Department of Health | AIDS Institute

UNINSURED CARE PROGRAMS

ADAP PLUS

ARTICLE-28

AGREEMENT FORM

1-800-832-5305

Uninsured Care Programs
Empire Station, P.O. Box 2052,
Albany, NY 12220-0052
1-800-732-9503 / 518-459-1641
adap@health.ny.gov

ADAP PLUS (PRIMARY CARE)

PROGRAM DESCRIPTION

To assist uninsured or underinsured persons with HIV, obtain necessary medical care and treatments, the AIDS Institute/New York State Department of Health has implemented a reimbursement pool that pays for ambulatory care services.

The ADAP Plus Program provides enrolled hospitals and clinics with reimbursement for ambulatory care services provided in an outpatient or clinic setting. This initiative is a partnership between New York State and the planning councils of the New York City, Long Island, Lower Hudson and Dutchess County Regions.

PROVIDER ELIGIBILITY

Hospitals and clinics licensed under Article 28, that have been approved for the NYS Medicaid Program, DOHM Memorandum 89-99, are eligible to enroll as providers under this Program. Eligible hospitals and clinics must be able to provide a full range of HIV primary care services.

CLIENT ELIGIBILITY

ADAP Plus serves HIV-infected New York State residents who are uninsured or underinsured for primary medical care. Participants must meet the following criteria:

(1) Residency: New York State

(2) Medical: HIV-Infection

(3) Financial: Financial eligibility is based on 500% of the Federal Poverty Level (FPL). FPL varies based on household size and is updated annually.

- Applicants who have partial insurance or limitations that inhibit access to primary care services are eligible for the Program. Such individuals will assign their insurance benefits to the Program. Their benefits will be coordinated by the Program, for maximum reimbursement to the program.
- Adolescents who do not have access to the financial or insurance resources of their parents/guardians will be eligible for the Program.
- There are **no** co-payments required.

REIMBURSEMENT

The Program will use established Medicaid Rate Schedules. Other covered services will be paid at the established Medicaid outpatient rate or PAC rate as appropriate for each provider. Due to Federal guidelines, HIV counseling and testing services are not reimbursable under this Program. To improve manageability and acceptability by providers the Program will make use of existing Medicaid billing and coding mechanisms. The Program will provide technical assistance on billing issues to enrolled hospitals and clinics.

APPLICATION

Interested hospitals and clinics may apply to participate in ADAP Plus by completing and signing the attached Assurances and Agreement Form, and the Provider Enrollment Form. Make a copy for your records and return the originals to ADAP Plus:

ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052
Or by email: adap@health.ny.gov

Applicants who meet Program eligibility requirements and provide the required documentation, will be eligible to bill for services retroactive to the date which the application is received from the provider by the Department of Health. Applicants who are accepted into the Program will receive written notification from the Department of Health, ADAP Plus.

QUESTIONS

If additional information is required, please call the Program at 1-800-542-2437 or 1-844-682-4058. Program staff are available weekdays between 8:00 am and 5:00 pm.

NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
ADAP PLUS ARTICLE-28
ASSURANCES AND AGREEMENT FORM

The New York State Department of Health has received grant funding to implement a reimbursement Program for outpatient services provided to uninsured or underinsured, HIV-infected individuals in an effort to reach these individuals at an early disease stage when they will be able to receive the maximum benefit from the most recently discovered treatments.

The ADAP Plus (Primary Care) Program is administered by the AIDS Institute. To be eligible clinics and hospitals must be licensed under Article 28 and be enrolled in the NYS Medicaid Program and sign the following Assurances and Agreement Form:

1. The Provider agrees to provide or arrange for primary care for persons with HIV infection. The Provider agrees to abide by all reasonable policies, procedures, and instructions provided in writing by DOH to implement and execute primary care services for persons with HIV infection and AIDS and to bill DOH accurately in accordance with the reimbursement methodology. The reimbursement methodology consists of the prices established for the clinic services. The Provider understands and agrees that the reimbursement may change during the term of the agreement and that the Provider will be reimbursed at the rate available to the Program at the time the services were rendered.

2. The Provider agrees to provide the personnel and support necessary to implement and maintain primary care services for persons with AIDS and HIV infection at its site(s). The Provider also agrees to maintain procedures and support staff to identify and screen individuals without adequate insurance or Medicaid coverage for their potential eligibility for the Program and Medicaid. The Provider agrees to encourage and support eligible individuals to apply for Medicaid and the Program as appropriate.

3. The Provider agrees to provide or arrange for all necessary covered medical services to Program participants without charge to the participant. Further, the Provider agrees to make all laboratory services available directly or indirectly. The Provider will be reimbursed for all such services provided to the patient. When provided indirectly, the Provider will be responsible for paying the vendor.

4. The Provider agrees not to bill the Program for any services for which Medicaid, insurance companies or other third-party payers can reasonably be expected to make payment.

5. The Provider shall be responsible for following written instructions from the DOH pertaining to voids, adjustments, and other billing procedures in order to ensure that there is no duplicate billing.

6. The DOH will not be obligated to pay claims submitted more than 90 days after delivery of services.

7. The DOH will utilize the AIDS Institute Utilization Review (UR) Agent to review patient records for quality of care and appropriateness of billing. Provider agrees to provide access to all necessary patient and fiscal records for the UR agent to conduct its activities. Claims to the Program will be adjusted based upon the findings of the UR agent.

8. The Provider agrees to identify a senior management individual, who will be knowledgeable about and responsible for the Program and in regular contact with DOH.

9. The Provider agrees to provide or directly arrange comprehensive services to persons with HIV infection. Services shall include the following services:

   a. Routine general medical treatment for both HIV and non-HIV related illness;

   b. Standard laboratory tests;

   c. Health education regarding orientation to facility procedures, right/responsibilities of the client, risks of HIV infections, and risk reduction behaviors;

   d. Referral for special studies, tests and consultations to ensure appropriate care for patients;

   e. Psychosocial services including screening for social, economic and emotional problems, and referrals when necessary;

   f. Coordination of care including the designation of a professional member of the health care team as the care coordinator who will:

      1) assure continual input from all appropriate members of the health care team, including the client and significant other where appropriate;

      2) participate in the development of a plan of care;

      3) facilitate implementation of the plan;

      4) assure information flow between the ambulatory setting and other providers or sites of care;

      5) implement a system for follow-up on missed visits, rescheduling of visits, inability to contact patient and referral. All such follow-up activities will be documented in the medical record.

   g. Offer tuberculosis screening, therapy, when medically indicated, and referral when appropriate.

10. The Provider agrees further to:

   a. Provide after hours and emergency consultation and care for all patients.

   b. Use a comprehensive care record to document services provided.

   c. Maintain a system for protecting confidentiality of medical records, including HIV-related information consistent with Article 27F of the Public Health Law and Part 63 of 10 NYCRR.

   d. Have in place in written agreements with an AIDS Center hospital or other back-up hospital stipulating arrangements for referral of patients for medically indicted care regardless of ability to pay. Such agreements shall detail (but need not be limited to) the following:

      1) provisions for normal referral services;

      2) provisions offering reasonable access to hospital facilities and services and means for communications, scheduling, reporting and follow-up;

3) special tests and procedures to be performed;

4) procedures detailing how hospitalization for medical problems will occur;

5) a system for receiving information from referral sources and back-up hospitals.

e. Develop and implement a plan to inform the public of the availability of services and to increase early enrollment.

11. The Provider shall incorporate into the existing quality assurance Program a mechanism for review of the appropriateness of care provided to persons with early HIV infection and AIDS.

12. The DOH may cancel this agreement if the Provider has failed to substantially comply with the terms of participation, including, but not limited to failure to (a) permit access for patient records reviews; (b) accurately complete costs reports, or (c) accurately bill DOH under reimbursement methodology.

13. The Provider agrees that the DOH may determine new visit types and rates during the term of this agreement. Such visit types and rates shall be available to the Provider and shall be incorporated as part of this agreement upon written notice to the Provider.

14. The DOH, its employees, representatives, and designees shall have the responsibility for determining contract compliance, as well as the quality of services being provided. The DOH shall conduct such visits and Program reviews as it deems necessary to assess the quality of services being provided and to determine contract compliance.

15. The Provider shall assure the DOH and its authorized representatives prompt access to all Program sites and all financial, clinical or other records and reports relating to the Program. The DOH shall access patient information, including HIV-related information as required for the administration and monitoring of this Program.

16. The Provider shall maintain Program reports including financial, administrative, utilization, and patient care data in such a manner as to allow the identification of expenditure, revenue and utilization data associated with health care provided to HIV infected patients, and DOH supported items as identified in this agreement for six years. Records containing the information as described in this paragraph including patient-specific records shall be available at all times to the DOH upon request and shall be subject to audit. Patient records shall be held by the DOH in strict confidence, and patients' rights to privacy shall be protected, in accordance with Article 27-F of the Public Health Law and Part 63 of 10 NYCRR.

Endorsed By: ____ Dated:_________________

Print Name: _____________________________________ Title:_______________________

Please return this agreement to:

ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

by email: adap@health.ny.gov by fax:518-459-7429

New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station
P.O. Box 2052 Albany, NY 12220
Phone: 1-800-542-2437 Fax: 518-459-7429

Article-28 ADAP Plus Provider Enrollment Form

Please print clearly

MMIS Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ Circle one: APG or FQHC Rates

NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ MMIS Locator Code: ___ ____ ____

Tax ID Number: ___ ___- ___ ___ ___ ____ ____ ____ ____

Facility Name:____

Address:____

City: __________________________ State: ___ ___ Zip+4: ___ ___ ___ ___ ___- ___ ___ ___ ___

Clinic Phone Number: (____)_____________________ Clinic Fax Number:(___)__________________

Does this facility provide dental services? **[ ] Yes or [ ] No** Phone:(___)_______________________

Does this facility provide mental health services? **[ ] Yes or [ ] No** Phone:(___)__________________

Billing Address (if different from above):
Facility Name:____
Address:____
City: __________________________________ State: ___ ___ Zip Code: ___ ___ ___ ___ ___
Phone: (___)______________________ Ext: ______________

Credentialing/Administrative Contact: ______________________________ Title:___________________

Credentialing/Administrative Phone Number: (___)__________________________

Credentialing/Administrative Fax Number: (___)____________________________

Credentialing/Administrative Email: _______________________________________

Billing Contact: ____ Title:________________________

Billing Phone Number: (___)_______________________________

Billing Fax Number: (___)________________________________

Email:____

Rev. 07/2021

Additional Locations for this Facility:

NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ MMIS Locator Code: ___ ____ ____

Tax ID Number: ___ ___- ___ ___ ___ ____ ____ ____ ____

Facility Name:____

Address:____

City: _________________________ State: ___ ___ Zip+4: ___ ___ ___ ___ ___- ___ ___ ___ ___

Clinic Phone Number: (____)__________________ Clinic Fax Number: (___)____________________

Does this facility provide dental services? **[ ] Yes or [ ] No** Phone: (___)_____________________

Does this facility provide mental health services? **[ ] Yes or [ ] No** Phone: (___)_________________

Billing Address (if different from above):

Facility Name: ____

Address: ____

City: __________________________________ State: ___ ___ Zip Code: ___ ___ ___ ___ ___

Phone: (___)_____________________ Ext: _____________

Additional Locations for this Facility:

NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ MMIS Locator Code: ___ ____ ____

Tax ID Number: ___ ___- ___ ___ ___ ____ ____ ____ ____

Facility Name: ____

Address: ____

City: _________________________ State: ___ ___ Zip+4: ___ ___ ___ ___ ___- ___ ___ ___ ___

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Billing Address (if different from above):

Facility Name: ____

Address: ____

City: __________________________________ State: ___ ___ Zip Code: ___ ___ ___ ___ ___

Phone: (___)_____________________ Ext: _____________