibility verification and Medicaid provider claim submission and payments.

1.54 Emergency Medical Condition — A medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity (including,

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but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part or (iv) serious disfigurement of such person.

1.55 Emergency Services — Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R Part 438 and that are needed to evaluate or stabilize an Emergency Medical Condition.

1.56 Encounter — An encounter is a professional face-to-face contact or transaction between a Participant and a provider who delivers services. An encounter is comprised of the procedure(s) or service(s) rendered during the contact. An encounter should be operationalized in an information system as each unique occurrence of Participant and provider.

1.57 Encounter Data — The record of a Participant receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy, and transaction standards and format as specified in guidance.

1.58 Enrollment — The processes by which an individual who is eligible for the Demonstration is enrolled in a FIDA Plan.

1.59 Enrollment Broker — An independent entity contracted with the State, which is responsible for processing all enrollment and disenrollment transactions. The Enrollment Broker will educate Participants on all potential plan choices and ensure ongoing customer service related to outreach, education, and support for individuals eligible for the Demonstration. The Enrollment Broker will incorporate the option of Program of All-Inclusive Care for the Elderly plan (PACE) enrollment into its scripts and protocols.

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1.60 Episode of Care — All clinically related services for one patient for a discrete diagnostic condition from the onset of symptoms until treatment is complete. For individuals with a mental health diagnosis, an Episode of Care for an outpatient service with an Out-of-Network provider will not exceed two (2) years from the date of Enrollment. For inpatient care, the Episode of Care is complete at discharge.

1.61 External Quality Review Organization (EQRO) — An organization contracted with NYSDOH that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 C.F.R. § 438.358.

1.62 External Grievance — A Grievance with an adverse decision at the FIDA Plan level that is filed with CMS and/or the State. This is not an Appeal.

1.63 Facility-based Long-Term Services and Supports (LTSS) — Facility-based LTSS are a range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health which are provided in a long-term care facility, such as a nursing facility (not including assisted living residences).

1.64 Federally-Qualified Health Center (FQHC) — An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).

1.65 Fee-For-Service — The method of paying providers for each Encounter or service rendered.

1.66 FIDA Administrative Hearing Unit — The unit within the New York State Office of Temporary and Disability Assistance which reviews adverse decisions made by FIDA Plans.

1.67 FIDA Plan Benefit Package(s) (also FIDA Plan's Benefit Package(s)) — The FIDA Plan's submission to CMS and the State of the Covered Items and Services it will provide through the FIDA Plan.

1.68 Financial Exploitation — The improper use of an adult's funds, property, or resources by another individual, including but not limited to, Fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers or denial of access to assets.

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1.69 First Tier, Downstream and Related Entity — An individual or entity that enters into a written arrangement with the FIDA Plan, acceptable to CMS and NYSDOH, to provide administrative or health care services of the FIDA Plan under this Contract.

1.70 Fiscal Agent — 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.

1.71 Fiscal Intermediary (FI) — An entity that has a contract with the FIDA Plan to provide wage and benefit processing for consumer directed personal assistants and other fiscal intermediary responsibilities specified in subdivision (i) of Section 505.28 of Title 18 of the NYCRR.

1.72 Fraud — Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

1.73 Fully Integrated Duals Advantage Plan (FIDA Plan) — A managed care plan under contract with CMS and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA Demonstration.

1.74 Grievance — In accordance with 42 CFR § 438.400, Grievance means an expression of dissatisfaction about any matter other than an "Adverse Action." A Grievance is filed and decided at the FIDA Plan level. Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the FIDA Plan's or provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the FIDA Plan, or failure to respect the Participant's rights, as provided for in 42 C.F.R. § 438.400 and Appendix B.

1.75 Group Practice — A group of Primary Care Providers (PCPs) who share a practice or are affiliated and provide direct medical or other services to Participants of any PCP within that practice.

1.76 Habilitation — An effort directed toward the alleviation of a disability or toward increasing an individual's level of physical, mental, social or

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economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling, and other services.

1.77 Health and Recovery Plans (HARPs) — For adult populations meeting the serious mental illness (SMI) and substance use disorder (SUD) targeting criteria and risk factors, the State will enroll individuals in specialty lines of business within the qualified mainstream MCOs statewide. These distinct specialty lines of business will be called HARPs. Within the HARPs, an enhanced benefit package in addition to the State Plan services will be offered for enrolled individuals who meet both targeting and needs-based criteria for functional limitations. The needs based criteria are in addition to any targeting and risk factors required for HARP eligibility. The enhanced benefit package will help maintain participants in home and community-based settings. These enhanced benefit packages will be provided by the qualified full-benefit HARPs. The qualified HARP, contracting with Health Homes, will provide care management for all services including the 1915(i)-like services in compliance with home and community-based standards and assurances.

1.78 Health Care Acquired Conditions (HCACs) — Conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions pursuant to § 1886 (d)(4)(D)(iv) of the Social Security Act (SSA) (as described in § 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT/pulmonary embolism (PE)) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

1.79 Health Commerce System or "HCS" — A closed communication network dedicated to secure data exchange and distribution of health related information between various health facility providers and the NYSDOH. HCS functions may include: collection of Medicaid complaint and disenrollment information; collection of Medicaid financial reports; collection and reporting of managed care provider networks systems (PNS); and the reporting of Medicaid encounter data systems (MEDS).

1.80 Healthcare Effectiveness Data and Information Set (HEDIS) — Tool developed and maintained by the National Committee for Quality

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Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.81 Health Maintenance Organization (HMO) — A health maintenance organization as defined in Article 44 of the New York State Public Health Law (PHL).

1.82 Health Outcomes Survey (HOS) — Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.83 Health Plan Management System (HPMS) — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, FIDA Plan Benefit Packages, formularies, and other information via HPMS.

1.84 Home and Community-Based Services (HCBS) Waivers — Waivers under Section 1915(c) of the Social Security Act that allow the State to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

1.85 Indian Participant (also Native American Participant) — A Participant who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. § 1603(c)).

1.86 Individual(s) with Intellectual Disabilities (IID) — A person with a disability which:

a1. Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, or autism;

a2. Is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such person; or

a3. Is attributable to dyslexia resulting from a disability described in

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subparagraph (1) or (2) of this paragraph;
b. originates before such person attains age twenty-two;
c. has continued or can be expected to continue indefinitely; and
d. constitutes a substantial handicap to such person's ability to function normally in society.

1.87 Institutionalization — Long-term or residency in a Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or State operated facility, but does not include short-term admission stays in an acute care facility or Rehabilitation hospital setting.

1.88 Instrumental Activities of Daily Living (IADL) — Managing money, bill paying, shopping, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health, and being alone.

1.89 Integrated Administrative Hearing Officer — An Administrative Law Judge (ALJ) who works for the Integrated Administrative Hearing Office within OTDA.

1.90 Interdisciplinary Team (IDT) — The team of individuals that will provide person-centered care coordination and Care Management to Participants. Each Participant will have an IDT. Each IDT will be comprised, first and foremost, of the Participant and/or his/her Designee, if desired by the Participant; the designated FIDA Plan Care Manager; the Primary Care Provider or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant; Behavioral Health Service Professional, if there is one, or a designee with clinical experience from the Behavioral Health Service Professional's practice who has knowledge of the needs of the Participant; the Participant's home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of the needs of the Participant, if the Participant is receiving home care and approves the home care aid/designee's participation on the IDT; the Participant's Nursing Facility representative who is a clinical professional, if receiving Nursing Facility care; and additional individuals including other providers either as requested by the Participant or his/her Designee or as recommended by the IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee or the Registered Nurse (RN) who completed the Participant's Comprehensive Assessment, if approved

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by the Participant and/or his/her Designee. The IDT facilitates timely and thorough coordination between the FIDA Plan, the IDT, the primary care physician, and other providers. The IDT will make coverage determinations. Accordingly, the IDT's decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, his/her providers, and his/her representatives. IDT service planning, coverage determinations, care coordination, and care management will be delineated in the Participant's Person-Centered Service Plan and will be based on the assessed needs and articulated preferences of the Participant.

1.91 Interdisciplinary Team Policy or IDT Policy — The FIDA Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management released by NYSDOH, with prior approval from CMS in accordance with Section 3.1.1.2, as binding on FIDA Plans.

1.92 Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID) — A facility for individualswho have physical, intellectual, social and emotional needs, that provides services primarily for ambulatory adults with Intellectual Disabilities and addresses itself to the needs of individuals with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR).

1.93 Internal Grievance — A Grievance filed with the FIDA Plan.

1.94 Involuntary Disenrollment — Disenrollments under Sections 2.3.2.7 and 2.3.2.8 or Section 3.2.5.5 of this Contract.

1.95 Local Department of Social Services (LDSS) — A city or county social services district as constituted by §61 of the New York State Social Services Law (SSL).

1.96 Long-Term Care (LTC) Facility or Nursing Facility (NF) — (i) A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit; (ii) a part of a hospital in which Skilled Nursing or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

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1.97 Mainstream Managed Care Plan — The NYSDOH Medicaid Managed Care Program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider, including as applicable, a special needs managed care plan or a comprehensive HIV special needs plan.

1.98 Managed Care Organization (MCO) — An entity that meets the definition of managed care organization as defined at 42 C.F.R. § 438.2, that is certified under Article 44 of the PHL, and that has a contract with CMS and NYSDOH to provide services in the Demonstration. It includes the FIDA Plan and may also include other such entities with such contracts.

1.99 Managed Long Term Care Program — The NYSDOH long term managed care program that contracts with Medicaid Advantage Plus plans, Partially Capitated Managed Long Term Care Plans (MLTCPs), and Program of All-inclusive Care for the Elderly plans (PACE) to provide managed Community-based or Facility-based LTSS to eligible consumers.

1.100 Mandated Reporting — Immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be experiencing Abuse, Neglect, or Financial Exploitation.

1.101 Marketing, Outreach, and Participant Communications — Any informational materials targeted to Participants that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260. These include materials regarding choice of MCO, selecting a PCP, Participant Handbooks, Basic Information as set forth in Section 2.15, and any information or notices distributed by the FIDA Plan or required to be distributed to Eligible Individuals, Potential Participants, or Participants by CMS and NYSDOH or regulations promulgated from time to time under 42 C.F.R. §§ 438 and 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and423.2260 et. seq.; and the Medicare Marketing Guidelines. This also includes the activities identified in the marketing plan the FIDA Plan is required to submit for NYSDOH approval.

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1.102 Medicaid — The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations thereunder, and the State Plan and waivers thereof approved by CMS.

1.103 Medicaid Advantage Plus Program — The partially-integrated Medicare and Medicaid managed care program for Medicare-Medicaid Participants who require Community-based or Facility-based LTSS.

1.104 Medicaid Managed Care Plan — A health maintenance organization ("HMO") or prepaid health service plan ("PHSP") certified under Article 44 of the PHL that is under contract with NYSDOH to provide most of the Medicaid services in New York.

1.105 Medicaid Program — The program under Title XIX of the Social Security Act that provides medical benefits to people with low income.

1.106 Medicaid Renewal — The process through which an individual's Medicaid eligibility is reevaluated and is either continued until the next Medicaid Renewal date or is terminated due to the individual no longer meeting eligibility requirements.

1.107 Medicaid Waiver — Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act. A Section 1115(a) waiver is also referred to as a demonstration.

1.108 Medical Record — A complete record of items and services rendered by all Participating and Non-Participating Providers documenting the specific items and services rendered to the Participant, including but not limited to inpatient, outpatient, emergency care, routine, and LTSS items and services. The record must be kept in accordance with all applicable Federal, State, and local laws, rules and regulations. Such record shall be signed by the provider rendering the services.

1.109 Medically Necessary Items and Services (Also Medical Necessity) — Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, the FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and

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NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

1.110 Medicare-Medicaid Coordination Office — Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.111 Medicare — Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as Skilled Nursing Facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers Physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.112 Medicare Advantage — The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.

1.113 Mental Health Clinics — A program for adults, adolescents, and/or children which provides an array of treatment services for assessment and/or symptom reduction or management. Services include, but are not limited to, individual and group therapies. The purpose of such services is to enhance the person's continuing functioning in the community. The intensity of services and number/duration of visits may vary.

1.114 Minimum Data Set (MDS) — A clinical screening system, mandated by Federal law for use in Nursing Facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for Nursing Facility Residents.

1.115 Money Follows the Person — A program operated by NYSDOH for purposes of transitioning Medicaid-eligible individuals out of Nursing Facilities and into community-based settings where they can be supported with Community-based LTSS.

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1.116 National Committee for Quality Assurance (NCQA) — A private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification, and recognition, e.g., health plan accreditation.

1.117 National Council for Prescription Drug Program (NCPDP) — The electronic HIPAA transaction that the FIDA Plan transfers to the NYSDOH that identifies health care claims for pharmacy claims and Encounters.

1.118 Neglect — A failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a Resident, or (iii) to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect includes Active Neglect, Passive Neglect, and Self Neglect defined as follows.

1.118.1 Active Neglect — Willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.

1.118.2 Passive Neglect — Non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

1.118.3 Self Neglect — An adult's inability, due to physical and/or mental impairments to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; or managing financial affairs.

1.119 Net Available Monthly Income (NAMI) — The amount of medical expenses the LDSS determines a "medically needy" individual must incur in any period in order to be eligible for medical assistance and

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that a Nursing Facility Resident must pay monthly to the Nursing Facility in accordance with the requirements of the medical assistance program.

1.120 New to Service — Eligible Individuals who are not already receiving Facility-based or Community-based LTSS.

1.121 New York State Department of Health (NYSDOH) — The agency responsible for administering the Medicaid program in the State of New York and the terms of this Demonstration.

1.122 New York State Office of Mental Health (OMH) — The agency responsible for operating psychiatric centers across the State and regulating, certifying, and overseeing more than 4,500 programs, which are operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient programs, emergency, community support, residential, and family care programs.

1.123 New York State Office of Temporary and Disability Assistance (OTDA) — The agency responsible for conducting State Medicaid fair hearings and supervising programs that provide assistance and support to eligible families and individuals.

1.124 New York State Office of the Medicaid Inspector General — The agency responsible for enhancing the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

1.125 Non-Participating Provider — (also Out-Of-Network Provider) A provider that does not have a Provider Agreement with the FIDA Plan.

1.126 Nursing Facility — (also Long-Term Care Facility) A residential health care facility as defined in subdivision three of 2801 of the PHL, and assisted living residences, as defined in article 46-B of the PHL, or any facilities which hold themselves out or advertise themselves as providing assisted living services and which are required to be licensed or certified under the SSL or the PHL and adult care facilities as defined in subdivision 21 of section 2 of the SSL.

1.127 Nursing Facility Clinically Eligible — A standard of eligibility for care in a Nursing Facility, based on an individual's care needs and

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functional, cognitive, and medical status as determined upon completion of the NYSDOH Approved Assessment.

1.128 Nursing Home Transition & Diversion 1915(c) Waiver — Social Security Act Section 1915(c) waiver that gives New York State the Medicaid authority to provide home and community-based services to certain medically needy individuals. These services enable these individuals to live at home or in the community with appropriate supports rather than in a Nursing Facility.

1.129 NYSDOH Approved Assessment — Protocol used by the FIDA Plans to conduct a Comprehensive Assessment of each Participant's medical, Behavioral Health Services, Community-based or Facility-based LTSS, and social needs completed by the FIDA Plan IDT. Assessment domains will include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants' preferences, strengths, and goals. The Uniform Assessment System – New York (UAS-NY) or State-approved equivalent will be the assessment used to conduct these assessments for Participants.

1.130 Opt-In Enrollment — An Enrollment in which the Eligible Individual voluntarily elects a specific FIDA Plan.

1.131 Opt Out — A process by which an Eligible Individual or his/her Authorized Representative can choose not to be passively enrolled in the Demonstration. An Eligible Individual can opt out before he/she receives a prospective notice of their Passive Enrollment date, after he/she receives notice but before the Passive Enrollment effective date, or after the effective date. If the latter, opt out is also Voluntary Disenrollment.

1.132 OPWDD — New York State Office for People with Developmental Disabilities (OPWDD).

1.133 OPWDD Services — Services include: long term therapy services provided by Article 16 clinic treatment facilities, certified by OPWDD under 14 NYCRR, Part 679 or provided by Article 28 Diagnostic & Treatment Centers explicitly certified by NYSDOH as serving primarily Individuals with Intellectual Disabilities(IID); day treatment services provided in an Intermediate Care Facility for Individuals with

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Intellectual Disabilities (ICF/IID) or comparable facility and certified by OPWDD under 14 NYCRR, Part 690; Comprehensive Medicaid Case Management services; and home and community based waiver program services for Individuals with Intellectual Disabilities.

1.134 Other Supportive Services the IDT Determines Necessary — Additional supportive services or items determined by the Participant's IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant.

1.135 Partially Capitated MLTCP — A managed care plan that provides Medicaid Community-based or Facility-based LTSS to both Medicare-Medicaid Participants and individuals who qualify only for Medicaid.

1.136 Participant — Any Eligible Individual who is enrolled in FIDA Plan.

1.137 Participant Advisory Committee (PAC) — A group convened in person, at least quarterly by the FIDA Plan to solicit input for consideration by the FIDA Plan's governing board. The PAC is open to all Participants and the Participant Ombudsman. The PAC reflects the diversity of the FIDA Plan's Participant population. The FIDA Plan provides the PAC with information on any updates and proposed changes about the FIDA Plan including data on the number and nature of Grievances and Appeals, information about quality assurance and improvement, information about Enrollments and Disenrollments, and more.

1.138 Participant Feedback Sessions — Sessions for FIDA Plan Participants to raise problems and concerns and provide positive feedback to the FIDA Plan. The FIDA Plan convenes at least two Participant Feedback Sessions per year in each Service Area, as described in the Readiness Review tool and must assist Participants with the costs, transportation, reasonable accommodations, and other challenges of attending. The FIDA Plan summarizes each Participant Feedback Session and makes the summary available to Participants and the public.

1.139 Participant Handbook — The publication prepared by the FIDA Plan and issued to Participants at the time of Enrollment and annually thereafter to inform them of their benefits and services, how to access health care services, and to explain their rights and responsibilities as a FIDA Plan Participant.

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1.140 Participant Ombudsman (PO) — An independent, conflict-free entity under contract with NYSDOH or authorized entity to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their FIDA Plan. The PO will be accessible to all Participants through telephonic and, where appropriate, in-person access. The PO will provide advice, information, referral, and assistance in accessing benefits and assistance in navigating FIDA Plans, providers, or NYSDOH. The PO may participate in FIDA Plan Participant Advisory Committee activities.

1.141 Participant Services Telephone Line — A toll-free telephone call center, operated by the FIDA Plan from 8:00 A.M. to 8:00 P.M. EST seven days per week to provide Participants with assistance.

1.142 Participating Pharmacy — A pharmacy with which the FIDA Plan has entered into a written agreement.

1.143 Participating Provider — A person or entity with whom the FIDA Plan has entered into a written Provider Agreement.

1.144 Partnership Plan — Social Security Act Section 1115(a) waiver that provides New York State the Medicaid authority to enroll Medicaid enrollees and Medicare-Medicaid Participants in a Medicaid MLTCP.

1.145 Party/Parties — The State, through NYSDOH, CMS, and the FIDA Plan.

1.146 Passive Enrollment — An enrollment process through which an Eligible Individual is enrolled by NYSDOH (or its vendor) into a FIDA Plan, when the individual not affirmatively elected a FIDA Plan, following a minimum 60-day advance notification that includes the plan selection and the opportunity to select a different FIDA Plan, or decline enrollment into a FIDA Plan, or opt out of the Demonstration prior to the effective date.

1.147 Payment Arrangement — An arrangement between a FIDA Plan and a Nursing Facility provider that describes reimbursement for services in absence of a contract.

1.148 Performance Measure — A quantifiable measure to assess how well an organization carries out a specific function or process.

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1.149 Personal Assistant — An individual who provides Personal Care to a Participant when it has been determined by the Care Manager that the Participant has the ability to supervise the Personal Assistant.

1.150 Person-Centered Service Plan (PCSP) — A written description in the care management record of Participant-specific health care goals to be achieved and the amount, duration, and scope of the Covered Items and Services to be provided to a Participant in order to achieve such goals. The individual Person-Centered Service Plan is based on assessment of the Participant's health care needs and developed by the IDT in consultation with the Participant and his/her informal supports. The FIDA Plan will use the NYSDOH Approved Assessment and include consideration of the current and unique psycho-social and medical needs and history of the Participant, as well as the Participant's functional level and support systems and clinical and non-clinical needs. The Comprehensive Assessment identifies services to be provided or arranged to meet the identified needs and includes goals, interventions, and expected outcomes. Effectiveness of the Person-Centered Service Plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-Covered Items and Services which interrelate with the Covered Items and Services identified on the Person-Centered Service Plan and services of informal supports necessary to support the health care goals and effectiveness of the Covered Items and Services should be clearly identified in the Person-Centered Service Plan or elsewhere in the care management record.

1.151 Pharmacy Network (Also Participating Pharmacies) — Pharmacies that have contracted with the FIDA Plan (i.e., Participating Pharmacies) to provide Participants with access to formulary and non-formulary drugs covered by the FIDA Plan.

1.152 Physician — An individual licensed to practice medicine in all its branches in New York.

1.153 Physician Incentive Plan (PIP) — Any compensation arrangement between the FIDA Plan 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 FIDA Plan's Participants.

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1.154 Post-Stabilization Services — Covered Items and Services related to Participant's underlying condition that are provided after the Participant's Emergency Medical Condition has been stabilized and/or under the circumstances described in 42 C.F.R. §§ 438.114(b) and 438.114(e).

1.155 Potential Participant — An individual who either 1) is an Eligible Individual or 2) is not yet an Eligible Individual but may become an Eligible Individual in the foreseeable future.

1.156 Prevalent Languages — Six most common non-English languages spoken by individuals with limited-English proficiency in the State of New York, based on United States census data. Currently the six most common non-English languages are Spanish, Chinese, Russian, Italian, Haitian-Creole, and Korean. The State will inform FIDA Plans of any changes to these languages.

1.157 Primary Care Provider (PCP) — A provider, including a specialist serving as a PCP, who within the provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Participants in the MCO.

1.158 Prior Approval — Review and written approval by the NYSDOH and CMS of any FIDA Plan materials or actions, as set forth in the Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that the FIDA Plan must obtain before such materials are used or such actions are executed, implemented, or followed.

1.159 Prior Authorization — Review and approval by the FIDA Plan's IDT that must be obtained prior to a Participant receiving Covered Items and Services for which prior authorization is required.

1.160 Privacy — Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR §§ 431.300 through 431.307, as well as relevant New York privacy laws for the purpose for protecting personal and individually identifiable health and other information from being shared without the approval or consent of the Participant.

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1.161 Program Integrity Plan — A document developed by the FIDA Plan that defines how the FIDA Plan will adequately identify and report suspected Fraud, waste, and Abuse by Participants, by Participating providers, by First Tier, Downstream, and Related Entities, and by the FIDA Plan.

1.162 Program of All-Inclusive Care for the Elderly (PACE) — A comprehensive service delivery and financing model that integrates medical and LTSS under dual Capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area.

1.163 Protected Health Information (PHI) — Except as otherwise provided in HIPAA, which shall govern the definition of PHI, information created or received from or on behalf of a covered FIDA Plan as defined in 45 C.F.R. § 160.103, that relates to (i) the provision of health care to an individual; (ii) the past, present or future physical or mental health or condition of an individual; or (iii) the past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or that there is a reasonable basis to believe can be used to identify the individual. PHI is the information transmitted or held in any form or medium.

1.164 Provider — A person or organization enrolled with CMS to provide Medicare Covered Items or Services, or issued a provider identification number by NYSDOH to provide Medicaid Covered Items or Services, to a Participant. The FIDA Plan is not a provider.

1.165 Provider Agreement — The written agreement between the FIDA Plan and a provider related to the provider's participation with the FIDA Plan for purposes of the FIDA Demonstration.

1.166 Provider-Based Marketing Activities and Provider Affiliation Information — The FIDA Plan may allow Participating Providers to provide objective and neutral information to Participants and Potential Participants and assistance with Enrollment to the extent allowed by Section 70.11.1 of the Medicare Marketing Guidelines. For example, the FIDA Plan may allow Participating Providers to make available or distribute FIDA Plan marketing materials. In addition, consistent with Section 70.11.2 of the Medicare Marketing Guidelines, the FIDA Plan

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may allow Participating Providers to announce a new affiliation once through direct communication to Participants or Potential Participants (through direct mail, email, or phone), and multiple times if done though general advertising or if the communication includes of all the FIDA Plans that Participating Provider has contracts with (pending CMS approval of all marketing materials). Plans with continuing affiliations may continue to use contracted providers to distribute written materials only if the Plan ensures that contracted providers include a list of all plans with which the provider contracts in additional direct mail and\or email communications.

1.167 Provider Network — Providers that have contracted with the FIDA Plan (i.e., Participating Providers) to provide Participants with access to the full range of Covered Items and Services, including Behavioral Health Services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Items and Services in Appendix A).

1.168 Provider Preventable Condition — Such policies and procedures shall be consistent with Federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with Title 10, Sub-part 86-1.42 and the NYSDOH's policies, procedures, and guidance on Provider Preventable Conditions as outlined in the NY Register and on the www.health.ny.gov website.

1.169 Quality Improvement Program — The FIDA Plan's overarching mission, vision and values, which, through its goals, objectives and processes committed in writing, are demonstrated through continuous improvement and monitoring of medical care, Participant safety, Behavioral Health Services, and the delivery of services to Participants, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, providers, other entities delegated to provide services to Participants, and the extended community involved with Participants.

1.170 Quality Improvement Organization (QIO) — An organization designated by CMS as set forth in Section 1152 of the Social Security Act and 42 C.F.R. § 476, that provides Quality Assurance, quality studies and inpatient utilization review for NYSDOH in the Fee-For-Service

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program and Quality Assurance and quality studies for the NYSDOH in the HCBS setting. It also refers to an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

1.171 Quality Improvement Project — An ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves (i) measurement of performance using objective quality indicators, (ii) implementation of system interventions to achieve improvement in quality, (iii) evaluation of the effectiveness of the interventions, and (iv) planning and initiation of activities for increasing or sustaining improvement.

1.172 Readiness Review — The readiness review will evaluate each FIDA Plan's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Participants, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Items and Services. CMS and the NYSDOH use the results to inform its decision of whether the FIDA Plan is ready to begin marketing and accepting enrollment under the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective FIDA Plan's headquarters.

1.173 Referral — An authorization provided by a PCP to enable a Participant to seek medical care from another provider. Referrals are not required for Covered Items and Services under the FIDA Demonstration.

1.174 Rehabilitation — The process of restoration of skills to an individual who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible in therapeutic, social, physical, behavioral, and vocational areas.

1.175 Resident — A Participant who is living in a facility and whose facility services are eligible for Medicaid and Medicare payment.

1.176 Roster — The enrollment list generated on a monthly basis by NYSDOH by which the LDSS and FIDA Plan are informed of

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specifically which Eligible Individuals the FIDA Plans will be serving in the FIDA Demonstration for the coming month, subject to any revisions communicated in writing or electronically by NYSDOH or LDSS or entity designated by the State.

1.177 Self-Direction (also Consumer Direction) — The ability for a Participant to direct his/her own services through the Consumer-Directed Personal Assistance Services option.

1.178 Serious Mental Illness — A diagnosable mental disorder experienced by an adult that is sufficiently severe and enduring to cause functional impairment in one or more life areas and a recurrent need for mental health services.

1.179 Service Area — The specific geographical area of New York designated in the CMS HPMS, and as referenced in Appendix H, for which the FIDA Plan agrees to provide Covered Items and Services to all Participants who opt in or who are passively enrolled into the FIDA Plan.

1.180 Service Authorization Request — A request to the IDT by a Participant or by a provider on behalf of a Participant for the provision of a Covered Item or Service.

1.181 Single Case Agreement — An agreement established between the FIDA Plan and a Non-Participating Provider when Participants require specialty care not available from a Participating Provider.

1.182 Skilled Nursing — Nursing services provided within the scope of the New York Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

1.183 Skilled Nursing Facility (SNF) — A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.

1.184 Solvency — Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

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1.185 Spend-down — The policy that allows an individual to qualify for the Medicaid Program by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-down amount represents medical expenses the individual is responsible to pay.

1.186 Stabilization, Stabilized, or Stabilizing — The term "to stabilize" means, with respect to an Emergency Medical Condition (1) to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, (2) with respect to an Emergency Medical Condition to deliver (including the placenta) that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

1.187 State — The State of New York.

1.188 State Plan — The New York Medicaid State Plan filed with Federal CMS, in compliance with Title XIX of the Social Security Act.

1.189 Third Party — Any Person other than CMS, NYSDOH, the FIDA Plan, or any of the FIDA Plan's Affiliates.

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

1.190.1 Accident-only coverage or disability income insurance;

1.190.2 Accident-only coverage or disability income insurance;

1.190.3 Coverage issued as a supplement to liability insurance;

1.190.4 Liability insurance, including auto insurance;

1.190.5 Workers compensation or similar insurance;

1.190.6 Automobile medical payment insurance;

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1.190.7 Credit-only insurance;

1.190.8 Coverage for on-site medical clinics;

1.190.9 Dental-only, vision-only, or long-term care insurance;

1.190.10 Specified disease coverage;

1.190.11 Hospital indemnity or other fixed dollar indemnity coverage; or

1.190.12 Prescription-only coverage.

1.191 Urgent Care — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, Physician's office, or in a hospital emergency department if a clinic or Physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

1.192 Utilization Management — A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of the Demonstration. Utilization Management typically includes new activities or decisions based upon the analysis of care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as Appeals introduced by the provider, payer or Participant.

1.193 Voluntary Disenrollment — Disenrollment initiated by a Participant or his/her Authorized Representative including all such individuals recognized by the laws of New York.

2 Section 2. FIDA Plan Responsibilities

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Through the FIDA Demonstration, CMS and NYSDOH will work in partnership to offer Eligible Individuals the option of enrolling in a FIDA Plan, which consists of a comprehensive network of health and social service providers. The FIDA Plan will deliver and coordinate all components of Medicare and Medicaid Covered Items and Services for Participants.

2.1 **Compliance:**

The FIDA Plan must, to the satisfaction of CMS and NYSDOH:

2.1.1 Comply with all provisions set forth in this Contract;

2.1.2 Maintain during the term of this Contract a valid Certificate of Authority to operate a Managed Long Term Care Plan (MLTCP) under Article 44 of the PHL, PHL §4403-f.

2.1.3 Comply with all applicable provisions of Federal and State laws, regulations, guidance, waivers, administrative bulletins issued by NYSDOH, and Demonstration terms and conditions, including the requirement to have and implement a compliance plan. The FIDA Plan must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. §§ 422 and 423, except to the extent that waiversfrom these requirements are provided in the Memorandum of Understanding (MOU) signed by CMS and NYSDOH for this initiative.

2.1.4 Comply with Other Laws.

2.1.4.1 No obligation imposed herein on the FIDA Plan shall relieve the FIDA Plan of any other obligation imposed by law or regulation, including, but not limited to, those imposed by the laws of the State of New York, the Federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the State of New York or CMS.

2.1.4.2 NYSDOH and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

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2.1.4.3 NYSDOH or CMS will inform the FIDA Plan of any such report unless the appropriate agency to which NYSDOH or CMS has reported requests that the NYSDOH or CMS not inform the FIDA Plan.

2.1.5 Adopt and implement an effective compliance program to prevent, detect and correct Fraud, waste, and Abuse that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, 42 C.F.R. § 423.504, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455, and PHL §4414. The compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

2.1.5.1 Articulate the FIDA Plan's commitment to comply with all applicable Federal and State standards, including but not limited to;

2.1.5.1.1 Fraud detection and investigation;

2.1.5.1.2 Procedures to guard against Fraud and Abuse;

2.1.5.1.3 Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.5.1.4 Obligation to suspend payments to providers;

2.1.5.1.5 Disclosure of ownership and control of the FIDA Plan;

2.1.5.1.6 Disclosure of business transactions;

2.1.5.1.7 Disclosure of information on persons convicted of health care crimes; and

2.1.5.1.8 Reporting Adverse Actions taken for Fraud, integrity, and quality;

2.1.5.2 Describe compliance expectations as embodied in the FIDA Plan’s standards of conduct;

2.1.5.3 Implement the operation of the compliance program;

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2.1.5.4 Provide guidance to employees and others on dealing with potential compliance issues;

2.1.5.5 Identify how to communicate compliance issues to appropriate compliance personnel;

2.1.5.6 Describe how potential compliance issues are investigated and resolved by the FIDA Plan; and

2.1.5.7 Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

2.1.6 Comply with any behavioral health program changes that take effect during the Demonstration period.

2.1.7 Comply with all aspects of the joint Readiness Review.

2.1.8 Comply with requirements and recommendations as they are adopted by the Medicaid Redesign Team's Health Disparities Work Group and enacted by NYSDOH.

2.1.9 Adopt and implement policies ensuring Culturally Competent care coordination and service delivery, making oral interpretation services for any Participant that so requires, and making all written information available in Prevalent Languages.

2.1.10 Impose these requirements on all Participating Providers.

2.1.11 Accreditation

2.1.11.1 The FIDA Plan must report to NYSDOH any deficiencies noted by the National Committee for Quality Assurance (NCQA) for the MCO's Medicare and/or Medicaid product lines within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

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2.1.12 Program Integrity: The FIDA Plan must have a comprehensive Program Integrity Plan to detect, correct and prevent Fraud, waste, and Abuse.

2.1.12.1 The Program Integrity Plan must define how the FIDA Plan will adequately identify and report suspected Fraud, waste, and Abuse by Participants, by Participating Providers, by First Tier, Downstream, and Related Entities, and by the FIDA Plan.

2.1.13 Mergers and Acquisitions

2.1.13.1 In addition to the requirements at 42 C.F.R. § 422 Subpart L, the FIDA Plan must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify NYSDOH and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.).

2.1.14 Financial Requirements.

2.1.14.1 General

2.1.14.1.1 The FIDA Plan, at all times, shall be in compliance with all financial requirements of 10 NYCRR Part 98 and 42 C.F.R. § 438.116.

2.1.14.2 Financial Viability

2.1.14.2.1 Consistent with Section 1903(m) of the Social Security Act, and regulations found at 42 C.F.R. § 422.402, 42 C.F.R. § 438.106, and 42 C.F.R. § 438.116, the FIDA Plan shall meet all State and Federal financial soundness requirements. These must include: The FIDA Plan must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Participants will be liable neither for the entity's debts, if the entity becomes insolvent; nor for Covered

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Items and Services provided to the Participants for which the State and/or CMS does not pay the FIDA Plan, or the State or CMS or the FIDA Plan does not pay the Participant or provider that furnishes the health care services under a contractual, referral or other arrangement.

2.1.14.2.2 The FIDA Plan shall comply with the escrow deposit requirements of 10 NYCRR Part 98 and must meet the contingent reserve fund and minimum net worth requirements established by the State.

2.1.14.2.3 The FIDA Plan must also maintain reserves to meet the State's reserve requirements, which are outlined in the Reserve Requirements Guidance.

2.1.14.2.4 If the FIDA Plan becomes insolvent, the FIDA Plan must cover continuation of services to Participants for the duration of period for which payment has been made as well as for inpatient admissions until the time at which that Participant is discharged.

2.1.14.3 Medical Loss Ratio (MLR)

2.1.14.3.1 Medical Loss Ratio Guarantee: The FIDA Plan has a Target Medical Loss Ratio (TMLR) threshold of eighty-five (85) percent.

2.1.14.3.2 If the MLR calculated as set forth below is less than the TMLR, the FIDA Plan shall refund to CMS and NYSDOH an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the coverage year revenue. CMS and NYSDOH shall calculate a MLR for Participants under this

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Contract for each coverage year, and shall provide to the FIDA Plan the amount to be refunded, if any, to CMS and NYSDOH, respectively. Any refunded amounts will be distributed back to the Medicare and Medicaid programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and NYSDOH, separately, any amount to be refunded may be recovered either by requiring the FIDA Plan to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, CMS and NYSDOH may adopt NAIC reporting standards and protocols after giving written notice to the FIDA Plan.

2.1.14.3.3 The MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:

2.1.14.3.3.1 All Covered Items and Services required in the Demonstration under Section 2.4 and Appendix A;

2.1.14.3.3.2 Any items and services purchased in lieu of more costly Covered Items and Services and consistent with the objectives of the FIDA Demonstration; and

2.1.14.3.3.3 Care Management Expense. That portion of the personnel costs for Care Managers whose primary duty is direct Participant contact that is

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attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for FIDA Plan's medical director that is attributable to this Contract shall be included as a benefit expense.

2.1.14.3.4 The revenue used in the MLR calculation will consist of the Capitation Payments paid by CMS and NYSDOH for the coverage year. Revenue for the purpose of the MLR calculation will include amounts withheld pursuant to Section 4.3.4, regardless of whether the FIDA Plan actually receives the amount in Section 4.3.4.

2.1.14.4 Data Submission. The FIDA Plan shall submit to CMS and NYSDOH, in the form and manner prescribed by CMS and NYSDOH, the necessary data to calculate and verify the MLR after the end of the coverage year.

2.1.14.5 Medical Loss Ratio Calculation. Within ninety (90) days following the six (6) month claims run-out period following the coverage year, CMS and NYSDOH shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point.

2.1.14.6 Coverage Year. The coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available from the coverage year, including incurred but not paid (IBNP) and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months.

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2.2 **Contract Management and Readiness Review Requirements**

2.2.1 Contract Readiness Review Requirement

2.2.1.1 CMS and NYSDOH or their designee, will conduct a Readiness Review of each FIDA Plan, which must be completed successfully, as determined by CMS and NYSDOH, prior to the Contract Operational Start Date.

2.2.1.2 CMS and the NYSDOH Readiness Review Responsibilities:

2.2.1.2.1 CMS and NYSDOH will conduct a Readiness Review of each FIDA Plan that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and Enrollment of Eligible Individuals into the FIDA Plan. CMS and NYSDOH will conduct the Readiness Review to verify the FIDA Plan's assurances that the FIDA Plan is ready and able to meet its obligations under the Contract.

2.2.1.2.2 The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1 Participating Provider composition and access, in accordance with Section 2.7;

2.2.1.2.2.2 Staffing, including key management positions and functions directly impacting on Participants (e.g., adequacy of Care Manager and Participant Services staffing), in accordance with Sections 2.2.3, 2.5, and 2.10;

2.2.1.2.2.3 Capabilities of First Tier, Downstream, and Related

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Entities, in accordance with Section 2.7.2.3 and Appendix C;

2.2.1.2.2.4 Content of Provider Agreements, including any Physician Incentive Plans, in accordance with Section 5.1.7;

2.2.1.2.2.5 Care Coordination capabilities, in accordance with Section 2.5;

2.2.1.2.2.6 Participant services capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.10;

2.2.1.2.2.7 Comprehensiveness of quality management / quality improvement and Utilization Management strategies, in accordance with Section 2.13;

2.2.1.2.2.8 Internal Grievance and Appeal policies and procedures, in accordance with Sections 2.12 and 2.13;

2.2.1.2.2.9 Fraud and Abuse and program integrity, in accordance with Sections 2.1.5;

2.2.1.2.2.10 Financial solvency requirements;

2.2.1.2.2.11 Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in

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accordance with Section 2.16 and Section 2.17, including IT testing and security assurances.

2.2.1.2.3 No Eligible Individual shall be enrolled into the FIDA Plan unless and until CMS and NYSDOH determine that the FIDA Plan is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.4 CMS and NYSDOH or their designee will identify to the FIDA Plan all areas where the FIDA Plan is not ready and able to meet its obligations under the FIDA Plan and provide an opportunity for the FIDA Plan to correct such areas to remedy all deficiencies prior to the Contract Operational Start Date.

2.2.1.2.5 CMS or NYSDOH may, in its discretion, postpone the Contract Operational Start Date for the FIDA Plan if the FIDA Plan fails to satisfy all Readiness Review requirements. If, for any reason, the FIDA Plan does not fully satisfy to CMS or NYSDOH that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date , and CMS or NYSDOH does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or NYSDOH may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3 FIDA Plan Readiness Review Responsibilities

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2.2.1.3.1 The FIDA Plan must demonstrate to CMS and NYSDOH's satisfaction that the FIDA Plan is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the FIDA Plan engaging in marketing of its Demonstration product.

2.2.1.3.2 The FIDA Plan must provide CMS and NYSDOH with the corrected materials requested by the Readiness Review report.

2.2.2 Contract Management

2.2.2.1 The FIDA Plan must employ a qualified individual to serve as the Compliance Officer of its FIDA Plan and this Contract. The Compliance Officer must be primarily dedicated to the FIDA Plan, hold a senior management position in the FIDA Plan's organization, and be authorized and empowered to represent the FIDA Plan in all matters pertaining to the FIDA Plan. The Compliance Officer must act as liaison between the FIDA Plan, CMS, and NYSDOH, and has responsibilities that include, but are not limited to, the following:

2.2.2.1.1 Ensure the FIDA Plan's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2 Oversee all activities by the FIDA Plan and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the FIDA Plan's quality management director, medical director, and behavioral health clinician;

2.2.2.1.3 Ensure that Participants receive written notice of any significant change in the manner in

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which services are rendered to Participants at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;

2.2.2.1.4 Receive and respond to all inquiries and requests made by CMS and NYSDOH in time frames and formats specified by CMS and NYSDOH;

2.2.2.1.5 Meet with representatives of CMS or NYSDOH, or both, on a periodic or as-needed basis to resolve issues within specified timeframes;

2.2.2.1.6 Ensure the availability to CMS and NYSDOH upon either's request, of those members of the FIDA Plan's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Participant services, Utilization Management, Provider Network management, and benefit coordination;

2.2.2.1.7 Represent the FIDA Plan, when requested, at NYSDOH and CMS meetings related to the FIDA Demonstration;

2.2.2.1.8 Coordinate requests and activities among the FIDA Plan, all First Tier, Downstream, and Related Entities, CMS, and NYSDOH;

2.2.2.1.9 Make best efforts to promptly resolve any issues related to the Contract identified by the FIDA Plan, CMS, or NYSDOH; and

2.2.2.1.10 Meet with CMS and NYSDOH at the time and place requested by CMS and NYSDOH, if CMS or NYSDOH, or both, determine that

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the FIDA Plan is not in compliance with the requirements of the Contract.

2.2.3 Organizational Structure

2.2.3.1 The FIDA Plan shall establish and maintain the interdepartmental structures and processes to support the operation and management of its FIDA Demonstration line of business in a manner that fosters integration of physical health, Behavioral Health Service, and Community-based and Facility-based LTSS service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The FIDA Plan shall describe the interdepartmental structures and processes to support the operation and management of its Demonstration line of business.

2.2.3.2 On an annual basis, and on an ad hoc basis when changes occur or as directed by NYSDOH or CMS, the FIDA Plan shall submit to the CMT an overall organizational chart that includes senior and mid-level managers for the FIDA Plan.

2.2.3.3 The FIDA Plan shall have a Participant Advisory Committee and shall host Participant Feedback Sessions as described in Section 2.10.

2.2.3.4 Participant Representation within the FIDA Plan governance structure. After October 1, 2014, the FIDA Plan must have individuals with disabilities, including Participants, within the governance structure of the FIDA Plan. The FIDA Plan will also be encouraged to include Participant representation on its boards of directors.

2.3 **FIDA Plan Role in Enrollment Activities**

2.3.1 Enrollment Generally. Enrollment and Disenrollment transactions will be processed through the State Enrollment

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Broker. NYSDOH (or its vendor) will submit Enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) Enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to NYSDOH identifying individuals who have elected to disenroll from a FIDA Plan, Opt Out of Passive Enrollment, or have enrolled in or have selected another type of available Medicare coverage that is not a FIDA Plan. NYSDOH will share Enrollment, Disenrollment, and Opt Out transactions with contracted FIDA Plans.

2.3.1.1 All Opt-In and Passive Enrollments are processed through the Enrollment Broker consistent with the Enrollment Effective Date requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. In the event that a Participant directly contacts the FIDA Plan to request Enrollment into the FIDA Plan, the FIDA Plan shall do a three-way call to the Enrollment Broker and warmly transfer (i.e., directly connect) the Participant to the Enrollment Broker for Enrollment counseling and assistance with FIDA Plan Enrollment.

2.3.1.2 Enrollment Effective Date(s) – The FIDA Plan will be required to accept Opt-In Enrollments as communicated by the Enrollment Broker of eligible individuals no earlier than thirty (30) days prior to the initial effective date of no earlier than October 1, 2014, and begin providing coverage for Opt-In enrolled individuals no earlier than October 1, 2014.

2.3.1.3 Effective Date of Opt-In Enrollment. If an Opt-In Enrollment, which includes Enrollment from one FIDA Plan to a different FIDA Plan, is received by the Enrollment Broker and acceptedby the NYSDOH's database prior to noon on the twentieth (20th) of the month or noon on the last business day before the twentieth (20th) of the month in the event that the twentieth falls on a weekend or holiday, coverage shall begin on the first day of the following calendar month.

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2.3.1.4 The FIDA Plan will be responsible for providing Covered Items and Services to Participants from the effective date of Enrollment.

2.3.1.5 The FIDA Plan must have a mechanism for receiving timely information about all Enrollments in the FIDA Plan, including the effective date of Enrollment, from CMS, NYSDOH, and the Enrollment Broker's systems consistent with the timeframes outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.1.6 The FIDA Plan shall accept for Enrollment all Eligible Individuals, as described in Section 3.2.1 of the Contract, in the order in which they are referred by NYSDOH, without restriction, except that the FIDA Plan shall notify NYSDOH of any third party liability in accordance with Section 5.1.12**.** The FIDA Plan shall accept for Enrollment all Eligible Individuals identified by NYSDOH at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

2.3.1.7 Welcome Packet. Within ten (10) Business Days after receipt of the 834 Enrollment File from NYSDOH confirming that an Opt-In Enrollment was accepted, the FIDA Plan shall send a Welcome Packet to the Participant. For Passive Enrollments, the FIDA Plan shall send the Welcome Packet no later than thirty (30) days prior to the effective date. The packet shall include all Basic Information as set forth in Section 2.15.4.

2.3.1.8 For Passive Enrollments, the FIDA Plan sends the following to the Participant no later than the last calendar day of the month prior to the effective date of coverage:

2.3.1.8.1 A single ID card for accessing all Covered Items and Services under the FIDA Plan; and

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2.3.1.8.2 A Participant Handbook (Evidence of Coverage).

2.3.1.9 For Passive Enrollments, the FIDA Plan sends to the Participant thirty (30) days prior to the Effective Date of Enrollment:

2.3.1.9.1 A FIDA Plan-specific Summary of Benefits;

2.3.1.9.2 A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the FIDA Plan;

2.3.1.9.3 A combined Provider and Pharmacy Directory; and

2.3.1.9.4 Proof of health insurance coverage that include the prescription drug data necessary to access benefits so that the Participant may begin using FIDA Plan services as of the Effective Date of Enrollment.

2.3.1.10 For Opt-In Enrollments, the FIDA Plan provides the following materials to the Participant no later than ten (10) Business Days from receipt of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:

2.3.1.10.1 A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the FIDA Plan;

2.3.1.10.2 A combined Provider and Pharmacy Directory;

2.3.1.10.3 A single ID card; and

2.3.1.10.4 A Participant Handbook (Evidence of Coverage).

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2.3.1.11 The number of Participants enrolled with FIDA Plan will be limited to a level that will not exceed FIDA Plan's physical and professional capacity.

2.3.1.12 NYSDOH and CMS, through the CMT, will review documentation provided by the FIDA Plan that sets forth the FIDA Plan's physical and professional capacity: (i) before the first enrollment and as regularly provided subsequently; (ii) when the FIDA Plan requests a review and NYSDOH agrees to such review; (iii) when there is a change in Covered Items and Services, categories of Eligible Individuals, Service Area, or Capitation that can reasonably be expected to impact the FIDA Plan's capacity; (iv) when there is a Change of Control, or a sale or transfer of the FIDA Plan; and, (v) when CMS and NYSDOH determines that the FIDA Plan's operating or financial performance reasonably indicates a lack of provider or administrative capacity. Such documentation must demonstrate that the FIDA Plan offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Participants in the Service Area and that the FIDA Plan maintains a network of Participating Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Participants in the Service Area. In the event NYSDOH reasonably finds that the FIDA Plan has failed to restore Participating Provider and administrative capacity, the CMT may freeze Passive Enrollment during the implementation phase or take other corrective actions.

2.3.1.13 Adjustments to the volume of Passive Enrollment based on the capacity of the FIDA Plan will be subject to any capacity determinations including but not limited to those documented in the CMS and NYSDOH final Readiness Review report and ongoing monitoring by CMS and the NYSDOH. CMS and NYSDOH, upon agreement of both parties, may stop Enrollments into any FIDA Plan at any time.

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2.3.1.14 No Enrollments will be accepted within six (6) months (or less) of the end of the Demonstration.

2.3.1.15 Notification of FIDA Plan selection and Enrollment options will be provided by the State to each Eligible Individual no fewer than sixty (60) calendar days prior to the effective date of the proposed Enrollment with the opportunity to opt out until the last day of the month prior to the Enrollment effective date.

2.3.2 Disenrollment

2.3.2.1 Participants may request to be disenrolled from the FIDA Plan at any time for any reason, orally or in writing. A Disenrollment request may be made by the Participant to the Enrollment Broker or 1-800-MEDICARE.

2.3.2.1.1 In the event that a Participant directly contacts the FIDA Plan to request Disenrollment from the FIDA Plan, the FIDA Plan shall:

2.3.2.1.1.1 Conduct a three-way call to the Enrollment Broker and warmly transfer (i.e., directly connect) the Participant to the Enrollment Broker for assistance with Disenrollment.

2.3.2.1.1.2 Not interfere with the Participant's right to disenroll through threat, intimidation, pressure, or otherwise.

2.3.2.2 Voluntary Disenrollments are processed by the Enrollment Broker consistent with the enrollment effective date requirements set forth in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including the State-Specific Appendix 5, and the Contract between NYSDOH and the Enrollment Broker.

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2.3.2.3 The FIDA Plan shall have a mechanism for receiving timely information about all Voluntary Disenrollments from the Enrollment Broker, including the Effective Date of Disenrollment, from CMS and NYSDOH and Enrollment Broker's systems. All Voluntary Disenrollment related transactions will be performed by the Enrollment Broker. Participants can elect to disenroll from the FIDA Plan or the Demonstration at any time and enroll in another FIDA Plan, a Medicare Advantage Plan; or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive his/her Medicaid benefits through PACE; Medicaid Advantage Plus; MLTCP; or Medicaid FFS if the individual enrolled in a FIDA Plan directly from Medicaid FFS. Voluntary Disenrollments received by the Enrollment Broker or received by CMS, or the CMS contractor, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.4 Any time an Eligible Individual requests to Opt Out of Passive Enrollment or disenroll from the Demonstration, the State will send a letter confirming the Opt-Out and Disenrollment effective date in addition to providing information on the benefits available to the Participant once they have opted out or disenrolled.

2.3.2.5 The FIDA Plan shall cease providing Covered Items and Services to a Participant upon the Effective Date of Disenrollment.

2.3.2.6 The FIDA Plan shall notify NYSDOH of any Participant who is no longer eligible to remain enrolled in the FIDA Plan per CMS Enrollment Guidance, in order for NYSDOH to disenroll the Participant. This includes where a Participant remains out of the Service Area or for whom residence in the FIDA Plan Service Area cannot be confirmed for more than six consecutive months.

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2.3.2.7 Under no circumstances shall the FIDA Plan cease to provide services to a Participant until NYSDOH or CMS or the Enrollment Broker informs the FIDA Plan that the Participant may be terminated because the Participant has received appropriate notice and waived or exhausted all Appeal rights. Termination shall take effect on the effective date indicated by NYSDOH, CMS, or the Enrollment Broker.

2.3.2.8 Discretionary Involuntary Disenrollments: The FIDA Plan shall not seek to terminate Enrollment because of an adverse change in a Participant's health status or because of the Participant's utilization of Covered Items and Services, diminished mental capacity, uncooperative or disruptive behavior resulting from such Participant's special needs (except to the extent such Participant's continued Enrollment with the FIDA Plan seriously impairs the FIDA Plan's ability to furnish Covered Items and Services to the Participant or other Participants as defined in Section 2.4 and Appendix A, or take an Adverse Action in connection with a Participant who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate Enrollment in violation of this Section 2.3.2 will be considered a breach of this Contract.

2.3.2.8.1 The FIDA Plan, however, has the option to submit a written request, accompanied by the supporting documentation required by Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, to the CMT, to disenroll a Participant, for cause. For the purposes of implementing this Section 2.3.2.8, the CMT shall serve as the agent for CMS and NYSDOH. CMS and NYSDOH shall not have independent authority to review requests for discretionary Involuntary Disenrollment under this Section beyond their representation on the

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CMT. The CMT may approve a FIDA Plan request to disenroll a member for disruptive behavior only after the FIDA Plan has met the requirements of Sections 40.3 and 40.4. If despite efforts by the FIDA Plan to, where appropriate, resolve and provide an opportunity for the Participant to cure the problems, the following exist:

2.3.2.8.1.1 Consistent with Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance,, the Participant engages in conduct or behavior that seriously impairs the FIDA Plan's ability to furnish Covered Items and Services to either this Participant or other Participants and provided the FIDA Plan made and documented reasonable efforts to resolve the problems presented by the Participant.

2.3.2.8.1.2 Consistent with Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, the Participant provides fraudulent information on an Enrollment form or the Participant willfully misuses or permits another person to misuse the Participant's ID card.

2.3.2.8.1.3 The Participant fails to pay or make arrangements satisfactory to the FIDA Plan to pay the amount, as determined

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by the LDSS, owed to the FIDA Plan as spend-down/surplus or Net Available Monthly Income (NAMI) within thirty (30) days after such amount first becomes due, provided that during that thirty (30) day period the FIDA Plan first makes a reasonable effort to collect such amount, including making a written demand for payment, and advising the Participant in writing of his/her prospective Disenrollment.

2.3.2.8.1.4 The Participant knowingly fails to complete and submit any necessary consent or release allowing the FIDA Plan and/or providers to access necessary health care and service information for the purpose of compliance with the care delivery system requirements in Section 2.5 of this Contract.

2.3.2.8.2 To support the CMT's evaluation of the FIDA Plans request for Involuntary Disenrollment, the FIDA Plan shall submit all documentation required by Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance and the following:

2.3.2.8.2.1 In all cases, document what steps the FIDA Plan has taken to locate and engage the Participant, and the impact of or response to each attempt;

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2.3.2.8.2.2 Provide a monthly report to the CMT of all Participants who have not participated in either the Comprehensive Assessment, Comprehensive Reassessment, or Patient-Centered Service Plan process, and whether this is because the FIDA Plan could not locate or engage the Participant, because the Participant declined, or another reason;

2.3.2.8.2.3 Transfer Participant medical record information promptly to the new FIDA Plan or NYSDOH or its designee as appropriate upon Disenrollment of the Participant from the Demonstration or at the Participant's request to transfer to another FIDA Plan in accordance with Section 5.2.4 ; and

2.3.2.8.2.4 If the Participant transfers to another FIDA Plan, with the Participant's written consent, and in accordance with applicable laws and regulations, transfer current Minimum Data Set-Home Care (MDS-HC) or Minimum Data Set-Nursing Facility (MDS-NF) assessment information to the new FIDA Plan. The information shall be provided no later than ten (10) calendar days from the receipt of the

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notice of Disenrollment to the FIDA Plan and no later than the effective date of transfer in the method and format specified by NYSDOH and CMS.

2.3.2.8.3 The CMT will determine when and if a FIDA Plan's request to terminate the Enrollment of a Participant will be granted based on the criteria in Section 2.3.2 above and in Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. In the event that the CMT approves a FIDA Plan's request for Involuntary Disenrollment for cause, the CMT will notify the FIDA Plan and instruct the FIDA Plan to send the Participant a CMT developed Involuntary Disenrollment Form, with a copy to the CMT and to the Enrollment Broker.

2.3.2.8.4 Termination of a Participant's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the Disenrollment is processed.

2.3.2.8.5 The CMT will develop a process to evaluate discretionary Involuntary Disenrollment requests. If the CMT determines that the FIDA Plan too frequently requests discretionary Involuntary Disenrollments for Participants, the CMT reserves the right to deny such requests and require the FIDA Plan to initiate steps to improve the FIDA Plan's ability to serve such Participants.

2.3.2.9 The FIDA Plan must make a reasonable effort to identify for the Participant, both verbally and in writing, those actions of the Participant that have interfered with the effective provision of Covered Items and Services as

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well as explain what actions or procedures are acceptable.

2.3.2.10 The FIDA Plan shall give prior verbal and written notice to the Participant, with a copy to the CMT, of its intent to request Disenrollment. The written notice shall advise the Participant that the request has been forwarded to the CMS for review and approval. The written notice must include the mailing address and telephone number of the CMT.

2.4 **Covered Items and Services**

2.4.1 The Interdisciplinary Team (IDT) must authorize, arrange, integrate, and coordinate the provision of all Covered Items and Services for its Participants. (See Covered Items and Services in Appendix A.) Covered Items and Services must be available to all Participants twenty-four (24) hours a day, seven (7) days a week, in accordance with Medical Necessity requirements and as authorized in accordance with the IDT policy. Covered Items and Services will be managed and coordinated by the FIDA Plan through the Participant's IDT (see Section 2.5.2.1). Covered Items and Services shall be provided in the amount, duration and scope as set forth in this Contract, and shall be sufficient to achieve the purposes for which such Covered Items and Services are furnished. FIDA Plan shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.

2.4.1.1 The FIDA Plan must provide at least the full range of Behavioral Health Services covered by a Mainstream Managed Care Plan under the Partnership Plan.

2.4.2 The FIDA Plan must provide the full range of Covered Items and Services. If either Medicare or Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the FIDA Plan must provide the most expansive set of services required by either program. The FIDA Plan may not limit or deny services to

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Participants based on Medicare or Medicaid providing a more limited range of services than the other program.

2.4.3 As described herein and in the IDT Policy, the majority of Covered Items and Services are authorized by the IDT.

2.4.4 Because nearly all Covered Items and Services are authorized by the IDT, referrals are not necessary and may not be required by the FIDA Plan or any of its Participating Providers when a Participant is obtaining Covered Items or Services under the FIDA Demonstration.

2.5 **Care Delivery Model**

2.5.1 Care Management. The FIDA Plan shall offer Care Management services to all Participants to ensure effective linkages and coordination between all Participating and Non-Participating Providers and Covered Items and Services and to coordinate the full range of medical and social supports needed by the Participant. Care Management services will be provided to all Participants and will be provided by the Care Manager in concert with the Participant's IDT. Care Management and the operation of the IDT shall be provided in accordance with the requirements of this Contract and with the IDT Policy.

2.5.2 Provision of Care Management

2.5.2.1 Requirements for an IDT. Every Participant shall have an IDT, developed with input of the Participant and led by a Care Manager. As outlined in the IDT Policy, the IDT will ensure the integration of the Participant's medical, Behavioral Health Services, substance use, Community-based or Facility-based LTSS, and social needs. The IDT will be person-centered, built on the Participant's specific preferences and needs and with his or her input, deliver services with transparency, individualization, accessibility, respect, linguistic and Cultural Competence, and dignity. The role of the IDT and the requirements for each IDT are outlined in the IDT Policy.

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2.5.2.2 As outlined in the IDT Policy, the IDT's decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, his/her providers, and his/her representatives. IDT service planning, coverage determinations, care coordination, and Care Management will occur in accordance with the terms outlined in the IDT Policy.

2.5.2.3 Interdisciplinary Team Training: The FIDA Plan will provide training to all members of the IDT on the IDT process. IDT members must agree to participate in approved training on the person-centered planning processes, Cultural Competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This will include ADA/*Olmstead* requirements.

2.5.2.4 FIDA Plan members of the IDT must be trained on the following topics: IDT policies and procedures; person-centered care planning processes; accessibility and reasonable accommodations; cultural and disability competencies; the Participant Ombudsman; compliance with the Americans with Disabilities Act; independent living and recovery; and wellness philosophies. FIDA Plans will offer similar trainings to additional members of the IDT team: Primary Care Providers and specialists, as appropriate.

2.5.2.5 Care Manager Responsibilities: The Care Manager will lead the IDT and will be responsible for leading the provision of Care Management services, as determined by a Participant's needs and preferences. Care Management includes referral to and coordination of other necessary medical, social, Behavioral Health Services, prescription drugs and non-prescription drugs, Community-based or Facility-based LTSS, educational, financial and other services of the Person-Centered Service Plan that support the Participant's psychosocial needs irrespective of whether such services are covered

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by the FIDA Plan. More detail about the Care Manager responsibilities is provided in the IDT Policy.

2.5.2.6 Care Manager Qualifications:

2.5.2.6.1 Care Managers must have the experience, qualifications and training appropriate to the individual needs of the Participant, and the FIDA Plan must establish policies for appropriate assignment of Care Managers.

2.5.2.6.2 Care Managers must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.

2.5.2.7 Care Management Assignment and Change Request

2.5.2.7.1 The FIDA Plan shall assign every Participant to a Care Manager with the appropriate experience and qualifications based on a Participant's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.2.7.2 The FIDA Plan must have a process to ensure that a Participant and/or caregiver is able to request a change in his or her Care Manager at any time.

2.5.2.8 Care Manager Caseloads. The FIDA Plan must ensure that the Care Manager's caseload is reasonable to provide appropriate care coordination and Care Management and to ensure compliance with the requirements of the IDT Policy.

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2.5.2.8.1 Care Manager Contact Standards. Care Managers shall maintain contact with Participants as frequently as outlined in the Person-Centered Service Plan (PCSP) but not less than one telephone contact per month.

2.5.3 Transition of Care.

2.5.3.1 Transition of Care Process. The FIDA Plan will manage transitions of care and continuity of care for Participants moving from an institutional setting to a community living arrangement. The FIDA Plan's process for facilitating continuity of care will include ensuring that the IDT does the following:

2.5.3.1.1 Communication with entities involved in Participants' transition.

2.5.3.1.2 Assurance that the hospitals and Nursing Facilities are not imposing a requirement for a three (3) day hospital stay prior to covering a skilled Nursing Facility stay.

2.5.3.1.3 Making accommodations so that all community supports, including housing, are in place prior to the Participant's move and that providers are fully knowledgeable and prepared to support the Participant, including interface and coordination with and among social supports, clinical services and LTSS.

2.5.3.1.4 Work with and ensuring that each IDT cooperates with the work of the transition centers to maximize use of the Money Follows the Person (MFP) program to support transitions for appropriate Participants. The IDT must cooperate with the work of the MFP contractor as relates to the Participant.

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2.5.3.1.5 Tracking the number of Participants who wish to move to the community and are referred to the MFP Program and reports this information to the NYSDOH.

2.5.3.1.6 Environmental adaptations and equipment and technology the Participant needs for a successful care setting transition.

2.5.3.1.7 Stabilization and provision of uninterrupted access to Covered Items and Services for the Participant.

2.5.3.1.8 Assessment of Participants' ongoing care needs;

2.5.3.1.9 Monitoring of continuity and quality of care, and services provided.

2.5.3.1.10 Helping Participants transition to another Participating Provider if their Participating Provider leaves the FIDA Plan's network; and

2.5.3.1.11 Transitioning Participants to new Participating Providers, if needed, once the PCSP is completed.

2.5.4 Pre-existing Conditions. Upon the Effective Date of Enrollment, the FIDA Plan shall assume full responsibility for any Covered Items and Services necessary to treat medical conditions that may have existed prior to a Participant's Enrollment with the FIDA Plan. The FIDA Plan shall support the continuation of any existing treatment plan provided that the Participant's treatment plan is current, a Covered Item or Service, and Medically Necessary. The FIDA Plan shall evaluate the appropriateness of integrated Care Management and education for each Participant who it determines to have a pre-existing condition.

2.5.5 Health Promotion and Wellness Activities

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2.5.5.1 Participant Health Education. The FIDA Plan will offer an expansive set of health education programs, including such programs through Care Managers that use comprehensive outreach and communication methods to effectively educate Participants, and their families and other caregivers, about health and self-care and how to access FIDA Plan benefits and supports.

2.5.5.2 Collaborative Education Development and Oversight: The FIDA Plan's medical management department and medical director shall be responsible for development, maintenance and oversight of Participant health education programs.

2.5.5.3 Health and Wellness Education and Outreach for Participants and Caregivers. The FIDA Plan will identify regional community health education opportunities, improve outreach and communication with Participants and community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion. This service includes i) the provision of: 1) classes, support groups, and workshops, 2) educational materials and resources, and 3) website, email, or mobile application communications; ii) at no cost to the Participant; iii) on topics including, but not limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.

2.5.5.4 Flu Prevention Program. The FIDA Plan shall make a flu prevention program available for all Participants and will provide education and outreach to all Participants. The program will educate Participants about preventing the transmission of the influenza virus.

2.5.5.5 Telehealth/Tele-Monitoring and Web-Phone Based Technology. The FIDA Plan must provide telehealth, tele-monitoring, and web-phone based technology

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services to Participants with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent Physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute long-term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

2.6 **Comprehensive Assessments and PCSP**

2.6.1 Comprehensive Assessment.

2.6.1.1 Each Participant shall receive, and be an active participant in, a timely comprehensive assessment of medical, Behavioral Health Service, community-based or facility-based LTSS, and social needs completed by a registered nurse (RN). The Comprehensive Assessment must be completed in accordance with the timelines and requirements outlined in the IDT Policy.

2.6.2 Reassessments.

2.6.2.1 Each Participant shall have a Comprehensive Reassessment in accordance with the timeframes and requirements outlined in the IDT Policy.

2.6.2.1.1 The Comprehensive Assessment is performed using the NYSDOH Approved Assessment Tool, which will be the Uniform Assessment System for New York (i.e., UAS-NY) or State-approved equivalent;

2.6.2.1.2 Comprehensive Assessment domains will include, but not be limited to, the following:

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social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants' preferences, strengths, and goals.

2.6.2.1.3 Relevant and comprehensive data sources, including the Participant, providers, and family/caregivers, shall be used by the FIDA Plans' Comprehensive Assessment RNs in completing the Comprehensive Assessment.

2.6.2.1.4 The FIDA Plan will use the results of the Comprehensive Assessment to confirm the appropriate acuity or risk stratification level for the Participant and as the basis for developing the integrated, PCSP.

2.6.2.1.5 The Participant will continue to receive any community-based or facility-based LTSS in his/her existing PCSP during this time period and all transition requirements for services, as outlined in Section 2.6.6, will be adhered to.

2.6.2.2 Timing of Comprehensive Assessment. Upon Enrollment in the FIDA Plan, all Participants will receive a Comprehensive Assessment to be completed no later than sixty (60) calendar days from the Participant's Enrollment effective date for Eligible Individuals who are Passively Enrolled for an effective date on or after January 1, 2015 through May 1, 2015. For all other Eligible Individuals enrolled into the FIDA Demonstration, upon Enrollment in the FIDA Plan, Participants will receive a Comprehensive Assessment to be completed no later than thirty (30) calendar days from the individual's Enrollment effective date.

2.6.2.3 Timing of Re-Assessments and Person-Centered Service Plan Updates: The FIDA Plan must ensure that a

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Comprehensive Reassessment and a Person-Centered Service Plan update are performed:

2.6.2.4 As warranted by the Participant's condition but at least every six (6) months after the initial assessment completion date;

2.6.2.5 When there is a change in the Participant's health status or needs;

2.6.2.6 As requested by the Participant, his/her caregiver, or his/her provider; and

2.6.2.7 Upon any of the trigger events outlined in the IDT Policy.

2.6.2.8 The Comprehensive Assessment and all Comprehensive Reassessments must be performed by a RN in-person with the Participant (e.g., in the Participant's home, hospital, Nursing Facility any other setting using the NYSDOH Approved Assessment).

2.6.3 Person-Centered Service Plans. The FIDA Plan shall assign an IDT, with a Care Manager, to the Participant; and, the IDT, in conjunction with the Participant, will develop a comprehensive, written Person-Centered Service Plan for each Participant. Within thirty (30) days of the FIDA Plan conducting a Comprehensive Assessment, a Person-Centered Service Plan will be completed for each Participant by the Participant's IDT. For Comprehensive Reassessments, a Person-Centered Service Plan will be reviewed and revised, if necessary, within thirty (30) days of the Comprehensive Reassessment. Every Participant must have a Person-Centered Service Plan, unless the Participant refuses and such refusal is documented. The Person-Centered Service Plan must include all elements outlined in the IDT Policy.

2.6.3.1 Include current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems;

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2.6.3.2 Include identifiable and measurable short- and long-term treatment and service goals and interventions to address the Participant's needs and preferences and to facilitate monitoring of the Participant's progress and evolving service needs;

2.6.3.3 Include expected outcomes with completion timeframes;

2.6.3.4 Include, in the development, implementation, and ongoing assessment of the Person-Centered Service Plan, an opportunity for input by the Participant and/or his/her designee and an opportunity for input from the IDT; and

2.6.3.5 Identify and evaluate risks associated with the Participant's care. Factors considered include, but are not limited to, the potential for deterioration of the Participant's health status; the Participant's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Participant and reasonable accommodations; and, behavioral or other compliance risks. The FIDA Plan shall incorporate the results of the risk assessment into the Person-Centered Service Plan.

2.6.3.6 Follow conflict-free guidelines for contracted entities participating in the Person-Centered Service Plan process so that these entities offer choices to the Participant regarding the services and supports they receive and from available alternatives;

2.6.3.7 Includes a method for the Participant to request changes to the Person-Centered Service Plan;

2.6.3.8 Records the alternative HCBS and settings that were considered by the participant; and

2.6.3.9 Grants Participants no less than Appeal rights provided for under Medicaid statute, regulation, and policy.

2.6.3.10 Include, as appropriate, the following elements:

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2.6.3.10.1 The Participant's personal or cultural preferences, such as types or amounts of services;

2.6.3.10.2 The Participant's preference of providers and any preferred characteristics, such as gender or language;

2.6.3.10.3 The Participant's living arrangements;

2.6.3.10.4 Covered Items and Services and non-Covered Items and Services to address each identified need;

2.6.3.10.5 Participation in the Consumer-Directed Personal Assistance option;

2.6.3.10.6 IDT service planning, coverage determinations, care coordination, and Care Management;

2.6.3.10.7 Actions and interventions necessary to achieve the Participant's objectives;

2.6.3.10.8 Follow-up and evaluation;

2.6.3.10.9 Collaborative approaches to be used;

2.6.3.10.10 Desired outcome and goals, both clinical and non-clinical;

2.6.3.10.11 Barriers or obstacles;

2.6.3.10.12 Responsible parties;

2.6.3.10.13 Standing Referrals;

2.6.3.10.14 Community resources;

2.6.3.10.15 Reasonable accommodations;

2.6.3.10.16 Informal supports;

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2.6.3.10.17 Timeframes for completing actions;

2.6.3.10.18 Status of the Participant's goals;

2.6.3.10.19 Home visits as necessary and appropriate for Participants who are homebound (as defined in 42 U.S.C. § 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation;

2.6.3.10.20 Back-up plan arrangements for critical services;

2.6.3.10.21 Crisis plans for a Participant with behavioral health conditions; and,

2.6.3.10.22 Wellness program plans.

2.6.3.11 The FIDA Plan will monitor the Person-Centered Service Plans and any gaps in care will be addressed in an integrated manner by the IDT, including any necessary revisions to the Person-Centered Service Plan.

2.6.4 Participant Engagement and Education. The FIDA Plan shall use a multifaceted approach to locate, engage, and educate Participants and shall capitalize on every Participant contact to obtain and update Participant information. The FIDA Plan shall solicit input from Participants and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.

2.6.4.1 NYSDOH will conduct an educational outreach effort for Participants and Participating Providers during the first ninety (90) days of the Demonstration. This educational outreach effort will consist of NYSDOH and FIDA Plan staff traveling to locations throughout the Service Area to provide Participants and Eligible Individuals with information about the FIDA Demonstration and FIDA Plan. The educational outreach effort should continue to educate Participants and Participating Providers on their FIDA Plan

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Enrollment options, rights and responsibilities, and other important Demonstration elements. This effort must include participation from the Enrollment Broker, choice counseling entities, Participant Ombudsman, and any other group providing Enrollment support for Participants or Participating Providers through written notice distribution, outgoing phone calls or other method.

2.6.4.2 The FIDA Plan shall use a multifaceted approach to locate, engage, and educate Participants and shall capitalize on every Participant contact to obtain and update Participant information. The FIDA Plan shall solicit input from Participants and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.

2.6.5 Self-directed Care. All Participants have the opportunity to direct their own services through the Consumer Directed Personal Assistance Program (CDPAS).

2.6.5.1 The RN that completes the Comprehensive Assessment and Comprehensive Reassessment must inform Participants of the option to self-direct their own services at each Comprehensive Assessment and Comprehensive Reassessment.

2.6.5.2 Each IDT informs each Participant of the option to self-direct his/her own services when the Person-Centered Service Plan is created and any time it is updated.

2.6.5.3 The RN and IDT must:

2.6.5.3.1 Explain that self-direction of services is voluntary, and the extent to which Participants would like to self-direct their services is the Participant's choice;

2.6.5.3.2 Explain the options to select self-directed supports or services; and

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2.6.5.3.3 Provide an overview of the supports and resources available to assist Participants to participate to the extent desired in self-direction.

2.6.5.4 The FIDA Plan is required to:

2.6.5.4.1 Provide the Participant with written educational materials outlining the roles and responsibilities for the Participant/designated representative if Participant expresses an interest in CDPAS.

2.6.5.4.2 Assess whether the Participant is eligible to receive home care or personal care services.

2.6.5.4.2.1 A Participant is eligible to receive home care or personal care services if the Participant: (1) has a stable medical condition; (2) is self-directing or if, non-self-directing, has a designated representative; (3) needs some or total assistance with one or more personal care services, home health aide services or skilled nursing tasks; (4) is able and willing or has a designated representative able and willing to fulfill the responsibilities of a Participant, including but not limited to, making informed choices as to the type and quality of services, including but not limited to Nursing Facility care, personal care, transportation and respite services; (5) participates, as needed, or has a designated representative participate in the required Comprehensive Assessment and bi-annual Comprehensive Reassessment process, or if the FIDA Plan

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determines an unexpected change in the Participant's social circumstances, mental status, or medical condition has occurred during the CDPAS authorization or reauthorization period that would affect the type, amount or frequency of CDPAS provided during such period and does not have (a) voluntary assistance available from informal caregivers, including, but not limited to, the Participant's family, friends or other responsible adult, provided that this shall include an evaluation of the potential contribution of informal supports, such as family members or friends, to the Participant's care, which must consider the number and kind of informal supports available to the Participant; the ability and motivation of informal supports to assist in care; the extent of informal supports' potential involvement; the availability of informal supports for future assistance; and the acceptability to the Participant of the informal supports' involvement in his or her care; or formal services provided by an entity or agency; or (b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies are provided to the Participant and can safely and cost-effectively meet the need for services.

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2.6.5.4.3 Have the IDT determine if the Participant is able and willing to assume all responsibilities associated with receiving the service, or has a designated representative or other identified adult, able and willing to act on the Participant's behalf.

2.6.5.4.4 Determine the Participant's eligibility for the program through its Comprehensive Assessment, Reassessments, and Person-Centered Service Plan process. The IDT will authorize the level and amount of services and will authorize payment for the CDPAS and communicate such authorization to the Participant, or if applicable, the designated representative, and the Fiscal Intermediary (FI). The IDT shall not refuse to authorize CDPAS when a Participant is otherwise eligible unless it reasonably expects that such assistance cannot maintain the Participant's health and safety in the home or other setting in which CDPAS may be provided and that a designated representative either cannot be identified or would not result in a change in the Participant's ability to maintain his or her health and safety in the home or other setting in which CDPAS may be provided.

2.6.5.4.5 The FIDA Plan shall ensure that the IDT notifies the FI in the event that the IDT makes changes to the authorization for the amount duration or scope of CDPAS; or determines that the Participant is no longer eligible to participate in the CDPAS program; or that the Participant is no longer able to fulfill the Participant's responsibilities under the CDPAS program.

2.6.5.4.6 The FIDA Plan shall ensure that the IDT receives and promptly reviews the FI

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notification to the FIDA Plan of any circumstances that may affect the Participant's or, if applicable, the Participant's designated representative's ability to fulfill the Participant's responsibilities under the CDPAS program and make changes in the Participant's authorization and reauthorization as needed.

2.6.5.4.7 The FIDA Plan shall ensure that the IDT is monitoring the FI's performance to ensure that the FI is fulfilling its responsibilities to the Participant.

2.6.5.4.8 Have the IDT monitor the Participant's on-going eligibility for the CDPAS program and discontinue authorization for CDPAS services when the IDT determines that the Participant or their designated representative is no longer able to fulfill their responsibilities or no longer desires to continue in the CDPAS program and a designated representative or alternative designated representative cannot be identified. In such case, the IDT must authorize other services as required.

2.6.5.4.9 Have the IDT assess and document the Participant's PCSP to assure adequate supports are available to meet the Participant's needs.

2.6.5.4.10 Have the IDT authorize the type, amount, and level of CDPAS required by the Participant.

2.6.5.4.11 Have the IDT include in the PCSP the tasks to be completed by the personal assistant. The PCSP will be maintained with the FIDA

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Plan and a copy will be provided to the Participant.

2.6.5.4.12 If it is determined that the Participant is no longer eligible to continue receiving CDPAS or the FIDA Plan terminates the Participant's receipt of CDPAS, the FIDA Plan will assess on an ongoing basis whether the Participant requires personal care, home health care, or some other level of service.

2.6.5.4.13 Provide the Participant with appropriate notices including a notice of fair hearing for reduction, termination of the level, and amount of services or determining that the Participant is not eligible or no longer eligible to receive CDPAS.

2.6.5.5 The FIDA Plan's policies regarding self-direction must conform to the State requirements. The FIDA Plan must describe:

2.6.5.5.1 How it will educate Participants and informal caregivers on self-directed (consumer-directed) options;

2.6.5.5.2 How it will monitor the education efforts;

2.6.5.5.3 How it will evaluate the self-directed (consumer-directed) services; and

2.6.5.5.4 How it will monitor and evaluate the percentage of Participants that use the self-directed (consumer-directed) option.

2.6.6 Continuity of Care. The FIDA Plan must develop policies and procedures to ensure continuity of care for all Participants as follows:

2.6.6.1 The FIDA Plan allows Participants receiving any Covered Item or Service at the time of Enrollment other

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than Nursing Facility services or Behavioral Health Services to maintain current providers, including with providers who are currently out of the FIDA Plan's Provider Network (i.e., Non-Participating Providers), and service levels, including prescription drugs, until the later of:

2.6.6.1.1 For at least ninety (90) days after Enrollment; or

2.6.6.1.2 Until the PCSP is finalized and implemented.

2.6.6.2 The FIDA Plan allows Participants who reside in a Nursing Facility to maintain current Nursing Facility providers for the duration of the Demonstration.

2.6.6.3 The FIDA Plan shall allow Participants who are receiving Behavioral Health Services to maintain current Behavioral Health Service Providers (i.e., Participating and Non-Participating) for the current episode of care. The IDT may review a current episode of care to determine whether it needs to be continued with the Behavioral Health Service Provider that was providing services before the Participant's Enrollment in the FIDA Plan. This requirement will be in place for not to exceed two (2) years from the date of a Participant's Enrollment and applies only to episodes of care that were ongoing during the transition period from Medicaid FFS to Enrollment in a FIDA Plan.

2.6.6.4 The FIDA Plan assures that, within the first ninety (90) days of coverage, it will provide:

2.6.6.4.1 In outpatient settings, up to ninety (90) days worth of temporary supply(ies) of drugs, consistent with 42 CFR § 423.120(b)(3), when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules) that otherwise meets the definition of a Part

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D drug during the first ninety (90) days following Enrollment in the FIDA Plan; and

2.6.6.4.2 In long-term care settings, a temporary supply of at least ninety-one (91) days and up to ninety-eight (98) days of non-formulary drugs including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules that otherwise meet the definition of a Part D drug, consistent with 42 C.F.R. § 423.120(b)(3); and

2.6.6.4.3 A ninety (90) day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.

2.6.6.4.4 Part D transition rules and rights will continue as provided for in current law and regulation.

2.6.6.5 During the transition period, for any provider seen by the Participant within the previous six (6) months prior to transition, the FIDA Plan will allow access to that provider within the first ninety (90) days of Enrollment, even on a Non-Participating Provider basis.

2.6.6.6 During the transition period, FIDA Plans will advise the Participants' IDTs if and when Participants have received care that would not otherwise be covered at an in-network level.

2.6.6.7 On an ongoing basis, and as appropriate, FIDA Plans must also contact providers (i.e., Non-Participating) currently serving FIDA Participants, but who are not already members of their network with information on becoming credentialed as Participating Providers.

2.6.6.8 Any reduction, suspension, denial, or termination of previously authorized services shall trigger the FIDA

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Plan to issue the notice required under 42 CFR § 438.404 and as further described under Section 2.13 of this Contract.

2.6.6.9 The FIDA Plan has policies and procedures to:

2.6.6.9.1 Expeditiously obtain, accept, and honor established service plans provided on paper or electronically transferred from Fee-for-Service or prior plans when Participants transition with service plans in place such that there is no disruption in service delivery of care already authorized under the existing service plan;

2.6.6.9.2 Ensure transfer of Comprehensive Assessment, Comprehensive Reassessment, PCSPs, contact information, and other pertinent information necessary to assure continuity of care to other FIDA Plans or other plans (i.e., Medicaid Advantage Plus, MLTCP, PACE, and MA-PD) or NYSDOH or its designee for FIDA Participants that disenroll from the FIDA Plan or transfer to another FIDA Plan. The information shall be provided no later than ten (10) calendar days from the receipt of the notice of Disenrollment to the FIDA Plan and no later than the effective date of transfer in the method and format specified by NYSDOH and CMS; and

2.6.6.10 The FIDA Plan may not transition Participants to a Participating PCP until:

2.6.6.10.1 The Participant chooses or is assigned a Participating PCP in accordance with Section 2.8.4 and the Participating PCP is capable of serving the Participant's needs appropriately;

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2.6.6.10.2 A Comprehensive Assessment and PCSP are complete;

2.6.6.10.3 The IDT consulted with the new PCP and determined that the Participating PCP is accessible, competent, and can appropriately meet the Participant's needs; and

2.6.6.10.4 A new PCSP has been drafted and implementation of the new PCSP has begun.

2.6.6.11 The FIDA Plan may not transition Participants to a Participating specialist or Community-based or Facility-based LTSS Participating Provider until:

2.6.6.11.1 A Comprehensive Assessment and PCSP are complete;

2.6.6.12 Notwithstanding exceptions related to Behavioral Health Services in Section 2.6.6.3, all Prior Authorizations for non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of Enrollment will be honored for ninety (90) days after Enrollment and will not be terminated at the end of ninety (90) days without advance notice to the Participant and transition to other services, if needed.

2.6.6.13 Out-of-Network Reimbursement Rules. The FIDA Plan must reimburse an Out-of-Network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Participants maintain balance billing protections.

2.6.6.14 If a Participant is receiving any Covered Item or Service that would not otherwise be covered by the FIDA Plan at an in-network level after the continuity of care period, the FIDA Plan must notify the Participant's IDT prior to

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the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568. The Participant shall be entitled to all Appeal rights, including continuation of benefits pending Appeal, if applicable, as outlined in Section 2.13 of this Contract.

2.6.6.15 The FIDA Plan must provide an appropriate transition process for Participants who are prescribed Part D drugs that are not on its formulary (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.6.6.16 If a Participant is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, the FIDA Plan shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that acute care hospital episode and subsequent follow-up care. The FIDA Plan must maintain documentation of such transfer of responsibility of medical care or treatment. For services traditionally covered by Medicare, the FIDA Plan must cover, through discharge, inpatient services if the individual was a Participant at the beginning of the inpatient stay.

2.6.6.17 Out-of-Network Provider. In the event that the Provider of a newly enrolled Participant who is in an active, ongoing course of treatment with a Provider who is not in the FIDA Plan's provider Network, the FIDA Plan will permit such Participant to continue an ongoing course of treatment with such Physician for up to ninety (90) days only if the Out-of-Network Provider agrees to provide such ongoing course of treatment, and if such Out-of-Network Provider agrees to: (i) accept

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reimbursement at the FIDA Plan's established rates based on a review of the level of services provided, (ii) adhere to the FIDA Plan's quality requirements , and (iv) adhere to the FIDA Plan's policies and procedures.

2.6.6.18 The FIDA Plan covers Items and Services from Out-of-Network Providers and pharmacies when a Participating Provider or pharmacy is not available within a reasonable distance from the Participant's place of residence. The FIDA Plan must adequately and timely cover these Covered Items and Services Out of Network for the Participant, for as long as the entity is unable to provide them. The FIDA Plan must ensure that cost to the Participant is no greater than it would be if the services were furnished within the Provider Network.

2.6.6.19 For Covered Items and Services that are part of the traditional Medicare benefit package, FIDA Plans will be required to pay Non-Participating Providers at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized Out-of-Network services. For Nursing Facility services that are part of the traditional Medicaid benefit package, FIDA Plans will be required to pay Non-Participating Providers the Medicaid FFS rate until at least December 31, 2015.

2.6.6.20 For Covered Items and Services that are part of the traditional Medicaid benefit package, the FIDA Plan shall pay any OMH or OASAS licensed or certified provider of Behavioral Health Services at least the applicable Medicaid Fee for Service rate for a period of not more than two (2) years from the date that at least one Health and Recovery Plan (HARP) shall have been approved in the FIDA Plan's Service Area. The State will consider approving alternative payment methods, consistent with State law, if both the provider and FIDA Plan come to an agreement.

2.7 **Provider Network**

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2.7.1 General.

2.7.1.1 The FIDA Plan must demonstrate annually that it has an adequate Provider Network, as approved by CMS and NYSDOH, to ensure adequate access to medical, Behavioral Health Service, pharmacy, Community-based and Facility-based LTSS providers that are appropriate for and proficient in addressing the needs of Participants, including physical, communication, and geographic access. The FIDA Plan must maintain a Provider Network sufficient to provide all Participants with access to the full range of Covered Items and Services, including Behavioral Health Services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Items and Services in Appendix A). The FIDA Plan must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days after becoming aware of an issue, including a change in the FIDA Plan's network of Participating Providers that renders the FIDA Plan unable to provide one (1) or more Covered Items and Services within the access to care standards set forth in Section 2.8, with the goal of providing notice to the CMT at least sixty (60) calendar days prior to the effective date of any such change.

2.7.1.2 Participating Provider Credentialing, Recredentialing, and Board Certification. The FIDA Plan shall credential Participating Providers in accordance with managed care standards at 42 C.F.R. §§ 438.214 and 422.204 and must ensure that providers meet the accreditation, credentialing, and re-credentialing requirements outlined in this Section 2.7.1.2. Beginning in Demonstration Year 2, the FIDA Plan must ensure that new Participating Providers and Participating Providers who are re-credentialed meet the following accreditation, credentialing, and re-credentialing requirements:

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2.7.1.2.1 The FIDA Plan must use the CAQH credentialing application process for FIDA Plan credentialing and recredentialing of all Participating Providers within provider types covered by the CAQH application and use the single, uniform information form created by NYSDOHfor obtaining additional information.

2.7.1.2.2 The FIDA Plan must employ the single, uniform information form referenced in Section 2.7.1.2.1 for credentialing and re-credentialing of all Participating Providers within provider types not covered by the CAQH credentialing process.

2.7.1.3 Recredentialing. Re-credentialing shall occur not less than every three years. At re-credentialing and on a continuing basis, the FIDA Plan shall verify minimum credentialing requirements and monitor Participant Grievances and Appeals, quality of care and quality of service events, and Medical Record review.

2.7.1.4 Delegated Credentialing. The FIDA Plan may subcontract or delegate all or part of its credentialing functions when the First Tier or Downstream Entity, such as a Participating Provider organization, maintains a formal credentialing program in compliance with the FIDA Plan, NCQA, CMS, NYSDOH and applicable regulatory standards. The FIDA Plan shall remain responsible for delegated Participating Provider credentialing and re-credentialing.

2.7.1.5 The FIDA Plan may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. § 1001 et. seq. Federal financial participation (FFP) is not available for amounts expended for Providers excluded by Medicare,

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Medicaid, or the State Children's Health Insurance Program, except for Emergency Services.

2.7.1.6 The FIDA Plan shall establish, maintain and monitor a network supported by written agreements, that is sufficient to provide adequate access to all Covered Items and Services under the Contract including the appropriate range of preventive, primary care, and specialty service, taking into consideration:

2.7.1.6.1 The anticipated number of Participants;

2.7.1.6.2 The expected utilization of Covered Items and Services, in light of the characteristics and health care needs of the FIDA Plan's Participants;

2.7.1.6.3 The number and types of providers required to furnish the Covered Items and Services;

2.7.1.6.4 The number of Participating Providers who are not accepting new patients; and

2.7.1.6.5 The geographic location of Participating Providers and Participants, taking into account distance, travel time, the means of transportation, and whether the location provides physical access for Participants with disabilities.

2.7.1.6.5.1 Proximity Access Standards

2.7.1.6.5.1.1 The FIDA Plan must have a Provider Network that is geographically accessible to Participants in the Service Area.

2.7.1.6.5.1.2 The FIDA Plan must demonstrate annually that its Provider Network

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meets the stricter of the following standards:

2.7.1.6.5.1.3 For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html);

2.7.1.6.5.1.4 For Medicare pharmacy providers, time, distance and minimum number as required in Appendix D, Article II, Section I and 42 C.F.R. § 423.120; or

2.7.1.6.5.1.5 Within the following State-specific standards:

2.7.1.6.5.1.5.1 Travel time / distance to primary care sites shall not exceed thirty (30) minutes from the Participant's residence in non-metropolitan areas.

2.7.1.6.5.1.5.2 Participants may, at their discretion, select participating PCPs located

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farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves. Travel time / distance to specialty care, hospitals, behavioral health, lab, and X-ray providers shall not exceed thirty (30) minutes / thirty (30) miles from the Participant's residence.

2.7.1.6.5.1.5.3 Travel time and distance will be calculated on a typical day of traffic volume.

2.7.1.6.5.1.5.4 The FIDA Plan shall make reasonable accommodations, including access to Out-of-Network Providers, if necessary, so that no Participant that is too frail to travel thirty (30) minutes or thirty (30) miles shall be required to do so to see a

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Participating Provider.

2.7.1.7 The FIDA Plan's entire Provider Network must meet the existing applicable Medicare and Medicaid Provider Network requirements. State Medicaid standards shall be utilized for Community-based and Facility-based LTSS, as described below, for Behavioral Health Services, and for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more favorable to the Participant (i.e., offer broader coverage). For any Covered Items and Services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of Participating Providers or facilities), the FIDA Plan must meet the Medicare requirements. To the extent that Medicaid requires a more rigorous network adequacy standard than Medicare (including time, distance, and/or minimum number of Participating Providers or facilities), the FIDA Plan must meet the Medicaid requirements. Medicare Provider Network standards account for the type of Service Area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The NYSDOH and CMS may grant exceptions to these general rules to account for patterns of care for Participants, but will not do so in a manner that will dilute access to care for Participants. Provider Networks will be subject to confirmation through Readiness Reviews.

2.7.1.8 The FIDA Plan's Provider Network must meet all of the following requirements:

2.7.1.8.1 In no instance may the FIDA Plan's Provider Network have less than two (2) of any Provider type necessary to provide Covered Items and Services.

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2.7.1.8.2 All Participating Providers' physical sites must be accessible to all Participants as must all Participating Providers that deliver services in the Participants' locations.

2.7.1.8.2.1 The FIDA Plan must collect completed ADA Accessibility Attestation forms from new Network Providers that join their networks during the Demonstration.

2.7.1.8.2.2 Effective in Demonstration Year 2, all Participating Providers must submit to the FIDA Plan and the FIDA Plan must maintain on file a signed ADA Accessibility Attestation Form indicating that they meet the ADA Accessibility standards.

2.7.1.8.2.3 All Participating Providers must notify the FIDA Plan within ten (10) Business Days of any change in its ability to meet the ADA Accessibility standards as outlined in the signed ADA Accessibility Attestation Form.

2.7.1.8.3 The FIDA Plan must establish and implement mechanisms to ensure that Participating Providers comply with the timely access requirements outlined herein, must monitor Participating Providers regularly to determine compliance, and must take corrective action if there is a failure to comply.

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2.7.1.8.4 The following minimum appointment availability standards apply to physical health and Behavioral Health Services:

2.7.1.8.4.1 For emergency care: immediately upon presentation at a service delivery site.

2.7.1.8.4.2 For urgent care: within twenty-four (24) hours of request.

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

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

2.7.1.8.4.5 Specialist appointments (not urgent): within four (4) weeks of request.

2.7.1.8.4.6 Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Participating Provider (as included in the FIDA Plan's Benefit Package): within five (5) days of request, or sooner if clinically indicated.

2.7.1.8.4.7 Non-urgent mental health or substance abuse visits with a Participating Provider (as included in the FIDA Plan's

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Benefit Package): within two (2) weeks of request.

2.7.1.8.4.8 Participating Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a Participant's ability to perform work within ten (10) days of request.

2.7.1.8.4.9 Mental Health Clinics must provide a clinical assessment within five (5) days of request for Participants in the following designated groups:

2.7.1.8.4.9.1 Participants in receipt of services from a mobile crisis team not currently receiving treatment;

2.7.1.8.4.9.2 Participants in domestic violence shelter programs not currently receiving treatment;

2.7.1.8.4.9.3 Homeless Participants and those present at homeless shelters who are not currently receiving treatment;

2.7.1.8.4.9.4 Participants aging out of foster care who are not currently receiving treatment;

2.7.1.8.4.9.5 Participants who have been discharged from an

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inpatient psychiatric facility within the last sixty (60) days who are not currently receiving treatment;

2.7.1.8.4.9.6 Participants referred by rape crisis centers; and

2.7.1.8.4.9.7 Participants referred by the State court system.

2.7.1.8.5 The following minimum access standards apply to Community-based LTSS services:

2.7.1.8.5.1 For New to Service Participants (meaning those not already receiving Community-based LTSS), Community-based LTSS service delivery must begin (along with completion of the Comprehensive Assessment) within thirty (30) days of Enrollment.

2.7.1.8.5.2 For Participants that are not New to Service but transitioning from a MLTCP, from another plan, or from Medicare and/or Medicaid FFS, FIDA Plans must provide continuity of Community-based LTSS immediately upon Enrollment, as further outlined in the continuity of care/transition policy. The FIDA Plan must contract with an adequate number of Community-based LTSS providers to allow Participants

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a choice of at least two (2) providers of each covered Community-based LTSS service within a 15-mile radius or 30 minutes from the Participant's ZIP code of residence.

2.7.1.8.6 The following minimum access standards apply to Facility-based LTSS:

2.7.1.8.6.1 For New to Service Participants (meaning those not already receiving Facility-based LTSS), FIDA Plans must enter into contracts or make Payment Arrangements with Nursing Facilities as meets the minimum access standards outlined for all providers in this section . FIDA Plans must include eight (8) Nursing Facilities per county in their Network for Participants that are New to Service. Minimum quality standards will be established for Demonstration Years 2 and 3.

2.7.1.8.6.2 For Participants that are not New to Services but are transitioning from a MLTCP, from another FIDA Plan, or from Medicare and/or Medicaid FFS, FIDA Plans must either enter into contracts or make other Payment Arrangements with all Nursing Facilities in the Service Area to ensure Participants' residency and

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access to services are not interrupted.

2.7.1.8.7 Each FIDA Plan must provide access to medical services and coverage to Participants through their PCPs and obstetrics/gynecologists (OB/GYNs,) on a twenty-four (24) hour a day, seven (7) day a week basis. The FIDA Plan must instruct Participants on what to do to obtain services after business hours and on weekends.

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

2.7.1.8.9 The FIDA Plan is required to coordinate Participant transportation, including for non-emergent and non-medical needs.

2.7.1.8.10 Participants must be assured choice of all Participating Providers, including the Care Manager and others that will participate in their IDT.

2.7.1.8.11 Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.14(h)(2).

2.7.1.8.12 The FIDA Plan is directly responsible for the provision of all other Medically Necessary Covered Items and Services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the FIDA Plan and for which the FIDA Plan is accountable to NYSDOH, or directly through the FIDA Plan's Provider Network).

2.7.1.8.13 The State and CMS have developed transition requirements that specify continuation of existing Non-Participating

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Providers for Covered Items and Services outlined in Section 2.6.6.

2.7.1.8.14 The FIDA Plan provides and arranges for timely access to all Medically Necessary Items and Services covered by Medicare and/or Medicaid, taking into account the urgency of need for such services. Both NYSDOH and CMS will monitor access to Covered Items and Services through survey, utilization, and Grievance and Appeal data to assess the need for FIDA Plan Provider Network corrective actions. NYSDOH will conduct reviews of FIDA Plans to ensure compliance with network adequacy standards.

2.7.1.8.15 NYSDOH and CMS will finalize the standards, based on administrative data and stakeholder input. NYSDOH and CMS will monitor access to care and the prevalence of needs indicated through Participant assessments, and, based on those findings, may require that the FIDA Plan initiate further Provider Network expansion over the course of the Demonstration.

2.7.1.9 Provider Networks will be subject to confirmation through Readiness Reviews and on an ongoing basis. If access problems are detected, the FIDA Plan shall actively recruit, train, and/or subcontract with additional providers, including independent practitioners, to meet the needs of Participants. Additionally, in the event of access problems being detected, NYSDOH and/or CMS reserve the right to reassess the FIDA Plan Provider Network

2.7.1.10 The FIDA Plan must make reasonable efforts to contact Out-of-Network Providers, including providers and prescribers that are providing services to Participants during the initial ninety (90)day continuity of care

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period, and provide them with information on becoming Participating Providers. If the provider does not become an Participating Provider, or if the Participant does not select a new Participating Provider by the end of the ninety (90) day period, the FIDA Plan shall choose a Participating Provider for the Participant.

2.7.1.11 The FIDA Plan covers Covered Items and Services from Out-of-Network Providers and pharmacies when a Participating Provider cannot be reasonably expected to obtain such prescription drugs at a network pharmacy and when such use is not routine. The FIDA Plan must adequately and timely cover these Items and Services Out-of-Network for the Participant for as long as the Participating Provider or pharmacy is unable to provide them. The FIDA Plan must ensure that cost to the Participant is no greater than it would be if the services were furnished within the Network. Out-of-Network Providers must coordinate with the FIDA Plan in respect to payment.

2.7.1.12 The FIDA Plan provides for a second opinion 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 FIDA Plan determines that it does not have a Participating Provider in its Provider Network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the FIDA Plan shall make a referral to an appropriate Non-Participating Provider. The FIDA Plan 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

2.7.1.13 The FIDA Plan ensures that it contracts with or has a Payment Arrangement with all Nursing Facilities in which any newly enrolled or current Participant resides

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2.7.1.14 The FIDA Plan ensures that Participants have access to the most current and accurate information by updating its online and paper copy Provider and Pharmacy Directory and search functionality on a timely basis.

2.7.1.14.1 Beginning in Demonstration Year 2, this information includes identifying which Participating Providers have attested that they meet the ADA Accessibility Attestation Form requirements in terms of physical and communications accessibility for Participants who are Blind or Deaf as well as other reasonable accommodations.

2.7.1.14.2 The FIDA Plan shall update its on-line Provider and Pharmacy Directory regularly to account for any changes in Participating Provider ADA accessibility. A paper copy Provider and Pharmacy Directory must be provided to Participants annually.

2.7.1.15 The FIDA Plan shall ensure that its Participating Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless Participants, disabled Participants, or other special population served by the FIDA Plan, including the capacity to communicate with Participants in languages other than English, when necessary, as well as those who are Deaf, hard-of-hearing or Blind.

2.7.1.16 The FIDA Plan shall educate Participating Providers through a variety of means about their legal obligations under State and Federal law to communicate with Participants with limited English proficiency, including the provision of interpreter services, and the resources available to help Participating Providers comply with those obligations. All such written communications shall be subject to review at NYSDOH's and CMS' discretion;

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2.7.1.17 The FIDA Plan shall ensure that multilingual Participating Providers and, to the extent that such capacity exists within the FIDA Plan's Service Area, all Participating Providers, understand and comply with their obligations under State or Federal law to assist Participants with skilled medical interpreters and the resources that are available to assist Participating Providers to meet these obligations.

2.7.1.18 The FIDA Plan shall ensure that Participating Providers and interpreters or translators are available for those Participants who are Deaf or hearing-impaired within the FIDA Plan's Service Area.

2.7.1.19 The FIDA Plan shall not include in its Participating Provider Agreements any provision that directly or indirectly prohibits, through incentives or other means, limits or discourages Participating Providers from participating as Network or Out-of-Network Providers in any Provider Network other than the FIDA Plan's Provider Network(s).

2.7.1.20 The FIDA Plan shall not establish selection policies and procedures for Participating Providers that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.7.1.21 The FIDA Plan shall ensure that the Provider Network provides female Participants with direct access to a women's health specialist, including an obstetrician or gynecologist (OB/GYN), within the Provider Network for Covered Items and Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Participants, women's health specialists as PCPs

2.7.1.22 The FIDA Plan must demonstrate that it has made reasonable efforts to contract with Indian health care

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providers; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in the Network to ensure timely access to services available under the contract for Indian Participants who are eligible to receive services from such providers.

2.7.1.23 The FIDA Plan shall ensure that its Participating Providers have a strong understanding of disability culture and Community-based and Facility-based LTSS.

2.7.1.24 If the FIDA Plan declines to include individuals or groups of providers in its Provider Network, the FIDA Plan must give the affected providers written notice of the reason for its decision.

2.7.1.25 The FIDA Plan must permit any Indian who is enrolled in a non-Indian demonstration and eligible to receive services from a participating Indian health care provider; IHS; and I/T/U provider, to choose to receive Covered Items and Services from that I/T/U provider, and if that I/T/U provider participates in the Provider Network as a PCP, to choose that I/T/U as his or her PCP, as long as that provider has capacity to provide the services.

2.7.1.26 The FIDA Plan shall include as Participating Providers any Provider of Mental Health Services operated by the New York State Office of Mental Health (OMH) and any Provider of Chemical Dependence Services operated by the New York State Office of Alcoholism and Substance Abuse Services (OASAS

2.7.1.27 The FIDA Plan shall include as Participating Providers any Community Provider of Behavioral Health Services determined essential by NYSDOH and licensed or certified by OMH or OASAS

2.7.2 Provider Qualifications and Performance

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2.7.2.1 Primary Care Qualifications: For purposes of establishing the Provider Network, and consistent with Section 2.8, a PCP must be one of the following:

2.7.2.1.1 A Primary Care Physician that is:

2.7.2.1.1.1 Licensed by the State of New York;

2.7.2.1.1.2 Specialized in Family Practice, Internal Medicine, General Practice, OB/GYN, or Geriatrics; and

2.7.2.1.1.3 In good standing with the Medicare and Medicaid programs.

2.7.2.1.2 A Physician extender who is:

2.7.2.1.2.1 A Nurse Practitioner licensed by the State of New York; or

2.7.2.1.2.2 A Physician Assistant who is licensed by State Education Department, Office of the Professions.

2.7.2.2 Prior to contracting with a new provider, the FIDA Plan verifies the following:

2.7.2.2.1 A valid license to practice medicine, when applicable;

2.7.2.2.2 A valid Drug Enforcement Act (DEA) certificate, when applicable, by specialty;

2.7.2.2.3 Other education or training, as applicable, by specialty;

2.7.2.2.4 Malpractice insurance coverage, when applicable;

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2.7.2.2.5 Work history;

2.7.2.2.6 History of medical license loss;

2.7.2.2.7 History of felony convictions;

2.7.2.2.8 History of limitations of privileges or disciplinary actions;

2.7.2.2.9 Medicare or Medicaid sanctions; and

2.7.2.2.10 Malpractice history.

2.7.2.3 Subcontracting Requirements

2.7.2.3.1 The FIDA Plan remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the FIDA Plan subcontracts for performance of any Contract responsibility. The FIDA Plan shall require each First Tier, Downstream or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the FIDA Plan of its legal responsibilities under the Contract.

2.7.2.3.2 The FIDA Plan is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities and shall subject them to formal review according to a periodic schedule established by the State, consistent with State laws and regulations. First Tier, Downstream and Related Entities are required to meet the same Federal and State financial and program reporting requirements as the FIDA Plan. The FIDA Plan is required to evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. §

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438.20. Additional information about subcontracting requirements is contained in Appendix C.

2.7.2.3.3 The FIDA Plan must establish contracts and other written agreements between the FIDA Plan and First Tier, Downstream and Related Entities for Covered Items and Services not delivered directly by the FIDA Plan or its employees;

2.7.2.3.4 The FIDA Plan must have written policies and procedures and a description of its policies and procedures for selection and retention of Participating Providers following the State's policy for credentialing and recredentialing as outlined in Section 2.7.1.

2.7.2.3.5 Contract only with qualified or licensed Providers who continually meet Federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.7.2.3.6 The FIDA Plan must provide Grievance and Appeal procedures and timeframes, pursuant to 42 C.F.R. § 438.10(g) as modified by the FIDA Demonstration integrated Appeals and Grievances processes outlined in the MOU and in this Contract, to all providers and First Tier, Downstream, and Related Entities at the time they enter into a contract.

2.7.3 Plan Risk Arrangements

2.7.3.1 The FIDA Plan shall provide a detailed description of its risk arrangements with providers under subcontract with the FIDA Plan. This description shall be made available to FIDA Plan Participants upon request. It will not be permissible for any incentive arrangements to

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include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical Items or Services to Participants.

2.7.3.2 Except as otherwise specified in Section 2.6.6.20, by July 1, 2015, the FIDA Plan will be required to develop a plan for a fully integrated payment system through which Participating Providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment).

2.7.3.3 After State approval and no earlier than January 2016, the FIDA Plan will be required to implement the approved plan, which will remain in effect throughout the duration of the Demonstration.

2.7.4 Non-Payment and Reporting of Provider Preventable Conditions

2.7.4.1 The FIDA Plan agrees to take such action as is necessary in order for NYSDOH to comply with and implement all Federal and State laws, regulations, policy guidance, and State policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, including 42 U.S.C. § 1396b-1 and regulations promulgated thereunder.

2.7.4.2 As a condition of payment, the FIDA Plan shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with Federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with Title 10, Sub-part 86-1.42 and the NYSDOH's policies, procedures, and guidance on Provider Preventable Conditions as outlined in the NY Register and on the www.health.ny.gov website. The FIDA Plan's policies and procedures shall also be consistent with the following:

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2.7.4.2.1 The FIDA Plan shall not pay a Participating or Non-Participating Provider for a Provider Preventable Condition.

2.7.4.2.2 The FIDA Plan shall require, as a condition of payment from the FIDA Plan, that all Participating Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the FIDA Plan and/or NYSDOH.

2.7.4.2.3 The FIDA Plan shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Participant existed prior to the provider's initiation of treatment for that Participant.

2.7.4.2.4 A FIDA Plan may limit reductions in provider payments to the extent that the following apply:

2.7.4.2.4.1 The identified Provider Preventable Condition would otherwise result in an increase in payment.

2.7.4.2.4.2 The FIDA Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.

2.7.4.2.5 The FIDA Plan shall ensure that its non-payment for Provider Preventable Conditions does not prevent Participant access to services.

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2.7.5 Participating Provider Education and Training

2.7.5.1 The FIDA Plan must ensure that all medical, behavioral, and Community-based and Facility-based LTSS Participating Providers receive training in physical accessibility, which is defined in accordance with U.S. Department of Justice ADA guidance for providers, in the following areas:

2.7.5.1.1 Their obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities.

2.7.5.1.2 Utilizing waiting room and exam room furniture that meet needs of all Participants, including those with physical and non-physical disabilities.

2.7.5.1.3 Accessibility along public transportation routes and/or provide enough parking;

2.7.5.1.4 Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities; and

2.7.5.1.5 Any other requirements included in the ADA Accessibility Attestation Form.

2.7.5.2 Cultural Competency. The FIDA Plan will provide the Cultural Competency requirements at orientation, training sessions, and updates as needed. This will also include ADA compliance, accessibility, and accommodations as required in Section 2.8.

2.7.5.3 Disability Training. The FIDA Plan requires disability training for its medical, behavioral, and Community-based and Facility-based LTSS Participating providers, including information about the following:

2.7.5.3.1 Various types of chronic conditions prevalent among Eligible Individuals;

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2.7.5.3.2 Awareness of personal prejudices;

2.7.5.3.3 Legal obligations to comply with the ADA requirements;

2.7.5.3.4 Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;

2.7.5.3.5 Types of barriers encountered by the Eligible Individuals;

2.7.5.3.6 Training on person-centered planning (i.e., PCSPs) and self-determination, the social model of disability, the independent living philosophy, and the recovery model;

2.7.5.3.7 Use of evidence-based practices and specific levels of quality outcomes; and

2.7.5.3.8 Working with Participants with mental health diagnoses, including crisis prevention and treatment.

2.7.5.4 The FIDA Plan makes resources available (such as language lines) to medical, behavioral, Community-based and Facility-based LTSS, and pharmacy Participating Providers who work with Participants who require culturally-, linguistically-, or disability-competent care.

2.7.5.5 State Minimum Training Requirements. The FIDA Plan requires Participating Providers to meet applicable State minimum training requirements, including minimum hours and topics of training.

2.7.5.6 The FIDA Plan provides training to providers that balance billing is prohibited under the Demonstration.

2.7.5.7 Training for IDT Members. The FIDA Plan will conduct training for IDT members on:

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2.7.5.7.1 IDT Policy and procedures;

2.7.5.7.2 The PCSP processes;

2.7.5.7.3 Cultural Competence;

2.7.5.7.4 Independent living and recovery;

2.7.5.7.5 Wellness principles; and

2.7.5.7.6 Accessibility and reasonable accommodations; and

2.7.5.7.7 Other required training, as specified by the State, which will include ADA / *Olmstead* requirements;

2.7.5.8 For training in Section 2.7.5.7, the FIDA Plan shall:

2.7.5.8.1 Require IDT members to agree to participate in approved training;

2.7.5.8.2 Document completion of the training by all IDT members, including both employed and contract personnel;

2.7.5.8.3 Address non-completion of the training.

2.7.5.9 Training for All Participating Providers and IDT Members. The FIDA Plan training for all Participating Providers and IDT members includes:

2.7.5.9.1 Coordinating with Behavioral Health Service and Community-based and Facility-based LTSS Participating Providers;

2.7.5.9.2 Providing information about accessing Behavioral Health Service and Community-based and Facility-based LTSS; and

2.7.5.9.3 Furnishing lists of community supports available.

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2.7.5.10 Training for PCPs. The training program for PCPCs includes:

2.7.5.10.1 How to identify behavioral health needs;

2.7.5.10.2 How to assist the Participant in obtaining Behavioral Health Services;

2.7.5.10.3 How to identify Community-based and Facility-based LTSS needs; and

2.7.5.10.4 How to assist the Participant in obtaining Community-based and Facility-based LTSS.

2.7.5.11 Participating Provider Manual. The FIDA Plan prepares an understandable, accessible Participating Provider Handbook (or handbooks for medical, behavioral, Community-based and Facility-based LTSS, and pharmacy Participating Providers). The Participating Provider Manual shall be updated at least annually and shall be a comprehensive online reference tool for the Participating Provider and staff regarding, but not limited to:

2.7.5.11.1 Updates and revisions;

2.7.5.11.2 Overview and model of care;

2.7.5.11.3 FIDA Plan contact information;

2.7.5.11.4 Participant information;

2.7.5.11.5 Covered Items and Services;

2.7.5.11.6 Quality improvement for health services programs;

2.7.5.11.7 Participant rights and responsibilities, including Participant rights not to be balanced billed;

2.7.5.11.8 Reasonable accommodations;

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2.7.5.11.9 Cultural and linguistic competency;

2.7.5.11.10 Provider billing and reporting.

2.7.5.11.11 Administrative, Prior Authorization, and IDT processes;

2.7.5.11.12 Claims and Encounter submission processes;

2.7.5.11.13 Clinical practice guidelines;

2.7.5.11.14 Availability and access standards, including but not limited to requirements in the ADA Accessibility Attestation Form; and

2.7.5.11.15 A provision explaining that the FIDA Plan may not limit a participating provider's communication with Participants as provided in Section 5.1.10.

2.7.5.12 Participating Provider and Pharmacy Directory. The FIDA Plan shall make its Participating Provider and Pharmacy Directory available to Participating Providers via the FIDA Plan's website or webportal and in paper copy.

2.7.5.13 Provider-based Health Education for Participants. The IDT provides health education to Participants. The FIDA Plan shall ensure that Care Managers and Participating Providers have the preventive care, disease-specific, and FIDA Plan services information necessary to provide health education to Participants.

2.7.5.14 Health, Safety and Welfare Education. As part of its Participating Provider education, the FIDA Plan shall include information related to identifying, preventing and reporting Abuse, Neglect, Financial Exploitation, critical incidents, and Mandated Reporting requirements as relates to Participants who receive services from Nursing Facilities.

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2.8 **Network Management**

2.8.1 General Requirements.

2.8.1.1 The FIDA Plan shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Participants, quality, consistent practice patterns, Cultural Competence, ADA compliance and accessibility, integration, and cost effectiveness. The management strategy shall address all Participating Providers. Such strategy shall include at a minimum:

2.8.1.1.1 Conducting on-site visits to Participating Providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

2.8.1.1.2 Ensuring that its Provider Network is adequate to assure access to all Covered Items and Services, and that all Participating Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Items and Services.

2.8.1.2 Participating Provider Enrollment. The FIDA Plan shall assure that all Participating Providers that provide Medicare Covered Items and Services are enrolled as Medicare Providers in order to submit claims for reimbursement or otherwise participate in the Medicare program. All Participating Providers that provide services traditionally covered under Medicaid must meet the requirements of participating in the State Medicaid Program. The FIDA Plan shall make a good faith effort to give written notice of termination of a Participating Provider as soon as practicable, but in no event later than fifteen (15) calendar days following such termination, to each Participant who received his or her primary care from, or was seen on a regular basis by, the terminated Participating Provider. The FIDA

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Plan shall also assist Participants in transitioning to a new Participating Provider, when a Participating Provider's contract is terminated.

2.8.1.3 The FIDA Plan shall not limit or prohibit Provider-Based Marketing Activities or Provider Affiliation Information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The FIDA Plan shall not prohibit a provider from informing Participants of the Provider's affiliation or change in affiliation.

2.8.1.4 Non-Participating Providers. It is understood that in some instances Participants will require specialty care not available from a Participating Provider and that the FIDA Plan will arrange that such services be provided by a Non-Participating Provider. In such event, the FIDA Plan will promptly negotiate an agreement ("Single Case Agreement") with a Non-Participating Provider the applicable Medicaid or Medicare Fee-For-Service rate to treat the Participant until a qualified Participating Provider is available. The FIDA Plan shall make best efforts to have any Non-Participating Provider billing for services be enrolled in the Medicare program or New York State Medicaid program, as appropriate and in the same manner as Participating Providers under Section 2.8.1.2, prior to paying a claim.

2.8.1.5 Access to Participating Provider Locations. Participating Provider locations shall be confirmed by the FIDA Plan through site visits to be accessible for Participants with disabilities. The FIDA Plan shall collect sufficient information from Participating Providers to assess compliance with the ADA. Access shall be confirmed through Provider attestation to the ADA Accessibility Attestation Form and a random sampling of on-site compliance review throughout the Demonstration. As necessary to serve Participants, Participating Provider locations where Participants receive services shall be ADA compliant. All Participating Providers must meet ADA requirements and have a signed ADA Accessibility Attestation Form

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on file with the FIDA Plan per Section 2.7.1.8.2.2. The FIDA Plan shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and Providers regarding the Participant's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the FIDA Plan's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which any Participating Pharmacy within the FIDA Pharmacy Network is open, (e.g., a FIDA Plan whose Pharmacy Network includes twenty-four (24) hour pharmacies must operate its pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.8.1.5.1 Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.8.1.5.2 Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.8.1.5.3 Disconnect rate of all incoming calls not to exceed five (5) percent.

2.8.2 Quality Standards. Participation of Nursing Facilities in the Demonstration will be subject to quality standards in Demonstration Years 2 and 3. These will be communicated through policy guidance.

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2.8.3 Safety Net Providers. The FIDA Plan will prioritize recruiting safety net providers, such as Federally Qualified Health Centers (FQHCs), as Participating Providers. The FIDA Plan shall not refuse to contract with an FQHC that is willing to accept the FIDA Plan's standard rates and contractual requirements and meets the FIDA Plan's quality standards.

2.8.4 PCP Selection and Assignment.

2.8.4.1 Choice of Primary Care Provider. The FIDA Plan shall offer each Participant the choice of no fewer than three (3) PCPs within distance/travel time standards as set forth in Section 2.7.1.6.5.1 of this Contract. The FIDA Plan must assign a PCP to Participants who fail to select a PCP.

2.8.4.1.1 A PCP may only be assigned after written notification of the Participant by the FIDA Plan and only after the FIDA Plan has made reasonable efforts to contact the Participant and inform him/her of his/her right to choose a PCP; or in the case of a Participant restricted for primary care services, in accordance with 18 NYCRR 360-6.4 and 42 CFR 431.54(e).

2.8.4.1.2 The existing PCP should be retained to the extent that the PCP is a Participating Provider. To the extent that the existing PCP is not a Participating Provider or that the Participant does not make an alternative selection, PCP assignments should be made taking into consideration the following: i) Participant's geographic location; ii) any special health care needs, if known by the FIDA Plan; and iii) any special language needs, if known by the FIDA Plan.

2.8.4.1.3 In circumstances where the FIDA Plan operates or contracts with a multi-provider clinic to deliver primary care services, the

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Participant must choose or be assigned a specific Participating Provider or Participating Provider team within the clinic to serve as his/her PCP. This "lead" Participating Provider will be held accountable for performing the PCP duties.

2.8.4.2 Participant Changes to PCP

2.8.4.2.1 The FIDA Plan must allow Participants the freedom to change PCPs, without cause, at any time, and in accordance with 18 NYCRR 360-6.4 and 42 C.F.R. § 431.54(e) (rules around recipient restriction), where applicable.

2.8.4.2.2 The FIDA Plan must process a request to change PCPs and advise the Participant of the effective date of the change, which shall be within five (5) Business Days of the request.

2.8.4.2.3 The FIDA Plan will provide Participants with an opportunity to select a new PCP in the event that the Participant's current PCP leaves the Provider Network or otherwise becomes unavailable.

2.8.4.2.4 In the event that an assignment of a new PCP is necessary due to the unavailability of the Participant's former PCP, such assignment shall be made in accordance with the requirements of Section 2.8.4 of this Contract.

2.8.4.2.5 In addition to those conditions and circumstances under which the FIDA Plan may assign a Participant a PCP when the Participant fails to make an affirmative choice of a PCP, the FIDA Plan may initiate

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a PCP change for a Participant under the following circumstances:

2.8.4.2.5.1 The Participant requires specialized care for an acute or chronic condition and the Participant and FIDA Plan agree that reassignment to a different PCP is in the Participant's interest;

2.8.4.2.5.2 The Participant's place of residence has changed such that he/she has moved beyond the PCP travel time/distance standard;

2.8.4.2.5.3 The Participant's PCP ceases to participate in the FIDA Plan's Provider Network;

2.8.4.2.5.4 The Participant's behavior toward the PCP is disruptive and the PCP has made all reasonable efforts to accommodate the Participant; or

2.8.4.2.5.5 The Participant has taken legal action against the PCP or the PCP has taken legal action against the Participant.

2.8.4.2.5.5.1 The Participant is newly restricted for primary care services or a condition for changing the Recipient Restriction Program Provider is met, as specified in 18 NYCRR

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360-6.4 and 42 C.F.R. § 431.54(e).

2.8.4.3 Whenever initiating a change, the FIDA Plan must offer affected Participants, except for Participants restricted in accordance with 2.8.4.2.5.5.1, the opportunity to select a new PCP in the manner described in this Section.Specialists As PCPs. The FIDA Plan must adopt and implement procedures by which a Participant with a life-threatening, degenerative, or disabling disease or condition can have a specialist serve as his/her PCP, if the specialist agrees to the requirements imposed on PCPs (IDT participation and otherwise). The designation of a specialist as PCP must be addressed in the Participant's PCSP.

2.8.4.4 Homebound. Due to the integration of benefits under the Demonstration, there is no homebound requirement for the provision of Home Health services.

2.8.5 FQHCs Reimbursements

2.8.5.1 The FIDA Plan shall ensure that its payments to FQHCs for services to Participants are no less than the sum of:

2.8.5.1.1 The level and amount of payment that the FIDA Plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and

2.8.5.1.2 The applicable Medicaid copayment amount for FQHC services, to the extent that they are required in New York's Medicaid State Plan, that would be paid in FFS.

2.8.6 Primary Care Payment Rates

2.8.6.1 As directed by NYSDOH, the FIDA Plan shall set payment rates for primary care services provided by eligible providers in accordance with Section 1202 of the ACA and 42 U.S.C. § 1396a(13)(C), and all applicable

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Federal and State laws, regulations, rules, and policies related to the implementation of such requirement. Notwithstanding the generality of the foregoing, the FIDA Plan shall, in accordance with 42 C.F.R. § 438.6(c)(5)(vi), for payments for primary care services in calendar year 2014 furnished to Participants under 42 C.F.R. § 447(g):

2.8.6.1.1 Make payments to those specified Physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 C.F.R. § 447(g); and

2.8.6.1.2 Provide documentation to NYSDOH, sufficient to enable NYSDOH to ensure that provider payments are made as required by this Section 4.1.

2.9 **Participant Access to Services**

2.9.1 General. The FIDA Plan must provide services to Participants as follows:

2.9.1.1 The IDT must authorize, arrange, coordinate and provide to Participants all Medically Necessary Covered Items and Services as specified in the IDT Policy and Appendix A, in accordance with the requirements of the Contract;

2.9.1.2 The FIDA Plan shall offer adequate choice and availability of primary, specialty, acute care, Behavioral Health Service, and Community-based and Facility-based LTSS Participating providers that meet CMS and NYSDOH standards as provided in Section 2.7;

2.9.1.3 The FIDA Plan shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.

2.9.1.4 Offer adequate choice and availability of Participating Providers as follows:

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2.9.1.4.1 PCP to Participant Ratio. The FIDA Plan shall comply with § 1932(b)(97) of the Social Security Act.

2.9.1.4.1.1 The FIDA Plan agrees to adhere to the member-to-PCP ratios shown below. These ratios are FIDA Plan-specific, and assume the provider is a full time equivalent (FTE) (defined as a provider practicing forty (40) hours per week for the FIDA Plan):

2.9.1.4.1.2 No more than 1,500 Participants for each Physician, or 2,400 for a Physician practicing in combination with a registered physician assistant or a certified nurse practitioner.

2.9.1.4.1.3 No more than 1,000 Participants for each certified nurse practitioner.

2.9.1.4.1.4 The FIDA Plan agrees that these ratios will be prorated for Participating Providers who represent less than one FTE to the FIDA Plan.

2.9.1.4.1.5 The FIDA Plan agrees that ratios will be no more than at least one (1) primary care dentist for each 2,000 Participants.

2.9.1.4.1.6 The FIDA Plan agrees that these ratios will be prorated for Participating Providers

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who represent less than one FTE to the FIDA Plan.

2.9.1.5 Reasonably accommodate Participants and ensure that the Covered Items and Services are as accessible (including physical and geographic access) to a Participant with disabilities as they are to a Participant without disabilities. The FIDA Plan and its Participating Providers must comply with the ADA (28 C.F.R. § 35.130) and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Participants. The FIDA Plan shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Participants with disabilities from obtaining all Covered Items and Services from the FIDA Plan by:

2.9.1.5.1 Providing flexibility in scheduling to accommodate the needs of the Participants;

2.9.1.5.2 Providing interpreters or translators for Participants who are Deaf or hard of hearing, visually impaired, and those who do not speak English;

2.9.1.5.3 Ensuring that Participants with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Participant and include but are not limited to:

2.9.1.5.3.1 Providing large print (at least 16-point font) versions of all Marketing, Outreach, and Participant Communications to

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Participants with visual impairments;

2.9.1.5.3.2 Ensuring that all Marketing, Outreach, and Participant Communications are available in formats compatible with optical recognition software;

2.9.1.5.3.3 Reading notices and other Marketing, Outreach, and Participant Communications to Participants upon request;

2.9.1.5.3.4 Assisting Participants in filling out forms over the telephone;

2.9.1.5.3.5 Ensuring effective communication to and from Participants with disabilities through email, telephone, and other electronic means;

2.9.1.5.3.6 TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf; and

2.9.1.5.3.7 Individualized assistance.

2.9.1.5.4 Ensuring safe and appropriate physical access to buildings, services and equipment;

2.9.1.5.5 Demonstrating compliance with the ADA by surveying Participating Providers or conducting site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance

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and monitoring correction of deficiencies; and

2.9.1.5.6 Identifying to CMS and NYSDOH the individual, and the job title, in its organization who is responsible for ADA compliance related to this Demonstration. The FIDA Plan must also establish and execute a work plan to achieve and maintain ADA compliance.

2.9.1.6 When a PCP or any medical, Behavioral Health Service, Community-based or Facility-based LTSS Participating Provider is terminated from the FIDA Plan or leaves the Provider Network for any reason, the FIDA Plan must make a good faith effort to give written notification of termination of such Participating Provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Participant who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral, Community-based or Facility-based LTSS Participating Provider. For terminations of PCPs, the FIDA Plan must also report the termination to NYSDOH and provide assistance to the Participant in selecting a new PCP within five (5) Business Days. For Participants who are receiving treatment for a chronic or ongoing medical condition or Community-based or Facility-based LTSS, the FIDA Plan shall ensure that there is no disruption in services provided to the Participant.

2.9.2 Availability of Services

2.9.2.1 After Hours. PCP, Behavioral Health Service, and specialty provider contracts shall provide on-call coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

2.9.3 Services Not Subject to Prior Authorization

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2.9.3.1 The FIDA Plan will assure coverage of Emergency Medical Conditions and Urgent Care services. The FIDA Plan must not require Prior Authorization for the following services:

2.9.3.1.1 Any services for Emergency Conditions as defined in 42 C.F.R §§ 422.113(b)(1) and 438.114(a), which includes emergency behavioral health care;

2.9.3.1.2 Urgent Care sought outside of the Service Area;

2.9.3.1.3 Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted provider is unavailable or inaccessible;

2.9.3.1.4 Out-Of-Network Dialysis when the Participant is out of the Service Area;

2.9.3.1.5 PCP visits;

2.9.3.1.6 For any Participant that is an Indian eligible to receive services from a participating Indian health care provider; IHS; and I/T/U provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services;

2.9.3.1.7 Public health agency facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB/DOT);

2.9.3.1.8 Immunizations;

2.9.3.1.9 Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of

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the State University of New York to obtain covered optometry services;

2.9.3.1.10 Dental Services through Article 28 Clinics Operated by Academic Dental Centers;

2.9.3.1.11 Cardiac Rehabilitation, first course of treatment (a Physician or RN authorization is required for subsequent courses of treatment);

2.9.3.1.12 Supplemental Education, Wellness, and Health Management Services; and

2.9.3.1.13 Family planning and Women's Health specialists services, including sufficient information and access on the process and available providers for accessing Family Planning Services among Participating and Non-Participating Providers.

2.9.4 Authorization of Services. For services requiring authorization, the Participant's IDT shall authorize services as follows:

2.9.4.1 All services specified in Section VII.C.1. of the IDT Policy shall be authorized in the Participant's PCSP and shall be authorized by the complete IDT in writing prior to service delivery, as specified in the IDT Policy.

2.9.4.2 All other Covered Items and Services outlined in Appendix A of this Contract, except for the services that may be directly accessed by the Participant and listed in Section 2.9.3, shall be authorized by the IDT in accordance with Section VII.C.2 of the IDT Policy. Except that:

2.9.4.2.1 Preventive Dental X-rays and Comprehensive Dental shall be authorized by a dentist;

2.9.4.2.2 Eye wear shall be authorized by an ophthalmologist or optometrist; and

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2.9.4.2.3 Hearing Aids shall be authorized by an audiologist.

2.9.4.3 For the processing of requests for initial and continuing authorizations of Covered Items and Services, the FIDA Plan shall, in accordance with the IDT Policy:

2.9.4.3.1 Have in place for its IDTs and ensure that they follow written policies and procedures for initial and continuing authorization of services;

2.9.4.3.2 Have in place procedures to allow Participants to initiate requests for provisions of Covered Items and Services;

2.9.4.3.3 Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.9.4.3.4 Consult with the requesting provider if the requesting provider is not a member of the IDT.

2.9.4.4 Any decision 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 health care professional who has appropriate clinical expertise in treating the Participant's medical condition, performing the procedure, or providing the treatment, in accordance with the procedures outlined in the IDT Policy and 42 C.F.R. § 438.210. Behavioral Health Services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health Services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.9.4.5 The FIDA Plan shall ensure that all behavioral health authorization activities are in compliance with 42 U.S.C.

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§ 1396u-2(b)(8). The FIDA Plan must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.9.4.6 The FIDA Plan must notify the requesting provider, either orally or in writing, and give the Participant written notice of any decision by the FIDA Plan to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 2.13.1.1.1, and must:

2.9.4.6.1 Be produced in a manner, format, and language that can be easily understood;

2.9.4.6.2 Be made available in Prevalent Languages, upon request; and

2.9.4.6.3 Include information, in the most commonly used languages about how to request translation services and Alternative Formats. Alternative Formats shall include materials which can be understood by persons with limited English proficiency.

2.9.4.7 The IDT must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.210(d) and Article 49 of NYS PHL:

2.9.4.7.1 For a service that must be pre-authorized, the IDT must decide and provide notice of a determination to the Participant or Participant's designee and the Participant's health care provider by telephone and in writing within three (3) Business Days of receipt of the necessary information.

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2.9.4.7.2 For a determination involving 1) continued or extended health care services, 2) additional services for a Participant undergoing a course of continued treatment prescribed by a health care provider, or 3) home health care services following an inpatient hospital admission, the FIDA Plan shall provide notice of such determination to the Participant or the Participant's designee (which may be satisfied by notice to the Participant's health care provider) by telephone and in writing within one (1) Business Day of receipt of the necessary information. The one-Business Day timeframe must be followed except, with respect to home health care services following an inpatient hospital admission, the notice must be within seventy-two (72) hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday.

2.9.4.7.3 For a determination involving health care services which have been already delivered, within fourteen (14) calendar days of receipt of the necessary information.

2.9.4.7.4 Failure by the IDT to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to PHL 4904.

2.9.4.7.5 For standard authorization decisions, provide notice as expeditiously as the Participant's health condition requires and no later than three (3) calendar days after receipt of the request for service, with a possible extension not to exceed three (3) additional calendar days. Such extension shall only be allowed if:

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2.9.4.7.5.1 The Participant or the provider requests an extension, or

2.9.4.7.5.2 The FIDA Plan can justify (to the satisfaction of NYSDOH and CMS upon request) that:

2.9.4.7.5.2.1 The extension is in the Participant's interest; and

2.9.4.7.5.2.2 There is a need for additional information where:

2.9.4.7.5.2.2.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.9.4.7.5.2.2.2 Such outstanding information is reasonably expected to be received within three (3) calendar days.

2.9.4.7.6 FIDA Plan will ensure that when Participants are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization, IDTs shall provide any prior authorizations within forty-eight (48) hours of readiness for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery.

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2.9.4.7.7 For expedited service authorization decisions, where the provider indicates or the FIDA Plan determines that following the standard timeframe in Section 2.9.4.7.5 could seriously jeopardize the Participant's life or health or ability to attain, maintain, or regain maximum function, the FIDA Plan must make a decision and provide notice as expeditiously as the Participant's health condition requires and no later than twenty-four (24) hours after receipt of the request for service, with a possible extension not to exceed three (3) additional calendar days. Such extension shall only be allowed if:

2.9.4.7.7.1 The Participant or the provider requests an extension; or

2.9.4.7.7.2 The FIDA Plan can justify (to NYSDOH and CMS upon request) that:

2.9.4.7.7.3 The extension is in the Participant's interest; and

2.9.4.7.7.4 There is a need for additional information where:

2.9.4.7.7.4.1.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.9.4.7.7.4.1.2 Such outstanding information is reasonably expected to be

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received within three (3) calendar days.

2.9.4.7.8 In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to members of the IDT must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Items or Services to any Participant.

2.9.5 Quality Assurance, Utilization Review and Peer Review.

2.9.5.1 The FIDA Plan must have in effect a program consistent with the utilization control requirements of 42 C.F.R. § 456. This program will include, when so required by the regulations, written plans of care (i.e., PCSPs), and certifications of need of care.

2.9.5.2 The FIDA Plan shall ensure Participating labs are capable of reporting lab values to the FIDA Plan directly. The FIDA Plan shall use the electronic lab values to calculate HEDIS® performance measures.

2.9.5.3 FIDA Plan shall adopt practice guidelines that meet, at a minimum, the following criteria:

2.9.5.3.1 The clinical guidelines shall rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and other relevant factors;

2.9.5.3.2 Consider the needs of the Participants are adopted in consultation with Participating Providers.

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2.9.5.3.3 Are reviewed and updated periodically, as appropriate; and

2.9.5.3.4 Are available to all affected Participating Providers, non-Participating Providers, Participants, and Eligible Individuals.

2.9.5.4 The FIDA Plan requires Participating Providers to use evidence-based practices. In doing so, the FIDA Plan shall:

2.9.5.4.1 Develop and employ mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery.

2.9.5.4.2 Demonstrate how it will ensure that its Participating Providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options.

2.9.5.4.3 Identify how it will employ systems to identify and track Participants in ways that provide patient-specific and population based support, reminders, data and analysis, and Participating Provider feedback.

2.9.5.4.4 Demonstrate how it will educate its Participating Providers and clinical staff about evidence-based best practices and how it will support its Participating Providers and clinical staff (through training or consultations) in following evidence-based practices.

2.9.5.4.5 Require its Participating Providers and their practices to provide services in accordance with established evidence-based clinical

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practice guidelines appropriate for the Participants they serve.

2.9.5.4.6 Demonstrate how it will monitor and oversee that its Participating Providers are providing services in accordance with evidence-based practices specific to their practice areas.

2.9.5.5 The FIDA Plan shall establish and maintain a Peer Review Program approved by NYSDOH and CMS to review the quality of care being offered by the FIDA Plan and its employees, First Tier, Downstream, and Related Entities, and Participating Providers.

2.9.5.6 The FIDA Plan shall comply with the quality assurance standards outlined in Section 2.14.

2.9.5.7 The FIDA Plan shall comply with the utilization review standards and peer review standards outlined in the IDT Policy.

2.9.5.8 The FIDA Plan shall conduct a program of ongoing review that evaluates the effectiveness of its quality assurance and performance improvement strategies designed in accordance with the terms of Section 2.14.

2.9.5.9 The FIDA Plan shall not compensate individuals that conduct utilization review activities on the IDT in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue Covered Items and Services that are Medically Necessary for any Participant.

2.9.5.10 The FIDA Plan shall ensure that decisions governed by its practice guidelines, including Utilization Management, Participant education, coverage determinations and other areas to which the guidelines apply, are made consistently with those practice guidelines.

2.9.6 Critical Incidents Required Reporting

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2.9.6.1 The FIDA Plan shall train all of the FIDA Plan's employees, Participating Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with the Participant or Participant's PCSP to recognize potential concerns related to Abuse, Neglect, and Financial Exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect, or Financial Exploitation. The FIDA Plan's employees who, in good faith, report suspicious or alleged Abuse, Neglect, or Financial Exploitation to the appropriate authorities shall not be subjected to any Adverse Action from the FIDA Plan, its Participating Providers, Affiliates or First Tier, Downstream, or Related Entities.

2.9.6.2 The FIDA Plan shall provide NYSDOH and CMS, upon request, with its protocols for reporting suspected Abuse, Neglect, and Financial Exploitation and other critical incidents that are reportable.

2.9.6.3 The FIDA Plan shall provide NYSDOH and CMS, upon request, with its protocols for assuring the health and safety of the Participant after an allegation of Abuse, Neglect, or Financial Exploitation, or a critical incident, is reported.

2.9.6.4 Critical Incident Reporting

2.9.6.4.1 The FIDA Plan staff is adequately trained to handle critical incident and Abuse reporting. Training includes, among other things, ways to detect and report instances of Abuse, Neglect, and Financial Exploitation of Participants by Providers and/or natural supports providers (i.e., Participating Providers and Non-Participating Providers).

2.9.6.4.2 The FIDA Plan staff is adequately trained to educate Participants to identify signs of Abuse, Neglect, and Financial Exploitation.

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2.9.6.4.3 The FIDA Plan shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within the FIDA Plan and, when required or otherwise appropriate, to the investigating authority.

2.9.6.4.4 The FIDA Plan shall maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed.

2.9.6.4.5 The FIDA Plan shall have systems in place to report, monitor, track, and resolve critical incidents and reports of Abuse, Neglect, or Financial Exploitation for Participants receiving Community-based or Facility-based LTSS and concerning restraints and restrictive interventions.

2.9.6.4.5.1 The FIDA Plan shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The FIDA Plan shall require that events involving the use of restraint or seclusion are reported to the FIDA Plan as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or Financial Exploitation.

2.9.6.4.5.2 The FIDA Plan shall make reasonable efforts to detect unauthorized use of restrictive interventions. The FIDA Plan

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shall require that events involving the use of restrictive interventions are reported to the FIDA Plan as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect, or Financial Exploitation.

2.9.7 Emergency, Out-of-Service Area Elective Care, and Post-Stabilization Care Coverage

2.9.7.1 Emergency Services.

2.9.7.1.1 The FIDA Plan's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Participants, whether they reside in institutions or in the community. The FIDA Plan must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. §§ 438.114(c) and 438.114(e).

2.9.7.1.2 The FIDA Plan shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the FIDA Plan. The FIDA Plan shall pay a Non-Participating Provider of Emergency and Post-Stabilization Care an amount equal to or, if the FIDA Plan can negotiate a lower payment, less than the amount allowed under Medicare Fee-for-Service rates, less any payments for indirect costs of medical education and direct costs of graduate medical education. The FIDA Plan shall ensure that the Participant is not billed for the difference, if any, between such rate and the non-Participating Provider's charges.

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2.9.7.1.3 The FIDA Plan shall not deny payment for treatment for an Emergency Condition, including cases in which the absence of immediate medical attention would not have resulted in placing the individual in serious jeopardy, pursuant to 42 C.F.R. § 438.114.

2.9.7.1.4 The FIDA Plan shall not deny payment for Emergency Services if a representative of the FIDA Plan instructed the Participant to seek Emergency Services.

2.9.7.1.5 The FIDA Plan shall not limit what constitutes an Emergency Condition on the basis of lists of diagnoses or symptoms.

2.9.7.1.6 The FIDA Plan shall require providers to notify the Participant's PCP of an Participant's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.9.7.1.7 An Participant who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the patient.

2.9.7.1.8 The attending emergency Physician, or the provider actually treating the Participant, is responsible for determining when the Participant is sufficiently Stabilized for transfer or discharge, and that determination is binding on the FIDA Plan if:

2.9.7.1.8.1 Such transfer or discharge order is consistent with generally accepted principles

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of professional medical practice; and

2.9.7.1.8.2 Is a Covered Item or Service under the Contract.

2.9.7.1.9 The FIDA Plan, through the IDTs, shall provide ongoing education to Participants regarding the appropriate use of Emergency Services. The FIDA Plan shall use a range of management techniques, policies and Participant or provider initiatives to avoid unnecessary utilization of Emergency Services and to promote Care Management through a Participant's IDT.

2.9.7.1.10 The FIDA Plan shall not impose any requirements for prior authorization of Emergency Services.

2.9.7.2 Post-Stabilization Services.

2.9.7.2.1 The FIDA Plan shall cover and pay for Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c). FIDA Plan shall cover Post-Stabilization Services provided by a Participating or Non-Participating Provider in any of the following situations: (i) the FIDA Plan authorized such services; (ii) such services were administered to maintain the Participant's Stabilized condition within one (1) hour after a request to the FIDA Plan for authorization of further Post-Stabilization Services; or (iii) the FIDA Plan does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, the FIDA Plan could not be contacted, or the FIDA Plan and the treating provider cannot reach an agreement concerning the Participant's care and a

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Participating Provider is unavailable for a consultation, in which case the treating provider must be permitted to continue the care of the Participant until a Participating Provider is reached and either concurs with the treating provider's plan of care or assumes responsibility for the Participant's care.

2.9.8 Emergency Medical Treatment and Labor Act (EMTALA)

2.9.8.1 The FIDA Plan and providers shall comply with EMTALA, which, in part, requires:

2.9.8.1.1 Qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and,

2.9.8.1.2 As applicable, to provide individuals Stabilizing treatment or, if the hospital lacks the capability or capacity to provide Stabilizing treatment, appropriate transfers.

2.9.8.1.3 The FIDA Plan's contracts with its providers must clearly state the provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.9.9 FIDA Participant Ombudsman

2.9.10 The FIDA Plan must cooperate with the FIDA Participant Ombudsman. This requires:

2.9.10.1 The FIDA Plan shall respond to FIDA Participant Ombudsman calls, emails, letters, or faxes within one (1) Business Day of the contact.

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2.9.10.2 The FIDA Plan shall designate a single staff person to service as liaison between the FIDA Plan and the FIDA Participant Ombudsman.

2.9.10.3 The FIDA Plan shall provide the FIDA Participant Ombudsman with general FIDA Plan-specific information about coverage, policies, and procedures and also Participant-specific information about the Participant's coverage, PCSP, IDT, and more.

2.9.10.4 The FIDA Plan shall comply with the State-established rules for Participants to authorize the FIDA Participant Ombudsman to act on their behalf.

2.9.10.5 The FIDA Plan shall document all interactions with the FIDA Participant Ombudsman, including, but not limited to, the reason for the contact, the options discussed, the resolution reached, the timing of contact and resolution, and any follow-up steps required as a result of the interaction.

2.9.10.6 The FIDA Plan is required to notify Participants of the availability of the Participant Ombudsman in Enrollment materials, annual notice of Grievance and Appeal procedures, all written notices of denial, reduction or termination of a service, and during calls with Participant Services Representatives regarding a potential Grievance or Appeal and during calls with the Coverage Determinations, Grievances, and Appeals Call Center, if applicable.

2.10 Participant Participation on Governing and Advisory Boards

2.10.1 The FIDA Plan will obtain Participant and community input on issues of program management and Participant care through a range of approaches.

2.10.2 The FIDA Plan will be required to have at least one Participant Advisory Committee (PAC) open to all Participants and family representatives as well as to the Demonstration's Participant Ombudsman.

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2.10.2.1 The PAC must be composed primarily of Participants, with at least sixty percent (60%) of those serving on the PAC being FIDA Plan Participants;

2.10.2.2 The FIDA Plan must have a plan for the PAC to meet at least quarterly and conduct these meetings in-person.

2.10.2.3 The FIDA Plan must establish a process for the PAC to provide input to the FIDA Plan.

2.10.2.4 The FIDA Plan must facilitate and provide all transportation and supportive services, including reasonable accommodations, necessary to ensure in-person access to PAC meetings.

2.10.2.5 The FIDA Plan must share any updates or proposed changes as well as information about the number and nature of Grievances and Appeals, information about quality assurance and improvement, information about Enrollments and Disenrollments, and more.

2.10.2.6 The PAC members must be invited to voice questions and concerns about topics including but not limited to quality of life and service delivery and would be encouraged to provide input and feedback into topics raised by the FIDA Plan.

2.10.2.7 The FIDA Plan must demonstrate that the PAC composition reflects the diversity of the FIDA Participant population, and participation of individuals with disabilities, including Participants, within the governance structure of the FIDA Plan.

2.10.2.8 The PAC meetings must be open to all Participants and their family representatives.

2.10.2.9 The PAC meetings must be open to the Participant Ombudsman, and the FIDA Plan must invite the Participant Ombudsman.

2.10.3 FIDA Plan must conduct at least two Participant Feedback Sessions in its Service Areas each year. It is sufficient for a

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FIDA Plan to hold at least two (2) Participant Feedback Sessions for the five NYC counties (i.e., at least two sessions can cover all five (5) NYC counties rather than at least two (2) sessions in each of the five (5) NYC counties). For FIDA Plans servicing Nassau, Suffolk, and Westchester Counties, FIDA Plans must hold at least two (2) Participant Feedback Sessions each year in each of these counties.

2.10.3.1 Participants must be invited to raise problems and concerns and to provide positive feedback.

2.10.3.2 The FIDA Plan must allow for Participants to participate in-person and remotely, and Participants can choose whether they want to participate in-person or remotely.

2.10.3.3 The FIDA Plan must assist Participants with the costs, transportation, reasonable accommodations, and other challenges of attending these in-person Participant Feedback Sessions.

2.10.3.4 The FIDA Plan must summarize each session and make the summary available to Participants and the public.

2.10.3.5 The FIDA Plan shall also review and discuss Participant Ombudsman reports in quarterly updates to the Participant Advisory Committee and shall participate in all statewide stakeholder and oversight convenings as requested by NYSDOH and/or CMS

2.11 Participant Services

2.11.1 Participant Service Representatives (PSRs). The FIDA Plan must employ PSRs trained to answer inquiries and concerns from Participants and Eligible Individuals, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements for PSRs:

2.11.1.1 Be trained to answer Participant inquiries and concerns from Participants and Eligible Individuals;

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2.11.1.2 Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;

2.11.1.3 Be capable of speaking directly with, or arranging for an interpreter to speak with, Participants in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;

2.11.1.4 Inform callers that interpreter services are free;

2.11.1.5 Be knowledgeable about the New York State Medicaid program, Medicare, and the terms of the Contract, including the Covered Items and Services listed in Appendix A;

2.11.1.6 Be available to Participants to discuss and provide assistance with resolving Participant Grievances;

2.11.1.7 Have access to the FIDA Plan's Participant database, the FIDA Plan's Participant Handbook, and an electronic Provider and Pharmacy Directory;

2.11.1.8 Make oral interpretation services available free-of-charge to Participants in all non-English languages spoken by Participants, including American Sign Language (ASL);

2.11.1.9 Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters, and other services for Deaf and hard of hearing Participants;

2.11.1.10 Demonstrate sensitivity to culture, including disability culture and the independent living philosophy;

2.11.1.11 Provide assistance to Participants with cognitive impairments; for example, provide Marketing, Outreach, and Participant Communications in simple,

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clear language at a 4th to 6th grade reading and below, and individualized guidance from PSRs to ensure materials are understood;

2.11.1.12 Provide reasonable accommodations needed to assure effective communication and provide Participants with a means to identify their disability to the FIDA Plan;

2.11.1.13 Maintain employment standards and requirements (e.g., education, training, and experience) for Participant services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.11.1.14 Ensure that PSRs make available to Participants and Eligible Individuals, upon request, information concerning the following:

2.11.1.14.1 The identity, locations, qualifications, and availability of Participating Providers;

2.11.1.14.2 Participants' rights and responsibilities;

2.11.1.14.3 The procedures available to a Participant and Provider(s) to challenge or Appeal the failure of the FIDA Plan to provide a Covered Item or Service and to Appeal any Adverse Actions (denials);

2.11.1.14.4 How to access oral interpretation services and Marketing, Outreach, and Participant Communications in Prevalent Languages and Alternative Formats, which are cognitively accessible;

2.11.1.14.5 Information on all Covered Items and Services and other available services or resources (e.g., State agency services) either directly or through Referral or authorization;

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2.11.1.14.6 Information on the availability of reasonable accommodations and how they can be arranged and delivered;

2.11.1.14.7 The procedures for a Participant to change FIDA Plans or to Opt Out of the FIDA Demonstration and information on how Participants can access the Enrollment Broker to effectuate such a change;

2.11.1.14.8 Information on the IDT process;

2.11.1.14.9 Information on the availability of the Participant Ombudsman;

2.11.1.14.10 Information on the role of the Enrollment Broker; and

2.11.1.14.11 Additional information that may be required by Participants and Eligible Individuals to understand the requirements and benefits of the FIDA Plan.

2.11.2 Participant Service Telephone Responsiveness

2.11.2.1 The FIDA Plan must operate a call center during normal business hours and never less than from 8:00 a.m. to 8:00 p.m. (Eastern Time), seven (7) days a week, consistent with the required Marketing Guidelines. Live PSRs must be available Monday through Friday, at least from 8:00 a.m. to 8:00 p.m. (Eastern Time). The FIDA Plan may use alternative call center technologies, which include interactive voice response system or similar technologies, to meet the customer service call center requirements for Saturdays, Sundays, and holidays.

2.11.2.2 The FIDA Plan's PSRs must answer eighty percent (80%) of all Participant telephone calls within thirty (30) seconds or less. The FIDA Plan must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone

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response system, or recorded greeting and before reaching a live person. The FIDA Plan must limit the disconnect rate of all incoming calls to five percent (5%). The FIDA Plan must have a process to measure the time from which the telephone is answered to the point at which a Participant reaches a PSR capable of responding to the Participant's question in a manner that is sensitive to the Participant's language and cultural needs.

2.11.3 Coverage Determinations, Grievances, and Appeals Call Center Requirements

2.11.3.1 The FIDA Plan must operate a toll-free call center with live customer service representatives available to respond to providers' or Participants' requests for information related to Covered Items or Services and coverage rules (including information about requests for Medicare exceptions and prior authorizations). Through this toll-free call center, the FIDA Plan shall provide immediate access to information on how the coverage determinations, Grievances, and Appeals processes work and help providers and Participants navigate these processes. This toll-free call center will not provide actual coverage determinations or decisions on grievance and appeals. The call center must operate during normal business hours and never less than from 8:00 a.m. to 6:00 p.m. (Eastern Time), Monday through Friday. The FIDA Plan must accept requests for information about Medicare or Medicaid coverage, including coverage determinations /renewals, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.11.3.1.1 Indicates that the mailbox is secure;

2.11.3.1.2 Lists the information that must be provided so the case can be worked (e.g., provider

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identification, participant identification, type of request (coverage determination or Appeal), Physician support for an exception request, and whether the Participant is making an expedited or standard request);

2.11.3.1.3 For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours after the call for expedited requests and seventy-two (72) hours for standard requests; and

2.11.3.1.4 For Appeals calls, articulates the process and information needed and provides for a resolution within the timeframes provided in Section 2.13.1.1.2.

2.11.4 Nursing Hotline

2.11.4.1 The FIDA Plan operates a toll-free nursing hotline with live nurses available to answer clinical questions twenty-four (24) hours a day, seven (7) days a week.

2.11.4.2 Nursing Hotline nurses provide general clinical information as well as assistance in accessing IDT members and service authorizations outside of normal business hours.

2.11.4.3 Nursing hotline staff must have access to all FIDA Plan Participants' PCSPs as well as to contact information for members of all FIDA Plan Participants' IDTs.

2.12 **Participant Grievance**

2.12.1 Grievance Filing.

2.12.1.1 Timing of Grievance Filing.

2.12.1.1.1 All Grievances must be filed within sixty (60) calendar days of the incident or

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whenever there is dissatisfaction (in the event there is not one specific incident).

2.12.1.2 Internal Grievance Filing. A Participant, or an Authorized Representative, may file an Internal Grievance with the FIDA Plan or its providers by calling or writing to the FIDA Plan or provider. If the Internal Grievance is filed with a provider, the FIDA Plan must require the provider to forward it to the FIDA Plan.

2.12.1.3 External Grievance Filing. The FIDA Plan shall inform Participants that they, or their Authorized Representative, may file an External Grievance through 1-800 Medicare. The FIDA Plan must display a link to the electronic Grievance form on the Medicare.gov Internet web site on the FIDA Plan's main web page. The FIDA Plan must inform Participants of the email address, postal address or toll-free telephone number where a Grievance may be filed.

2.12.1.4 External Grievances filed with the NYSDOH shall be forwarded to the Contract Management Team and entered into the CMS Complaints tracking module, which will be accessible to the FIDA Plan.

2.12.2 Internal Grievance Administration Process

2.12.2.1 The FIDA Plan must have a formally structured Grievance system, consistent with this Contract, 42 C.F.R. § 431(e), and 42 C.F.R. § 438(f), in place for addressing Participant Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The FIDA Plan must maintain written records of all Grievance activities, and notify CMS and the NYSDOH of all Internal Grievances.

2.12.2.2 The FIDA Plan maintains an established process to track and maintain records on all Grievances, received both orally and in writing, including, at a minimum:

2.12.2.2.1 The date of receipt;

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2.12.2.2.2 Final Disposition of the Grievance;

2.12.2.2.3 The date of Final Disposition of the Grievance; and

2.12.2.2.4 The date the FIDA Plan notified the Participant of the disposition.

2.12.2.3 The system must meet the following standards:

2.12.2.3.1 Timely acknowledgement of receipt of each Grievance;

2.12.2.3.2 Timely review of each Grievance;

2.12.2.3.3 Informal attempt by the FIDA Plan to resolve all Grievances;

2.12.2.3.4 Provide the Participant with reasonable assistance in filing Grievance and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capacity, as well as providing the applicable forms and instructions on how the Participant may appoint an authorized representative to represent the Participant throughout the Grievance process;

2.12.2.3.5 Provide every Participant with notice of the availability of the Participant Ombudsman to assist in filing Grievances or advising about the Grievance process; and

2.12.2.3.6 Providing the Participant with a notice of the disposition of the Grievance. The State and CMS will establish the method for such notice. The method of the notice will comply with all applicable Medicare and Medicaid rules, including 42 CFR 438.408.

2.12.3 Timeframe for Plan Decision and Notification on Grievance.

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2.12.3.1 A FIDA Plan must respond to a Participant's Grievance as fast as the Participant's condition requires, but in the following circumstances no later than:

2.12.3.1.1 Expedited: Paper review – decision and notification within twenty-four (24) hours (in certain circumstances). For all other circumstances where a standard decision would significantly increase the risk to a Participant's health, decision and notification within forty-eight (48) hours after receipt of all necessary information and no more than seven (7) calendar days from the receipt of the Grievance. Certain circumstances requiring a response within twenty-four (24) hours are defined as:

2.12.3.1.2 The complaint involves a FIDA Plan's decision to invoke an extension relating to an organization determination.

2.12.3.1.3 The complaint involves a FIDA Plan's refusal to grant a Participant's request for an expedited organization determination under 42 C.F.R. § 422.570.

2.12.3.2 Standard Timeframe: Notification of decision within thirty (30) calendar days of the FIDA Plan receiving the written or oral Grievance.

2.12.4 Availability to Participants of information about Participant Appeals, as described in Section 2.13, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.12.5 Ensure that decision makers on grievances were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Participant's condition or disease if any of the following apply:

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2.12.5.1 A Grievance regarding denial of expedited resolutions of an appeal.

2.12.5.2 Any Grievance involving clinical issues.

2.13 Participant Appeals

Commented [MS1]: Note that Section 2.13 is PENDING further CMS/NYSDOH discussion

2.13.1 Other than Medicare Part D appeals, which shall remain unchanged, the below is the approach for an integrated Medicare-Medicaid Appeals process. CMS and NYSDOH will work to continue to coordinate Grievances and Appeals for all services, including those related to Part D.

2.13.1.1 Integrated / Unified Appeals Process

2.13.1.1.1 Integrated Notice. In accordance with 42 C.F.R. §§ 438.10(g)(1), 438.404, 422.568 and 422.570, the FIDA Plan must give the Participant written notice of any Adverse Action. Such notice shall be provided, in accordance with 42 C.F.R. § 438.404 and with applicable notice requirements set forth at 42 C.F.R. § 422(m). Participants will be notified of all applicable Medicare and Medicaid Appeal rights through a single notice specific to the item or service type in question, developed jointly by CMS and the State. All notices shall be integrated and shall communicate the steps in the integrated Appeals process identified herein as well as the availability of the Participant Ombudsman to assist with Appeals. Notices must explain:

2.13.1.1.1.1 The Action the FIDA Plan has taken or intends to take;

2.13.1.1.1.2 The reasons for the Action;

2.13.1.1.1.3 The citation to the regulations supporting such Action;

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2.13.1.1.1.4 The Participant's or the provider's right to file an Appeal;

2.13.1.1.1.5 Procedures for exercising Participant's rights to Appeal;

2.13.1.1.1.6 Circumstances under which expedited resolution is available and how to request it; and

2.13.1.1.1.7 If applicable, the Participant's rights to have benefits continue pending the resolution of the Appeal.

2.13.1.1.2 Integrated Appeal Process and Time Frames. Time frames for filing an Appeal related to benefits will be unified. There are four (4) levels of Appeal: 1) the Initial Appeal to the FIDA Plan; 2) Appeal to the FIDA Administrative Hearing Unit at the Office for Temporary and Disability Assistance; 3) Appeal to the Medicare Appeals Council; and 4) Appeal to Federal District Court.

2.13.1.1.2.1 Appeal Filing Deadline. The FIDA Plan shall establish standard and expedited Appeals processes in accordance with 42 C.F.R. §§ 438.408 and 438. 410(a) and with applicable requirements set forth at 42 C.F.R. § 422(m). Participants, their providers, and their representatives will have sixty (60) calendar days to file an Appeal related to denial or reduction or

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termination of authorized Medicare or Medicaid benefit coverage. This first level of Appeal is an internal Appeal, to be decided by the FIDA Plan. The Appeal must be requested verbally or in writing within sixty (60) calendar days of postmark date of notice of Action if there is no request to continue benefits while the Appeal decision is pending. If the Appeal involves the termination or modification of a previously authorized service and the Appeal is filed within ten (10) calendar days of the notice's postmark or by the intended effective date of the Action, the Participant shall continue to receive benefits while the Appeal decision is pending.

2.13.1.1.2.2 Acknowledgement of Appeal. The FIDA Plan shall be required to send written acknowledgement of Appeal to the Participant within fifteen (15) calendar days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement.

2.13.1.1.2.3 Timeframe for Plan Decision on Appeal. The FIDA Plan shall be required to decide the

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Appeal and notify the Participant (and provider, as appropriate) of its decision as fast as the Participant's condition requires, but no later than the following:

2.13.1.1.2.3.1 Expedited: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than within seventy-two (72) hours of the receipt of the Appeal. Expedited Appeals shall be granted where a standard decision would significantly increase the risk to a Participant's health.

2.13.1.1.2.3.2 Standard: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than seven (7) calendar days from the date of the receipt of the Appeal on Medicaid prescription drug appeals and no later than thirty (30) calendar days from the date of the receipt of the Appeal.

2.13.1.1.2.3.3 Benefits will continue pending an Appeal in

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accordance with Section 2.13.1.1.2.14.

2.13.1.1.2.4 Extension. An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA Plan requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited Grievance if he or she disagrees with the FIDA Plan's decision to grant an extension. If the FIDA Plan denies the request for an expedited resolution of the Appeal, it must transfer the Appeal to the standard timeframe from the date the FIDA Plan received the Appeal with a possible fourteen- (14) day extension and make reasonable efforts to give the Participant prompt oral notice, and must give written notice within two (2) calendar days of the denial or reduction or termination of authorized Medicare or Medicaid benefit coverage.

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2.13.1.1.2.5 Notification of Appeal Decision. The FIDA Plan must make a reasonable effort to provide prompt oral notice to the Participant for expedited Appeals and must document those efforts. The FIDA Plan must send written notice within two (2) calendar days of providing oral notice of its decision for standard and expedited Appeals. The written notification of Appeal decision must include the results and the date of the Appeal decision. For decisions not wholly in the Participant's favor, the notification must inform the Participant that such adverse decision will be automatically forwarded to the Integrated Administrative Hearing Office at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). The notification must inform the Participant of the process and timeframe for the hearing before OTDA. The notification must inform Participants that if they are receiving continuing benefits pending Appeal, this will continue and that, even if the FIDA Plan's Action is upheld, the Participant shall not be liable for the cost of any continued benefits.

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2.13.1.1.2.6 Automatic Administrative Hearing. Any wholly or partially adverse decision by the FIDA Plan is automatically forwarded along with the Appeal review record to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at OTDA.

Commented [P2]: The plan may have a role in quality validation. This is pending CMS and NYSDOH discussion.

2.13.1.1.2.7

2.13.1.1.2.7.1 The case must be auto-forwarded within two (2) Business Days of the adverse decision being reached.

2.13.1.1.2.7.2 This must be done electronically by email to a designated mail box with a cover note that clearly indicates:

2.13.1.1.2.7.2.1 The name of the FIDA Plan;

2.13.1.1.2.7.2.2 The type of Appeal (i.e., expedited, Medicaid prescription drug, or other);

2.13.1.1.2.7.2.3 The name of the contact person at the FIDA Plan for use by the FIDA Administrative Hearing Unit; and

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2.13.1.1.2.7.2.4	The Participant's name, address, phone number or other contact , social security number and Medicaid or CIN number.
2.13.1.1.2.7.3	This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed for matters before OTDA).
2.13.1.1.2.7.4	Benefits will continue pending an Appeal in accordance with Section 2.13.1.1.2.14.
2.13.1.1.2.7.5	The FIDA Plan shall notify the Participant that an Appeal was sent to OTDA. The notice shall also indicate that once OTDA receives the notice from the FIDA Plan, OTDA will contact the Participant regarding the

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hearing date and also that the Participant should contact OTDA in the event that he/she doesn't hear from OTDA to schedule the hearing within:

2.13.1.1.2.7.5.1 Twenty-four (24) hours for the expedited Appeals;

2.13.1.1.2.7.5.2 Five (5) calendar days for the Medicaid prescription drug Appeals; and

2.13.1.1.2.7.5.3 Ten (10) calendar days for all other Appeals.

2.13.1.1.2.8 Notices of Automatic Administrative Hearing.

2.13.1.1.2.8.1 Acknowledgement. The FIDA Plan shall be required to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within fourteen (14) calendar days of forwarding the administrative record with a copy to the Integrated

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Administrative Hearing Office (IAHO). If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement.

2.13.1.1.2.8.2 Hearing Notice. The Integrated Administrative Hearing Office shall provide the Participant and the FIDA Plan with a Notice of Administrative Hearing at least ten (10) calendar days in advance of the hearing date.

2.13.1.1.2.9 Participation in the Administrative Hearing. The FIDA Plan must participate in the Administrative Hearing. The staff person participating must be knowledgeable in the Appeal decision reached by the FIDA Plan and the basis for the decision.

2.13.1.1.2.10 Administrative Record for Administrative Hearing. The Integrated Administrative Hearing Office shall create the administrative record at the second level of Appeal and allow for requesting and receiving copies of the administrative record in accordance with 42 C.F.R. § 405.1042.

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2.13.1.1.2.11 Timeframe for Decision on Administrative Hearing.

2.13.1.1.2.11.1 Standard Timeframe: The Integrated Administrative Hearing Office shall conduct a phone or in-person hearing and render a decision as expeditiously as the Participant's condition requires, but always within seven (7) calendar days for Medicaid drug coverage matters and for all other matters within ninety (90) calendar days of receipt of the Appeal from the FIDA Plan for the first year of the Demonstration and thirty (30) calendar days of receipt of the Appeal from the FIDA Plan for Demonstration Years 2 and 3.

Commented [P3]: The timeline here is PENDING further CMS and NYSDOH discussion.

2.13.1.1.2.11.2 Expedited Timeframe: The Integrated Administrative Hearing Office shall conduct a phone or in-person hearing and notify the Participant (and the provider, as appropriate) of the decision via phone within seventy-two (72) hours of the forwarding of the FIDA Plan's

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Appeal decision and the Appeal review record.

2.13.1.1.2.11.3 Decision: The Integrated Administrative Hearing Office shall issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the Appeal process, including where to file the Appeals, the filing time frames, and other information required by applicable Federal and State requirements. Participants will be notified within the timeframes stated in Section 2.13.1.1.2.11. The FIDA Plan is bound by the decision of the Integrated Administrative Hearing Office and may not seek further review. The FIDA Plan must implement the decision of the Integrated Administrative Hearing Office immediately (within no more than one (1) Business Day).

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2.13.1.1.2.12 Medicare Appeals Council. If a Participant disagrees with the Integrated Administrative Hearing Officer's decision, the

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Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the Integrated Administrative Hearing Office's decision. The Medicare Appeals Council will apply all Medicare and Medicaid coverage rules as specified in Appendix A of this contract. The Participant submits his/her request for Medicare Appeals Council review to the Integrated Administrative Hearing Office. This must be done within sixty (60) calendar days of the date of the adverse decision by the Integrated Administrative Hearing Office. The Integrated Administrative Hearing Office will forward the Appeal and the record to the Medicare Appeals Council. These Appeals must be filed with the FIDA Administrative Hearing Unit, which will forward the request for Appeal and administrative record to the Medicare Appeals Council. The Medicare Appeals Council will complete a paper review and will issue a decision within ninety (90) calendar days from the receipt of the appeal request. Benefits will continue pending an Appeal in accordance with Section 2.13.1.1.2.14.

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2.13.1.1.2.13 Federal District Court. An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which serves as the fourth level of Appeal.

2.13.1.1.2.14 Continuation of Benefits Pending Appeal. Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan Appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original Appeal is requested to the FIDA Plan within ten (10) calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later. The FIDA Plan must authorize or provide the disputed services immediately (within no more than one (1) Business Day), and as expeditiously as the Participant's health condition requires, if the services were not furnished while the Appeal is pending and the FIDA Plan or the Integrated Administrative Hearings Officer reverses a decision to deny, limit, or delay services. The FIDA Plan or the State must pay for the

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disputed services, in accordance with State policy and regulations, if the FIDA Plan or the Integrated Administrative Hearings Office reverses a decision to deny authorization of services and the Participant received the disputed services while the Appeal was pending.

2.13.1.1.2.15 Validation of Integrated Administrative Hearing Officer Decisions. [

Commented [P5]: This section is PENDING further CMS/NYSDOH discussion.

2.13.2 General. All FIDA Plans shall utilize and all Participants may access the existing Part D Appeals Process, as described in Appendix D. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Part D independent review entity (IRE) if the FIDA Plan misses the applicable adjudication timeframe. The Part D IRE is contracted by CMS.

2.13.2.1 A Participant, their provider, or an Authorized Representative may file an Appeal, either orally or in writing with the FIDA Plan. The Participant or provider may file an expedited Appeal either orally or in writing; no additional Participant follow-up is required. The FIDA Plan must ensure that no punitive action is taken against any provider who requests an expedited resolution or supports a Participant's Appeal.

2.13.2.2 The FIDA Plan shall provide the Participant with reasonable assistance in filing the Appeal forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability, as well as providing the applicable forms and instructions on how the Participant may appoint an Authorized Representative to represent the Participant throughout the Grievance process.

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2.13.2.3 The FIDA Plan shall provide each Participant with information about the availability of the Participant Ombudsman to assist the Participant in filing and pursuing the Appeal.

2.13.2.4 The FIDA Plan shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Participant's condition or disease if any of the following apply:

2.13.2.4.1 Any Appeal decision that is a denial based on a lack of Medical Necessity.

2.13.2.4.2 An Appeal regarding denial of expedited resolutions of an Appeal.

2.13.2.4.3 Any Appeal involving clinical issues.

2.13.2.5 The FIDA Plan shall:

2.13.2.5.1 Ensure that oral inquiries seeking to Appeal an Action are treated as Appeals and confirm those inquiries in writing, unless a decision is reached before the written acknowledgement is sent.

2.13.2.5.2 Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and inform the Participant of the limited time available to do this in the case of an expedited resolution;

2.13.2.5.3 Allow the Participant and representative opportunity before and during the Appeals process to examine the Participant's case file, including Medical Records and any other documents and records.

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2.13.2.5.4 Consider the Participant, representative, or estate representative of a deceased Participant as parties to the Appeal.

2.13.2.5.5 The FIDA Plan shall ensure that the Participants are informed:

2.13.2.5.6 That a Participant has a right to an Administrative Hearing;

2.13.2.5.7 Of representation rules at Administrative Hearings; and

2.13.2.5.8 Parties to Administrative Hearings include the FIDA Plan and the Participant and his or her representative or the representative of the deceased Participant's estate.

2.13.2.5.9 2.13.2.5.7 The FIDA Plan shall maintain written records of all Appeal activities, consistent with this Contract, 42 C.F.R. § 431(e), and 42 C.F.R. § 438(f), and notify CMS and the NYSDOH of all internal Appeals.

2.13.3 Integrated Coverage Determination Notice - Participants will receive a written notice with coverage determinations and all of Participants' Appeal rights each time 1) there is a PCSP created or updated ad 2) there is a coverage determination reached and a service or item authorized that is not reflected in the most recent PCSP. These notices will delineate all Appeal rights under the FIDA Demonstration (include all applicable Demonstration Medicare and Medicaid Appeal rights).

2.13.4 The Integrated Coverage Determination Notice will explain:

2.13.4.1.1 The determination made and the Action the FIDA Plan intends to take;

2.13.4.1.2 The reasons for the decision or Action, including clinical rationale, if any;

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2.13.4.1.3 The citation to the regulations supporting such Action;

2.13.4.1.4 The availability, upon request of the Participant, or the Participant's designee, of the clinical review criteria relied upon to make such determination;

2.13.4.1.5 The Participant's or authorized representative or the provider's right to file an Appeal;

2.13.4.1.6 And explanation of the steps of the Integrated Appeal Process, including procedures and timelines for exercising the Participant's rights to Appeal and instructions on how to initiate a standard or expedited Appeal, and information on the levels of the Integrated Appeal Process;

2.13.4.1.7 What, if any, additional necessary information should be provided in order for the FIDA Plan to render a decision on the Appeal.

2.13.4.1.8 The availability of the Participant Ombudsman to help the Participant in understanding his/her appeal rights and in exercising his/her Appeal rights;

2.13.4.1.9 Information on how to access the Participant Ombudsman;

2.13.4.1.10 Circumstances under which expedited resolution is available and how to request it; and

2.13.4.1.11 If applicable, the Participant's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Participant may be required to pay the costs of these services.

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2.13.4.2 The notice must use easily understood language and format, be available in Alternative Formats, and in an appropriate manner that takes into consideration those with special needs. All Participants and Eligible Individuals must be informed that information is available in Alternative Formats and how to access those Alternative Formats.

2.13.4.3 The notice must be translated for the individuals who speak Prevalent Languages.

2.13.4.4 The notice must include language clarifying that oral interpretation is available for all languages and how to access it.

2.13.4.5 The FIDA Plan shall ensure that:

2.13.4.5.1 Participants receive Integrated Coverage Determination Notices at least 15 days in advance of the date of its Adverse Action.

2.13.4.5.2 Each IDT uses the required form notices provided by the State and CMS.

2.13.5 Appeal Process Notices

2.13.5.1 The State and CMS will provide the FIDA Plan with required form notices to use in the Initial Appeal process. These notices shall be integrated and shall communicate the steps in the integrated Appeals process identified herein as well as the availability of the Participant Ombudsman to assist with Appeals.

2.13.5.2 The FIDA Plan shall ensure that it uses the required form notices provided by the State and CMS.

2.13.6 Hospital Discharge Appeals

2.13.6.1 When a Participant is being discharged from the hospital, the FIDA Plan must comply with requirements in 42 C.F.R. §§ 422.620-422.622 and assure that the Participant receives a written notice of explanation

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called an "Important Message from Medicare About your Rights" regarding the right to appeal the discharge decision from an inpatient hospital admission.

2.13.6.2 The Participant has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first Business Day after the receipt of the notice.

2.13.6.3 If the Participant asks for immediate review by the QIO, the Participant is entitled to this process instead of the standard Appeals process described above. A Participant may file an oral or written request for an expedited seventy-two- (72) hour FIDA Plan Appeal if the Participant has missed the deadline for requesting the QIO review.

2.13.6.4 The QIO will make its decision within one Business Day after it receives the Participant's request, Medical Records, and any other information it needs to make its decision.

2.13.6.5 If the QIO agrees with the FIDA Plan's decision, the FIDA Plan is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Participant of its decision.

2.13.6.6 If the QIO overturns the FIDA Plan's decision, the FIDA Plan must pay for the remainder of the hospital stay.

2.13.7 Additional Medicare QIO rights, including those that relate to individuals in a Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facilities (SNF), or receiving Home Health benefits, will continue to be available pursuant to existing Medicare law, regulations including 42 C.F.R. §§ 422.624 and 422.626, and guidance.

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2.14 Quality Improvement Program

2.14.1 The FIDA Plan shall:

2.14.1.1 Deliver quality care that enables Participants to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.14.1.1.1 Quality of physical health care, including primary and specialty care;

2.14.1.1.2 Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.14.1.1.3 Quality of Community-based and Facility-based LTSS;

2.14.1.1.4 Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and Community-based and Facility-based LTSS providers and services;

2.14.1.1.5 Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.14.1.1.6 Participant experience and access to high quality, coordinated and Culturally Competent clinical care and services, inclusive of Community-based and Facility-based LTSS across the care continuum.

2.14.1.2 Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the FIDA Plan's service delivery system through ongoing analysis, evaluation, and systematic enhancements based on:

2.14.1.2.1 Quantitative and qualitative data collection and data-driven decision-making;

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2.14.1.2.2 Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.14.1.2.3 Feedback provided by Participants and Participating Providers in the design, planning, and implementation of its CQI activities; and

2.14.1.2.4 Issues identified by the FIDA Plan, NYSDOH and/or CMS;

2.14.1.3 Disseminate such best practice guidelines to new Participating Providers, to all affected Participating Providers, upon adoption and revision, and, upon request, to Participants and Eligible Individuals. The FIDA Plan shall make the clinical and practice guidelines available via the FIDA Plan's website. The FIDA Plan shall notify Participating Providers of the availability and location of the guidelines, and shall notify Participating Providers whenever changes are made; and

2.14.1.4 Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health Services, and Community-based and Facility-based LTSS.

2.14.2 QI Program

2.14.2.1 The FIDA Plan shall structure its QI program for the Demonstration separately from any of its existing Medicaid, or Medicare, or commercial lines of business. For example, required measures for this Demonstration must be reported for the Demonstration population only. Integrating the Demonstration population into an existing line of business shall not be acceptable.

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The FIDA Plan shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the FIDA Plan's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. FIDA Plan's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438(d), Quality Assessment and Performance Improvement, 42 C.F.R. § 422(d), Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2.14.2.2 The FIDA Plan shall:

2.14.2.2.1 Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.14.2.2.2 Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the FIDA Plan's service delivery system;

2.14.2.2.3 Seek the input of providers and medical professionals representing the composition of the FIDA Plan's Provider Network in developing functions and activities;

2.14.2.2.4 Establish internal processes to ensure that the Quality Management activities for Primary, Specialty, and Behavioral Health

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Services, and Community-based and Facility-based LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.10 of this Contract and, in addition, the following elements:

2.14.2.2.4.1 A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS), and other measurement results in designing QI activities;

2.14.2.2.4.2 A Medical Record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The FIDA Plan shall submit its process for Medical Record reviews and the results of its Medical Record reviews to NYSDOH;

2.14.2.2.4.3 A process to measure Participating Providers and Participants, at least annually, regarding their satisfaction with the FIDA Plan. The FIDA Plan shall submit a survey

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plan to NYSDOH for approval and shall submit the results of the survey to NYSDOH and CMS;

2.14.2.2.4.4 A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

2.14.2.2.4.5 A process for including Participants and their families in Quality Management activities, as evidenced by participation in Participant Advisory Committee and Participant Feedback Sessions; and

2.14.2.2.4.6 In collaboration with and as further directed by NYSDOH, develop a customized Medical Record review process to monitor the assessment for and provision of Community-based and Facility-based LTSS.

2.14.2.2.5 Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the FIDA Plan's QI initiatives. Such description shall:

2.14.2.2.5.1 Address all aspects of health care, including specific reference to behavioral health care and to Community-based and Facility-based LTSS, with respect to monitoring and improvement efforts, and

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integration with physical health care. Behavioral Health Services and Community-based and Facility-based LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

2.14.2.2.5.2 Address the roles of the designated Physician(s), behavioral health clinician(s), and Community-based and Facility-based LTSS providers with respect to QI program;

2.14.2.2.5.3 Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.14.2.2.5.4 Include organization-wide policies and procedures that document processes through which the FIDA Plan ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management;

2.14.2.3 The FIDA Plan shall submit to NYSDOH and CMS an annual QI Work Plan that shall include the following components or other components as directed by NYSDOH and CMS:

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2.14.2.3.1 Planned clinical and non-clinical initiatives;

2.14.2.3.2 The objectives for planned clinical and non-clinical initiatives;

2.14.2.3.3 The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.14.2.3.4 The individual(s) responsible for each clinical and non-clinical initiative;

2.14.2.3.5 Any issues identified by the FIDA Plan, NYSDOH, Participants, and providers, and how those issues are tracked and resolved over time;

2.14.2.3.6 Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.14.2.3.7 Process for correcting deficiencies.

2.14.2.4 The FIDA Plan shall evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the NYSDOH Quality monitor and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the FIDA Plan's assessment of the quality of physical and behavioral health care rendered, the effectiveness of Community-based and Facility-based LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan.

2.14.2.5 The FIDA Plan shall also maintain sufficient and qualified staff employed by the FIDA Plan to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience)

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for employees who will be responsible for Quality Management. QI staff shall include:

2.14.2.5.1 At least one designated Physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment and delivery of Community-based and Facility-based LTSS with substantial involvement in the QI program;

2.14.2.5.2 A qualified individual to serve as the Demonstration QI Director who will be directly accountable to the FIDA Plan's New York Executive Director and, in addition, if the FIDA Plan offers multiple products or services in multiple states, will have access to the FIDA Plan's executive leadership team. This individual shall be responsible for:

2.14.2.5.2.1 Overseeing all QI activities related to Participants, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.14.2.5.2.2 Maintaining an active role in the FIDA Plan's overall QI structure;

2.14.2.5.2.3 Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

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2.14.2.5.2.3.1 Physical and behavioral health care;

2.14.2.5.2.3.2 Pharmacy management;

2.14.2.5.2.3.3 Care management;

2.14.2.5.2.3.4 Community-based and Facility-based LTSS;

2.14.2.5.2.3.5 Financial;

2.14.2.5.2.3.6 Statistical/analytical;

2.14.2.5.2.3.7 Information systems;

2.14.2.5.2.3.8 Marketing, publications;

2.14.2.5.2.3.9 Enrollment; and

2.14.2.5.2.3.10 Operations management.

2.14.2.6 The FIDA Plan shall actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by NYSDOH, or its designee, that may be attended by representatives of NYSDOH, the FIDA Plan, and other entities, as appropriate; and serve as a liaison to, and maintaining regular communication with, State QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.14.2.7 The FIDA Plan's QI Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Participant care outcomes. The QI Program shall include provision for the interpretation and dissemination of such data to the FIDA Plan's Participating Providers. The QI Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to

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improve efficiency, effectiveness, appropriate health care utilization, and Participant health status, per 42 C.F.R. § 438.242. The FIDA Plan shall ensure that data received from Participating Providers and included in reports are accurate and complete by:

2.14.2.7.1 Verifying the accuracy and timeliness of reported data;

2.14.2.7.2 Screening the data for completeness, logic, and consistency; and

2.14.2.7.3 Collecting service information in standardized formats to the extent feasible and appropriate.

2.14.2.8 In the aggregate, without reference to individual Physicians or Participant identifying information, all QI findings, conclusions, recommendations, actions taken, results or other documentation relative to QI shall be reported to CMS and NYSDOH on a quarterly basis or as requested by CMS and NYSDOH. CMS and NYSDOH, and in the case of providers of Behavioral Health Services, OMH or OASAS as appropriate, shall be notified of any Participating Provider or First Tier, Downstream or Related Entityto the FIDA Plan who ceases to be a Participating Provider or First Tier, Downstream, or Related Entity to the FIDA Plan for a quality of care issue.

2.14.3 QI Activities

2.14.3.1 The FIDA Plan shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Participant experience.

2.14.3.2 The FIDA Plan's QI program must include a health information system to collect, analyze, and report

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quality performance data as described in 42 C.F.R. § 438.242(a), and 42 C.F.R. § 422.516(a) and § 423.514 for Parts C and D, respectively.

2.14.3.3 Performance Measurement

2.14.3.4 The FIDA Plan shall engage in performance measurement and QI Projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in a clinical care and non-clinical care processes, outcomes and Participant experience. The FIDA Plan's QI Program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a) and 423.514 for Parts C and D, respectively.

2.14.3.5 FIDA Plan shall perform and report the quality and utilization measures identified by CMS and NYSDOH and in accordance with requirements in the Memorandum of Understanding between CMS and New York State of August 26, 2013 (MOU), Table 7-B Core Quality Measures included as Appendix J to this Contract, and as further articulated in this Contract and shall include, but are not limited to:

2.14.3.5.1 All HEDIS, Health Outcomes Survey (HOS), and CAHPS data, as well as all other measures specified in Appendix J. HEDIS, HOS, and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.14.3.6 The FIDA Plan shall not modify the reporting specifications methodology prescribed by CMS and NYSDOH without first obtaining CMS and the State's written approval. The FIDA Plan must obtain an independent validation of its findings by a recognized

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entity, e.g., NCQA-certified auditor, as approved by CMS and NYSDOH. CMS and NYSDOH (or its designee) will perform an independent validation of at least a sample of FIDA Plan's findings.

2.14.3.7 The FIDA Plan shall monitor other performance measures not specifically stated in the Contract that are required by CMS. CMS will use its best efforts to notify the FIDA Plan of new Federal CMS requirements.

2.14.3.8 The FIDA Plan shall have mechanisms in place to:

2.14.3.8.1 Detect both underutilization and overutilization of services;

2.14.3.8.2 Assess the quality and appropriateness of care furnished to Participants.

2.14.3.9 The FIDA Plan shall collect annual data and contribute to all Demonstration QI-related processes, as directed by NYSDOH and CMS, as follows:

2.14.3.9.1 Collect and submit to NYSDOH, CMS, and/or CMS' contractors, in a timely manner, data for the measures specified in Appendix J;

2.14.3.9.2 Contribute to all applicable NYSDOH and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by CMS and/or NYSDOH and rectifying those inadequacies, as directed by CMS and/or NYSDOH;

2.14.3.9.3 Contribute to NYSDOH and CMS data regarding the individual and aggregate performance of NYSDOH FIDA Plans with respect to the noted measures; and

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2.14.3.9.4 Contribute to NYSDOH processes culminating in the publication of any additional technical or other reports by NYSDOH related to the noted measures.

2.14.3.10 The FIDA Plan shall demonstrate how to utilize results of the measures specified in Appendix J in designing QI initiatives.

2.14.3.11 Participant Experience Surveys

2.14.3.12 The FIDA Plan shall conduct Participant experience survey activities, as directed by NYSDOH and/or CMS, disclose the survey results to NYSDOH and CMS, disclose the identified CAHPS measurement set and the survey results to Participants upon request, and provide NYSDOH with access to the de-identified CAHPS response set upon request, as follows:

2.14.3.12.1 Conduct, as directed by NYSDOH and CMS, an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;

2.14.3.12.2 Contribute, as directed by NYSDOH and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by NYSDOH and CMS and rectifying those inadequacies, as directed by NYSDOH and CMS; and

2.14.3.12.3 The FIDA Plan shall demonstrate best efforts to utilize Participant experience survey results in designing QI initiatives.

2.14.4 Quality Improvement Project Requirements

2.14.4.1 The FIDA Plan shall implement and adhere to all processes relating to the Quality Improvement Project

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Requirements, as directed by NYSDOH and CMS, as follows:

2.14.4.1.1 In accordance with 42 C.F.R. § 438.240(d) and 42 C.F.R. § 422.152(d), collect information and data in accordance with Quality Improvement Project Requirement specifications for its Participants; using the format and submission guidelines specified by NYSDOH and CMS in annual guidance provided for the upcoming Contract year;

2.14.4.1.1.1 The purpose of these studies will be to promote quality improvement within the FIDA Plan. At least one (1) performance improvement project each year beginning in January 2015 will be selected as a priority and approved by NYSDOH. Results of other NYSDOH Quality Improvement Projects will be included in the minutes of the quality committee and reported to NYSDOH and CMS upon request.

2.14.4.1.2 Implement the Quality Improvement Project Requirements, in a Culturally Competent manner;

2.14.4.1.3 Evaluate the effectiveness of QI interventions;

2.14.4.1.4 Plan and initiate processes to sustain achievements and continue improvements;

2.14.4.1.5 Submit to NYSDOH and CMS, comprehensive written reports, using the format, submission guidelines and

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frequency specified by NYSDOH and CMS. Such reports shall include information regarding progress on Quality Improvement Project Requirements, barriers encountered, and new knowledge gained. As directed by NYSDOH and CMS, the FIDA Plan shall present this information to NYSDOH and CMS at the end of the Quality Improvement Requirement Project cycle as determined by NYSDOH and CMS; and

2.14.4.1.6 In accordance with 42 C.F.R. § 422.152(c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the CCIP. The CCIP must be relevant to and target the FIDA Plan's population. Although the FIDA Plan has the flexibility to choose the design of their CCIPs, NYSDOH and CMS may require them to address specific topic areas.

2.14.4.2 CMS-Specified Performance Measurement and Performance Improvement Projects

2.14.4.2.1 The FIDA Plan shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.14.4.3 Risk Assessment

2.14.4.3.1 The FIDA Plan shall assess the risks from external and internal sources to identify and analyze the relevant risks to the achievement of objectives. A mechanism shall be employed to identify and evaluate key exposures or vulnerabilities and establish plans for mitigating overall risks to the Participant, NYSDOH, and the FIDA Plan. The FIDA Plan is responsible for conducting (at least annually) a risk

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assessment of events that occur or could occur that impact the vulnerability of the Participant, NYSDOH, and the FIDA Plan. The impact of the risk shall be measurable or definable. Definable terms are measurable common measurement units (e.g., dollars, ratios in areas of health and safety).

2.14.4.3.2 The risk assessment shall include input from staff throughout the FIDA Plan organization seeking input given the objectives about processes, resources and solutions.

2.14.4.3.3 The FIDA Plan QI Program shall list how the impact can best be measured and a description of the controls in place to manage risk and the effectiveness of those controls.

2.14.4.3.4 FIDA Plan QI Program shall perform and report the risk assessment outcomes and improvement in the committee minutes.

2.14.5 External Quality Review (EQR) Activities

2.14.5.1 The FIDA Plan shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by NYSDOH and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include, but are not limited to:

2.14.5.1.1 Annual validation of performance measures reported to NYSDOH as directed by NYSDOH, or calculated by NYSDOH;

2.14.5.1.2 Annual validation of quality improvement projects required by NYSDOH and CMS; and

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2.14.5.1.3 At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of NYSDOH, regarding access, structure and operations, and quality of care and services furnished to Participants. The FIDA Plan shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.14.5.1.3.1 Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:

2.14.5.1.3.1.1 Oversee and be accountable for compliance with all aspects of the EQR activity;

2.14.5.1.3.1.2 Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, NYSDOH, and/or CMS staff in a timely manner;

2.14.5.1.3.1.3 Serve as the liaison to the EQRO, QIO, NYSDOH and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS, and NYSDOH in a timely manner; and

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2.14.5.1.3.1.4 Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS, or NYSDOH.

2.14.5.1.3.2 Maintaining data and other documentation necessary for completion of EQR activities specified above. The FIDA Plan shall maintain such documentation for a minimum of ten (10) years;

2.14.5.1.3.3 Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or NYSDOH;

2.14.5.1.4 Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and NYSDOH;

2.14.5.1.5 Implementing actions, as directed by NYSDOH and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, NYSDOH, and CMS in subsequent years; and

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2.14.5.1.6 Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by NYSDOH and CMS.

2.15 Marketing, Outreach, and Participant Communications Standards

2.15.1 General Marketing, Outreach, and Participant Communications Requirements

2.15.1.1 The FIDA Plan is subject to rules governing marketing and Participant Communications as specified under section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), §§ 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), and the CY 2014, CY 2015, CY 2016, and CY 2017 Marketing Guidance for New York's Medicare-Medicaid Plans with the following exceptions or modifications:

2.15.1.1.1 The FIDA Plan must refer Participants and Potential Participants who inquire about the Demonstration eligibility or Enrollment to the Enrollment Broker although the FIDA Plan may provide Participants and Potential Participants with factual information about the FIDA Plan's Demonstration Plan and its benefits prior to referring a request regarding eligibility or Enrollment to the Enrollment Broker;

2.15.1.1.2 The FIDA Plan must make available to CMS and NYSDOH, upon request, current schedules of all educational events conducted by the FIDA Plan to provide information to Participants or Potential Participants;

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2.15.1.1.3 The FIDA Plan must convene all educational and marketing events at sites within the FIDA Plan's Service Area that are physically accessible to all Participants or Potential Participants, including persons with disabilities and persons using public transportation.

2.15.1.1.4 The FIDA Plan may not offer financial or other incentives, including private insurance, to induce Potential Participants to enroll with the FIDA Plan or to refer a friend, neighbor, or other person to enroll with the FIDA Plan;

2.15.1.1.5 The FIDA Plan may not market directly to Participants or Potential Participants on a one-on-one basis, including door-to-door, telephone, or other unsolicited contacts;

2.15.1.1.6 The FIDA Plan may not market directly to Participants or Potential Participants on a one-on-one bases but may participate in group marketing events and provide general audience materials (such as general circulation brochures and media and billboard advertisements);

2.15.1.1.7 The FIDA Plan must have a process to mitigate Participant shifting from the FIDA Plan to other plans operated by the same parent company which includes but is not limited to counseling by 1-800-Medicare and the Enrollment Broker about the cost and other implications of making the change; and

2.15.1.1.8 The FIDA Plan may not use any Marketing, Outreach, or Participant Communications materials that contain any assertion or statement (whether written or oral) that:

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2.15.1.1.8.1 The Participant or Potential Participant must enroll in the FIDA Plan in order to obtain benefits or in order not to lose benefits;

2.15.1.1.8.2 The FIDA Plan is endorsed by CMS, NYSDOH, Medicare, Medicaid, the Federal government, New York, or similar entity.

2.15.2 The FIDA Plan must develop and obtain NYSDOH approval of its plan for Marketing, Outreach, and Participant Communications activities and meet all requirements described in the Marketing Guidance for New York's Medicare-Medicaid Plans for CY 2014 and any subsequent years

2.15.3 The FIDA Plan's Marketing, Outreach, and Participant Communications materials must be:

2.15.3.1 Made available in Alternative Formats, upon request and as needed, to assure effective communication for blind and vision-impaired Participants;

2.15.3.2 Provided in a manner, format, and language that may be easily understood by persons with limited English proficiency, or for Individuals with Intellectual Disabilities or cognitive impairments; and

2.15.3.3 Translated into Prevalent Languages. The following materials must be translated into these languages:

i. Summary of Benefits (SB);
ii. Annual Notice of Change (ANOC);
iii. Evidence of Coverage (i.e., EOC / Participant Handbook);
iv. Formulary;
v. Provider and Pharmacy Directory;
vi. Part D Transition Letter;

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vii. NYSDOH Approved Assessment;
viii. Patient-Centered Service Plan; and
ix. Ad-hoc communications regarding payments / reimbursements.

2.15.3.4 Updated by the FIDA Plan consistent with the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance;

2.15.3.5 For the materials included in Section 2.15.3.3, sent in the appropriate Prevalent Language to any Participant whose primary language is known to be one of the Prevalent Languages in; and

2.15.3.6 Mailed with a multi-language insert that indicates that the Participant can access free interpreter services to answer any questions about the FIDA Plan. This message shall be written in the languages required in the Medicare-Medicaid marketing guidance; and

2.15.3.7 Distributed to the FIDA Plan's entire Service Area as specified in Appendix H of this Contract.

2.15.4 Submission, Review, and Approval of Marketing, Outreach, and Participant Communications Materials

2.15.4.1 The FIDA Plan must receive Prior Approval of all marketing and Participant Communications materials in categories of materials that CMS and NYSDOH require to be prospectively reviewed. In accordance with State rules, the State will conduct prospective review of certain Participant communication materials.

2.15.4.2 FIDA Plan materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and NYSDOH.

2.15.4.3 CMS and NYSDOH may agree to defer to one or the other Party for review of certain types of Marketing,

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Outreach, and Participant Communications, as agreed in advance by both Parties.

2.15.4.4 The FIDA Plan must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.15.4.5 CMS and NYSDOH may conduct additional types of review of the FIDA Plan's Marketing, Outreach, and Participant Communications activities, including, but not limited to:

2.15.4.5.1 Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.15.4.5.2 Random review of actual Marketing, Outreach, and Participant Communications pieces as they are used in the marketplace.

2.15.4.5.3 "For cause" review of materials and activities when complaints are made by any source, and CMS or NYSDOH determines it is appropriate to investigate.

2.15.4.5.4 "Secret shopper" activities where CMS or NYSDOH request the FIDA Plan's Marketing, Outreach, and Participant Communications.

2.15.4.6 Beginning of Marketing, Outreach and Participant Communications Activity

2.15.4.6.1 The FIDA Plan may not begin Marketing, Outreach, and Participant Communications activities to new Eligible Individuals or Participants more than ninety (90) days prior to the effective date of Enrollment for the following Contract year.

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2.15.5 Requirements for Dissemination of Marketing, Outreach, and Participant Communications Materials

2.15.5.1 Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the FIDA Plan must provide new Participants with the following materials which, with the exception of the materials specified in Sections 2.15.4.1.3 and 2.15.4.1.4, must also be provided annually thereafter:

2.15.5.1.1 An Evidence of Coverage (EOC)/Participant Handbook document that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.411, and 423.128 and includes additional State content; that includes information about all Covered Items and Services, as outlined below; and, that uses the model document developed by CMS and NYSDOH:

2.15.5.1.1.1 Participant rights and responsibilities (see Appendix B);

2.15.5.1.1.2 Eligibility requirements;

2.15.5.1.1.3 How the assessment and care planning processes work;

2.15.5.1.1.4 An explanation of the process by which clinical information, including diagnostic and medication information, may be available to key caregivers;

2.15.5.1.1.5 How to request and obtain a copy of the Participant's Medical Records, and to request that they be amended or corrected;

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2.15.5.1.1.6 How to obtain access to specialty, Behavioral Health Services, pharmacy, and long-term services and supports Participating Providers;

2.15.5.1.1.7 How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.15.5.1.1.7.1 What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Services, with reference to the definitions in 42 C.F.R. §§ 422.113(a) and (c), and 438.114(a),(b) and (e);

2.15.5.1.1.7.2 The fact that prior authorization is not required for Emergency Services;

2.15.5.1.1.7.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.15.5.1.1.7.4 Which services require Prior Authorization;

2.15.5.1.1.7.5 The locations of any emergency settings and

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other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;

2.15.5.1.1.7.6 Access and network adequacy requirements;

2.15.5.1.1.7.7 That the Participant has a right to use any hospital or other setting for emergency care;

2.15.5.1.1.7.8 The Post-Stabilization Care Services rules at 42 C.F.R. § 422.113(c).

2.15.5.1.1.8 How to access the Provider and Pharmacy Directory, how to choose providers, and how to change providers;

2.15.5.1.1.9 The availability of self-directed services and how to begin accessing self-directed services;

2.15.5.1.1.10 How to access Services not subject to Prior Authorization;

2.15.5.1.1.11 Written Information about Advance Directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128 and Articles 29-B and 29-C of the NYS PHL), including Participant rights under New York State law; the FIDA

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Plan's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with the FIDA Plan; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Participant. The written information provided by the FIDA Plan must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change;

2.15.5.1.1.12 How to obtain assistance from PSRs;

2.15.5.1.1.13 How to file Grievances and Appeals, including:

2.15.5.1.1.13.1 Grievance, Appeal, and fair hearing procedures and timeframes;

2.15.5.1.1.13.2 Toll-free numbers that the Participant can use to file a Grievance or an Appeal by phone; and

2.15.5.1.1.13.3 A statement that continuation of benefits

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at the FIDA Plan level must be provided in accordance with Section 2.13.1.1.2.14 if the original appeal is requested within ten (10) days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later; and

2.15.5.1.1.14 How the Participant can identify who the Participant wants to receive written notices of denials, terminations, and reductions;

2.15.5.1.1.15 How to obtain assistance with the Appeals processes through the PSR and other assistance mechanisms as NYSDOH or CMS may identify, including the Participant Ombudsperson;

2.15.5.1.1.16 The extent to which, and how, Participants may obtain services accessed through the Medicare or Medicaid Fee-for-Service program, including Medicare and Medicaid hospice services; out-of-network family planning services; directly observed therapy for tuberculosis; and methadone maintenance treatment;

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2.15.5.1.1.17 That Participants have the right to change FIDA Plans and how to request a change;

2.15.5.1.1.18 That Participants have the right to disenroll from the FIDA Plan and how to disenroll voluntarily;

2.15.5.1.1.19 Explanation that the FIDA Plan ID card replaces the Medicare and Medicaid cards;

2.15.5.1.1.20 How to contact the FIDA Plan's call centers and the types of information each call center can provide, including the Participant services telephone line; the coverage determinations, Grievances, and Appeals telephone line; and the nursing hotline.

2.15.5.1.1.21 How to contact the Participant Ombudsman for any assistance.

2.15.5.1.1.22 How to obtain additional information in Alternative Formats or languages; and

2.15.5.1.1.23 The name of the FIDA Plan's parent company and any DBA (Doing Business As) that may be used.

2.15.5.1.2 A Summary of Benefits (SB) that that uses the model document developed by CMS and NYSDOH and contains a concise description of the important aspects of enrolling in the FIDA Plan, as well as the benefits offered

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under the FIDA Plan, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the model document developed by CMS and NYSDOH. The SB must provide sufficient detail to ensure that Participants understand the benefits to which they are entitled. For new Participants, the SB is required only for Participants enrolled through Passive Enrollment. For current Participants, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.15.5.1.3 A combined Provider and Pharmacy Directory that is consistent with the requirements in Section 2.15.6.

2.15.5.1.4 A single identification (ID) card for accessing all Covered Items and Services under the Demonstration Plan that uses the model document developed by CMS and NYSDOH;

2.15.5.1.5 A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and NYSDOH's outpatient prescription drug benefit and that uses the model document developed by CMS and NYSDOH.

2.15.5.1.6 The procedures for a Participant to change Demonstration Plans or to Opt Out of the Demonstration.

2.15.5.2 Welcome Calls. The FIDA Plan will make Welcome Calls to newly enrolled Participants. These calls include, but are not limited to:

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2.15.5.2.1 Introducing Participants to the FIDA Plan;

2.15.5.2.2 Explaining the Comprehensive Assessment and PCSP processes; and

2.15.5.2.3 Explaining the role of the Care Manager and the IDT

2.15.5.3 The FIDA Plan must provide Participants the following materials:

2.15.5.3.1 An ANOC that summarizes all major changes to the FIDA Plan's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and NYSDOH. The ANOC is a

2.15.5.3.2 written notice of any significant change to the coverage or program, as required in 42 CFR 438.10(f)(4);

2.15.5.3.3 A combined Provider and Pharmacy Directory, as frequently as specified in Section 2.15.6, that includes all providers of Medicare, Medicaid, and additional benefits; and

2.15.5.3.4 As needed to replace old versions or upon a Participant's request, a single identification (ID) card for accessing all Covered Items and Services provided by the FIDA Plan.

2.15.5.4 The FIDA Plan must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.15.5.5 Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the FIDA Plan must provide Participants with at least sixty (60) days advance notice regarding

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changes to the comprehensive, integrated formulary. The requirement at 42 C.F.R. § 423.120(b)(5) that FIDA Plans provide at least sixty (60) days advance notice regarding Part D formulary changes also applies to FIDA Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits;

2.15.5.6 The FIDA Plan must ensure that all information provided to Participants and Potential Participants (and families or caregivers when appropriate) is provided in a manner and format that is easily understood and that is:

2.15.5.6.1 Made available in large print (at least 16 point font) to Participants as an Alternative Format, upon request;

2.15.5.6.2 For vital materials, available in Prevalent Languages, as defined in Section 1;

2.15.5.6.3 Written with cultural sensitivity and at a fourth to sixth grade reading level; and

2.15.5.6.4 Available in Alternative Formats, according to the needs of Participants and Potential Participants, including Braille, oral interpretation services in non-English languages, as specified in Section 2.15.3 of this Contract; audiotape; American Sign Language video clips, and other alternative media, as requested.

2.15.6 Provider and Pharmacy Directory

2.15.6.1 Maintenance and Distributions. The FIDA Plan must:

2.15.6.1.1 Maintain a combined Provider and Pharmacy Directory that uses the model document developed by CMS and NYSDOH. This shall be a combined Provider and Pharmacy Directory that

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includes all Participating Providers of Medicare, Medicaid, and additional benefits;

2.15.6.1.2 Ensure an up-to-date copy is available on the FIDA Plan's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.15.6.1.2.1 Beginning in Demonstration Year 2, regularly, but not less than monthly, update the Provider and Pharmacy Directory on the FIDA Plan's website or webportal to account for any changes in Participating Provider ADA accessibility.

2.15.6.1.3 Update at least annually the paper copy of the Provider and Pharmacy Directory.

2.15.6.1.4 Provide a paper copy, as specified in the Medicare-Medicaid marketing guidance, to all new Participants at the time of Enrollment and, upon request, to both new and continuing Participants;

2.15.6.1.5 Provide a paper copy, as specified in the Medicare-Medicaid marketing guidance, to continuing Participants at least every year after the time of Enrollment, unless there is a significant change to the network, in which case the FIDA Plan must send a special mailing of an updated Provider and Pharmacy Directory or information about the network change and provide a paper copy, as specified in the Medicare-Medicaid marketing guidance, immediately;

2.15.6.1.6 Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice

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of termination of a Participating Provider or pharmacy, at least thirty (30) calendar days before the termination effective date, to all members who regularly use the Provider or pharmacy's services; if a contract termination involves a Primary Care Provider, all Participants who are patients of that Primary Care Provider must be notified; and

2.15.6.1.7 Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Participants.

2.15.6.2 Content of Provider and Pharmacy Directory. The Provider and Pharmacy Directory must include, at a minimum, the following information for all providers/pharmacies in the FIDA Plan's Provider and Pharmacy Network:

2.15.6.2.1 The names, addresses, and telephone numbers of all current Participating Providers and pharmacies.

2.15.6.2.2 Participating Providers with areas of special experience, skills and training, including providers with expertise in treating:

2.15.6.2.2.1 Persons with physical disabilities, chronic illness, HIV/AIDS;

2.15.6.2.2.2 Persons with serious mental illness;

2.15.6.2.2.3 Persons who are Deaf or hard-of-hearing and blind or visually impaired;

2.15.6.2.2.4 Persons with co-occurring disorders;

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2.15.6.2.2.5 Persons with ESRD; and

2.15.6.2.3 Other specialties.

2.15.6.2.4 Office hours for each Participating Provider, including the names of any Participating Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

2.15.6.2.5 The cultural and linguistic capabilities of Participating Providers, including languages spoken by the Participating Provider or by skilled medical interpreter at the Participating Provider's site;

2.15.6.2.6 Participating Provider licensing information;

2.15.6.2.7 Whether the Participating Provider is accessible for people with physical disabilities, including its office, exam room(s) and equipment;

2.15.6.2.8 Whether the Participating Provider is accepting new patients;

2.15.6.2.9 Participating Provider access by public transportation;

2.15.6.2.10 In accordance with Section 2.7.1.8.2, whether the Participating Provider or Pharmacy meets the ADA Accessibility Attestation Form requirements;

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2.15.6.2.11 Languages other than English spoken by providers or by skilled medical interpreters at the provider's site, including ASL, and whether translation services are available;

2.15.6.2.12 For Behavioral Health Services providers, qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use);

2.15.6.2.13 For pharmacies, instructions for the Participant to contact the FIDA Plan's toll-free Participant Services telephone line (as described in Section 2.11) for assistance in finding a convenient pharmacy; and

2.15.6.2.14 A description of the roles of the PCP and IDT and the process by which Participants select and change PCPs.

2.16 Data Submissions, Reporting Requirements, and Surveys

2.16.1 General Requirements for Data. The FIDA Plan must provide and require its First Tier, Downstream and Related Entities to provide:

2.16.1.1 All information CMS and the NYSDOH require under the Contract related to the performance of the FIDA Plan's responsibilities, including non-medical information for the purposes of research and evaluation;

2.16.1.2 Any information CMS and the NYSDOH require to comply with all applicable Federal or State laws and regulations; and

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2.16.1.3 Any information CMS or the NYSDOH require for external rapid cycle evaluation, including, but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Participant satisfaction, Participant Grievances and Appeals and enrollment/disenrollment rates.

2.16.2 General Reporting Requirements

2.16.2.1 The FIDA Plan shall:

2.16.2.1.1 Submit to NYSDOH the applicable NYSDOH reports as required in this Contract and the CMS CY 2014 Core Reporting Requirements, including Appendix 6: Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York-Specific Reporting Requirements;

2.16.2.1.2 Submit to CMS applicable Medicare reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, and § 438 et. seq.

2.16.2.1.3 Submit to CMS and NYSDOH all applicable FIDA Plan reporting requirements;

2.16.2.1.4 Submit to CMS and the NYSDOH all required reports and data in accordance with the specifications, templates and time frames described in this Contract and the CMS CY 2014 Core Reporting Requirements, including Appendix 6:Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York-Specific Reporting Requirements unless otherwise directed or agreed to by CMS and the NYSDOH;

2.16.2.1.5 Report HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements

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for HEDIS, plus additional Medicaid measures required by the NYSDOH. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the FIDA Plan must report to CMS and the NYSDOH;

2.16.2.1.6 Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by the NYSDOH; and

2.16.2.1.7 Submit at the request of CMS or the NYSDOH additional ad hoc or periodic reports or analyses of data related to the Contract.

2.16.3 Information Management and Information Systems

2.16.3.1 General. The FIDA Plan shall:

2.16.3.1.1 Maintain Information Systems (Systems) that will enable the FIDA Plan to meet all of the NYSDOH's requirements as outlined in this Contract. The FIDA Plan's Systems shall be able to support current State requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following State standards:

2.16.3.1.1.1 The User Experience and Style Guide Version 2.0;

2.16.3.1.1.2 Information Technology Architecture Version 2.0; and

2.16.3.1.1.3 Enterprise Web Accessibility Standards 2.0.

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2.16.3.1.1.4 Ensure a secure, HIPAA-compliant exchange of Participant information between the FIDA Plan and the NYSDOH and any other entity deemed appropriate by the NYSDOH. Such files shall be transmitted to the NYSDOH through secure FTP, HTS, or a similar secure data exchange as determined by the NYSDOH;

2.16.3.1.1.5 Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Participants and providers to quickly and easily locate all relevant information. The FIDA Plan must establish appropriate links, as provided by NYSDOH, on the FIDA Plan's website that direct users back to the NYSDOH's website portal; and

2.16.3.1.1.6 The FIDA Plan shall cooperate with the NYSDOH in its efforts to verify the accuracy of all FIDA Plan data submissions to the NYSDOH.

2.16.3.2 Design Requirements

2.16.3.2.1 The FIDA Plan shall comply with the NYSDOH's requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

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2.16.3.2.2 The FIDA Plan's Systems shall interface with the NYSDOH's Legacy MMIS system, the NYSDOH's MMIS system.

2.16.3.2.3 The FIDA Plan shall have adequate resources to support the MMIS interfaces. The FIDA Plan shall demonstrate the capability to successfully send and receive interface files, which include, but are not limited to:

2.16.3.2.3.1 Inbound Interfaces

2.16.3.2.3.2 Daily Inbound Demographic Change File;

2.16.3.2.3.3 HIPAA 834 History Request File;

2.16.3.2.3.4 Inbound Co-pay Data File (daily); and

2.16.3.2.3.5 Monthly Demonstration Plan Provider and Pharmacy Directory.

2.16.3.2.3.6 Outbound Interfaces

2.16.3.2.3.7 HIPAA 834 Outbound Daily File;

2.16.3.2.3.8 HIPAA 834 Outbound Full File;

2.16.3.2.3.9 HIPAA 834 History Response;

2.16.3.2.3.10 Fee-For-Service Wrap Services;

2.16.3.2.3.11 HIPAA 820; and

2.16.3.2.3.12 TPL Carrier Codes File.

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2.16.3.2.4 The FIDA Plan shall conform to HIPAA compliant standards for data management and information exchange.

2.16.3.2.5 The FIDA Plan shall have controls to maintain information integrity.

2.16.3.2.6 The FIDA Plan shall maintain appropriate internal processes to determine the validity and completeness of data submitted to NYSDOH.

2.16.3.3 Participant Medical Record. The FIDA Plan must maintain a Medical Record to which all members of the IDT have swift and easy access. The FIDA Plan is strongly encouraged to use an electronic health record system that meets the meaningful use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The IDT must have and implement a communications and information sharing plan (as outlined in the IDT Policy) that allows the Participant's health information and Patient-Centered Service Plan to be accessible to the IDT. The FIDA Plan is encouraged to join regional health information networks or qualified health information technology (HIT) entities for data exchange and share information with all providers participating in a Person-Centered Service Plan.

2.16.3.4 System Exchange of Encounter Data

2.16.3.4.1 The FIDA Plan's systems shall generate and transmit Encounter Data files according to the specifications outlined Section 2.17 of this Contract, as updated from time-to-time; and

2.16.3.4.2 The FIDA Plan shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in

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accordance with the standards specified Section 2.17.

2.16.4 Accepting and Processing Assessment Data

2.16.4.1 System Access Management and Information Accessibility Requirements

2.16.4.1.1 The FIDA Plan shall make all systems and system information available to authorized CMS, NYSDOH and other agency staff as determined by CMS or the NYSDOH to evaluate the quality and effectiveness of the FIDA Plan's data and systems.

2.16.4.1.2 The FIDA Plan is prohibited from sharing or publishing CMS or State data and information without prior written consent from CMS or the NYSDOH.

2.16.4.2 System Availability and Performance Requirements

2.16.5 The FIDA Plan shall ensure that its Participant and provider web portal functions and phone-based functions are available to Participants and providers twenty-four (24) hours a day, seven (7) days a week.

2.16.6 The FIDA Plan shall draft an alternative plan that describes access to Participant and provider information in the event of system failure. Such plan shall be contained in the FIDA Plan's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to the NYSDOH upon request. In the event of system failure or unavailability, the FIDA Plan shall notify the CMT upon discovery and implement the COOP immediately.

2.16.7 The FIDA Plan shall preserve the integrity of Participant-sensitive data that reside in both live and archived environments.

2.17 Encounter Reporting

Commented [MS6]: Section 2.17 is PENDING further CMS and NYSDOH discussion.

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2.17.1 The FIDA Plan must meet any diagnosis and/or Encounter reporting requirements that are in place for Medicare Advantage plans, as may be updated from time to time. Furthermore, the FIDA Plan's Systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS or the NYSDOH and updated from time to time. The FIDA Plan shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section. CMS and the NYSDOH will provide technical assistance to the FIDA Plan for developing the capacity to meet encounter reporting requirements.

2.17.2 Requirements. The FIDA Plan shall:

2.17.2.1 Collect and maintain one hundred percent (100%) Encounter Data for all Covered Items and Services provided to Participants, including from any subcapitated sources. Such data must be able to be linked to the NYSDOH's eligibility data;

2.17.2.2 Participate in site visits and other reviews and assessments by CMS and the NYSDOH, or its designee, for the purpose of evaluating the FIDA Plan's collection and maintenance of Encounter Data;

2.17.2.3 Upon request by CMS, the NYSDOH, or their designee, provide Medical Records of Participants and a report from administrative databases of the Encounters of such Participants in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.17.2.4 Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, the NYSDOH, or their designee. Such Encounter Data shall include elements and level of detail determined necessary by CMS and the NYSDOH. As directed by CMS and the NYSDOH, such Encounter Data shall also include the National Provider Identifier

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(NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);

2.17.2.5 Provide Encounter Data to CMS and the NYSDOH on a monthly basis or within time frames specified by CMS and the NYSDOH, including at a frequency determined necessary by CMS and the NYSDOH to comply with any and all applicable statutes, rules, regulations and guidance;

2.17.2.6 Submit Encounter Data that meets the State's requirements for completeness and accuracy. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the FIDA Plan must have systems in place to monitor and audit claims. The FIDA Plan must also correct and resubmit denied encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than three percent (3%) and the number of encounters that need to be manually overridden is no more than one percent (1%); and

2.17.2.7 If CMS, the NYSDOH, or the FIDA Plan, determines at any time that the FIDA Plan's Encounter Data is not complete and accurate, the FIDA Plan shall:

2.17.2.7.1 Notify CMS and the NYSDOH, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.17.2.7.2 Submit for CMS and the NYSDOH approval, within a time frame established by CMS and the NYSDOH, which shall in no event exceed thirty (30) days from the day the FIDA Plan identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or

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enhancements to bring the accuracy and/or completeness to an acceptable level;

2.17.2.7.3 Implement the CMS and the NYSDOH - approved corrective action plan within a time frame approved by CMS and the NYSDOH, which shall in no event exceed thirty (30) days from the date that the FIDA Plan submits the corrective action plan to CMS and the NYSDOH for approval; and

2.17.2.7.4 Participate in a validation study to be performed by CMS, the NYSDOH, and/or their designee, following the end of a twelve (12) month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The FIDA Plan may be financially liable for such validation study.

2.17.2.8 Report as a voided claim in the monthly Encounter Data submission any claims that the FIDA Plan pays, and then later determines should not have paid.

3 Section 3. CMS and NYSDOH Responsibilities

3.1 Contract Management

3.1.1 Administration. Contract Management.

CMS and the NYSDOH will:

3.1.1.1 Designate a Contract Management Team (CMT) that will include at least one representative from CMS and at least one contract manager from the NYSDOH authorized and empowered to represent CMS and the NYSDOH about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office

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(MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and the NYSDOH representatives will act as liaisons among the FIDA Plan and CMS and the NYSDOH for the duration of the Contract. The Contract Management Team will:

3.1.1.1.1 Monitor compliance with the terms of the Contract, including, but not limited to, issuance of joint notices of non-compliance and enforcement.

3.1.1.1.2 Coordinate periodic audits and surveys of the FIDA Plan;

3.1.1.1.3 Receive and respond to External Grievances;

3.1.1.1.4 Conduct regular meetings with the FIDA Plan;

3.1.1.1.5 Coordinate requests for assistance from the FIDA Plan and assign CMS and NYSDOH staff with appropriate expertise to provide technical assistance to the FIDA Plan;

3.1.1.1.6 Make best efforts to resolve any issues applicable to the Contract identified by the FIDA Plan, CMS, or the NYSDOH;

3.1.1.1.7 Inform the FIDA Plan of any discretionary action by CMS or the NYSDOH under the provisions of the Contract;

3.1.1.1.8 Coordinate review of marketing materials and procedures; and

3.1.1.1.9 Coordinate review of Grievance and Appeals data, procedures,

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3.1.1.1.9.1 Review, approve, and monitor the FIDA Plan's Outreach and orientation materials and procedures;

3.1.1.1.9.2 Review, approve, and monitor the FIDA Plan's Complaint and Appeals procedures;

3.1.1.1.9.3 Monitor compliance with all applicable rules and requirements, and issue compliance notices, as appropriate;

3.1.1.1.9.4 Apply one or more of the sanctions provided in Section 5.3.14 including termination of the Contract in accordance with Section 5.5, if CMS and the NYSDOH determine that the FIDA Plan is in violation of any of the terms of the Contract stated herein;

3.1.1.1.9.5 Conduct site visits as determined necessary by CMS and the NYSDOH to verify the accuracy of reported data; and

3.1.1.1.9.6 Coordinate the FIDA Plan's external quality reviews conducted by the external quality review organization.

3.1.1.2 Conduct prior review and provide written approval of any changes to State or Federal Requirements or Instructions provided in Sections 5.6.1.3 and 5.6.2.5. The non-updating Party (CMS or NYSDOH) shall review and provide written approval of any updates made by the updating Party (CMS or NYSDOH) to the

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documents referenced in Sections 5.6.1.3 and 5.6.2.5, within a reasonable period of time. Written approval by the non-updating Party (CMS or NYSDOH) shall be provided to the CMT.

3.1.2 Performance Evaluation

CMS and the NYSDOH will, at their discretion:

3.1.2.1 Evaluate, through inspection or other means, the FIDA Plan's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.16 and 2.17, and the quality, appropriateness, and timeliness of services performed by the FIDA Plan and its Provider Network. CMS and the NYSDOH will provide the FIDA Plan with the written results of these evaluations;

3.1.2.2 Conduct periodic audits of the FIDA Plan, including, but not limited to, an annual independent external review and an annual site visit;

3.1.2.3 Conduct annual Participant surveys and provide the FIDA Plan with written results of such surveys; and

3.1.2.4 Meet with the FIDA Plan at least semi-annually to assess the FIDA Plan's performance.

3.2 **Eligibility and Enrollment Activities**

3.2.1 Individuals are eligible for the FIDA Demonstration in accordance with Section C.1. of the Memorandum of Understanding between CMS and New York State of August 26, 2013 with the following changes and clarifications:

3.2.1.1 Individuals who are Nursing Facility Clinically Eligible and receiving facility-based LTSS are limited to those individuals who are not already receiving Facility-based or Community-based LTSS (New to Service). These individuals are eligible for the FIDA Demonstration contingent upon submission and approval of an

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amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a);

3.2.1.2 Individuals who are eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver are excluded from Passive Enrollment; and

3.2.1.3 Individuals enrolled in a Medicaid Advantage Plus plan are not excluded from Passive Enrollment.

3.2.2 Enrollment Generally. Enrollment and Disenrollment transactions will be processed through the State Enrollment Broker. Individuals will have the option to contact 1-800-MEDICARE to decline Passive Enrollment into a FIDA Plan or, once enrolled, request Disenrollment. NYSDOH (or its vendor) will submit Enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) Enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to NYSDOH identifying individuals who have elected to disenroll from a FIDA Plan, Opt Out of Passive Enrollment, or have enrolled in or have selected another type of available Medicare coverage that is not a FIDA Plan. NYSDOH will share Enrollment, Disenrollment, and Opt Out transactions with contracted FIDA Plans.

3.2.2.1 All Voluntary and Passive Enrollments are processed through the Enrollment Broker consistent with the enrollment effective date requirements in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

3.2.3 Passive Enrollment - The following eligible individuals are subject to Passive Enrollment, unless expressly excluded by Section C.1. of the MOU:

3.2.3.1 Individuals who are enrolled in an MLTC or MAP Plan as of September 1, 2014, in accordance with Section 3.2.4.2.

3.2.3.1.1 Any individual enrolled in MLTC or MAP who has a fair hearing pending will have

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their Passive Enrollment delayed until such time as he/she has exhausted all appeal rights or waived any additional appeal rights and only following receipt of notices as required in Section 3.2.4.5.

3.2.3.2 Individuals who become eligible to participate in FIDA or MLTCP on or after September 1, 2014 but fail to elect a FIDA Plan, an MLTC Plan, a MAP Plan, or a PACE program.

3.2.3.3 Participants in a FIDA Plan that ceases to operate during the Demonstration, in the event that these Participants fail to elect a different FIDA Plan, an MLTC Plan, a MAP Plan, or PACE Program.

3.2.4 Enrollment Effective Date(s) – All Enrollment effective dates are prospective. Opt-In Enrollment is effective the first day of the month following the initial receipt of an Eligible Individual's request to enroll. In accordance with Section 2.3.1.3, if an Opt-In Enrollment, which includes enrollment from one FIDA Plan to a different FIDA Plan, is entered by the Enrollment Broker and accepted by the NYSDOH's database prior to noon on the twentieth (20th) of the month or noon on the last business day before the twentieth (20th) of the month in the event that the twentieth falls on a weekend or holiday, coverage shall begin on the first day of the following calendar month; any Opt-in Enrollments after the 20th will be effective the first day of the second month following the request. Passive Enrollment is effective on the first day of the month no sooner than sixty (60) days after Participant notification of the right to select a FIDA Plan and the option to decline Passive Enrollment until the last day of the month prior to the effective date of Enrollment.

3.2.4.1 Passive Enrollment Schedule for Individuals in an MLTCP Plan or in a MAP Plan as of October 1, 2014. No earlier than January 1, 2015, the State will begin to conduct Passive Enrollment for those Eligible Individuals who have not submitted a request to enroll in a FIDA Plan. The effective dates above are subject to

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the FIDA Plan meeting CMS and State requirements including the FIDA Plan's capacity to accept new Participants.

3.2.4.1.1 Phase-in Process for MLTC and MAP Participant Phase-In. Once Passive Enrollment is initiated for the MLTC and MAP Participant, it will be phased in as follows:

3.2.4.1.1.1 No earlier than January 1, 2015, NYSDOH will passively enroll:

3.2.4.1.1.1.1 Eligible Individuals with a Medicaid Eligibility Authorization that was renewed in March 2014, April 2014, and May 2014.

3.2.4.1.1.1.2 Eligible Individuals who do not undergo annual Medicaid Renewal and have a birthday within the months of January, February, and March.

3.2.4.1.1.2 No earlier than February 1, 2015, NYSDOH will passively enroll

3.2.4.1.1.2.1 Eligible Individuals with a Medicaid Eligibility Authorization that was renewed in June 2014, July 2014, and August 2014.

3.2.4.1.1.2.2 Eligible Individuals who do not undergo annual Medicaid Renewal and have a birthday within

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the months of April, May, and June.

3.2.4.1.1.3 No earlier than March 1, 2015, NYSDOH will passively enroll

3.2.4.1.1.3.1 Eligible Individuals with a Medicaid Eligibility Authorization that was renewed in September 2014 and October 2014.

3.2.4.1.1.3.2 Eligible Individuals who do not undergo annual Medicaid Renewal and have a birthday within the months of July, August, and September.

3.2.4.1.1.4 No earlier than April 1, 2015, NYSDOH will passively enroll

3.2.4.1.1.4.1 Eligible Individuals with a Medicaid Eligibility Authorization that was renewed in November 2014 and December 2014.

3.2.4.1.1.4.2 Eligible Individuals who do not undergo annual Medicaid Renewal and have a birthday within the months of October, November, and December.

3.2.4.1.1.5 No earlier than May 1, 2015, NYSDOH will passively enroll

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3.2.4.1.1.5.1 Eligible Individuals with a Medicaid Eligibility Authorization that was renewed in January 2015 and February 2015 and any other Eligible Individual that would have qualified for Passive Enrollment between January and May 1, 2015 but was not Passively Enrolled.

3.2.4.2 Passive Enrollment Schedule for Individuals requiring Facility-Based LTSS who are New to Service on or after June 1, 2014. Individuals New to Service on or after June 1, 2014 who meet all eligibility requirements for the FIDA Demonstration and reside in the Service Area will be Passively Enrolled into the FIDA Demonstration if they are enrolled in MLTC as of September 1, 2014.

3.2.4.3 CMS and NYSDOH, upon agreement of both parties, may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the FIDA Plan in making any such adjustments.

3.2.4.4 Passive Enrollment Notice. The State will provide three (3) notices of Passive Enrollment: 1) ninety (90) days prior to the effective date of Passive Enrollment: 2) at least sixty (60) days prior to the effective date of Passive Enrollment; and 3) at least thirty (30) days prior to the effective date of Passive Enrollment. The State will accept Opt Out requests through the last day of the month prior to the effective date of Enrollment. These notices will explain the Eligible Individual's options, including the option to decline Passive Enrollment into the FIDA Plan, or once enrolled, to request prospective disenrollment from the Demonstration.

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3.2.4.5 The sixty (60)day notice will include the name of the FIDA Plan into which the Eligible Individual would be enrolled as of his/her enrollment effective date unless he / she selects another FIDA Plan or Opts Out of the Demonstration prior to his/her enrollment effective date.

3.2.4.6 Thirty (30) days prior to the Passive Enrollment effective date, a second notice will be provided to Eligible Individuals who are scheduled to be passively enrolled and who have not yet chosen a FIDA Plan. The notice will include the name of the FIDA Plan into which the Eligible Individual will be enrolled unless he/she selects another FIDA Plan or Opts Out of the Demonstration. NYSDOH will proceed with Passive Enrollment into the identified FIDA Plan for Eligible Individuals who do not make a different choice prior to the Enrollment effective date as described in the Section 2.3.1.3.

3.2.4.7 Any time an Eligible Individual requests to Opt Out of Passive Enrollment, the State will send a letter confirming the Opt-Out and providing information on the benefits available to the Participant once he/she Opts Out

3.2.4.8 Eligible Individuals who otherwise are included in Medicare reassignment effective January 1 of a given year or from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will not be eligible for Passive Enrollment that same year. For example:

3.2.4.8.1 Those reassigned to a new PDP effective January 1, 2015, will be eligible for Passive Enrollment into an FIDA Plan effective no earlier than January 1, 2016.

3.2.4.8.2 The State and CMS must agree in writing to any changes to the Enrollment effective dates. CMS will provide identifying

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information to the State about Eligible Individuals no later than one hundred twenty (120) days prior to the date of the first Passive Enrollment period.

3.2.4.9 Passive Enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy. The State will assign Eligible Individuals to FIDA Plans through a process that considers current managed care plan Enrollment and current providers. CMS and NYSDOH may stop Passive Enrollment to the FIDA Plan if the FIDA Plan does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and NYSDOH.

3.2.4.10 CMS and NYSDOH will monitor Enrollments, Disenrollments and Opt Outs, based on Participant health needs, evaluation purposes, and for compliance with applicable marketing and Enrollment laws, regulations, and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices.

3.2.4.10.1 Any FIDA Plan whose parent company operates a Medicaid Managed Care plan for which the State has terminated or suspended Enrollment and marketing activities related to the Medicaid Managed Care plan is not permitted to conduct marketing activities related to the FIDA Plan until the Medicaid Managed Care plan deficiencies are resolved or may be disqualified from the FIDA Demonstration.

3.2.4.10.2 Any FIDA Plan under sanction as described in 42 C.F.R. § 422.750 and 42 C.F.R. § 423.750 will not be permitted to conduct Enrollment or Marketing activities related to the FIDA Plan until the FIDA Plan is no longer under such sanction .

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3.2.4.10.3 Any FIDA Plan that is an outlier in the CMS past performance analysis for Contract Year (CY) 2014 and / or has a Consistently Low Performing Icon on the Medicare Plan Finder will be ineligible to receive Passive Enrollment of new Participants until it is no longer considered by CMS to be a past performance outlier and / or no longer has a Consistently Low Performing Icon on Medicare Plan Finder. However, Eligible Individuals in a MA-PD or MLTCP operated by the FIDA Plan's parent organization or plan sponsor may be passively enrolled into the FIDA Plan.

3.2.4.10.4 CMS and NYSDOH will monitor any unusual shifts in Enrollment by individuals identified for Passive Enrollment into a particular FIDA Plan to a MA-PD plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and NYSDOH may discontinue further Passive Enrollment into the FIDA Plan. Any illegal marketing practices will be referred to appropriate agencies for investigation.

3.2.4.10.5 Effective Date of Opt-In Enrollment. If an Opt-In Enrollment, which includes Enrollment from one FIDA Plan to a different FIDA Plan, is received by the Enrollment Broker and accepted by the NYSDOH's database prior to noon on the twentieth (20th) of the month or noon on the last business day prior to the twentieth (20th) day of the month in the event that the twentieth day falls on a weekend or holiday, coverage shall begin on the first day of the following calendar month.

3.2.5 Disenrollment

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3.2.5.1 Voluntary Disenrollment. Participants may request to be disenrolled from the FIDA Plan at any time for any reason, orally or in writing. A Disenrollment request may be made by the Participant to the Enrollment Broker or 1-800-MEDICARE.

3.2.5.2 Voluntary Disenrollments can also result from a request to change coverage such as:

3.2.5.2.1 When a Participant elects to change FIDA Plans. Termination of coverage with the previous FIDA Plan shall take effect at 11:59 p.m. on the day immediately preceding the Participant's effective date of Enrollment with the new FIDA Plan.

3.2.5.2.2 When a Participant requests a new MA-PD plan through 1-800-Medicare and

3.2.5.2.3 When a Participant elects to receive his or her Medicare services through Medicare Fee-for-Service and a separate Medicare PDP.

3.2.5.3 Voluntary Disenrollments are processed by the Enrollment Broker consistent with the Medicare-Medicaid Enrollment and Disenrollment Guidance, including the state-specific Appendix 5, the Contract between NYSDOH and the Enrollment Broker, and other guidance documents specifying NYSDOH approved Enrollment Broker policies and procedures.

3.2.5.4 Voluntary Disenrollment requests submitted directly to the Enrollment Broker are confirmed orally and in writing by the Enrollment Broker.

3.2.5.5 Required Involuntary Disenrollments. NYSDOH and CMS shall terminate a Participant's coverage upon the occurrence of any of the conditions enumerated in Section 40.2 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance or upon the

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occurrence of any of the conditions described in this section. Except for the CMT's role in reviewing documentation related to a Participant's alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering disenrollment transactions described elsewhere in this contract.

3.2.5.5.1 Upon the Participant's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Participant dies. Termination may be retroactive to this date.

3.2.5.5.2 When a Participant remains out of the Service Area or for whom residence in the FIDA Plan Service Area cannot be confirmed for more than six (6) consecutive months.

3.2.5.5.3 When a Participant no longer resides in the Service Area, except for a Participant living in the Service Area who is admitted to a Nursing Facility outside the Service Area and placement is not based on the family or social situation of the Participant. If a Participant is to be disenrolled at the request of the FIDA Plan under the provisions of this Section, the FIDA Plan must first provide documentation satisfactory to NYSDOH and CMS that the Participant no longer resides in the Service Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which NYSDOH and CMS determine that the Participant no longer resides in the Service Area. Termination may be retroactive if NYSDOH and CMS are

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able to determine the month in which the Participant moved from the Service Area.

3.2.5.5.4 When CMS or NYSDOH is made aware that a Participant is incarcerated in a county jail, New York Department of Corrections facility, or Federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month during which the Participant was incarcerated.

3.2.5.5.5 When CMS or NYSDOH is made aware that the Participant is no longer eligible to participate in the FIDA Demonstration.

3.2.5.5.6 The termination or expiration of this Contract terminates coverage for all Participants with the FIDA Plan. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties

3.2.5.5.7 When the CMT approves a request based on information sent from any party to the demonstration showing that a Participant has materially misrepresented information regarding third-party reimbursement coverage according to Section 40.2.6 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

3.2.5.5.8 Termination of a Participant's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the Disenrollment is processed.

3.2.5.5.9 The Enrollment Broker will process the Disenrollment and may provide assistance

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to the Participant in securing alternative coverage.

3.2.5.5.10 The FIDA Plan shall complete a safe discharge process for Disenrollments under this section

3.3 **Enrollment and Disenrollment Systems**

3.3.1 CMS and the NYSDOH will maintain systems to provide:

3.3.1.1 Enrollment, Disenrollment, and Opt-Out information to the FIDA Plan; and

3.3.1.2 Continuous verification of eligibility status.

3.3.2 State Enrollment system

3.3.2.1 Enrollment and Disenrollment Systems. CMS and NYSDOH will maintain systems to provide:

3.3.2.1.1 Enrollment, Disenrollment, and Opt-Out information to the FIDA Plan; and

3.3.2.1.2 Continuous verification of eligibility status.

3.3.3 NYSDOH Enrollment Broker. NYSDOH will utilize an independent third party entity (Enrollment Broker) to facilitate Enrollments and Disenrollments into the FIDA Plan.

3.3.3.1.1 The Enrollment Broker shall:

3.3.3.1.2 Develop generic materials to assist Eligible Individuals in choosing whether to enroll in the Demonstration. Said materials shall present the FIDA Plan's Demonstration Plan in an unbiased manner to Eligible Individuals. The NYSDOH may collaborate with the FIDA Plan in developing Demonstration Plan-specific materials;

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3.3.3.1.3 Present the FIDA Plan in an unbiased manner to Eligible Individuals and Participants seeking to transfer from one FIDA Plan to another. Such presentation(s) shall ensure that Eligible Individuals and such Participants are informed prior to Enrollment of the following:

3.3.3.1.4 The rights and responsibilities of participation in the Demonstration;

3.3.3.1.5 The nature of the FIDA Plan's care delivery system, including, but not limited to, the Provider Network; and

3.3.3.1.6 Orientation and other Participant services made available by the FIDA Plan.

3.3.3.1.7 Enroll, disenroll, and process transfer requests of Participants in the FIDA Plan, including completion of the NYSDOH's Enrollment and Disenrollment forms;

3.3.3.1.8 Ensure that Participants are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by Federal law or waiver; and

3.3.3.1.9 Be knowledgeable about the FIDA Plan's policies, services, and procedures; and

3.3.3.2 Passive Enrollment will be phased in as described in Section 3.2.4.1.1.

4 Section 4. Payment and Financial Provisions

4.1 General Financial Provisions

4.1.1 Capitation Payments.

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4.1.1.1 CMS and the NYSDOH will each contribute to the total Capitation payment. CMS and the NYSDOH will each make monthly payments to the FIDA Plan for their respective portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth in accordance with Section 4.1.1.3 and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The FIDA Plan will receive three (3) monthly payments for each Participant: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from the NYSDOH reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.2 The Medicare Parts A/B Component will be risk adjusted using the Medicare Advantage CMS-HCC model and CMS-HCC ESRD model, except as specified in Section 4.2.4. The Part D direct subsidy portion of the Medicare Part D Component will be risk adjusted using the Part D RxHCC model. The Medicaid Component will utilize the rate cell methodology described in the annual rate report.

4.1.1.3 CMS and the NYSDOH will provide the FIDA Plan with a rate report, to be signed by all Parties, on an annual basis for the upcoming calendar year.

4.1.2 Demonstration Year Dates

Capitation Rate updates will take place on January 1st of each calendar year, however savings percentages and quality withhold percentages (see Sections 4.2.3.1 and 4.3.4 will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	October 1, 2014 - December 31, 2015
2	January 1, 2016 - December 31, 2016

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Demonstration Year	Calendar Dates
3	January 1, 2017 - December 31, 2017

4.2 **Capitated Rate Structure**

4.2.1 Underlying Rate Structure for the Medicaid Component

4.2.1.1 The NYSDOH shall pay the FIDA Plan a monthly Capitation (the Medicaid Component), a sum equal to the product of the approved Capitation Rate and the number of Participants enrolled as of the first day of that month.

4.2.2 Underlying Rate Structure for Medicare Component of the Capitation Rate

4.2.2.1 Medicare will pay the FIDA Plan a monthly Capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4**.** Medicare will also pay the FIDA Plan a monthly Capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2 Medicare A/B Baseline

4.2.2.2.1 The Medicare baseline spending for Parts A/B services are a blend of the Medicare Fee For Service (FFS) standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of Eligible Individuals projected to otherwise be in each program in the absence of the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician

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geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed. Starting January 2015, in calculating the Medicare Advantage projected payment rates, CMS will include frailty adjustment to the payment rates, to the extent applicable in Medicare Advantage rates outside of the Demonstration.

Commented [P7]: This section is PENDING further CMS/NYSDOH discussion.

4.2.2.2.2 Separate baselines will exist for Participants meeting the Medicare ESRD criteria. For Participants with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Participants in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3-star county rate (benchmark) for the applicable county.

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4.2.2.2.3 Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Participant risk scores will be applied to the standardized payment rates at the time of payment.

4.2.2.2.4 The Medicare A/B Component will be updated annually consistent with annual Fee-for-Service (FFS) estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5 If a Participant elects to receive the Medicare hospice benefit, the Participant may remain in the Demonstration Plan, but will obtain the hospice service through the Medicare FFS benefit and the Demonstration Plan would no longer receive the Medicare Parts A/B Component for that Participant as described in this section. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare FFS. Demonstration Plans and providers of hospice services would be required to coordinate these services with the rest of the Participant's care. The Demonstration Plan would continue to receive the Medicare Part D Component for all non-hospice covered drugs. Election of hospice services does not change the Medicaid Component.

4.2.2.3 Medicare Part D

4.2.2.3.1 The Medicare Part D Component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as

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well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2 The monthly Medicare Part D Component for a Participant can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts.

4.2.3 Aggregate Savings Percentages

4.2.3.1 Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and Medicaid components of the capitated rate herein.

4.2.3.1.1 Demonstration Year 1: 1%

4.2.3.1.2 Demonstration Year 2: 1.5%

4.2.3.1.3 Demonstration Year 3: 3% unless changed as a result of the provisions outlined in Section 4.3.3.6

4.2.3.2 Except as otherwise specified, rate updates will take place on January 1st of each calendar year.

4.2.3.3 Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

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4.2.4 Risk Adjustment Methodology

4.2.4.1 Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Participant. Except as specified in Section 4.2.4.2, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.4.2 Coding Intensity Adjustment Factor

4.2.4.2.1 In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Participants except as indicated in Section 4.2.4.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Participants in 2014 with Medicare Advantage experience in 2013. Operationally CMS will still apply the full prevailing Medicare Advantage coding intensity adjustment factor to the risk scores but will increase the Medicare A/B Component for non-ESRD Participants and Participants with an ESRD status of functioning graft, to offset this.

4.2.4.2.2 Because no Demonstration Enrollment is expected before September 30, 2014, in calendar year 2015 CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Participants in 2015 with Medicare Advantage experience in 2014.

4.2.4.2.3 After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Participants.

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4.2.4.2.4 The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Participant with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.3 Medicare Part D: The Medicare Part D national average bid amount will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

4.3 **Payment Terms**

4.3.1 CMS will make monthly, prospective Capitation payments to the FIDA Plan. The Department will make monthly Capitation payments to the FIDA Plan. The Medicare Parts A/B Component will be the product of the Participant's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate or the Medicare Advantage 3-star county rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Participant's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts. The Medicaid Component for each rate cell will be the product of the number of Participants in each category multiplied by the payment rate for that rate cell.

4.3.2 Timing of Capitation Payments

4.3.2.1 Enrollments

4.3.2.1.1 CMS and the NYSDOH will make monthly per member per month Capitation payments to the FIDA Plan. The per member per month (PMPM) Capitation payment for a particular month will reflect payment for the Participants with effective Enrollment into

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the FIDA Plan as of the first day of that month, as described in Section 2.3.1.3.

4.3.2.2 Disenrollments

4.3.2.2.1 The final per member per month Capitation payment made by CMS and the NYSDOH to the FIDA Plan for each Participant will be for the month in which the Disenrollment was submitted, the Participant loses eligibility, or the Participant dies (see Sections 2.3.2 and 3.2.5.5).

4.3.2.3 Timing of Medicaid Component of the Rate

4.3.2.3.1 Capitation paid by the NYSDOH for the Medicaid Component is due to the FIDA Plan within the service month. Payments due from NYSDOH, including late charges, will be paid in accordance with the New York State Finance Law when applicable. Collection of underlying amounts owed plus interest shall be the FIDA Plan's sole remedy against the NYSDOH for late payments by the State. Payment terms contained on the FIDA Plan's invoices shall have no force and effect.

4.3.2.4 Adjustments in amounts paid by the NYSDOH due to lags in the eligibility system are described in Section 4.2.1.

4.3.3 Modifications to Capitation Rates

CMS and the NYSDOH will jointly notify the FIDA Plan in advance and in writing of any proposed changes to the Capitation rates, and the FIDA Plan shall accept such changes as payment in full as described in Section 4.6.

4.3.3.1 Rates will be updated using a similar process for each calendar year. Subject to Section 4.3.3.2, changes to the Medicare and Medicaid baselines outside of the annual

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Medicare Advantage and Part D rate announcement and the annual Medicaid rate update will be made only if and when CMS and the NYSDOH jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity. CMS and/or NYSDOH will make changes to baseline estimates within thirty (30) days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.

4.3.3.2 For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.3.3.3 Subject to Section 4.3.3.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the NYSDOH to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.3.3.4 CMS will evaluate Participant risk scores in Demonstration Year 1 and Demonstration Year 2 to determine whether coding intensity in either or both years supports the need for adjustments to the baseline in Demonstration Year 3. CMS will incorporate such adjustments into the Demonstration Year 3 baseline, as appropriate, on a prospective basis to prevent overpayments due to increased coding intensity.

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4.3.3.5 Changes to the savings percentages will be made if and when CMS and the NYSDOH jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.3.3.6 In the event that a least one-third of FIDA Plans experience losses in Demonstration Year 1 exceeding three (3%) percent of revenue, based on at least twelve (12) months of data from Demonstration Year 1, the savings percentage for Demonstration Year 3 will be reduced to two and a half (2.5%) percent. CMS and NYSDOH will make such determination at least four months prior to the start of Demonstration Year 3.

4.3.4 Quality Withhold Policy for Medicaid and Medicare A/B Components

4.3.4.1 Under the Demonstration, both CMS and the NYSDOH will withhold a percentage of their respective components of the Capitation Rate, with the exception of the Part D Component amounts. The withheld amounts will be repaid subject to the FIDA Plan's performance consistent with established quality thresholds.

4.3.4.2 CMS and the NYSDOH will evaluate the FIDA Plan's performance according to the specified metrics required in order to earn back the quality withhold for a given Demonstration Year.

4.3.4.3 Whether or not the FIDA Plan has met the quality requirements in a given year will be made public.

4.3.4.4 Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

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4.3.4.5 Withhold Measures in Demonstration Year 1

4.3.4.5.1 Figure 4.1 below identifies core withhold measures for Demonstration Year 1. Additional details, including technical specifications, withhold methodology and required benchmarks, will be provided in subsequent guidance.

Figure 4.1: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Participants with initial assessments completed within 30 days of enrollment.	CMS/State defined process measure	X	
Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Participants get appointments and care • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	X	

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	• In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?			
Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure		X
Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: Of those Participants in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any nursing home certifiable Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-defined measure		X

4.3.4.6 Withhold Measures in Demonstration Years 2 and 3

4.3.4.6.1 The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3 and will be based on performance in the core Demonstration and State specified measures.

4.3.4.6.2 Payment will be based on performance on the quality withhold measures listed in Figure 4.2, below**:**

Figure 4.2: Quality Withhold Measures for Demonstration Years 2 and 3

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Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Plan All-cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	X
Improvement/Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-defined measure		X
Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year. <u>Nursing Facility Diversion Rate:</u> <u>Numerator</u>: Of those Participants in the denominator, those who did not reside in a NF for	State-defined measure		X

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	more than 100 continuous days during the current measurement year. Denominator: Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any nursing home certifiable Participants with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			

4.3.5 American Recovery and Reinvestment Act of 2009

4.3.5.1 All payments to the FIDA Plan are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.3.5.2 The FIDA Plan shall offer Indian Participants the option to choose an Indian Health Care Provider as a Primary Care Provider if the FIDA Plan has an Indian Primary Care Provider in its network that has capacity to provide such services;

4.3.5.3 The FIDA Plan shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Covered Items and Services for Indian Participant;

4.3.5.4 The FIDA Plan shall make prompt payment to Indian Health Care Providers;

4.3.5.5 The FIDA Plan shall reimburse an Indian Health Provider at least the full encounter rate or Fee-For-Service rate established by the NYSDOH for that provider, regardless of whether the provider is an Participating Provider.

4.3.5.6 The FIDA Plan shall pay non-network Indian Health Care Providers that are FQHCs for the provision of

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services to an Indian Participant at a rate equal to the rate that the FIDA Plan would pay to a network FQHC that is not an Indian Health Care Provider.

4.3.6 Suspension of Payments

4.3.6.1 The NYSDOH may suspend payments to the FIDAPlan in accordance with 42 C.F.R. § 455.23, et seq. and 130 CMR 450, et seq. as determined necessary or appropriate by New York.

4.4 **Transitions between Rate Cells and Risk Score Changes**

4.4.1 Medicare Risk Score Changes. Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.4.2 Medicaid changes would happen prospectively such that the next month's payment would reflect the change in status.

4.5 **Reconciliation, Audits, and Monitoring**

4.5.1.1 Using the NYSDOH Approved Assessment, the NHLOC designation will be made by FIDA Plans with NYSDOH review and audits of the assessments. NYSDOH and the New York State Office of the Medicaid Inspector General will jointly develop an audit plan, which is subject to CMS approval.

4.6 **Payment in Full**

4.6.1 The FIDA Plan must accept, as payment in full for all Covered Items and Services, the Capitation rate(s) and the terms and conditions of payment set forth herein, except as provided in A.3 of Appendix A.

4.6.2 Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, the NYSDOH and the FIDA Plan), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation rates.

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4.6.3 By signing this Contract, the FIDA Plan accepts that the Capitation rate(s) offered is reasonable; that operating within this Capitation rate(s) is the sole responsibility of the FIDA Plan; and that while data is made available by the Federal Government and the State to the FIDA Plan, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

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5 Section 5. Additional Terms and Conditions

5.1 Administration

5.1.1 Notification of Administrative Changes. The FIDA Plan must notify CMS and the NYSDOH through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The FIDA Plan must notify CMS and the NYSDOH in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Participants, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C**.** The FIDA Plan must notify CMS and the NYSDOH in HPMS of all other changes no later than five (5) Business Days prior to the effective date of such change.

5.1.2 Assignment. The FIDA Plan may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and the NYSDOH, which may be withheld for any reason or for no reason at all.

5.1.3 Independent Contractors:

5.1.3.1 The FIDA Plan, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents or employees of, or joint venturers with, the Federal government or State of New York.

5.1.3.2 The FIDA Plan must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

5.1.4 Subrogation. Subject to CMS and New York State lien and Third Party recovery rights, the FIDA Plan must:

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5.1.4.1 Be subrogated and succeed to any right of recovery of a Participant against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2 Require that the Participant pay to the FIDA Plan all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The FIDA Plan may ask the Participant to:

5.1.4.2.1 Take such action, furnish such information and assistance, and execute such instruments as the FIDA Plan may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the FIDA Plan hereunder; and

5.1.4.2.2 Notify the FIDA Plan hereunder and authorize the FIDA Plan to make such investigations and take such action as the FIDA Plan may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5 Prohibited Affiliations. In accordance with 42 USC § 1396 u-2(d)(1), the FIDA Plan shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the FIDA Plan's obligations under this Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the FIDA Plan's equity or be permitted to serve as a director, officer, or partner of the FIDA Plan.

5.1.6 Disclosure Requirements. The FIDA Plan must disclose to CMS and the NYSDOH information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. § 455(b). The FIDA Plan must obtain

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Federally required disclosures from all Participating Providers and applicants in accordance with 42 C.F.R. § 455(b) and 42 C.F.R. § 1002.3, and as specified by the NYSDOH, including but not limited to obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages. The FIDA Plan must maintain such disclosed information in a manner which can be periodically searched by the FIDA Plan for exclusions and provided to the NYSDOH in accordance with this Contract and relevant State and Federal laws and regulations. In addition, the FIDA Plan must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the FIDA Plan is not a Federally qualified Health Maintenance Organization under the Public Health Service Act.

5.1.7 Physician Incentive Plans

5.1.7.1 The FIDA Plan and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing Physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. The FIDA Plan must submit all information required to be disclosed to CMS and the NYSDOH in the manner and format specified by CMS and the NYSDOH, which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2 The FIDA Plan shall be liable for any and all loss of Federal financial participation (FFP) incurred by New York State that results from the FIDA Plan's or its subcontractors' failure to comply with the requirements governing Physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003; however, the FIDA Plan shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Participants in the FIDA Plan's Demonstration Plan, and the FIDA Plan shall not be liable if it can demonstrate, to the satisfaction of CMS and the NYSDOH, that it has

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made a good faith effort to comply with the cited requirements.

5.1.8 Physician Identifier. The FIDA Plan must require each Physician providing Covered Items and Services to Participants under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The FIDA Plan must provide such unique identifier to CMS and the NYSDOH for each of its PCPs in the format and time-frame established by CMS and the NYSDOH in consultation with the FIDA Plan.

5.1.9 Timely Provider Payments.

5.1.9.1 As defined in 42 C.F.R. § 447.46, the FIDA Plan pays all clean electronic claims within thirty (30) days of receipt and paper claims within forty-five (45) days per NYS Insurance Law Section 3224a.

5.1.9.2 The FIDA Plan or its pharmacy benefit manager (PBM) pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within fourteen (14) days of receipt for electronic claims and within thirty (30) days of receipt all other claims. The FIDA Plan or its PBM pays interest on clean claims that are not paid within fourteen (14) days (electronic claims) or thirty (30) days (all other claims).

5.1.9.3 The FIDA Plan or its PBM assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than thirty (30) days, nor more than ninety (90) days, to submit to the Part D sponsor claims for reimbursement.

5.1.9.4 The FIDA Plan's claims processing system checks claims payment logic to identify erroneous payments.

5.1.9.5 The FIDA Plan's claims processing system checks for pricing errors to identify erroneous payments.

5.1.10 Protection of Participant-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the FIDA Plan shall

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not prohibit or otherwise restrict a provider from advising a Participant about the health status of the Participant or medical care or treatment for the Participant's condition or disease, regardless of whether benefits for such care or treatment are provided under the Contract, if the provider is acting within the lawful scope of practice. In accordance with 42 C.F.R. § 438.102(a)(1), the FIDA Plan shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Participant who is his or her patient, for the following: 1) The Participant's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; 2) any information the Participant needs in order to decide among all relevant treatment options; 3) the risks, benefits, and consequences of treatment or nontreatment; and 4) the Participant's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

5.1.11 Protecting Participant from Liability for Payment

The FIDA Plan must:

5.1.11.1 In accordance with 42 C.F.R. § 438.106, not hold a Participant liable for:

5.1.11.1.1 Debts of the FIDA Plan, in the event of the FIDA Plan's insolvency;

5.1.11.1.2 Covered Items and Services provided to the Participant in the event that the FIDA Plan fails to receive payment from CMS or the NYSDOH for such services; or

5.1.11.1.3 Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Participant if the FIDA Plan had directly provided the services;

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5.1.11.2 Not charge Participants coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A, Section A.3;

5.1.11.3 Not deny any service provided under this Contract to a Participant for failure or inability to pay any applicable charge;

5.1.11.4 Not deny any service provided under this Contract to a Participant who, prior to becoming Medicare and Medicaid eligible, incurred a bill that has not been paid; and

5.1.11.4.1 Moral or Religious Objections. The FIDA Plan is not required to provide, reimburse for, or provide coverage of, a counseling or Referral service that would otherwise be required if the FIDA Plan objects to the service on moral or religious grounds. If the FIDA Plan elects not to provide, pay for, or provide coverage of, a counseling or Referral service because of an objection on moral or religious grounds, it must promptly notify the NYSDOH and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.11.4.1.1 To the State;

5.1.11.4.1.2 With its application for a contract;

5.1.11.4.1.3 Whenever it adopts the policy during the term of the contract; and

5.1.11.4.1.4 The information provided must be:

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5.1.11.4.1.4.1 Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.11.4.1.4.2 Provided to Eligible Individuals before and during Enrollment; and

5.1.11.4.1.4.3 Provided to Participants within ninety (90) days after adopting the policy with respect to any particular service.

5.1.12 Third Party Liability

5.1.12.1 Third Party Health Insurance Determination

5.1.12.1.1 Point of Service (POS). The FIDA Plan will make diligent efforts to determine whether Participants have third party health insurance (TPHI). The LDSS is also responsible for making diligent efforts to determine if Participants have TPHI and to maintain third party information on the WMS/eMedNY Third Party Resource System. If TPHI coverage is known at the POS, the FIDA Plan shall use the TPHI information to coordinate benefits (e.g., alert the provider and ask them to bill the TPHI that should be primary to the FIDA Plan). The FIDA Plan shall make good faith efforts to coordinate benefits and must inform the LDSS of any known changes in status of TPHI insurance eligibility within five (5) Business Days of learning of a change in TPHI. The FIDA Plan may use the Roster as one method to determine TPHI information.

5.1.12.1.2 Post Payment and Retroactive Recovery. The State, and/or its vendor, will also be vested with the responsibility to collect any reimbursement for FIDA Flan Benefit

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Package services obtained from TPHI. In no instances may a Participant be held responsible for disputes over these recoveries. A recovery shall not exceed the Encounter Data paid claim amount. The State will continue to identify available TPHI and post this information to the eMedNY System. The TPHI information will appear on the FIDA Plan's next roster and TPHI file. The FIDA Plan will have six months from the later of the date the TPHI has been posted (eMedNY transaction date) or the FIDA Plan's claim payment date to pursue any recoveries for medical services. All recoveries outside this period will be pursued by the State. For State-initiated and State-identified recoveries, the State will direct providers to refund the State directly. In those instances where the provider adjusted the recovery to the FIDA Plan in error, the FIDA Plan will refund the adjusted recovery to the State.

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

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

5.2 **Confidentiality**

5.2.1 Statutory Requirements. The FIDA Plan understands and agrees that CMS and the NYSDOH may require specific written assurances and further agreements regarding the security and Privacy of Protected Health Information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., parts 160 and 164 as well as PHL § 2780, PHL § 2782, SSL § 369 (4), MHL § 33.13, and SEL § 6530 (23). The FIDA Plan represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The FIDA Plan is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2 Personal Data. The FIDA Plan must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

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5.2.3 Data Security. The FIDA Plan must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Participant names. The FIDA Plan must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of Protected Health Information in accordance with 45 C.F.R. § 164.530(c). The FIDA Plan must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. § 164(c) the HIPAA Security Rule. FIDA Plan must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4 Return of Personal Data. The FIDA Plan must return any and all personal data, with the exception of Medical Records, furnished pursuant to this Contract promptly at the request of CMS or the NYSDOH in whatever form it is maintained by the FIDA Plan. Upon the termination or completion of this Contract, the FIDA Plan shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or the NYSDOH, will destroy such data or material.

5.2.5 Destruction of Personal Data. For any PHI received regarding an Eligible Beneficiary referred to FIDA Plan by the NYSDOH who does not enroll in FIDA Plan's plan, the FIDA Plan must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable State and Federal Privacy and security laws

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including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time. The FIDA Plan shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

5.2.6 Research Data. The FIDA Plan must seek and obtain prior written authorization from CMS and the NYSDOH for the use of any data pertaining to this Contract for research or any other purposes not directly related to the FIDA Plan's performance under this Contract.

5.3 **General Terms and Conditions**

5.3.1 Applicable Law.

The term "applicable law," as used in this Contract, means, without limitation, all Federal and State law, and the regulations, policies, procedures, and instructions of CMS and the NYSDOH all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2 Sovereign Immunity.

Nothing in this Contract will be construed to be a waiver by the NYSDOH or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3 Advance Directives.

Nothing in this Contract shall be interpreted to require a Participant to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4 Loss of Licensure

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If, at any time during the term of this Contract, the FIDA Plan or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the FIDA Plan's facilities or loss of necessary Federal or State approvals, the FIDA Plan must report such loss to CMS and the NYSDOH. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5 Indemnification

The FIDA Plan shall indemnify and hold harmless CMS, the NYSDOH, the Federal government, and New York, and their agencies, officers, employees, agents and volunteers, from and against any and all liability, loss, damage, costs, or expenses which CMS and or New York State may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the FIDA Plan, any person employed by the FIDA Plan, or any of its First Tier, Downstream, or Related Entities provided that the FIDA Plan is notified of any claims within a reasonable time from when CMS and New York State become aware of the claim.

5.3.6 Prohibition against Discrimination

5.3.6.1 In accordance with 42 USC §1396 u-2(b)(7), the FIDA Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the FIDA Plan's Provider Network who is acting within the scope of the provider's license or certification under applicable Federal or State law, solely on the basis of such license or certification. This section does not prohibit the FIDA Plan from including providers in its Provider Network to the extent necessary to meet the needs of the FIDA Plan's Participants or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the FIDA Plan.

5.3.6.1.1 The FIDA Plan shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry,

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age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, Article 15 of the Executive Law (also known as the Human Rights Law, Section 220-e of the Labor Law, Section 230 of the Labor Law, and Section 239 of the Labor Law.

5.3.6.1.2 The FIDA Plan further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract.

5.3.6.1.3 The FIDA Plan will not discriminate against Eligible Individuals, Potential Participants, or Participants on the basis of health status or need for health services.

5.3.6.1.4 The FIDA Plan will provide each provider or group of providers whom it declines to include in its network written notice of the reason for its decision.

5.3.6.1.5 Nothing in subsection (iv), above, may be construed to require the FIDA Plan to contract with providers beyond the number necessary to meet the needs of its Participants; precludes the FIDA Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the FIDA Plan from establishing measures that are designed to maintain quality of services and control costs and are

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consistent with its responsibilities to Participants.

5.3.6.2 If a complaint or claim about discrimination against the FIDA Plan is presented to New York for handling discrimination complaints, the FIDA Plan must cooperate with the investigation and disposition of such complaint or claim.

5.3.7 Anti-Boycott Covenant. During the time this Contract is in effect, neither the FIDA Plan nor any affiliated company, as hereafter defined, may participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended. As outlined in Appendix I, in accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this Contract exceeds $5,000, the FIDA Plan agrees, as a material condition of the contract, that neither the FIDA Plan nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the Federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such FIDA Plan, or any of the aforesaid affiliates of FIDA Plan, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The FIDA Plan shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4). Without limiting such other rights as it may have, CMS and NYSDOH will be entitled to rescind this Contract in the event of noncompliance with this section. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the FIDA Plan.

5.3.8 Information Sharing. During the course of a Participant's Enrollment or upon transfer or termination of Enrollment, whether voluntary or involuntary, and subject to all applicable

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Federal and State laws, the FIDA Plan must arrange for the transfer, at no cost to CMS, NYSDOH, or the Participant, of medical information regarding such Participant to any subsequent provider of medical services to such Participant, as may be requested by the Participant or such provider or as directed by CMS or NYSDOH, regulatory agencies of New York, or the United States Government. With respect to Participants who are in the custody of New York, the FIDA Plan must provide, upon reasonable request of the State agency with custody of the Participant, a copy of said Participant's Medical Records in a timely manner.

5.3.9 Other Contracts. Nothing contained in this Contract shall be construed to prevent the FIDA Plan from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the FIDA Plan must provide CMS and NYSDOH with a complete list of such plans and services, upon request. CMS and NYSDOH will exercise discretion in disclosing information that the FIDA Plan may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or NYSDOH from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10 Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.11 Entire Contract. This Contract, including those attachments, schedules, appendices, exhibits, and addenda that have been specifically incorporated herein and written plans submitted by the FIDA Plan and maintained on file by CMS or NYSDOH, pursuant to this Contract, constitutes the entire agreement of the Parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. No other Contract, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or to bind any of the parties or vary any of the terms contained in this Contract. The

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terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.12 No Third Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a Party hereto regarding such Party's obligations under this Contract.

5.3.13 Corrective Action Plan. If, at any time, CMS or NYSDOH reasonably determine that the FIDA Plan is deficient in the performance of its obligations under the Contract, CMS and NYSDOH may require the FIDA Plan to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and NYSDOH may require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The FIDA Plan must promptly and diligently implement the corrective action plan, and demonstrate to CMS and NYSDOH that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan may subject the FIDA Plan to termination of the Contract by CMS and NYSDOH or other intermediate sanctions as described in Section 5.3.14.

5.3.14 Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1 In addition to termination under Section 5.5, CMS and NYSDOH may impose any or all of the sanctions in Section 5.3.14.2 upon any of the events below; provided, however, that CMS and NYSDOH will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction. Sanctions may be imposed in accordance with this section if the FIDA Plan:

5.3.14.1.1 Fails substantially to provide Covered Items and Services required to be provided under this Contract to Participants;

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5.3.14.1.2 Imposes charges on Participants in excess of any permitted under this Contract;

5.3.14.1.3 Discriminates among Participants or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.14.1.4 Misrepresents or falsifies information provided to CMS, NYSDOH, Participants, or its Provider Network;

5.3.14.1.5 Fails to comply with requirements regarding Physician incentive plans (see Section 5.1.7);

5.3.14.1.6 Fails to comply with Federal or State statutory or regulatory requirements related to this Contract;

5.3.14.1.7 Violates restrictions or other requirements regarding marketing;

5.3.14.1.8 Fails to comply with quality management requirements consistent with Section 2.15;

5.3.14.1.9 Fails to comply with any corrective action plan required by CMS and NYSDOH;

5.3.14.1.10 Fails to comply with financial solvency requirements;

5.3.14.1.11 Fails to comply with reporting requirements; or

5.3.14.1.12 Fails to comply with any other requirements of this Contract.

5.3.14.2 Such sanctions may include:

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5.3.14.2.1 Intermediate sanctions consistent with 42 C.F.R. § 438.702;

5.3.14.2.2 Financial penalties consistent with 42 C.F.R. § 438.704;

5.3.14.2.3 The appointment of temporary management to oversee the operation of the FIDA Plan in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.14.2.4 Suspension of Enrollment (including assignment of Participants);

5.3.14.2.5 Suspension of payment to the FIDA Plan;

5.3.14.2.6 Disenrollment of Participants;

5.3.14.2.7 Denial of payment as set forth in 42 C.F.R. § 438.730; and

5.3.14.2.8 Suspension of marketing.

5.3.14.3 If CMS or NYSDOH have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the FIDA Plan has not successfully implemented an approved corrective action plan in accordance with **Section 5.3.13**, CMS and NYSDOH may:

5.3.14.3.1 Require the FIDA Plan to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and NYSDOH; or

5.3.14.3.2 Require the FIDA Plan to change the manner or method in which the FIDA Plan ensures the performance of such contractual responsibility.

5.3.14.4 Before imposing any intermediate sanctions, NYSDOH and CMS must give the entity timely written notice that

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explains the basis and nature of the sanction and other due process protections that CMS and NYSDOH elect to provide.

5.3.15 Additional Administrative Procedures. CMS and NYSDOH may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The FIDA Plan must comply with all such program memoranda as may be issued from time to time.

5.3.16 Effect of Invalidity of Clauses. If any clause or provision of this Contract is officially declared to be in conflict with any Federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.17 Conflict of Interest. The FIDA Plan certifies that neither the FIDA Plan nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and NYSDOH, with the performance of services under the Contract. Without limiting the generality of the foregoing, CMS and NYSDOH require that neither the FIDA Plan nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing FIDA Plan enrollment functions for NYSDOH. The FIDA Plan further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.18 Insurance for FIDA Plan's Employees. The FIDA Plan must agree to maintain at the FIDA Plan's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and NYSDOH with certification of same upon request. The FIDA Plan, and its professional personnel providing services to Participants, must obtain and maintain appropriate professional liability insurance coverage. The FIDA Plan must, at the request of CMS or NYSDOH, provide certification of professional liability insurance coverage.

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5.3.19 Waiver. The FIDA Plan, CMS, or NYSDOH shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the FIDA Plan, CMS, or NYSDOH in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and NYSDOH of any materials including, but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.20 Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.3.21 Other State Terms and Conditions. The FIDA Plan shall comply with the Standard Terms and Conditions as specified in Appendix I.

5.3.22 The FIDA Plan certifies that it and its employees will comply with applicable provisions of the U.S. Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the ADA(42 U.S.C. § 12101 et seq.) and applicable rules in performance under this Contract.

5.3.23 Non-Exclusion:

5.3.23.1 The FIDA Plan certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal or State department or agency.

5.3.23.2 If at any time during the term of this Contract, the FIDA Plan becomes barred, suspended, or excluded from participation in this transaction, the FIDA Plan shall, within thirty (30) days after becoming barred, suspended or excluded, provide to NYSDOH a written description of each offense causing the exclusion, the

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date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

5.3.24 Lobbying:

5.3.24.1 The FIDA Plan certifies that, to the best of its knowledge and belief, no Federally appropriated funds have been paid or will be paid by or on behalf of the FIDA Plan, to any Person for 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 awarding of any Federal contract, the making of any Federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative agreement.

5.3.24.2 If any funds other than Federally appropriated funds have been paid or will be paid to any Person for 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 this Federal contract, grant, loan or cooperative agreement, the FIDA Plan shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at the FIDA Plan's request from the Department's Bureau of Fiscal Operations.

5.3.24.3 The FIDA Plan shall require that the language of this certification be included in the award document for sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

5.3.24.4 This certification is a material representation of fact upon which reliance was placed when this Contract was

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executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

5.3.24.5 The FIDA Plan certifies that it has accurately completed the NY state anti-lobbying certification on Appendix I, #24.

5.4 **Record Retention, Inspection, and Audit**

5.4.1 The FIDA Plan must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices through ten years from the end of the final Contract period or completion of audit, whichever is later.

5.4.2 The FIDA Plan must make the records maintained by the FIDA Plan and its Provider Network, as required by CMS and NYSDOH and other regulatory agencies, available to CMS and NYSDOH and its agents, designees or FIDA Plans or any other authorized representatives of New York State or the United States Government, or their designees or FIDA Plans, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the FIDA Plan.

5.4.3 The FIDA Plan further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the FIDA Plan and its First Tier, Downstream and Related Entities that pertain to: the ability of the FIDA Plan to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

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5.4.4 The FIDA Plan must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Participants, and any additional relevant information that CMS or NYSDOH may require, in a manner that meets CMS and NYSDOH's record maintenance requirements.

5.4.5 The FIDA Plan must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, NYSDOH and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

5.5 **Termination of Contract**

5.5.1 Grounds for NYSDOH or CMS Termination With Cause

5.5.1.1 In addition to the grounds for termination under 42 C.F.R. § 422.510(a), NYSDOH and CMS shall have the right to terminate this Contract, in whole or in part if the FIDA Plan:

5.5.1.1.1 Takes any action that threatens the health, safety, or welfare of its Participants;

5.5.1.1.2 Based on creditable evidence, has committed or participated in false, fraudulent ,or abusive activities affecting the Medicare, Medicaid, or other State or Federal health care programs including any unacceptable practice under 18 NYCRR, Part 515, that affects the fiscal integrity of the Medicaid program;

5.5.1.1.3 No longer substantially meets the applicable conditions of 42 C.F.R. part 422 or 423 including if the FIDA Plan has has its Certificate of Authority suspended, limited or revoked by NYSDOH;

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5.5.1.1.4 Is under sanction as described in 42 C.F.R. § 422.750 and 42 C.F.R. § 423.750.

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

5.5.1.1.6 Becomes insolvent;

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

5.5.1.1.8 Knowingly has a director, officer, partner or person owning or controlling more than five percent (5%) of the FIDA Plan'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 FIDA Plan's contractual obligation who has been debarred or suspended by the Federal, State, or local government, or otherwise excluded from participating in procurement activities.

5.5.1.2 The NYSDOH and CMS will notify the FIDA Plan of its intent to terminate this Contract for the FIDA Plan's failure to meet the requirements of this Contract and provide FIDA Plan with a hearing prior to the termination.

5.5.1.3 If NYSDOH suspends, limits, or revokes FIDA Plan's Certificate of Authority under PHL Article 44, and:

5.5.1.3.1 If such action results in the FIDA Plan ceasing to have authority to serve the entire contracted Service Area, as defined by

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Appendix H of this Contract, this Contract shall terminate on the date the FIDA Plan ceases to have such authority; or

5.5.1.3.2 If such action results in the FIDA Plan retaining authority to serve some portion of the contracted Service Area, the FIDA Plan shall continue to offer its Demonstration Plan under this Contract in any designated geographic area not affected by such action, and shall terminate its Demonstration Plan in the geographic areas where the FIDA Plan ceases to have authority to serve.

5.5.1.4 No hearing will be required if this Contract terminates due to NYSDOH suspension, limitation or revocation of the FIDA Plan's Certificate of Authority.

5.5.1.5 Prior to the effective date of the termination the NYSDOH shall notify Participants of the termination, or delegate responsibility for such notification to the FIDA Plan, and such notice shall include a statement that Participants may disenroll immediately from the FIDA Plan's Demonstration Plan.

5.5.1.6 NYSDOH reserves the right to terminate this Contract in the event it is found that the certification filed by the FIDA Plan in accordance with New York State Finance Law 139-k was intentionally false or intentionally incomplete. Upon such finding, the State may exercise its termination right by providing written notification to the FIDA Plan is accordance with the written notification terms of this Contract.

5.5.2 FIDA Plan and NYSDOH/CMS Initiated Termination

5.5.2.1 The FIDA Plan and the NYSDOH/CMS each shall have the right to terminate this Contract in the event that NYSDOH/CMS and the FIDA Plan fail to reach agreement on the monthly Capitation Rates.

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5.5.3 FIDA Plan Initiated Termination

5.5.3.1 All FIDA Plan initiated terminations will be required to comply with the terms of 42 C.F.R 422.512(b).

5.5.3.2 The FIDA Plan shall have the right to terminate this Contract in the event that NYSDOH materially breaches the Contract or fails to comply with any term or condition of this Contract that is not cured within twenty (20) days, or to such longer period as the Parties may agree, of the FIDA Plan's written request for compliance. The FIDA Plan shall give NYSDOH written notice specifying the reason for and the effective date of the termination, which shall not be less time than will permit an orderly Disenrollment of Participants from the FIDA Plan.

5.5.3.3 The FIDA Plan shall have the right to terminate this Contract in the event that its obligations are materially changed by modifications to this Contract and its Appendices by NYSDOH and CMS. In such event, FIDA Plan shall give NYSDOH and CMS written notice within ninety (90) days of notification of changes to the Contract or Appendices specifying the reason and the effective date of termination, which shall not be less time than will permit an orderly disenrollment of Participants from the FIDA Plan.

5.5.3.4 The FIDA Plan shall have the right to terminate this Contract in its entirety or in specified counties of the FIDA Plan's service area if the FIDA Plan is unable to provide the Combined Medicare Advantage and FIDA Plan Benefit Package.

5.5.3.5 Package pursuant to this Contract because of a natural disaster and/or an act of God to such a degree that Participants cannot obtain reasonable access to Combined Medicare Advantage and FIDA Services within the FIDA Plan's organization, and, after diligent efforts, the FIDA Plan cannot make other provisions for the delivery of such services. The FIDA Plan shall give

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NYSDOH written notice of any such termination that specifies:

5.5.3.5.1 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;

5.5.3.5.2 The FIDA Plan's attempts to make other provision for the delivery of FIDA Covered Items and Services; and

5.5.3.5.3 The effective date of the termination, which shall be at least ninety (90) days after CMS and NYSDOH receive the FIDA Plan's notice of intent to terminate, and will in any event not be less time than will permit an orderly Disenrollment of Participants from the FIDA Plan.

5.5.4 Termination Due To Loss of Funding

5.5.4.1 In the event that State and/or Federal funding used to pay for Covered Items and Services under this Contract is reduced so that payments cannot be made in full, this Contract shall automatically terminate, unless both parties agree to a modification of the obligations under this Contract. The effective date of such termination shall be ninety (90) days after the FIDA Plan 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 NYSDOH shall give the FIDA Plan written notice of the earlier date upon which the Contract shall terminate. A reduction in State and/or Federal funding cannot reduce monies due and owing to the FIDA Plan on or before the effective date of the termination of the Contract.

5.5.5 Termination without Prior Notice

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5.5.5.1 In the event the FIDA Plan materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or New York State Medicaid programs, CMS or NYSDOH may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or NYSDOH may terminate the Contract in accordance with regulations that are current at the time of the termination.

5.5.5.2 Without limiting the above, if CMS and NYSDOH determine that participation of the FIDA Plan in the Medicare or New York State Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Participants or compromise the integrity of the Medicare or New York Medicaid program, CMS or the NYSDOH, without prior notice, may immediately terminate this Contract, suspend the FIDA Plan from participation, withhold any future payments to the FIDA Plan, or take any or all other actions under this Contract, law, or equity. Such action may precede enrollment of any Participant into any Demonstration Plan, and shall be taken upon a finding by CMS or the NYSDOH that the FIDA Plan has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Participants.

5.5.5.3 United States law will apply to resolve any claim of breach of this Contract.

5.5.6 Termination with Prior Notice

5.5.6.1 CMS or NYSDOH may terminate this Contract without cause upon no less than ninety (90) days prior written notice to the other Party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the FIDA Plan may choose to not renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a), and may terminate the contract by mutual consent of CMS

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and the NYSDOH at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and NYSDOH will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and NYSDOH prior to their use.

5.5.6.2 Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers FIDA Plan termination of this Contract with prior notice as described in paragraph 5.5.B.1 and non-renewal of this Contract as described in Section 5.7 to be circumstances warranting special consideration, and will not prohibit the FIDA Plan from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.7 Termination pursuant to Social Security Act § 1115A(b)(3)(B)

5.5.8 Termination for Cause

5.5.8.1 Any Party may terminate this Contract upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or NYSDOH determines that a delay in termination would pose an imminent and serious risk to the health of the Participants enrolled with the FIDA Plan or the FIDA Plan experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Participants, whereby CMS or NYSDOH may expedite the termination.

5.5.8.2 Pre-termination Procedures. Before terminating a Contract under 42 C.F.R. § 422.510 and § 438.708, the FIDA Plan may request a pre-termination hearing or develop and implement a corrective action plan. CMS or NYSDOH must:

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5.5.8.2.1 Give the FIDA Plan written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.8.2.2 Notify the FIDA Plan of its appeal rights as provided in 42 C.F.R. § 422(n) and § 438.710.

5.5.9 Termination due to a Change in Law

5.5.9.1 In addition, CMS or NYSDOH may terminate this Contract upon thirty (30) days' notice due to a material change in law or appropriation, or with less or no notice if required by law.

5.5.10 Continued Obligations of the Parties

5.5.10.1 In the event of termination, expiration, or non-renewal of this Contract, or if the FIDA Plan otherwise withdraws from the Medicare or New York State Medicaid programs, the FIDA Plan shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Items and Services to each Participant at the time of such termination or withdrawal until the Participant has been disenrolled from the FIDA Plan's Demonstration Plan; provided, however, that CMS and NYSDOH will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.10.2 In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.10.2.1 If CMS or NYSDOH, or both, elect to terminate or not renew this Contract, CMS and NYSDOH will be responsible for notifying all Participants covered under this

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Contract of the date of termination and the process by which those Participants will continue to receive care. If the FIDA Plan elects to terminate or not renew the Contract, the FIDA Plan will be responsible for notifying all Participants and the general public, in accordance with Federal and State requirements;

5.5.10.2.2 The FIDA Plan must promptly return to CMS and NYSDOH all payments advanced to the FIDA Plan for Participants after the effective date of their disenrollment; and

5.5.10.2.3 The FIDA Plan must supply to CMS and NYSDOH all information necessary for the payment of any outstanding claims determined by CMS and NYSDOH to be due to the FIDA Plan, and any such claims will be paid in accordance with the terms of this Contract.

5.5.11 Participant Transition Plan

5.5.11.1 Upon expiration and non-renewal, or termination of this Contract, and the establishment of a termination date, the FIDA Plan shall comply with the phase-out plan that the FIDA Plan has developed and that NYSDOH and CMS have approved.

5.5.11.2 The FIDA Plan shall contact other community resources to determine the availability of other programs to accept the Participants into their programs;

5.5.11.3 The FIDA Plan shall assist Participants by referring them, and by making their Care Management record and other Participants Medical Records available as appropriate to health care providers and/or programs;

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5.5.11.4 The FIDA Plan shall establish a list of Participants that is prioritized according to those Participants requiring the most skilled care; and

5.5.11.5 Based upon the Participant's established priority and a determination of the availability of alternative resources, individual care plans shall be developed by the FIDA Plan for each Participant in collaboration with the Participant, the Participant's family and appropriate community resources.

5.5.11.6 In conjunction with such termination and Disenrollment, the FIDA Plan shall provide such other reasonable assistance as the NYSDOH or CMS may request affecting that transaction.

5.5.11.7 Upon completion of PCSPs and reinstatement of the Participant's Medicaid benefits through the fee-for-service system or Enrollment in another managed care plan, a Participant shall be disenrolled from the FIDA Plan's Demonstration Plan.

5.5.12 Contract Close-Out Procedures

5.5.12.1 Upon termination or expiration of this Contract, in its entirety or in specific counties in the FIDA Plan's Service Area, and in the event that it is not scheduled for renewal, the FIDA Plan shall comply with close-out procedures that the FIDA Plan develops in conjunction with LDSS, and the NYSDOH, and CMS haves approved. The close-out procedures shall include the following:

5.5.12.1.1 The FIDA Plan shall promptly account for and repay funds advanced by NYSDOH and CMS for coverage of Participants for periods subsequent to the effective date of termination;

5.5.12.1.2 The FIDA Plan shall give NYSDOH and CMS, and other authorized Federal, state or

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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 Contract;

5.5.12.1.3 The FIDA Plan shall submit to NYSDOH and CMS, and other authorized Federal, State or local agencies, within ninety (90) days of termination, a final financial statement and audit report relating to this Contract, made by a certified public accountant, unless the FIDA Plan requests of NYSDOH and CMS and receives written approval from NYSDOH and CMS and all other governmental agencies from which approval is required, for an extension of time for this submission; and

5.5.12.1.4 NYSDOH and CMS shall promptly pay all claims and amounts owed to the FIDA Plan.

5.6 **Order of Precedence**

5.6.1 The following documents are incorporated into and made a part of this Contract, including all appendices:

5.6.1.1 Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.6.1.2 Memorandum of Understanding, a document between CMS and NYSDOH Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Participants (February 22, 2012); and

5.6.1.3 Any State or Federal Requirements or Instructions or updates thereto released to FIDA Plans. Examples

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include the annual rate report, Medicare-Medicaid Marketing Guidance, Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, IDT Policy, Reserve Requirements Guidance, ADA Accessibility Attestation Form, and Nursing Facility Quality Standards Guidance.

5.6.2 In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.6.2.1 The Contract terms and conditions, including all appendices, with the exclusion of Appendix I (Standard New York Terms and Conditions);

5.6.2.2 Appendix I to this Contract.

5.6.2.3 Capitated Financial Alignment Application;

5.6.2.4 The Memorandum of Understanding between CMS and New York State; and

5.6.2.5 Any State or Federal Requirements or Instructions or updates thereto released to MMPs. Examples include the annual rate report, State policy bulletins, Medicare-Medicaid Marketing Guidance, Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, IDT Policy, Reserve Requirements Guidance, ADA Accessibility Attestation Form, and Nursing Facility Quality Standards Guidance.

5.6.3 In the event of any conflict between this Contract and the Memorandum of Understanding, the Contract shall prevail.

5.7 **Contract Term**

This Contract shall be in effect from [date signed], and, so long as the FIDA Plan has not provided CMS and the Department with a notice of intention not to renew, and CMS/NYSDOH have not provided the FIDA Plan with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above, shall be renewed in one-year terms through [demo end date]. This contract will terminate, or its effectuation will be delayed, unless

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NYSDOH receives all necessary approvals from CMS, including but not limited to Section 1115(a) demonstration authority, and unless the FIDA Plan is deemed ready to participate in the FIDA Demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until NYSDOH has received all necessary approvals from CMS. No payments will be made nor Medicaid Federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary Section 1115(a) authority, the readiness review approval, or the effective date of this contract.

5.8 **Amendments**

The Parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the Parties may amend this Contract where such amendment does not violate Federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of each Parties, and attached hereto.

Any Amendment must be approved by the New York State Attorney General and Comptroller.

5.9 **Written Notices**

Notices to the Parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

Copies to:

_____
_____
_____
_____

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To NYSDOH: [Add NYSDOH Address]

Copies to:

General Counsel

Medicaid Director

Attorney General

State Comptroller

To the FIDA Plan: [Add FIDA Plan Address]

Copies to:

_____

_____

_____

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In Witness Whereof, CMS, the NYSDOH, and the FIDA Plan have caused this Contract to be executed by their respective authorized officers:

FIDA Plan:

_____ _____
(Authorized Signatory) (Date)

(Title)

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

_____ _____
(Authorized Signatory) (Date)

(Title)

New York State Department of Health

_____ _____
(Authorized Signatory) (Date)

(Title)

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Section 6: Appendices

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APPENDIX A – COVERED ITEMS AND SERVICES

A.1 Medical Necessity. The FIDA Plan shall provide services to Participants as follows:

A.1.1 The FIDA Plan shall authorize, arrange, coordinate, and provide to Participants all Medically Necessary Covered Items and Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 The FIDA Plan must provide all Covered Items and Services that are Medically Necessary, including but not limited to, those Covered Items and Services that:

A.1.2.1. Prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap.

A.1.3 Notwithstanding this definition, the FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

A.1.3.1. All care must be provided in accordance and compliance with the ADA, as specified by the Olmstead decision.

A.1.4 The FIDA Plan must cover all Items and Services outlined in the Contract and in the State and Federal guidance, including any guidance that may be issued during the Demonstration and may not impose more stringent coverage rules or Medical Necessity criteria for any Covered Item or Services.

A.1.5 The FIDA Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Item or Service solely because of diagnosis, type of illness, or condition of the Participant.

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A.1.6 The FIDA Plan shall not deny authorization for a Covered Item or Service that the Participant or the provider demonstrates is Medically Necessary.

A.1.7 The FIDA Plan may place appropriate limits on a Covered Item or Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The FIDA Plan's Medical Necessity guidelines must, at a minimum, be:

A.1.7.1. Developed with input from practicing Physicians in the Demonstration Plan's Service Area;

A.1.7.2. Developed in accordance with standards adopted by national accreditation organizations;

A.1.7.3. Developed in accordance with the definition of Medical Necessity in this Appendix;

A.1.7.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.7.5. Evidence-based, if practicable; and

A.1.7.6. Applied in a manner that considers the individual health care needs of the Participant.

A.1.8 The FIDA Plan's Medical Necessity guidelines, program specifications and service components for Behavioral Health Services must, at a minimum, be submitted to the NYSDOH annually for approval no later than (thirty) 30 calendar days prior to the start of a new Contract Year, and no later than thirty (30) calendar days prior to any change.

A.1.9 Services shall be provided in a setting that has a home-like character by providing full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and visitors at times convenient for the Participant. The settings/services support community integration, including facilitation of employment and easy access to resources and

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activities in the community. Community-based LTSS are not provided in institution-like settings except when such settings are employed to furnish short term respite to Participants. The State, either directly or through its MCO contracts, must ensure that:(1) all Participants receive appropriate services in the least restrictive and most integrated home and community-based setting, in accordance with CMS community-based setting requirements outlined in the regulatory text at 42 CFR 441.530; and (2) all Participants' engagement and community integration is supported and facilitated to the fullest extent desired by each participant and reflected in the member's PCSP, per regulatory text at 42 CFR 441.301, as covered under that regulation. The State must ensure that all Community-Based settings comply with any revisions to Medicaid regulations.

A.2 Covered Items and Services. The FIDA Plan agrees to provide Participants access to the following Covered Items and Services:

A.2.1 All Items and Services provided under New York State Plan services (including Long-Term Services and Supports (LTSS)), excluding ICF/MR services, and those services otherwise excluded or limited in A.4 or A.5 of this Appendix A.

A.2.2 All Home and Community Based Waiver Services as Specified in Appendix A

A.2.3 All Items and Services provided under Medicare Part A

A.2.4 All Items and Services provided under Medicare Part B

A.2.5 All Items and Services provided under Medicare Part D

A.2.5.1. The integrated formulary must include any Medicaid-covered prescription drugs and certain non-prescription drugs that are excluded by Medicare Part D. The Medicaid-covered prescription and certain non-prescription drugs required for inclusion in the integrated formulary are those listed in the Medicaid State Plan. In all respects, unless stated otherwise in the

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MOU or the Contract, Part D requirements will continue to apply.

A.2.6 As a term and condition of this Demonstration, the FIDA Plan will be required to provide all Medically Necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver Items and Services. Table 7-A provides a list of Planned FIDA Demonstration Services. The Planned FIDA Demonstration Services will be updated to address any changes due to State Plan Amendments, 1115(a) demonstration amendments, and 1915(c) waiver amendments

A.2.7 The FIDA Plan must provide Medicaid coverage of all Medicare Part A and B covered Items and Services, with certain exceptions as noted here or in the FIDA Plan Benefit Package Guidance Template. Specifically, Medicaid does not cover chiropractor services, which are covered by Medicare. Medicaid covers all other Medicare covered items and services.

A.2.8 All Covered Items and Services must be covered in accordance with current NYSDOH coverage rules as found in State and Federal laws and regulations, the Medicare Benefit Policy Manual, all applicable local and national coverage determinations, the State Medicaid Plan, on the www.health.state.ny.us website, on eMedNY or in other policies or guidance published by NYSDOH. Covered Items and Services definitions are subject to changes over time and the FIDA Plan shall comply with any changes made during the Demonstration. The FIDA Plan is required to maintain compliance with all applicable State and Federal policies around applicable Covered Items and Services definitions and coverage rules.

A.2.9 All Medically Necessary physical and Behavioral Health Services and all necessary long-term supports and services are to be provided at no cost to the Participant.

A.2.10 Supplemental Benefits in Addition to Required Covered Items and Services. The FIDA Plan may request NYSDOH and CMS approval to provide supplemental benefits in addition to all required Covered Items and Services. The approval must be

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sought annually and must apply to a full calendar year (three months for 2014) of the Demonstration.

A.2.11 Court-Ordered Services. The FIDA Plan shall provide any Covered Items and Services to Participants as ordered by a court of competent jurisdiction, regardless of whether such services are provided by a Participating Provider or by a Non-Participating Provider. Non-Participating Providers shall be reimbursed by the FIDA Plan at the Medicaid fee schedule. The FIDA Plan is responsible for court-ordered services to the extent that such court-ordered services are included in Covered Items and Services list. 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 Services (including mental health and/or chemical dependence services), or other Medicare and Medicaid Advantage Plus covered services.

A.2.12 All required Covered Items and Services are listed in Table A-1.

A.2.13 All Item and Service definitions are provided in Table A-2.

Table A-1 FIDA Demonstration Covered Items and Services

Abdominal Aortic Aneurism Screening	Medicare Part B Prescription Drugs
Adult Day Health Care	Medicare Part D Prescription Drug Benefit as Approved by CMS
AIDS Adult Day Health Care	Medication Therapy Management
Ambulance	Mobile Mental Health Treatment
Ambulatory Surgical Centers	Moving Assistance
Assertive Community Treatment (ACT)	Non-Emergency Transportation
Assisted Living Program	Nursing Facility (Medicaid)
Assistive Technology (State Plan and Supplemental to State Plan)	Nursing Hotline
Bone Mass Measurement	Nutrition (includes Nutritional Counseling and Educational Services)
Breast Cancer Screening (Mammograms)	NYS Office of Mental Health Licensed Community Residences
Cardiac Rehabilitation Services	Obesity Screening and Therapy to Keep Weight Down

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Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)	Opioid Treatment Services – Substance Abuse
Cardiovascular Disease Screening and Testing	Other Health Care Professional Services
Care Management (Service Coordination)	Other Supportive Services the Interdisciplinary Team Determines Necessary
Cervical and Vaginal Cancer Screening	Outpatient Blood Services
Chemotherapy	Outpatient Hospital Services
Chiropractic	Outpatient – Medically Supervised Withdrawal- Substance Abuse
Colorectal Screening	Outpatient Mental Health
Community Integration Counseling	Outpatient Rehabilitation (OT, PT, Speech)
Community Transitional Services	Outpatient Substance Abuse
Consumer Directed Personal Assistance Services	Outpatient Surgery
Continuing Day Treatment	Palliative Care
Day Treatment	Pap Smear and Pelvic Exams
Defibrillator (implantable automatic)	Partial Hospitalization (Medicaid)
Dental	Partial Hospitalization (Medicare)
Depression Screening	PCP Office Visits
Diabetes Monitoring (Self-Management Training)	Peer-Delivered Services
Diabetes Screening	Peer Mentoring
Diabetes Supplies	Personal Care Services
Diabetic Therapeutic Shoes or Inserts	Personal Emergency Response Services (PERS)
Diagnostic Testing	Personalized Recovery Oriented Services (PROS)
Durable Medical Equipment (DME)	Podiatry
Emergency Care	Positive Behavioral Interventions and Support
Environmental Modifications	Preventive Services
Family Planning Services	Private Duty Nursing
Freestanding Birth Center Services	Prostate Cancer Screening
Health/Wellness Education	Prosthetics
Hearing Services	Psychiatric Services
HIV Screening	Pulmonary Rehabilitation Services
Home and Community Support Services	Respiratory Care Services
Home Delivered and Congregate Meals	Respite
Home Health	Routine Physical Exam 1/year
Home Infusion Bundled Services	Sexually Transmitted Infections (STIs) Screening and Counseling
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs	Skilled Nursing Facility
Home Maintenance Services	Smoking and Tobacco Cessation
Home Visits by Medical Personnel	Social and Environmental Supports
Immunizations	Social Day Care
Independent Living Skills and Training	Social Day Care Transportation

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Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Specialist Office Visits
Inpatient Mental Healthcare	Structured Day Program
Inpatient Mental Health over 190-day Lifetime Limit	Substance Abuse Program
Intensive Psychiatric Rehabilitation Treatment Programs	Telehealth
Inpatient Services during a Non-covered Inpatient Stay	Transportation
Kidney Disease Services (including ESRD services)	Urgent Care
Mammograms	Vision Care Services
Medicaid Pharmacy Benefits as Allowed by State Law	"Welcome to Medicare" Preventive Visit
Medical Nutrition Therapy	Wellness Counseling
Medical Social Services	

Table A-2 FIDA Demonstration Item and Service Definitions

Covered Service	Description of Covered Service and Required Coverage
Abdominal Aortic Aneurism Screening	A one-time abdominal aortic aneurism ultrasound for someone at risk because he/she has a family history of abdominal aortic aneurysms or he is a man age 65 to 75 and has smoked at least 100 cigarettes in his lifetime. (Covered only if referred as a result of Welcome to Medicare preventive visit).
Adult Day Health Care	Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

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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. Individual and group counseling/education is provided in a structured program setting. Nursing care (including triage/assessment of new symptoms), medication adherence support, nutritional services (including breakfast and/or lunch), rehabilitative services, substance abuse services, mental health services, and HIV risk reduction services are among the services provided. Structured socialization and wellness activities such as group exercise are adjunct services provided in the ADHCP setting, but these adjunct services cannot be the sole reason for admission to the program. The program targets services to high need individuals with HIV, and comorbidities such substance abuse and mental illness, and those who may need assistance with managing other chronic condition such as diabetes and hypertension.
Ambulance	See Transportation.
Ambulatory Surgical Centers	The facility services furnished in connection with covered surgical procedures provided in an ambulatory surgical center.
Assertive Community Treatment (ACT) MI	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. The ACT program is designed to serve individuals who will not participate in place-based services in a planful way. All ACT referrals per regulation are

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	received through the local single point of access process (SPOA). The ACT program is an evidence-based practice and is successful in reducing emergency room visits and psychiatric inpatient days. It is planned for ACT teams to join HHS as a network provider and be the care management provider for those enrolled on the ACT team.
Assisted Living Program	Assisted Living Program services include personal care, housekeeping, supervision, home health aides, Personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting. These services are provided to a FIDA Plan Participant.
Assistive Technology (State plan and supplement to State Plan AT)	Those physical adaptations to the private residence of the participant or the family, required by the participant's PCSP, that are necessary to ensure the health, welfare and safety of the person or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation, i.e., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair. Environmental adaptations also cover the cost of repairs and maintenance to environmental equipment if justified as cost effective and the Participant demonstrates a continued need for

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	the adaptation.
Bone Mass Measurement	Bone Mass Measurement for people at risk or losing bone mass or as at risk of osteoporosis, the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.
Breast Cancer Screening (Mammograms)	Breast Cancer Screening (Mammograms) includes the following services: one baseline mammogram between the ages of 35 and 39; one screening mammogram every 12 months for women age 40 and older; and clinical breast exams once every 24 months.
Cardiac Rehabilitation Services	Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral or order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease):	We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.
Cardiovascular Disease Screening	Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).
Care Management (Service Coordination)	Care Management is an individually designed intervention integral to the interdisciplinary team approach to care planning and care management. Care management provides primary assistance to the participant in gaining access to needed services. These interventions are expected to result in assuring the participant's health and welfare and increasing independence, integration and productivity. The Care Management role is outlined throughout the Contract and the IDT Policy.

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Cervical and Vaginal Cancer Screening	Pap tests and pelvic exams to check for cervical and vaginal cancer. As part of the exam, Part B also covers a clinical breast exam to check for breast cancer. Part B covers these screening tests: once every 24 months for all women, once every 12 months if you’re at high risk for cervical or vaginal cancer, or if you’re of childbearing age and have had an abnormal Pap test in the past 36 months.
Chemotherapy	For cancer patients who are hospital inpatients and outpatients, as well as for patients in a doctor's office or freestanding clinic.
Chiropractic	Manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers.
Colorectal Screening	Colorectal screening for people, age 50 and older to help find precancerous growths or find cancer early, when treatment is most effective. May include: barium enema (once every 48 months if you're 50 or over and once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy), colonoscopy (once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy), fecal occult blood test (once every 12 months if you're 50 or older), or flexile sigmoidoscopy (once every 48 months for most people 50 or older. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy).
Community Integration Counseling	Community Integration Counseling is an individually designed service intended to assist participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability and/or living in the community. It is a counseling service provided to the participant who is coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to

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	significant others. This service is primarily provided in the provider's office or the participant's home. While Community Integration Counseling Services are primarily provided in one-to-one counseling sessions, there are times when it is appropriate to provide this service to the participant in a family counseling or group counseling setting. It is available to participants and/or anyone involved in an ongoing significant relationship with the participant when the issue to be discussed relates directly to the participant.
Community Transitional Services	Community Transitional Services (CTS) are defined as individually designed services intended to assist a participant to transition from living in a nursing home to living in the community. These funds are not available to move from the participant's home in the community to another location in the community. This service includes: the cost of moving furniture and other belongings, purchase of certain essential items such as linen and dishes, security deposits, including broker's fees required to obtain a lease on an apartment or home; purchasing essential furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or one time cleaning prior to occupancy. The service will not be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.
Consumer Directed Personal Assistance Services/ Self-Directed PAS	CDPAS provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Recipients have flexibility and freedom in choosing their caregivers. The consumer or the person acting on the consumer's behalf (such as

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	the parent of a disabled or chronically ill child) assumes full responsibility for hiring, training, supervising, and – if need be – terminating the employment of persons providing the services. Recipients must be able and willing to make informed choices regarding the management of the services they receive, or have a legal guardian or designated relative or other adult able and willing to help make informed choices. The consumer or designee must also be responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services; and keep payroll records.
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, and receive Medicaid reimbursement pursuant to 14 NYCRR Part 588.
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, and receive Medicaid reimbursement pursuant to 14 NYCRR Part 588.
Defibrillator (implantable automatic)	Defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.

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Dental (Preventive Dental and Comprehensive Dental)	Dental services include necessary preventive, prophylactic and other dental care, services, supplies, routine exams, prophylaxis, oral surgery and dental prosthetics and orthotic appliances required to alleviate a serious health condition including one which affects employability. Certain ambulatory dental services are subject to prior authorization.
Depression Screening	One depression screening per year conducted in a primary care setting (like a doctor's office) that can provide follow-up treatment and/or referrals.
Diabetes Monitoring (Self-Management Training)	Diabetes self-monitoring, management training and supplies, including coverage for glucose monitors, test strips, and lancets. OTC diabetic supplies such as 2x2 gauze pads, alcohol swabs/pads, insulin syringes and needles are covered by Part D.
Diabetes Screening	Tests to check for diabetes (including fasting glucose tests) if any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). May also be provided if 2 or more of the following apply: age 65 or older, overweight, family history of diabetes (parents, brothers, sisters), or a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds. Based on the results of these tests, the participant may be eligible for up to 2 diabetes screenings each year.
Diabetes Services and Supplies	Supplies, including: blood sugar (glucose) test strips, blood sugar testing monitors, lancet devices and lancets, glucose control solutions, and therapeutic shoes or inserts. Services, including diabetes self-management training, yearly eye exam, foot exam, glaucoma tests, and nutrition therapy services (medical).
Diabetic Therapeutic Shoes or Inserts	Diabetic therapeutic shoes are inserts are for Participants with diabetes who have severe diabetic foot disease. It includes one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year; or one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts

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	provided with such shoes). It also includes fitting the therapeutic custom-molded shoes or depth shoes and training to help Participants manage your diabetes, in some cases.
Diagnostic Testing	Diagnostic testing diagnostic tests, like CT scans, MRIs, EKGs, and X-rays, when a doctor or health care provider orders them as part of treating a medical problem. Includes medically-necessary clinical diagnostic laboratory services ordered by a treating doctor or practitioner to help a doctor diagnose or rule out a suspected illness or condition. Also includes some preventive tests and screenings to help prevent, find, or manage a medical problem.
Durable Medical Equipment (DME)	Durable Medical Equipment and Medical-Surgical Supplies must be ordered by a qualified practitioner. The product dispensed must be medically necessary to prevent, diagnose, correct or cure a condition which causes acute suffering; endangers life; results in illness or infirmity; interferers with the capacity for normal activity; or threatens to cause a significant handicap and is the least costly alternative to meet the medical need. Selected items have limits in the amount and frequency that can be dispensed to an eligible beneficiary. If a beneficiary exceeds the limit on an item, prior authorization must be requested with accompanying medical documentation as to why the limits need to be exceeded. Enteral formula is subject to regulatory benefit limits noted below (no override). Prior authorization is required for some high cost or high utilization items. DME can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury, are not usually fitted, designed or fashioned for a particular individual's use and where equipment is intended for use by only one Participant, it may be either custom-made or customized. No homebound prerequisite and benefit includes non-Medicare covered DME (e.g. tub stool, grab bars, over toilet commodes, shower

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	chairs). DME for short term or trial use must be rented. Medical-Surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value. Includes Medical- supplies such as, enteral/parenteral nutritional formula, incontinence products, catheters, ostomy, wound dressings, diabetic test strips, glucometers and hearing aid batteries. Coverage of enteral formula and nutritional supplements is subject to regulatory benefit limits, and is limited to 1) Participant who are fed via nasogastric, gastrostomy or jejunostomy tube; 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and, 3) children who require liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Standard milk based infant formulas are not covered. Enteral nutritional therapy is not covered as a convenient food substitute. (DOH is considering revised regulations extending coverage for oral formulas for adults who are underweight or losing significant weight due to a disease process such as AIDS or cancer, or for whom a feeding tube is medically contraindicated.)
Emergency Care	Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R Part 438 and that are needed to evaluate or stabilize an Emergency Medical Condition.
Environmental Modifications and Adaptive Devices	Environmental Modifications (E-mods) are internal and external physical adaptations to the home, that are necessary to assure the health, welfare and safety of the participant. These modifications enable the participant to function with greater independence and prevent institutionalization. E-mods may

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	include: installation of ramps and grab bars; widening of doorways; modifications of bathroom facilities; installation of specialized electrical or plumbing systems to accommodate necessary medical equipment; or any other modification necessary to assure the participant's health, welfare or safety. E-mods do not include improvements to the home (e.g. carpeting, roof repair, central air conditioning), that are not medically needed or do not promote the participant's independence in the home or community. An E-mod may alter the basic configuration of the participant's home if such alternation is necessary to successfully complete the modification, but may not add to the total square footage of the home. Home modifications must be provided where the participant lives. If a participant is moving to a new location, needed modifications may be completed prior to the participant's move. However, if an eligible individual is residing in an institution at the time of application, the modifications may be completed no more than thirty (30) days prior to the participant moving into the modified residence. All modifications must meet State and local building codes and may be subject to independent review. Modifications may also be made to a vehicle if it is the primary means of transportation for the participant. This vehicle may be owned by the participant, or a family member who has consistent and on-going contact with the participant, or a non-relative who provides primary, long term support to the participant. These modifications are approved only when the vehicle is used to improve the participant's independence and inclusion in the community.
Family Planning Services	Includes: o all types of birth control: pills, condoms, diaphragms, IUDs, Depo Provera, Norplant, and contraceptive foams; o emergency contraception;

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	○ pregnancy tests; ○ sterilization (tubal ligations and vasectomies); ○ testing and treatment for sexually transmitted diseases (STDs) including colposcopy, cryotherapy and LEEP;* ○ HIV testing and pre test and post test counseling;* ○ Pap smears; testing for cervical cancer, pelvic problems, breast disease, anemia, and high blood pressure;* ○ abortion. *As part of a family planning visit
Freestanding Birth Center Services	Includes coverage of all services at freestanding birth centers. A freestanding birth center is defined as a health facility that is not a hospital; where childbirth is planned to occur away from the pregnant woman's residence; that is licensed or otherwise approved by the state to provide prenatal care and delivery or postpartum care and other ambulatory services provided in the plan; and that complies with such other requirements relating to the health and safety of individuals provided services by the facility.
Health/Wellness Education/ Health Education	Health and Wellness Education for Participants and their caregivers includes i) the provision of: 1) classes, support groups, and workshops, 2) educational materials and resources, and 3) website, email, or mobile application communications; ii) at no cost to the Participant; iii) on topics including, but not limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.
Hearing Services (Hearing Exams and Hearing Aids)	Medicare and Medicaid hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including

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	examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. Also includes balance exams. Covered hearing aids include analog, digital, behind the ear, in the ear, programmable, monaural and binaural. Accessories for cochlear implants are also covered. Binaural aids for children under the age of 21 and monaural aids for adults 21 and over are prior authorized electronically if within service limits. Prior authorization/manual review with documentation of medical necessity is required for: binaural aids for adults 21 and over are covered for significant vocational or educational needs or visual impairments; override of service limits; special fittings; miscellaneous aids; and repairs over $70.
HIV Screening	For people who ask for an HIV screening test, who are pregnant, or who are at increased risk for HIV infection, includes: one screening exam every 12 months or up to three screening exams during a pregnancy.
Home and Community Support Services	Home and Community Support Services (HCSS) are the combination of personal care services (ADLs and IADLs) with oversight/supervision services or oversight/supervision as a discrete service primarily at a participant's home. HCSS is provided to a participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed. HCSS may be provided in Residential Programs for Adults, Enriched Housing or Adult Care Facilities. Services will be complimentary but not duplicative of other services. HCSS services are provided under the direction and supervision of a Registered Professional Nurse. The Registered Professional Nurse supervising the HCSS staff is responsible for developing a plan and for orienting the HCSS staff.

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	HCSS differs from Personal Care Services provided under the Medicaid State Plan in that oversight/supervision is not a discrete task for which personal care services are authorized. The provision of HCSS must be cost-effective and necessary to avoid institutionalization.
Home Delivered and Congregate Meals/ Meal Benefit	Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared. Congregate and Home Delivered Meals is an individually designed service that provides meals to participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supported in-home meal preparation. While the meals are intended to assist the participant maintain a nutritious diet, they do not constitute a full nutritional regimen. The service is not to be used to replace the regular form of "board" associated with routine living in an Adult Care Facility.
Home Health Services	Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Also includes non-Medicare covered home health services (e.g., home health aide services with nursing supervision to medically unstable individuals). Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for Participants who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved PCSP.
Home Infusion Bundled Services	The Part D covered infusion drug should be billed to Part D for payment and the cost of the administration of the drug and the cost of the supplies needed to administer the drug should be covered by the FIDA Plan as a medical benefit.
Home Maintenance Services	These services include those household chores and services that are required to maintain an individual's home environment in a sanitary, safe, and viable manner. Home maintenance

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	tasks/chores differ from those provided by personal care or home health aides. Environmental support functions in personal care includes such tasks as dusting and vacuuming rooms the Participant uses, making and changing beds, or light cleaning of the kitchen, bedroom and bathroom. The nature of personal care is to provide those routine tasks necessary to maintain the participant's health and safety in the home while Home Maintenance tasks are those chores that are accomplished in only one instance or on an intermittent basis. Chore services are provided on two levels: Light Chores – These services are provided when needed for the maintenance of the home environment. Programs utilize these services when other means of supplying such services are unavailable or more costly. This service is often an appropriate substitute for part or all of personal care services. Light Chore services may include (but are not limited to) tasks such as: - Cleaning and/or washing of windows, walls, and ceilings; - Snow removal and/or yard work to maintain egress and access; - Tacking down loose rugs and/or securing tiles; and, - Cleaning of tile work in bath and/or kitchen. Heavy-Duty Chores – These chore services are provided to prepare or restore a dwelling for the habitation of a participant. They are usually limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Since these services are labor intensive and more costly than routine cleaning, they should not be provided more than twice per year. Heavy-Duty Chore services may include (but are not limited to) tasks such as: - Scraping and/or cleaning of floor areas (including situations where the movement of heavy furniture and/or appliances is necessary in order to perform the cleaning task) - Cleaning of items within an individual's dwelling and/or removal of any item(s) that

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	may threaten the home's sanitary, fire safety, or other safety conditions. Home Maintenance Tasks – Other – These services include those essential services required for the maintenance of the individual's home and home environment but which are not suitable for setting specific rates because of the variety of case situations or individuals involved. Services included in this category might include (but are not limited to) tasks such as: - Unique tasks (such as maintenance of a leaky sink trap) - Other heavy-duty chore services (those for which rates may not be determined before provision)
Home Visits by Medical Personnel	Home Visits by Medical Personnel are individually designed services to provide diagnosis, treatment and wellness monitoring in order to preserve the participant's functional capacity to remain in the community. Wellness monitoring is important to the overall health of participants. Wellness monitoring includes disease prevention, the provision of health education and the identification of modifiable health risks. Through increased awareness and education, participants may make healthy lifestyle choices that will decrease the likelihood of unnecessary institutionalization. The frequency of wellness monitoring will be contingent on the participant's needs. Home Visits by medical personnel are expected to decrease the likelihood of exacerbation of chronic medical conditions and unnecessary and costly emergency room visits, hospitalizations and nursing facility placement. In addition to assessing the participant, this service will also include the evaluation of the home environment from a medical perspective, and the participant's informal support system's ability to maintain and/or assume the role of caregiver. The provider's assessment of the informal support system/ caregivers will focus

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	on the relationship to the participant in terms of the physical, social and emotional assistance that is currently provided or may be provided in the future. Based on the outcome of this assessment, the provider of this service can make referrals for or request that the Service Coordinator make referrals for additional assistance as appropriate to maintain the participant's ability to remain at home or in the least restrictive setting. Home Visits by Medical Personnel differs from what is offered under the State Plan because this service is used for wellness monitoring, the assessment of the informal support system and/or caregiver ability to provide assistance to the participant, and/or the evaluation of the participant's home environment from a medical perspective. This preventive activity decreases the likelihood of accidents in the home, lowers the participant's and caregiver's stress levels, increases the quality of medical care provided to the participant and increases the efficiency of medication management, all of which promote the participant's ability to remain at home. This service is especially beneficial for those participants who have significant difficulty traveling or are unable to travel for needed medical care provided by a physician, physician assistant or nurse practitioner because of one or more of the following: (1) severe pain; (2) severe mobility impairments; (3) terminal illness; (4) a chronic condition that can be exacerbated by travel; (5) medical providers at a physician's office and/or transportation providers refusing to provide services because an individual's disruptive behavior; (6) the home visit is cost-effective or (7) transportation to medical appointments is limited due to geographical or medical considerations. The Medical Personnel are an integral part of the participant's IDT and have the responsibility to inform the IDT and Care Manager of any recommendations for services

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	to meet the participant's medical needs and/or other significant findings. The IDT will utilize this information in revising the participant's PCSP.
Immunizations	Flu (one shot per flu season in the fall or winter), hepatitis B vaccine for people who are at risk, Pneumonia vaccine.
Independent Living Skills and Training	Independent Living Skills Training and Development (ILST) Services are individually designed to improve or maintain the ability of the participant to live as independently as possible in the community. ILST may be provided in the participant's residence and in the community. This service will be primarily provided on an individual basis; only in the unique situation, where the participants will receive greater benefit from other than a 1:1 situation, will this method of providing service be approved. ILST must be provided in the environment and situation which will result in the greatest positive outcome for the participant. It is expected that this service will be provided in the participant's environment; for example, in the participant's kitchen as opposed to the provider's kitchen. This expectation is based on the difficulty that many participants experience with transferring or generalizing knowledge and skills from one situation to another. It is recognized that there is a need for some practice of skills before using them in the environment. Services may include assessment, training, and supervision of or assistance to, an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and ability to maintain a household. This service may also be used to assist a participant in returning to, or expanding the participant's involvement in meaningful

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	activities, such as volunteering or paid employment. This use of this service for these purposes must occur only after it is clear that the participant is not eligible for services provided through the Vocational and Educational Services for Individuals in Disabilities (VESID) or the Commission for the Blind and Visually Handicapped (CBVH); that VESID and CBVH services have been exhausted; or the activity is not covered by VESID or CBVH services. It is expected that ILST providers will train natural supports, paid staff and providers to provide the type and level of supports that allows the participant to act and become as independent as possible in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This service may continue only when the participant has reasonable goals. It is used for training purposes and not ongoing long term supports and reasons to provide or continue this service must be clearly stated in a PCSP.
Inpatient Hospital Care Acute - Including Substance Abuse and Rehabilitation Services	All medically necessary inpatient hospital care acute – including substance abuse and rehabilitation services. Up to 365 days per year (366 days for leap year). Medicaid covers medically necessary inpatient stays and all of the services provided during that inpatient stay. Chemical dependence inpatient rehabilitation services provide intensive management of chemical dependence symptoms and medical management/monitoring of physical or mental complications from chemical dependence to clients who cannot be effectively served as outpatients and who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free-standing facility, and sponsorship may be voluntary not for profit, proprietary or State operated. Providers conduct intensive evaluation, treatment and rehabilitation services in a medically supervised 24 hour/day, 7 days/week setting. Services are provided according to an individualized treatment plan

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	and under the supervision of the IDT.
Inpatient Hospital Psychiatric/ Inpatient Mental Health and Inpatient Mental Health Over 190-Day Lifetime Limit	All medically necessary inpatient mental health services, including voluntary or involuntary admissions for mental health services and including days in excess of the Medicare 190-day lifetime maximum. All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190-Day Lifetime Limit. The FIDA Plan may provide the covered benefit for medically necessary mental health impatient services through hospitals licensed pursuant to Article 28 of the New York State P.H.L.
Intensive Psychiatric Rehabilitation Treatment Programs	A time limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR, Part 587.
Inpatient Services during a Non-covered Inpatient Stay	If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices

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	• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the Participant's physical condition • Physical therapy, speech therapy, and occupational therapy
Kidney Disease Services (including ESRD)	Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Certain drugs for dialysis.
Mammograms	See Breast Cancer Screening (Mammograms)
Medicaid Pharmacy Benefits as Allowed by State Law	Coverage for certain drugs excluded from the Medicare Part D benefit such as some prescription vitamins and some non-prescription drugs
Medical Nutrition Therapy	This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred or ordered by a doctor. It covers 3 hours of one-on-one counseling services during the first year that a

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	Participant receives medical nutrition therapy services under Medicare and 2 hours of one-one-one counseling services each year after that. If condition, treatment, or diagnosis changes, a Participant may be able to receive more hours of treatment with a physician's referral or order. A physician must prescribe these services and renew the referral or order each year if treatment is needed in the next calendar year.
Medical Social Services	Medical Social Services is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. They include services such as home visits to the individual, family or both; visits preparatory to transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services; may also assist participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability, integrating into the community, and on-going life in the community Medical Social Services are provided and arranged for by the provider and may include services such as: Home visits to the individual or family (or both); Visit(s) preparatory to transfer of the individual to the home; Individual and family counseling; and Consultation regarding specific social problems of individuals. These services must be provided by a qualified social worker as defined in Section 700.2(b)(24) 10 NYCRR.
Medicare Part B Prescription Drugs	These drugs are covered under Part B of Medicare, including the following drugs: • Drugs injected or infused while getting doctor, hospital outpatient, or ambulatory surgery center services

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	• Drugs taken using Durable Medical Equipment (such as nebulizers) that were authorized by the plan • Clotting factors given by self injection for Participants with hemophilia • Immunosuppressive drugs, if a Participant were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for Participants who are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themselves. • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoisis-stimulating agents • IV immune globulin for the home treatment of primary immune deficiency diseases.
Medicare Part D Prescription Drug Benefit	Drugs defined in 42 C.F.R. § 423.100.
Medication Therapy Management	Services provided to Participants by qualified Medicaid MTM pharmacists including: • Participant assessment (medical history as related by the patient); • Comprehensive Participant medication therapy review; • Personal medication record (retained by the Participant); • Medication action plan (for the Participant to follow); • Assistance in finding a primary care physician (if needed); • Documentation of problems, resolutions, education and evaluation of Participant response to medication therapy, including adverse events, and; • Follow-up to ensure Participant adherence with medication action plan

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	and encourage Participant self-management.
Mobile Mental Health Treatment	Mobile Mental Health Treatment is individual therapy that is provided in the home. This service is available to a Participant who has a medical condition or disability that limits his/her ability to come into an office for regular outpatient therapy sessions.
Moving Assistance	Moving Assistance Services are individually designed services intended to transport a Participant's possessions and furnishings when the Participant must be moved from an inadequate or unsafe housing situation to a viable environment which more adequately meets the participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the Participant is moving to a location where more natural supports will be available, and thus allows the Participant to remain in the community in a supportive environment. Moving Assistance does not include purchase of items such as security deposits, including broker's fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or cleaning prior to occupancy.
Non-Emergency Transportation	See Transportation.
Nursing Facility (Medicaid)	Nursing facilities are residential settings that are available for people who need 24-hour nursing care and supervision outside of a hospital.
Nursing Hotline	Nursing Hotline means a toll-free phone service to which Participants can call 24 hours a day, 7 days a week for both answers to general health related questions and for assistance in accessing services through the FIDA Plan. The individuals staffing the nursing hotline have access to all FIDA Plan Participants' PCSPs as well as to members of all FIDA Plan Participants' IDTs. These can be used in assisting Participants access care after hours.

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Nutrition	Nutrition services includes the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the Participant's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on specific dietary problems of Participants and nutrition teaching to Participants and families. These services must be provided by a qualified nutritionist as defined in Part 700.2(b)(5), 10 NYCRR. Includes Nutritional Counseling and Educational Services.
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 conditions associated with the person's mental illness. Residential programs provide an array of rehabilitative and supportive services. The services focus on intensive, goal-oriented intervention, within a structured program setting, to address residents' needs regarding community integration, or goal oriented interventions which focus on improving or maintaining resident skills to enable living in community housing.
Obesity Screening and Therapy to Keep Weight Down	Intensive counseling is provided to assist with weight loss for a participant with a body mass index of 30 or more.

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Opioid Treatment Services- Substance Abuse	Opioid treatment is a medical service designed to manage heroin addiction. Opioid treatment programs administer medication, generally methadone by prescription, in conjunction with a variety of other clinical services, to control the physical problems associated with heroin dependence and to provide the opportunity for Participants to make major life style changes over time. Methadone treatment is delivered on an ambulatory basis, with most programs located in either a community or hospital setting. Services include primary medical care, counseling and support services
Other Supportive Services the Interdisciplinary Team Determines Necessary	Additional supportive services or items determined by the Participant's IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant. One example would include a plan providing nutrition services to a participant who cannot chew to be allowed and encouraged to use plan dollars to pay for a blender to puree foods.
Outpatient Blood Services	Blood, beginning with the fourth pint of blood that you need and storage and administration beginning with the first pint of blood needed.
Outpatient Hospital Services	We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include: • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself

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	Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.
Outpatient – Medically Supervised Withdrawal-Substance Abuse	Medical supervision of persons undergoing mild to moderate withdrawal or who are at risk of mild to moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence. Services must be provided under the supervision and direction of a licensed Physician. The following services must be provided: medical supervision of intoxication and withdrawal conditions; evaluation; discharge and recovery care plan; pharmacological services shall be provided as a means of reasonably controlling, or preventing, active withdrawal symptoms and/or averting a life-threatening medical crisis or major suffering and/or disability; Participants must be seen by the Physician, nurse practitioner, physician assistant or Registered Nurse daily unless otherwise specified by the Physician based on the Participant's physical and emotional condition; a medical evaluation must be completed on each Participant, and referral for and linkage to ongoing treatment made as indicated; family educational services must be provided based upon the identified needs of the Participant and family and the availability of the family; the Participant and family member, when available, must be informed, both verbally and in writing, of the signs and symptoms of withdrawal, under what circumstances to call for advice, when to take another dose of medication, and under what circumstances to go to the nearest emergency room. The provider of services must provide or make available a twenty-four (24) hour telephone crisis line to help facilitate the provision of this information; and referral and

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	linkages to other appropriate and necessary services as required by the Participant in support of recovery.
Outpatient Mental Health	Individual and group therapy visits. Participant must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Rehabilitation (Medicaid Outpatient Rehabilitation)	Occupational therapy, physical therapy and speech and language therapy. Medicaid OT, PT, and ST are limited to twenty (20) visits per therapy per calendar year except for the Individuals with Intellectual Disabilities, individuals with traumatic brain injury, and individuals under age 21.
Outpatient Substance Abuse	Individual and group visits. Participant must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Surgery	Medically Necessary visits to an ambulatory surgery center or outpatient hospital facility.
Palliative Care	Health care treatment, including interdisciplinary end-of-life care, and consultation with Participant and family members, to prevent or relieve pain and suffering and to enhance the Participant's quality of life. Includes: Family Palliative Care Education, Pain and Symptom Management, Bereavement Services, Massage Therapy, and Expressive Therapies.
Pap Smear and Pelvic Exams	Medicare defines this as cervical and vaginal cancer screening and limits this to Pap tests and pelvic exams 1x/24mos unless high risk or abnormal pap and childbearing age, then 1x/12 months.
Partial Hospitalization (Medicaid)	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

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	intervention. These services are certified by OMH under NYCRR Part 587.
Partial Hospitalization (Medicare)	Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.
PCP Office Visits	Primary care doctor office visits.
Peer-Delivered Services	Peer support services provided by qualified peer support provider who assist individuals with their recovery from mental illness and substance abuse disorders.
Peer Mentoring	Peer Mentoring is an individually designed service intended to improve the participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information sharing, and self-advocacy training. This service is for seniors and people with disabilities who are struggling to regain a self-satisfying life and may benefit from relating to another person who has been successful in this effort. A Peer Mentor is able to assist the participant to overcome barriers that he or she may face in the community. The provider of Peer Mentoring will develop an ongoing relationship with local providers of health services for mutual training, and when appropriate, referral by one entity to the other to assure that participants receive the most appropriate services. This service is provided on an individual basis; specific goals must be established for individuals receiving this service. Peer Mentoring will primarily be available to participants who have recently transitioned into the community from a nursing home or during times of crisis.
Personal Care Services	Personal care services (PCS) are the provision

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	of some or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of the Participant's health and safety in his or her own home. Personal care must be medically necessary, ordered by the Participant's physician and provided by a qualified person as defined in Part 700.2(b)(14) 10 NYCRR, in accordance with a plan of care.
Personal Emergency Response Services (PERS)	Personal Emergency Response Services (PERS) is an electronic device which enables certain high-risk Participants to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a Participant's phone and signal a response center once a "help" button is activate. In the event of an emergency, the signal is received and appropriately acted upon by a response center.
Personalized Recovery Oriented Services (PROS)	PROS, licensed and reimbursed pursuant to 14 NYCCR 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.
Podiatry	Medically Necessary foot care, including care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) and routine foot care for members with conditions affecting the legs, such as diabetes

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Positive Behavioral Interventions and Support	Positive Behavioral Interventions and Support (PBIS) are individually designed and are provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. These services include but are not limited to: a comprehensive assessment of the individual's behavior (in the context of their medical diagnosis as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment; the development and implementation of a holistic structured behavioral treatment plan (Detailed Plan) including specific realistic goals which can also be utilized by other providers and natural supports; the training of family, natural supports and other provides so that they can also effectively use the basic principles of the behavioral plan; and regular reassessment of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed. The primary focus of the Detailed Plan for this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. None of these activities shall fall within the scope of the practice of mental health counseling set forth in Article 163 of the NYS Education Law. The Detailed Plan must include a clear description of successive levels of intervention, starting with the simplest and least intrusive level. All plans must be written in a manner so that all natural and paid supports will be able to follow the plan. An emergency intervention plan is warranted when there is the possibility of the participant becoming a threat to him or herself or others. The two key positions in PBIS are the Program Director and the Behavioral Specialist. The

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	Program Director is responsible for assessing the participant and developing the PBIS plan for each participant. The Director may work as a Behavioral Specialist, or may provide ongoing supervision to a Behavioral Specialist who will implement the plan. If a provider has more than one individual who meets the qualifications for the Program Director, all qualified individuals may develop individual PBIS plans. The Behavioral Specialist is responsible for implementation of the Detailed Plan under the direction of the Program Director. The PBIS should be provided in the situation where the severe maladaptive behavior occurs. The provision of PBIS must be documented in the PCSP and be provided by individuals or agencies approved as a provider of this service by NYSDOH.
Private Duty Nursing	Private duty nursing services are covered for continuous or intermittent skilled nursing services which are beyond the scope of care available from a certified home health agency and are provided in the Participant's home when ordered by a qualified practitioner and accompanied by a written treatment plan. Additional documentation required includes but is not limited to: a nursing assessment (done in the hospital if hospitalized or by a certified home health agency or public health nurse if the beneficiary is in the community); a back-up and training statement; a psycho-social assessment; information regarding any primary insurance coverage; and a letter of oversight from the attending physician. In the case that the beneficiary is on a ventilator, the home must be fully assessed for safety by a respiratory therapy company. If the beneficiary is attending a school program and private duty nursing is required, the school system or program's oversight agency must provide documentation as to why they are not providing the required nursing.
Prostate Cancer Screening	Prostate Cancer Screening exams once every 12 months for men age 50 and older.

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Prosthetics	Prosthetics, including orthotic appliances and orthopedic footwear, must be ordered by a qualified practitioner. The product dispensed must be medically necessary to prevent, diagnose, correct or cure a condition which causes acute suffering; endangers life; results in illness or infirmity; interferers with the capacity for normal activity; or threatens to cause a significant handicap and is the least costly alternative to meet the medical need. Selected items have limits in the amount and frequency that can be dispensed to an eligible beneficiary. If a Participant exceeds the limit on an item, prior authorization must be requested with accompanying medical documentation as to why the limits need to be exceeded. Footwear and support stockings are subject to regulatory benefit limits noted below (no override). Prior authorization is required for some high cost or high utilization items. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Support stockings are subject to a benefit limit and coverage is limited to medically necessary stockings for treatment of open venous stasis ulcers, children and support during pregnancy. Orthopedic footwear are 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. Orthopedic footwear coverage is subject to a benefit limit and is limited to medically necessary footwear for diabetics, children, or individuals who require a shoe attached to an orthotic appliance. Orthopedic footwear must be dispensed by a provider who is certified or employs others who are certified by one of the following: the American Board of Certification in Orthotics or the Board of Certification/Accreditation, International.

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	Prosthetic appliances and devices are appliances and devices, (other than artificial eyes and dentures) which replace any missing part of the body.
Pulmonary Rehabilitation Services	Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral or an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.
Respiratory Care Services	Includes Respiratory Therapy, which is an individually designed service, specifically provided in the home, intended to provide preventive, maintenance, and rehabilitative airway-related techniques and procedures.
Respite	Respite services is an individually designed service intended to provide scheduled relief to non-paid supports who provide primary care and support to a participant. The service may be provided in a 24-hour block of time as required. The primary location for the provision of this service is in the participant's home, but Respite services may also be provided in another community dwelling acceptable to the participant. Providers of the Respite services must meet the same standards and qualifications as the direct care providers of Home and Community Support Services (HCSS) for respite provided in the home.
Routine Physical Exam 1/year	Up to one routine physical per year. This includes an annual wellness visit to develop or update a personalized prevention plan based on current health and risk factors.
Sexually Transmitted Infections Screening and Counseling:	Sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis and/or Hepatitis B, for people with Medicare who are pregnant and/or for certain people who are at increased risk for an STI – once every 12 months or at certain times during pregnancy. Tests must be ordered by a primary care doctor

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	or other primary care practitioner. Also covers up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs, which must be provided by a primary care doctor or other primary care practitioner and take place in a primary care doctor's office or primary care clinic.
Skilled Nursing Facility	Medically necessary Medicare and Medicaid covered care provided in a skilled nursing facility. No prior hospital stay required. Non-Medicare Covered Care in Skilled Nursing Facility includes Skilled nursing facility days for FIDA Demonstration Participants provided by a licensed facility as specified in Chapter V, 10 NYCRR, in excess of the first 100 days in the Medicare Advantage benefit period.
Smoking and Tobacco Cessation Counseling	Medicaid coverage of comprehensive counseling and pharmacotherapy for cessation of tobacco use by all Medicaid eligible recipients, including pregnant women, will be provided. Such services will be provided face-to-face, by or under the supervision of a physician and no cost sharing (co-pays) will apply. In accordance with section 4107 of the Patient Protection and Affordable Care Act, current coverage of smoking cessation services for all Medicaid recipients, including pregnant women, will be modified to include a maximum of two quit attempts per 12 months, which will include a maximum of four face-to-face counseling sessions per quit attempt.
Social and Environmental Supports	Services and items to support member's medical needs. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.
Social Day Care	Social day care is a structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, care giver assistance and

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	case coordination and assistance. Social Day Care Transportation service includes providing transportation between the individual's home and the social day care facilities. Social Day Care Transportation service is limited solely to the purpose of transporting participants to and from approved social day care programs as discussed under that service section. The FIDA Plan must assure that transportation services are provided in accordance with the regulatory criteria specified by the New York State Departments of Transportation, Motor Vehicles, and Health as appropriate for the carrier.
Social Day Care Transportation	See Social Day Care
Specialist Office Visits/Specialty Care	Specialist office visits
Structured Day Program	Structured Day Program Services are individually designed services provided in an outpatient congregate setting or in the community, to improve or maintain the participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills and ability to maintain a household. This service may augment some other services when reinforcement of skills is necessary. This is due to the difficulty that many individuals have with transferring or generalizing skills learned in one setting to other settings, and the need for consistent reinforcement of skills. The PCSP should address how the services are complimentary and not duplicative. This service is intended to provide an opportunity for the participant to continue to strengthen skills that are necessary for greater

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	independence, improved productivity and/or increased community inclusion. The Structured Day Program may be provided within a variety of settings and with very different goals. Participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate or long-term goal, may focus on socialization skills. The Structured Day Program is responsible for providing appropriate and adequate space to meet the functional needs of the participants served. The program must provide adequate protection for the program participants' safety and fire safety, including periodic fire drills (minimum of 2 fire drills per year), and must be located in a building that meets all provisions of the NYS Uniform Fire Prevention and Building Codes. In addition, access to the program must meet and adhere to requirements of the Americans with Disabilities Act. The RRDS or NYSDOH Staff may determine the appropriateness of the physical space for the TBI Participants. The provision of Structured Day Programs is cost-effective and necessary to avoid institutionalization. This service differs from adult day health care services available under the Medicaid State Plan in that they are not required to be provided under the direct order of a Physician.
Substance Abuse Program	Substance Abuse Program Services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the Participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.

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	Substance Abuse Programs Services are provided in an outpatient, congregate setting and may include: an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the participant, family members, natural supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan may include both group and individual interventions and reflects the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with traumatic brain injury. The program must have a fully developed plan which details how it will work with existing community support programs, such as Alcoholic Anonymous and secular organizations for sobriety that provide ongoing support to individuals with substance abuse problems. Substance Abuse Program Services will also provide technical assistance to community-based self-help/support groups to improve the ability of the community support programs to provide ongoing supports to individuals with traumatic brain injury. This program differs from State Plan service in that these services will integrate non-residential services with participant specific interventions in the community in order to reinforce the training in a real life situation. The provision of Substance Abuse Programs Services is cost-effective and necessary to avoid institutionalization. All Substance Abuse Programs Services must be documented in the PCSP and provided by agencies approved as providers of this service by NYSDOH and certified/licensed by the State Office of Alcoholism and Substance Abuse Services (OASAS).

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Telehealth/Tele-Monitoring and Web-Phone Based Technology	Reimbursement for home telehealth services is to be provided for Participants with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriate reduce the need for on-site or in-office visits or acute long term care facility admissions. Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.
Transportation Services – Emergency and Non-Emergency Transportation	Transportation provided by an ambulance service, including air ambulance. Emergency transportation if for the purpose of obtaining hospital services for a Participant who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency services while the Participant is being transported. Includes transportation to a hospital emergency room generated by a "Dial 911". Transportation essential for a n Participant to obtain necessary medical care and services under the FIDA Demonstration or Medicaid fee-for-service. Includes transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Participant's medical condition. Also includes a transportation attendant to accompany the Participant, 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 Participant's family. For Participants with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.

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	Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets to obtain services and goods not otherwise attainable via State Plan transport.
Urgent Care	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, Physician's office, or in a hospital emergency department if a clinic or Physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Vision Care Services/Eye Exams and Eye Wear	Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed. If the FIDA Plan does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the FIDA Plan cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Participant wants and bill only the difference to the Participant. For example, if the FIDA Plan covers only standard bifocal lenses and the Participant wants no-line bifocal lenses, the Participant must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses).

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	However, the Participant may pay for upgraded lenses as a private customer and have the FIDA Plan pay for the frames or pay for upgraded frames as a private customer and have the FIDA Plan pay for the lenses. The Participant must be informed of this fact by the vision care provider at the time that the glasses are ordered.
"Welcome to Medicare" Preventive Visit	The "Welcome to Medicare" Preventive Visit is a one-time visit. The visit includes: a review of the Participant's health; education and counseling about the preventive services the Participant needs (including screenings and shots), and referrals for other care if needed.
Wellness Counseling	Wellness Counseling is an individually designed service intended to assist the medically stable participant in maintaining an optimal health status. A Registered Professional Nurse assists the participant to identify his/her health care needs and provides guidance to minimize, or in some cases prevent acute episodes of disease and utilize health care resources efficiently and effectively. This service differs from Medicaid (MA) State Plan Nursing Service as the wellness counseling is provided as a discrete service to medically stable individuals. Through Wellness Counseling, a Registered Professional Nurse (RN) can reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. Additionally, the RN is able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol. In addition to these services, the Registered Professional Nurse can assist the participant to identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder. If potential complications are identified, the RN will counsel the participant about appropriate interventions including the need for immediate medical attention or contact the participant's physician for referral to traditional Medicaid

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	State Plan services.

A.3 Description of Non-Covered Items and Services.

The following services are excluded from the FIDA Demonstration Covered Items and Services but, are covered by Medicare or Medicaid fee-for-service. The IDT will be responsible for coordinating, arranging, and ensuring receipt of these services by the Participant from the Medicare and Medicaid FFS programs when called for in a Participant's PCSP:

Hospice Services

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

Hospices are organizations which must be certified under Article 40 of the NYS PHL and approved by Medicare. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by Federal and State requirements. All services must be provided according to a written plan of care, which must be incorporated into the PCSP and reflect the changing needs of the Participant/family.

If a Participant in the FIDA Plan becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access the FIDA Plan's Benefit Package while Hospice costs are paid for by Medicare fee-for-service.

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Out of Network Family Planning Services

Out of network family planning services provided by qualified Medicaid providers to Participants will be directly reimbursed by Medicaid fee-for-service at the Medicaid fee schedule. Family Planning and Reproductive Health Care Services means those health services which enable Participants, including minors, who may be sexually active to prevent or reduce the incidence of unwanted pregnancy. These include: diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases and screening for disease and pregnancy. Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally, in accordance with 42 CFR 441.202 reproductive health care includes coverage of all medically necessary abortions. Fertility services are not covered.

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 the Office of Alcohol and Substance Abuse Services (OASAS) under Title 14 NYCRR, Part 828.

Directly Observed Therapy for Tuberculosis Disease

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen. While the clinical management of tuberculosis is covered in the FIDA Plan's Benefit Package, TB/DOT where applicable, can be billed directly to MMIS by any NYSDOH approved fee-for-service Medicaid TB/DOT provider. The FIDA Plan remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT provider.

The FIDA Plan will have discretion to use the capitated payment to enhance Covered Items and Services with additional non-Covered Items and Services where so doing would address a Participant's needs, as specified in the Participant's PCSP and determined by the IDT. The FIDA Plan will have the flexibility to cover Items or Services that are not traditionally included as

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Medicare or Medicaid Covered Items and Services but that are necessary and appropriate for the Participant.

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APPENDIX B – PARTICIPANT RIGHTS AND RESPONSIBILITIES

The FIDA Plan must have written policies regarding the Participant rights specified in this Appendix, as well as written policies specifying how information about these rights will be disseminated to Participants. Participants must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, functional status, and language needs. Participant rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Memorandum of Understanding (MOU) between CMS and the State. Specifically, each Participant must be guaranteed the right:

A. To receive medically necessary items and services as needed to meets the Participant's needs, in a manner that is sensitive to the Participant's language and culture, and that is provided in an appropriate care setting, including the home and community;
B. To receive timely access to care and services;
C. To request and receive written and oral information about the FIDA Plan, its Participating Providers, its benefits and services and the Participants' rights and responsibilities in a manner the Participant understands.
D. To receive materials and/or assistance in a foreign language and in Alternative Formats, if necessary.
E. To be provided qualified interpreters, free of charge, if a Participant needs interpreters during appointments with providers and when talking to the FIDA Plan;
F. To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality;
G. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
H. Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;
I. To not be discriminated against on the basis of and to get care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, marital status or religion;
J. To be told where, when and how to get the services the Participant needs, including how to get covered benefits from Out-of-Network Providers if they are not available in the FIDA Plan network;

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K. To complain to NYSDOH or the Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate;
L. To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.
M. To appoint someone to speak for him/her about the care he/she needs.
N. To be informed of all rights, and the right to exercise such rights, in writing prior to the effective date of coverage;
O. To participate in his/her care planning and participate in any discussions around changes to the Patient-Centered Service Plan, if/when they are warranted;
P. To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the Participant choice;
Q. To have telephone access to a medical professional from the plan 24/7 in order to obtain any needed emergency or urgent care or assistance;
R. To access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access for Participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;
S. To receive reasonable accommodations in accessing care, in interacting with the FIDA Plan and providers, and in receiving information about one's care and coverage;
T. To see a specialist and request to have a specialist serve as Primary Care Provider;
U. To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the Participant understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.
V. To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.
W. To receive a written explanation if Covered Items or Services were denied, without having to request a written explanation.

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X. To have privacy in care, conversations with providers, and Medical Records such that:
   - Medical and other records and discussions with providers will be kept private and confidential;
   - Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law;
   - Participant may request that any communication that contains Protected Health Information from the FIDA Plan be sent by alternative means or to an alternative address;
   - Participant is provided a copy of the FIDA Plan's Privacy practices, without having to request the same;
   - Participant may 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., if the privacy rule, as set forth in 45 CFR 160 and 164, A and E, applies; and
   - Participant may request information on how his/her health and other personal information has been released by the FIDA Plan;

Y. To seek and receive information and assistance from the independent, conflict free Participant Ombudsman;

Z. To make decisions about providers and coverage, which includes the right to choose and change providers within the FIDA Plan's network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage – whether by changing to another FIDA Plan or making other changes in coverage);

AA. To be informed at the time of enrollment and at PCSP update or revision meetings of the explanation of what is an Advance Directive and the right to make an Advance Directive – giving instructions about what is to be done if the Participant is not able to make medical decisions for him/herself - and to have the FIDA Plan and its Participating Providers honor it; and

BB. To access information about the FIDA Plan, its network of providers, and Covered Items and Services including:
   - information about the FIDA Plan's financial condition, its performance rating, how it compares to other plans, the number of appeals made by Participants;
   - information about the qualifications of the Participating Providers and how they are paid; and
   - information about the rules and restrictions on Covered Items and Services.

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CC. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

DD. The right to access to an adequate network of primary and specialty providers who are capable of meeting the Participant's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

EE. The right to have a voice in the governance and operation of the FIDA Plan system, provider or health plan, as detailed in this Contract.

FF. The right to participate in all aspects of care and to exercise all rights of appeal. Participants have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Participants must:

a. Receive an in-person Comprehensive Assessment upon enrollment in the FIDA Plan and to participate in the development and implementation of a Person-Centered Service Plan. The Comprehensive Assessment must include considerations of social, functional, medical, behavioral, Wellness and prevention domains, an evaluation of the Participant's strengths and weaknesses, and a plan for managing and coordination Participant's care. Participants, or their designated representative, also have the right to request a Comprehensive Reassessment by the Interdisciplinary Team, and be fully involved in any such Comprehensive Reassessment.

b. Receive complete and accurate information on his or her health and Functional Status by the Interdisciplinary Team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Participant's condition and ability to understand. A Participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

i. Before Enrollment.

ii. At Enrollment.

iii. At the time an Eligible Individual's or Participant's needs necessitate the disclosure and delivery of such information in

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order to allow the Eligible Individual or Participant to make an informed choice.

d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.

e. Be afforded the opportunity to file an Appeal if Items or Services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

GG. The right to free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the FIDA Plan and its providers or the State Agency or CMS provide, or arrange for the provision of, medical services to the Participant.

HH. The right to receive timely information about FIDA Plan changes. This includes the right to request and obtain the information listed in the Marketing, Outreach, and Participant Communications materials at least once per year, and , the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.

II. The right to be protected from liability for payment of any fees that are the obligation of the FIDA Plan.

JJ. The right not to be charged any cost sharing for Medicare Parts A and B services.

FIDA Participants have the following responsibilities:

1. To try to understand Covered Items and Services and the rules around getting Covered Items and Services;
2. To tell providers that they are enrolled in a FIDA Plan and show their FIDA Plan ID card;
3. To treat providers and employees of the FIDA Plan with respect;
4. To communicate problems immediately to the FIDA Plan;
5. To accept help from the FIDA Plan's employees without regard to race, religion, color, age, sex, national origin, or disability of the employee or FIDA Plan;
6. To keep appointments or notify the Interdisciplinary Team if an appointment cannot be kept;
7. To supply accurate and complete information to the FIDA Plan's employees;

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8. To actively participate in Person-Centered Service Plan development and implementation;
9. To notify the State and the FIDA Plan of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets;
10. To ask questions and request further information regarding anything not understood;
11. To use the FIDA Plan's Participating Providers for services included in the FIDA Plan Benefit Package;
12. To notify the FIDA Plan of any change in address or lengthy absence from the area;
13. To comply with all policies of the FIDA Plan as noted in the Participant Handbook;
14. To take prescribed medicines;
15. If sick or injured, to call their doctors or care coordinators for direction right away;
16. In case of emergency, to call 911; and
17. If Emergency Services are required out of the service area, to notify the FIDA Plan as soon as possible.

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APPENDIX C: RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

A. The FIDA Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on the FIDA Plan's behalf related to the operation of the Medicare-Medicaid Plan are in compliance with 42 C.F.R. §§ 422.504, 423.505, and 438.6(i).

B. The FIDA Plan shall specifically ensure:
   1. HHS, the Comptroller General, NYSDOH, the New York State Office of the Medicaid Inspector General, Office of State Comptroller, and Office of Attorney General, and their designees, and other State and Federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including Medical Records, documentation, and any pertinent information for of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, NYSDOH, the New York State Office of the Medicaid Inspector General, Office of State Comptroller, and Office of Attorney General, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Participant protections that include prohibiting providers from holding a Participant liable for payment of any fees that are the obligation of the FIDA Plan or any balances unpaid by the FIDA Plan, as balance billing is prohibited;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities must be in accordance with the FIDA Plan's contractual obligations to CMS and NYSDOH;
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where

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CMS, the State or the FIDA Plan determine that such parties have not performed satisfactorily;

5. Language that specifies the performance of the parties is monitored by the FIDA Plan on an ongoing basis and the FIDA Plan may impose corrective action as necessary;
6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Participant Privacy and confidentiality of Participant health records; and
7. Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.

D. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers comply with the Credentialing requirements in 2.7.1.2 of this Contract and contain the following language:
   (a) The credentials of medical professionals affiliated with the party or parties will be reviewed by the FIDA Plan; or
   (b) The credentialing process will be reviewed and approved by the FIDA Plan and the FIDA Plan must audit the credentialing process on an ongoing basis.

E. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers include language that the FIDA Plan retains the right to approve, suspend, or terminate any such arrangement.

F. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that neither the FIDA Plan nor the provider has the right to terminate the contract without cause and shall require the provider to provide at least 90 days' notice to the FIDA Plan and assist with transitioning Participants to new providers, including sharing the Participant's Medical Record and other relevant Participant information as directed by the FIDA Plan or Participant.

G. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the FIDA Plan shall provide a written statement to a provider of the reason or reasons for termination with cause.

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H. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:
   1. Language that the FIDA Plan is obligated to pay contracted medical providers under the terms of the contract between the FIDA Plan and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the FIDA Plan and the relevant medical provider in compliance with 42 C.F.R. § 447.45(d);
   2. Language that services are provided in a culturally and linguistically competent manner to all Participants, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
   3. Language that services must be accessible to all Participants and that reasonable accommodations must be provided to all Participants who require them;
   4. Language describing the Interdisciplinary Team authority to make coverage determinations and the service planning process and the obligations of providers as related to participation on and ongoing involvement with a Participants IDT;
   5. Language describing to Participant Ombudsman and the rights of the Participants to contact the Participant Ombudsman for information and assistance;
   6. Language describing the Participants' Rights;
   7. Language describing required training for providers;
   8. Language describing criminal background checks for providers;
   9. Language describing mandatory reporting requirements and procedures for providers as pertains to known or suspected abuse and neglect of Participants;
   10. Language that medical providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of Medical Records, or other health and enrollment information;
   11. Language that medical providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;
   12. Language that medical providers maintain Participant records and information in an accurate and timely manner;
   13. Language that medical providers ensure timely access by Participants to the records and information that pertain to them;

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14. Language that Participants will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Participants;
15. Language that clearly state the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA;
16. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Participants as patients unless the same limitations apply to all commercially insured Participants;
17. Language that prohibits the FIDA Plan from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Items and Services solely because such provider has in good faith:
    (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the FIDA Plan's health benefit plans as they relate to the needs of such provider's patients; or
    (b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the FIDA Plan for services provided to the patient;
18. Language that states the provider is not required to indemnify the FIDA Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the FIDA Plan based on the FIDA Plan's management decisions, utilization review provisions or other policies, guidelines or actions;
19. Language that states the FIDA Plan shall require providers to comply with the FIDA Plan's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
20. Language that states the FIDA Plan shall notify providers in writing of modifications in payments, modifications in Covered Items and Services or modifications in the FIDA Plan's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the FIDA Plan and the provider or unless such change is mandated by CMS or the Department without 30 days prior notice;

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21. Language that states all First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Specifically, FIDA Plan shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment made directly or indirectly to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Participant and
    (a) The Provider shall not profit from provision of Covered Items and Services that are not Medically Necessary or medically appropriate.
    (b) The FIDA Plan shall not profit from denial or withholding of Covered Items and Services that are Medically Necessary or medically appropriate
22. Language that states that no payment shall be made by the FIDA Plan to a provider for a Provider Preventable Condition; and
23. Language that states as a condition of payment, the provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the FIDA Plan. The provider shall comply with such reporting requirements to the extent the provider directly furnishes services.
24. Language that states the FIDA Plan shall monitor and ensure that all Utilization Management activities provided by a First Tier, Downstream, or Related Entity comply with all provisions of this three-way Contract.
25. Language that prohibits providers from billing Participants for missed appointments or refusing to provide services to Participants who have missed appointments. Such provider contracts shall require providers to work with Participants and the FIDA Plan to assist Participants in keeping their appointments.
26. Language that prohibits providers from refusing to provide services to a Participant because the Participant has an outstanding debt with the provider from a time prior to the Participant becoming a Member.

a. Nothing in this paragraph shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Physicians or Physician groups or that are made with respect to groups of Participants if such agreements, which impose risk on such Physicians or Physician groups for the costs of medical care, services and equipment provided or authorized by another Physician or health care provider, comply with paragraph I, below.

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I. The FIDA Plan shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers includes language that prohibits the FIDA Plan from imposing a financial risk on medical providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care provider such contract includes specific provisions with respect to the following:
   1. Stop-loss protection;
   2. Minimum patient population size for the Physician or Physician group; and
   3. Identification of the health care services for which the Physician or Physician group is at risk.

J. The FIDA Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

K. Nothing in this section shall be construed to restrict or limit the rights of the FIDA Plan to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

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APPENDIX D: ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and <<CONTRACT_NAME>>, the State of New York, acting by and through the New York State Department of Health (NYSDOH), and a Medicare-Medicaid Managed Care Organization (hereinafter referred to as FIDA Plan) agree to incorporate as part of the contract <<CONTRACT_ID>> governing FIDA Plan's operation of a Medicare-Medicaid Plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") this Appendix D under which FIDA Plan shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Should CMS and the State identify opportunities to further integrate operational aspects of the Medicare Prescription Drug Program into the Demonstration, this Contract will be amended accordingly.

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Article I
Voluntary Medicare Prescription Drug Plan

A. FIDA Plan agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this Appendix D, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). FIDA Plan also agrees to operate in accordance with the regulations at 42 C.F.R. § 423 (with the exception of Subparts Q, R, and S), §§ 1860D-1 through 1860D-43 (with the exception of §§ 1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to FIDA Plan consistent with the regulations at 42 C.F.R. § 423 (with the exception of Subparts Q, R, and S), §§ 1860D-1 through 1860D-43 (with the exception of §§ 1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. § 423 that impose new, significant regulatory requirements on FIDA Plan. This provision does not apply to new requirements mandated by statute

D. This addendum is in no way intended to supersede or modify 42 C.F.R. Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to FIDA Plan, New York State, and CMS.

Article II
Functions to be Performed by FIDA Plan

A. ENROLLMENT

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1. FIDA Plan agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. § 423.30(a) and who have elected to enroll in FIDA Plan's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. FIDA Plan agrees to provide the required prescription drug coverage as defined under 42 C.F.R. § 423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. § 423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. FIDA Plan also agrees to provide Part D benefits as described in FIDA Plan Benefit Package approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. FIDA Plan agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. § 423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. FIDA Plan agrees to provide the information required in 42 C.F.R. § 423.48.

2. FIDA Plan acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. § 423.505(o).

3. FIDA Plan certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. FIDA Plan agrees to operate quality assurance, drug Utilization Management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. § 423.

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2. FIDA Plan agrees to address complaints received by CMS against the FIDA Plan as required in 42 C.F.R. § 423.505(b)(22) by:

   (a) Addressing and resolving complaints in the CMS complaint tracking system; and
   (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

FIDA Plan agrees to comply with all requirements in Subpart M of 42 C.F.R. § 423, except to the extent those requirements are waived per Appendix 4 of the Memorandum of Understanding, governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. FIDA Plan acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to FIDA Plan through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO FIDA PLAN

FIDA Plan and CMS and the Department agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If FIDA Plan intends to participate in the Part D program for the next program year, FIDA Plan agrees to submit the next year's Part D FIDA Plan Benefit Package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. § 423 so that CMS, the Department and FIDA Plan may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. FIDA Plan acknowledges that failure to submit a timely FIDA Plan Benefit Package under this section may affect the FIDA Plan's ability to offer a plan, pursuant to the provisions of 42 C.F.R. § 422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

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1. FIDA Plan agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. § 423.

2. FIDA Plan agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. § 423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. FIDA Plan agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and NYSDOH (as defined in Appendix H) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and the Department that meet the requirements of 42 C.F.R. § 423.120.

2. FIDA Plan agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. § 423.124.

3. FIDA Plan agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. § 423.100), and long-term care pharmacies (as defined in 42 C.F.R. § 423.100) according to 42 C.F.R. § 423.505(b)(17).

4. FIDA Plan agrees to contract with any pharmacy that meets FIDA Plan's reasonable and relevant standard terms and conditions according to 42 C.F.R. § 423.505(b)(18).

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

FIDA Plan agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

FIDA Plan agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. § 423.

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L. BENEFICIARY FINANCIAL PROTECTIONS

FIDA Plan agrees to afford its Participants protection from liability for payment of fees that are the obligation of FIDA Plan in accordance with 42 C.F.R. § 423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. FIDA Plan agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. FIDA Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on FIDA Plan's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. § 423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

FIDA Plan must provide certifications in accordance with 42 C.F.R. § 423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. FIDA Plan shall submit prescription drug event data in accordance with 42 C.F.R. § 423.329(b) (3).

P. FIDA PLAN REIMBURSEMENT TO PHARMACIES

1. If FIDA Plan uses a standard for reimbursement of pharmacies based on the cost of a drug, FIDA Plan will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. FIDA Plan will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a Long-Term Care Facility) within 14 days of receipt of an electronically submitted claim

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or within 30 days of receipt of a claim submitted otherwise.

3. FIDA Plan must ensure that a pharmacy located in, or having a contract with, a Long-Term Care Facility will have not less than 30 days (but not more than 90 days) to submit claims to FIDA Plan for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

FIDA Plan agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

FIDA Plan agrees to submit information to CMS according to 42 C.F.R. §§ 423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND NEW YORK STATE LICENSE FOR USE OF FIDA PLAN FORMULARY

FIDA Plan agrees to submit to CMS and NYSDOH the FIDA Plan's formulary information, including any changes to its formularies, and hereby grants to CMS and NYSDOH, and any person or entity who might receive the formulary from CMS and NYSDOH, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. FIDA Plan agrees to comply with the confidentiality and Participant record accuracy requirements specified in 42 C.F.R. § 423.136.

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B. FIDA Plan agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2015. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. § 423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, FIDA Plan will be determined qualified to renew this addendum annually only if:

   (a) FIDA Plan has not provided CMS or the Department with a notice of intention not to renew in accordance with Article VII of this addendum, and

   (b) CMS or the Department has not provided FIDA Plan with a notice of intention not to renew.

2. Although FIDA Plan may be determined qualified to renew its addendum under this Article, if FIDA Plan, CMS, and the Department cannot reach agreement on the Part D FIDA Plan Benefit Package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VI
Nonrenewal of Addendum

A. NONRENEWAL BY FIDA PLAN

FIDA Plan may non-renew this addendum in accordance with 42 C.F.R. § 423.507(a).

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B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. § 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent of the Parties in accordance with 42 C.F.R. § 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. § 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article IX
Termination of Addendum by FIDA Plan

A. FIDA Plan may terminate this addendum only in accordance with 42 C.F.R. § 423.510.

B. If the addendum is terminated under section A of this Article, FIDA Plan must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. FIDA Plan acknowledges that, if it is a Capitated Financial Alignment FIDA Plan, the termination or nonrenewal of this addendum by any Party may require CMS to terminate or non-renew the FIDA Plan's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents FIDA Plan from meeting the requirements of 42 C.F.R. § 422.4(c), in which case the FIDA Plan must provide the notices specified in this contract,

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as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any Party shall not, by itself, relieve the Parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that FIDA Plan's Capitated Financial Alignment contract is terminated or nonrenewed by any Party, the provisions of this addendum shall also terminate. In such an event, FIDA Plan, the Department and CMS shall provide notice to Participants and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, FIDA Plan shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. § 423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. § 423 or, as applicable, 42 C.F.R. §§ 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

FIDA Plan agrees that it has not altered in any way the terms of the FIDA Plan addendum presented for signature by CMS. FIDA Plan agrees that any alterations to the original text FIDA Plan may make to this addendum shall not be binding on the Parties.

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C. ADDITIONAL CONTRACT TERMS

FIDA Plan agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. § 423.505(j).

D. CMS AND NEW YORK STATE APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

FIDA Plan agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and the Department's approval to begin FIDA Plan marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and the Department systems to process enrollment (or contracting with an entity qualified to perform such functions on FIDA Plan's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, FIDA Plan must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), FIDA Plan agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. FIDA Plan agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. § 423.505(b)(23), and by meeting and maintaining all financial requirements established by State laws and regulations.

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APPENDIX E: DATA USE ATTESTATION

The FIDA Plan shall restrict its use and disclosure of Medicare and Medicaid data obtained from CMS and NYSDOH information systems (listed in Attachment A) to those purposes directly related to the administration of the Demonstration for which it has contracted with the CMS and New York to administer. The FIDA Plan shall only maintain data obtained from CMS and New York information systems that are needed to administer the Demonstration that it has contracted with CMS and New York to administer. The FIDA Plan (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS or New York information systems, or data obtained from the CMS or New York information systems, to support any line of business other than the Demonstration for which the FIDA Plan contracted with CMS and New York.

The FIDA Plan further attests that it shall limit the use of information it obtains from its Participants to those purposes directly related to the administration of such Demonstration. The FIDA Plan acknowledges two exceptions to this limitation. First, the FIDA Plan may provide its Participants information about non-health related services after obtaining consent from the Participants. Second, the FIDA Plan may provide information about health-related services without obtaining prior Participant consent, as long as the FIDA Plan affords the Participant an opportunity to elect not to receive such information.

CMS may terminate the FIDA Plan's access to the CMS data systems, and New York State may terminate the FIDA Plan's access to the New York State data systems, immediately upon determining that the FIDA Plan has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Participants beyond the scope for which CMS and New York State have authorized under this Appendix E (herein, data use agreement). A termination of this data use agreement may result in CMS or New York State terminating the FIDA Plan's Contract(s) on the basis that it is no longer qualified to administer a Demonstration Plan. This data use agreement shall remain in effect as long as the FIDA Plan is a Demonstration Plan. This data use agreement excludes any public use files or other publicly available reports or files that CMS or New York State make available to the general public on their respective websites.

Attachment A

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The following list contains a representative (but not comprehensive) list of CMS and NYSDOH information systems to which the Data Use Attestation applies. CMS and NYSDOH will update the list periodically as necessary to reflect changes in CMS' and NYSDOH's information systems.

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS) and
Any and all systems NYSDOH deems necessary including but not limited to WMS and MMIS.

The following list contains a representative (but not comprehensive) list of the Department's information systems to which the Data Use Attestation applies. The Department will update the list periodically as necessary to reflect changes in the Department's information systems.

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APPENDIX F: MODEL FILE & USE CERTIFICATION FORM

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of New York, acting by and through the New York State (herein, NYSDOH), and (insert organization name), hereafter referred to as the FIDA Plan, governing the operations of the following health plan: (insert health plan name and Contract number), the FIDA Plan hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or the Department to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. § 422.2260 – § 422.2276 and 42 C.F.R. § 422.111 for Demonstration Plans and the Medicare Marketing Guidelines.

I agree that CMS or the Department may inspect any and all information, including those held at the premises of the FIDA Plan, to ensure compliance with these requirements. I further agree to notify CMS and New York immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the FIDA Plan.

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APPENDIX G: MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into <<DATE>>

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

<<CONTRACT_NAME>> (hereinafter "Licensee"),
with offices located at <<ADDRESS>>.

CMS Contract ID: <<CONTRACT_ID>>

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WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning <DATE>.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Contract, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Contract with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Contract and in any other lawful manner.
4. This Contract and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This Contract shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2013, concurrent with the

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execution of the Part D addendum to the three way contract. This Contract may be terminated by any Party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2013, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This Contract shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Contract even if Licensor has been advised of the possibility of such damages.
9. This Contract is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Contract.

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APPENDIX H: SERVICE AREA

The Service Area outlined below is contingent upon the FIDA Plan meeting all Readiness Review requirements in each county. CMS and NYSDOH reserve the right to amend Appendix H to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and NYSDOH.

Bronx
Kings
Nassau
New York
Queens
Richmond
Suffolk
Westchester

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APPENDIX I: STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

Commented [P8]: The standard Appendix A, possibly with a few modifications will be included here. This is PENDING further CMS and NYSDOH discussion.

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APPENDIX J: CORE QUALITY MEASURES UNDER THE DEMONSTRATION (MOU Table 7-B)

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
1. Antidepressant Medication Management	Percentage of Participants 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X		
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult Participants with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of Participants who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of Participants who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS	X		
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X		X
4. Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
5. SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for Participants. Element A: Coordination of Benefits for Dual Eligible Participants Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ SNP Structure & Process Measures	X		
6. Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X		
7. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X		
8. SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Participants through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions	NCQA/ SNP Structure & Process Measures	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Element E; Analyzing Transitions Element F: Reducing Transitions				
9. CAHPS, Health Plan plus supplemental items/questions (TBD). Of particular note are the following: Getting Information about Prescription Drug Coverage and Cost Rating of Plan for Coverage of Prescription Drugs	The percent of the best possible score that the plan earned on how easy it is for Participants to get information from their plan about prescription drug coverage and cost. A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? B. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? D. In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine? The percent of the best possible score that the plan earned from Participants who rated the plan for its coverage of prescription drugs. • Using any number from 0 to 10, where 0 is the worst prescription drug plan	AHRQ/CAHPS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Getting Needed Prescription and Non-Prescription Drugs	possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs? The percent of best possible score that the plan earned on how easy it is for Participants to get the prescription drugs and non-prescription drugs they need using the plan.				
Getting Needed Care	A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy? Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.				
Getting Appointments and Care Quickly	A. In the last 6 months, how often was it easy to get appointments with specialists? B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan? C. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan? Percent of best possible score the plan earned on how quickly				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Overall Rating of Health Care Quality	Participants can get appointments and care. A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? B. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? C. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?				
Overall Rating of Plan	Percent of best possible score the plan earned from Participants who rated the overall health care received. • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? Percent of best possible score the plan earned from Participants who rated the overall plan. • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	health plan?				
10. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan's pharmacy help desk.	CMS Call Center data	X		
11. Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by Participants who called the plan's customer service phone number.	CMS Call Center data	X		
12. Part D Appeals Auto–Forward	How often the plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X		
13. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.	Medicare Advantage Prescription Drug System (MARx)	X		
14. Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X		
15. Part D Participant Access and Performance Problems	To check on whether Participants are having problems getting access to care and to be sure that plans are following all of Medicare's rules,	CMS Administrative data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.				
16. Part D Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2013.	CMS Medicare Participant Database Suite of Systems	X		
17. Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X		
18. Part D High Risk Medication	The percent of the Participants who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X		
19. Part D Diabetes Treatment	Percentage of Medicare Part D Participants who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X		
20. Part D Medication Adherence for	Percent of Participants with a prescription for oral diabetes medication who fill their	CMS PDE data	X	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Oral Diabetes Medications	prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.				
21. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Participants with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X		
22. Part D Medication Adherence for Cholesterol (Statins)	Percent of Participants with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X		
23. Plan Makes Timely Decisions about Appeals	Percent of Participants who got a timely (per timelines in Section 2.13) response when they made a written appeal to the plan about a decision to refuse payment or coverage.	FIDA Administrative Hearing Unit	X		
24. Part D Appeals Upheld	How often an independent reviewer agrees with the plan's decision to deny or say no to a Participant's Part D appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.	IRE	X		
25. Non-Part D Appeals Upheld	How often an Integrated Administrative Hearing Officer agrees with the plan's non-Part D decision to deny or say no to a Participant's non-Part D appeal. This measure is defined as the percent of FIDA Administrative Hearing Unit confirmations of	FIDA Administrative Hearing Unit	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of non-Part D cases reviewed)] * 100.				
26. Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by Participants who called the plan's customer service phone number.	CMS Call Center data	X		
27. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X		
28. Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with Contract requirements.	CMS/State defined process measure	X		X
29. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? B. In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? C. In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X		X
30. Assessments	Percent of Participants with Comprehensive Assessments completed within 30 days of Enrollment.	CMS/State defined process measure	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
31. Person-Centered Service Plan	Percent of Participants with PCSPs within 30 days of Comprehensive Assessment.	CMS/State defined process measure	X	X	
32. Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure			X
33. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	X	
34. Risk stratification based on LTSS or other factors	Percent of risk stratifications using behavioral health (BH)/LTSS data/indicators.	CMS/State defined process measure	X	X	
35. Discharge follow -up	Percent of Participants with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X		
36. Care for Older Adults – Medication Review	Percent of Participants whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X		
37. Care for Older Adults – Functional Status Assessment	Percent of Participants whose doctor has done a functional status assessment to see how well they are doing activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X		
38. Care for Older Adults – Pain Screening	Percent of Participants who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X		
39. Diabetes Care – Eye Exam	Percent of Participants with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X		
40. Diabetes Care – Kidney Disease Monitoring	Percent of Participants with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X		
41. Diabetes Care – Blood Sugar	Percent of Participants with diabetes who had an A-1-C lab test during	NCQA/HEDIS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Controlled	the year that showed their average blood sugar is under control.				
42. Rheumatoid Arthritis Management	Percent of Participants with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X		
43. Reducing the Risk of Falling	Percent of Participants with a problem falling, walking, or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X		X
44. Plan All-Cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X		X
45. Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X	X
46. Comprehensive Medication Review	Percentage of Participants who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X		
47. Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Participants. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X		
48. Participant Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the	CMS Participant database	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.				
49. Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2014.	CMS	X		
50. Breast Cancer Screening	Percent of female Participants aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X		
51. Colorectal Cancer Screening	Percent of Participants aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X		
52. Cardiovascular Care – Cholesterol Screening	Percent of Participants with heart disease who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X		
53. Diabetes Care – Cholesterol Screening	Percent of Participants with diabetes who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X		
54. Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X		X
55. Improving or Maintaining Mental Health	Percent of all Participants whose mental health was the same or better than expected after two years.	CMS HOS	X		
56. Monitoring Physical Activity	Percent of senior Participants who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X		
57. Access to Primary Care Doctor Visits	Percent of all Participants who saw their primary care doctor during the year.	HEDIS	X		
58. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X		
59. Getting Care Quickly	Composite of access to Urgent Care.	AHRQ/CAHPS	X		
60. Being	Percentage of respondents who	AHRQ/CAHPS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Examined on the Examination table	report always being examined on the examination table.				
61. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X		
62. Health Status/Function Status	Percent of Participants who report their health as excellent.	AHRQ/CAHPS	X		
63. Percent of Residents Experiencing One or More Falls with a Major Injury	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	NQF/CMS		X	
64. Self-direction Participant-level Measure	Percent of Participants directing their own services through the Consumer-Directed Personal Assistance option at the plan each Demonstration Year.	State-specified measure		X	
65. Long Term Care Overall Balance Measure	Reporting of the number of Participants who did not reside in a nursing facility (NF) as a proportion of the total number of Participants in a plan. Numerator: Of those Participants in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Participants in a plan eleven out of twelve months during the current measurement year.	State-specified measure		X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Exclusions: Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.				
66. Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: Of those Participants in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any nursing home certifiable Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-specified measure		X	X
67. Long Term Care Rebalancing Measure	Reporting of the number of Participants who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Participants who resided in a NF during the previous year. Monthly Long Term Care Rebalancing Rate:	State-specified measure		X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Numerator: of those Participants in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year. Denominator: Participants enrolled in a plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.				
68. Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-specified measure		X	X
69. Participants Referred to Preadmission Screening Teams or Money Follows the Person (MFP) Program	Percent of Participants in the FIDA Demonstration who reside in a nursing facility, wish to return to the community, and were referred to preadmission screening teams or the MFP Program.	State-specified measure		X	