

Contract

Between

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

In Partnership with

**The State of New York,
Department of Health**

and

[Health Plan Name]

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This Contract, made on January 19, 2016, is hereby amended and restated effective January 1, 2018, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS) and the State of New York, acting by and through the State of New York, Department of Health (State/NYSDOH) and [Health Plan Name] (the FIDA-IDD Plan). The FIDA-IDD Plan's principal place of business is [Health Plan Address]. Further, the NYSDOH has entered into a Letter of Agreement (LOA) with the State of New York Office for People With Developmental Disabilities (OPWDD) to delegate certain program management responsibilities within the scope of OPWDD's authority under the laws and regulations of the State of New York and as outlined in this contract.

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, Title XIX, and Title XXI of the Social Security Act;

WHEREAS, pursuant to Article 44 of the New York State Public Health Law (PHL), the 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-IDD Plan is in the business of providing medical and Long Term Support services, and CMS and the State desire to purchase such services from the FIDA-IDD Plan;

WHEREAS, the FIDA-IDD 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;

WHEREAS, this Contract replaces in its entirety the Contract entered into by CMS, NYSDOH, and FIDA-IDD Plan executed January 19, 2016.

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

1. Section 1: Definition of Terms

- 1.1. 820 Payment File – The electronic HIPAA transaction that the FIDA-IDD Plan receives from the State that identifies each Participant for whom payment was made by the State to the FIDA-IDD Plan.
- 1.2. 834 Daily File – The electronic HIPAA transaction that the FIDA-IDD Plan retrieves from the State 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-IDD Plan retrieves monthly from the State 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:
 - 1.4.1. 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.
 - 1.4.2. Sexual Abuse – Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact, or forcing sex with a third party.
 - 1.4.3. 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. Accessibility Attestation Form – A form created by the State and which may be modified over the course of the Demonstration which contains questions about a Providers' Accessibility that all FIDA-IDD Plan Providers are required to complete and attest to the veracity of the responses provided.
- 1.6. 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 (does not include requests for items or services that are paid for fee-for-service outside the FIDA-IDD Plan); or failure to make a Grievance determination within required time frames.
- 1.7. Activities of Daily Living (ADL) – Activities such as eating, bathing, grooming, dressing, ambulating, transferring, and continence.
 - 1.8. Administrative Allowance – The portion of the Capitation, paid for the administrative cost of the Contract.
 - 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 recognized under State law 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. Aggregate Savings Percentages – Percentages applied in the rate-setting process to baseline Medicaid and Medicare Parts A and B costs. The Aggregate Savings Percentages allow both payers to proportionally share in the savings achieved through the FIDA-IDD Demonstration regardless of the underlying utilization patterns.
 - 1.12. 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.
 - 1.13. 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.
 - 1.14. Appeal – A Participant’s request for review of any update to or reauthorization of the Participant’s LP or an Action taken by the FIDA-IDD Plan related to items or services in accordance with Section 2.13 of the Contract.

- 1.15. Applicant – An individual who has expressed a desire to pursue enrollment in a FIDA-IDD 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-IDD Plan for the performance of all of the FIDA-IDD 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): 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 Sections 4.3 and 4.6. Total Capitation Rate Revenue will be calculated as if all FIDA-IDD Plans had received the full quality withhold payment.
- 1.21. Care Manager – An appropriately qualified professional who is the FIDA-IDD Plan’s designated accountable point of contact for each Participant’s care coordination and Care Management services. This three-way contract outlines detailed education, training, and occupational responsibilities for Care Managers.
- 1.22. Care Management – A collaborative process that assists each Participant in accessing services as identified in the Participant’s Life Plan (LP). 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 LP. 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 LP 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-IDD Plan; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a FIDA-IDD 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.
 - 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. 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 Health Record – A record kept by the FIDA-IDD Plan and available to all IDT members that contains at least appropriate identifying

information and the following documentation of care and services rendered to the Participant by Providers: A summary of emergency care and other inpatient or long-term care services; items and services furnished by Network and Out-Of-Network Providers; current and past Assessments, Reassessments, LPs, and any file notes that include the Participant's response to treatment; laboratory, radiological and other diagnostic test reports; medication records and, if applicable, any of the following documents: skilled nursing facility / nursing facility to hospital transfer forms; hospital discharge summaries, if applicable; reports of contact with informal support (for example, caregiver, legal guardian, or next of kin); physician orders; discharge summary, if applicable; advance directives, if applicable; and a signed release permitting disclosure of personal information.

- 1.30. Comprehensive Reassessment (CR) – A systematic evaluation of the Participant's care and service needs, that includes the elements of the OPWDD Approved Assessment (OA) and the Comprehensive Service Planning Assessment (CSPA) and also addresses the Participant's Comprehensive Health Record.
- 1.31. Comprehensive Service Planning Assessment (CSPA) – A systematic evaluation of the Participant's care and service needs. The CSPA will be conducted using the "It's All About Me" (IAM) tool. The FIDA-IDD Plan, as part of the care planning process, will complete the IAM, a person-centered assessment written in person-first language which describes the functional status, needs and wishes of a person with IDD across 24 domains and determines a recommended list of actions based on the person's current status. The IAM Tool covers the following domains: social, functional, medical, behavioral, wellness and prevention domains, caregivers' status and capabilities, as well as the Participant's preferences, strengths, and goals. The FIDA-IDD Plan's employed or contracted licensed professional, in compliance with section 2.6.2 of this agreement, shall use relevant and comprehensive data sources when completing the IAM, including the Participant, Providers, and their Caregivers/Representatives and/or Designees. The IAM results, in addition to the results of the OAA, will be used as the basis for developing the integrated LP.
- 1.32. 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.
- 1.33. 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 in writing should be kept confidential.
- 1.34. 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.
- 1.35. 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.
- 1.36. 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 Participants to report on and evaluate their experience with ambulatory and facility level care.
- 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, 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-IDD 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-IDD Plan

- specifying the terms and conditions pursuant to which a participating FIDA-IDD Plan may participate in this Demonstration.
- 1.40. Contract Management Team (CMT) – A group of CMS, NYSDOH, and OPWDD 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-IDD Plan is effective.
 - 1.42. Court-Ordered Services – Those services that the FIDA-IDD 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-IDD 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-IDD Plan, 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. Cultural competence also includes competencies which are required to ensure appropriate, culturally sensitive health care and specialized services to persons with intellectual and developmental disabilities.
 - 1.45. Designee - An adult that a Participant with capacity to designate has invited to participate in decision making about the Participant’s enrollment and services from the FIDA-IDD Plan.
 - 1.46. Demonstration (also FIDA-IDD Demonstration) – Initiative to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”) who have intellectual and developmental disabilities.
 - 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-IDD Plan terminates.
 - 1.50. Effective Date of Disenrollment (also Disenrollment Effective Date) – The date on which a Participant is no longer a member of the FIDA-IDD Plan.
 - 1.51. Effective Date of Enrollment – The date on which a Participant is a member of the FIDA-IDD 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-IDD 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, 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 Covered 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-IDD 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.
- 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 independent organization that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the FIDA-IDD Plan to their Participants as set forth in 42 C.F.R. §§ 438.354 and 42 C.F.R. § 438.358.
- 1.62. External Grievance – A Grievance 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, which is also known as institutional-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 the FIDA-IDD Plan.
- 1.67. Plan Benefit Package(s) (also FIDA-IDD Plan’s Benefit Package(s)) – The FIDA-IDD Plan’s submission to CMS and the State of the Covered Items and Services it will provide through the FIDA-IDD 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.
- 1.69. First Tier, Downstream and Related Entity – An individual or entity that enters into a written arrangement with the FIDA-IDD Plan, acceptable to CMS and the State, to provide administrative or health care services of the FIDA-IDD 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-IDD 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 for Participants receiving CDPAS services. See also OPWDD FI for the definition of FI for self-directed services through the Section 1915(c) OPWDD Comprehensive Waiver.
- 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 for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD Plan) – A managed care plan under contract with CMS and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA-IDD Demonstration.
- 1.74. Grievance – In accordance with 42 CFR § 438.400, Grievance means an expression of dissatisfaction about any matter other than an Action. A Grievance is filed and decided at the FIDA-IDD 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-IDD 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-IDD Plan, or failure to respect the Participant's rights, as provided for in 42 C.F.R. § 438.400 and Appendix B.

- 1.75. Habilitation – An effort directed toward the alleviation of a disability or toward increasing an individual's level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, protective services, counseling, and other services.
- 1.76. 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.
- 1.77. 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.
- 1.78. Health Commerce System (HCS) – A closed communication network dedicated to secure data exchange and distribution of health related information between various health facility Providers and the State. 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).

- 1.79. Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
- 1.80. Health Maintenance Organization (HMO) – A health maintenance organization as defined in Article 44 of the New York State Public Health Law (PHL).
- 1.81. 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.
- 1.82. 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-IDD Plan Benefit Packages, formularies, and other information via HPMS.
- 1.83. 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.
- 1.84. Indian Health Care Provider – A health care program, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603).
- 1.85. Indian Participant– A Participant who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 (25 U.S.C. §§ 1603(13), 1603(23), or 1679(a)) or who has been determined as an Indian under 42 C.F.R. § 136.12 and 42 C.F.R. § 447.51. As of July 1, 2017, Indian will be defined as any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.
- 1.86. Individualized Residential Alternative (IRA) – A facility certified by OPWDD as an IRA. An IRA is identified as a supervised IRA, if there are staff onsite or proximately available at all times when the persons are present. An IRA is identified as a supportive IRA if the facility provides practice in independent

- living under variable amounts of oversight delivered in accordance with the person's needs for such supervision, and staff typically is not onsite nor proximately available at all times when the persons are present.
- 1.87. Institutionalization – Long-term placement or residency in a Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or State operated institutional facility, but does not include short-term admission stays in an acute care facility, respite settings, 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 (IAHO) within OTDA.
 - 1.90. Intellectual and Developmental Disabilities – A Developmental Disability as defined in N.Y. MH.LAW § 1.03(22).
 - 1.91. Interdisciplinary Team (IDT) - The team of individuals that will provide person-centered Care Management to Participants. Each Participant will have an IDT. The IDT must inform Participants of the option to self-direct their own services through the following encounters; CSPA, CR and the creation of the LP and any time it is updated.
 - 1.92. Interdisciplinary Team Policy or IDT Policy – The FIDA-IDD Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management released by the State, with prior approval from CMS.
 - 1.93. Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID) – A residential facility certified by OPWDD as an ICF/IID providing comprehensive and individualized health care and habilitation services to individuals with IDD to promote their functional status and independence. ICF-IID is available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services.
 - 1.94. Internal Grievance – A Grievance filed with the FIDA-IDD Plan.
 - 1.95. Involuntary Disenrollment – Disenrollments under Sections 2.3.2 or 3.2.6 of this Contract.

- 1.96. Life Plan (LP)- An individualized person-centered care and service plan that is collaboratively developed with the Participant , his or her family/Representative and/or Designee, and other IDT members to address the full continuum of covered and non-covered physical, behavioral, and LTSS.
- 1.97. 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).
- 1.98. Long-Term Care (LTC) Facility or Nursing Facility (NF) – (i) A facility that provides Skilled Nursing or intermediate long-term care services other than ICF/IID, 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.
- 1.99. 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 the State to provide services in the Demonstration. It includes the FIDA-IDD Plan and may also include other such entities with such contracts.
- 1.100. 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.
- 1.101. 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.
- 1.102. 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 as set forth in Section 2.15, and any information or notices distributed by the FIDA-IDD Plan or required to be distributed to Eligible Individuals, Potential Participants, or Participants by CMS and the State 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, and 423.2260 et. seq.; and the Medicare

Marketing Guidelines. This also includes the activities identified in the marketing plan the FIDA-IDD Plan is required to submit for State approval.

- 1.103. 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.
- 1.104. Medicaid Advantage Plus Program – The partially-integrated Medicare and Medicaid managed care program in New York for Medicare-Medicaid Participants who require Community-based or Facility-based LTSS.
- 1.105. Medicaid Managed Care Plan – A health maintenance organization ("HMO") or prepaid health service plan ("PHSP") certified under Article 44 of the State Public Health Law that is under contract with NYSDOH to provide a comprehensive Medicaid health services plan in New York.
- 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. Medically Necessary – The standard applied to determine whether to approve a Covered Item or Service. Covered Items or Services are Medically Necessary if they are 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-IDD 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.
- 1.109. 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.

- 1.110. Medicare-Medicaid Coordination Office – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.
- 1.111. Medicare-Medicaid Enrollees – For the purposes of this Demonstration, individuals who are entitled to benefits under Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for full Medicaid benefits.
- 1.112. 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 (ALS). 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.
- 1.113. Medicare Advantage – The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.
- 1.114. 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.
- 1.115. 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.
- 1.116. Money Follows the Person – New York State was awarded the grant in 2007. The Affordable Care Act of 2010 extended the MFP Program through 2020 and includes all funding and programs offered through MFP and subject to the general and programmatic terms and conditions governing the grant. The MFP program goals include increasing the use of home and community-based services (HCBS) and reducing the use of institutionally-based services; eliminating barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice;

strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and putting procedures in place to provide quality assurance and improvement of HCBS.

- 1.117. 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.
- 1.118. National Council for Prescription Drug Program (NCPDP) – The electronic HIPAA transaction that the FIDA-IDD Plan transfers to the State that identifies health care claims for pharmacy claims and Encounters.
- 1.119. 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.
 - 1.119.1. 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.
 - 1.119.2. 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.
 - 1.119.3. 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.
- 1.120. 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 that a Nursing Facility Resident must pay monthly to the Nursing Facility in accordance with the requirements of the medical assistance program.

- 1.121. New to Service – Eligible Individuals who are not already receiving Facility-based or Community-based LTSS.
- 1.122. 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.
- 1.123. 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.
- 1.124. 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.
- 1.125. 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.
- 1.126. New York State Office for People with Developmental Disabilities (OPWDD) – The agency responsible for all services defined as OPWDD Services (see definition below) for persons with developmental disabilities and for collaborating with the NYSDOH and CMS on the administration of the FIDA-IDD Demonstration.
- 1.127. Non-Participating Provider – (also Out-Of-Network Provider) A Provider that does not have a Provider Agreement with the FIDA-IDD Plan.
- 1.128. 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.
- 1.129. Nursing Facility Clinically Eligible – A standard of eligibility for care in a Nursing Facility, based on an individual’s care needs and functional, cognitive, and medical status as determined upon completion of the State approved Pre-admission Screening and Resident Review tool (PASRR).

- 1.130. 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.
- 1.131. Opt-in Enrollment – The process by which eligible individuals actively choose to enroll in the FIDA-IDD Plan.
- 1.132. OPWDD Approved Assessment Tool (OAA) Protocol - The protocol assessing each Participant’s medical, developmental, habilitation, behavioral health, Community-based or Facility-based LTSS, and social needs that is performed by OPWDD. The most recent results will be provided to the FIDA-IDD Plan following the Participant’s enrollment. After this pre-enrollment OAA is provided to the FIDA-IDD Plan, the OAA elements will be included in the CR which will be completed by the FIDA-IDD Plan as described in this contract and the IDT policy.
- 1.133. OPWDD Early Alert - Early Alert is a process by which OPWDD assesses and identifies providers that require additional monitoring and supervision as a result of, but not limited to, continuing non-compliance with regulations, negative fiscal and governance issues, and/or serious systemic issues resulting in poor performance and negative outcomes. By informing providers of such issues, the goal of Early Alert is to assist in guiding such providers back to quality and compliance. A provider that has been placed on Early Alert will be removed from the list when it: Demonstrates that both site specific and systemic issues of concern have been corrected, and corrections have been sustained; Has implemented processes to prevent recurrence; Transitions service(s) to another provider; and/or no longer provides OPWDD services.
- 1.134. OPWDD Fiscal Intermediary (FI) – An entity that has a contract with the FIDA-IDD Plan to provide wage and benefit processing for self-directed staffing and claim processing for self-directed goods and services through the Section 1915(c) OPWDD Comprehensive Waiver.
- 1.135. OPWDD Services – The services operated, certified, funded, authorized or approved by OPWDD. 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 IID; day treatment services provided in an Intermediate Care Facility for Individuals with 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 IID.

- 1.136. 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.
- 1.137. Participant – Individuals enrolled in the FIDA-IDD Plan, including the duration of any month in which their eligibility for the Demonstration ends.
- 1.138. Participant Advisory Committee (PAC) – A group convened in person, at least quarterly by the FIDA-IDD Plan to solicit input for consideration by the FIDA-IDD Plan’s governing board. The PAC is open to all Participants, their Representatives and/or Designees, and the Participant Ombudsman. The PAC reflects the diversity of the FIDA-IDD Plan’s Participant population. The FIDA-IDD Plan provides the PAC with, at a minimum, information on any updates and proposed changes about the FIDA-IDD 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.
- 1.139. Participant Feedback Sessions – Sessions for FIDA-IDD Plan Participants to raise problems and concerns and provide positive feedback to the FIDA-IDD Plan. The FIDA-IDD 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-IDD Plan summarizes each Participant Feedback Session and makes the summary available to Participants and the public.
- 1.140. Participant Handbook – The publication prepared by the FIDA-IDD 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-IDD Plan Participant.
- 1.141. Participant Ombudsman (PO) – An independent, conflict-free entity under contract with the State to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their FIDA-IDD 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 the FIDA-IDD Plan, Plans, Providers, or NYSDOH. The PO may participate in FIDA-IDD Plan Participant Advisory Committee activities.

- 1.142. Participant Services Telephone Line – A toll-free telephone call center, operated by the FIDA-IDD Plan from 8:00 A.M. to 8:00 P.M. EST seven days per week to provide Participants with assistance.
- 1.143. Participating Pharmacy (also known as Pharmacy network) – Pharmacies that have contracted with the FIDA-IDD Plan (i.e., Participating Pharmacies) to provide Participants with access to prescription and non-prescription drugs covered by the FIDA-IDD Plan.
- 1.144. Participating Provider – A person or entity with whom the FIDA-IDD Plan has entered into a written Provider Agreement.
- 1.145. 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.
- 1.146. Party/Parties – The State, through NYSDOH/DHHS, through CMS, and the FIDA-IDD Plan.
- 1.147. Payment Arrangement – An arrangement between a FIDA-IDD 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.
- 1.149. Personal Care –Service that provides some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient’s health and safety in his or her own home.
- 1.150. Physician – An individual licensed to practice medicine in New York.
- 1.151. Physician Incentive Plan (PIP) – Any compensation arrangement between the FIDA-IDD 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-IDD Plan’s Participants.
- 1.152. 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).

- 1.153. 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.
- 1.154. Pre-Admission Screening and Resident Review (PASRR) - A federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.
- 1.155. Prevalent Languages – Those non-English languages that meet the more stringent of the following:
 - 1.155.1. Medicare’s five percent (5%) threshold for translation as specified in 42 CFR § 422.2264(e), or;
 - 1.155.2. A language that at least five percent (5%) of the plan’s enrolled population or 50 members, whichever is less, who do not speak English as a first language, speak as a primary language and do not speak English as a first language.
- 1.156. Preventive Services – Medicare and Medicaid preventive services including those specified in Appendix A and any others that Medicare and Medicaid cover or may begin to cover during the Demonstration.
- 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 State and CMS of any FIDA-IDD Plan materials or actions, as set forth in this Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that the FIDA-IDD 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-IDD Plan or 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.
- 1.161. Program Integrity Plan – A document developed by the FIDA-IDD Plan that defines how the FIDA-IDD 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-IDD Plan.
- 1.162. 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-IDD 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.
- 1.163. Provider – A person or organization enrolled with CMS to provide Medicare Covered Items or Services, or issued a Provider identification number by State to provide Medicaid Covered Items or Services, to a Participant. The FIDA-IDD Plan is not a Provider.
- 1.164. Provider Agreement – The written agreement between the FIDA-IDD Plan and a Provider related to the Provider’s participation with the FIDA-IDD Plan for purposes of the FIDA-IDD Demonstration.
- 1.165. Provider-Based Marketing Activities and Provider Affiliation Information – The FIDA-IDD 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-IDD Plan may allow Participating Providers to make available or distribute FIDA-IDD Plan marketing materials in common areas. In addition, consistent with Section 70.11.2 of the Medicare Marketing Guidelines, the FIDA-IDD Plan may allow Participating Providers to announce new and continuing affiliations. The FIDA-IDD Plan may use Participating Providers to distribute written

materials consistent with Sections 70.11 and 70.11.1 of the Medicare Marketing Guidelines.”

- 1.166. Provider Network – Providers that have contracted with the FIDA-IDD 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).
- 1.167. 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. § 438.3(g), 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 on the www.health.ny.gov website.
- 1.168. Qualified Intellectual Disability Professional (QIDP) – As defined in 42 C.F.R. § 483.430, a QIDP is a professional with at least one (1) year of experience working directly with IDD or other developmental disabilities; and is a doctor of medicine or osteopathy, a registered nurse, or a professional who holds at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology). The QIDP completes the OAA Tool, the OAA elements of the CR, and may participate in the IDT meetings.
- 1.169. Quality Improvement Program – The FIDA-IDD 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 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 the FIDA-IDD 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 State use the results to inform decisions about whether the FIDA-IDD Plan is ready to begin marketing and accepting enrollment under the Demonstration. At a minimum, the Readiness Review includes a desk review and a site visit to the prospective FIDA-IDD 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-IDD 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. Representative - An organization or adult person authorized under law, to act on behalf of a Participant. Unless otherwise stated in this subpart, the Representative will have all the rights and responsibilities of a Participant or party in filing a grievance, and in obtaining an organization determination or in dealing with any of the levels of the appeals process.
- 1.176. Resident – A Participant who is living in a facility and whose facility services are eligible for Medicaid or Medicare payment.
- 1.177. Roster – The enrollment list generated on a monthly basis by the State by which the LDSS and FIDA-IDD Plan are informed of specifically which Eligible Individuals the FIDA-IDD Plan will be serving in the FIDA-IDD Demonstration for the coming month, subject to any revisions

communicated in writing or electronically by the State or entity designated by the State.

- 1.178. Rural Health Centers (RHCs) - An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(l)(2)(A) and (B), as defined in Section 1861(aa)(2) of the Social Security Act.
- 1.179. Self-Direction (also Consumer Direction) – The ability for a Participant and/or their Representative to direct their own services through Self-Direction, by allowing choice and flexibility in the range of supports the Participant and/or their Representative want with the exercise of employer authority and budget authority and or as defined in the 1915(c) OPWDD Comprehensive Waiver or the consumer-directed personal assistance option. Self-Direction includes: Person-Centered Planning Process; Service Plan; Individualized Budget and Information and Assistance in Support of Self-Direction.
- 1.180. 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.
- 1.181. Service Area – The specific geographical area of New York designated in the CMS HPMS, and as referenced in Appendix H, for which the FIDA-IDD Plan agrees to provide Covered Items and Services to all Participants who enroll into the FIDA-IDD Plan.
- 1.182. Service Authorization Request – A request to the IDT or FIDA-IDD Plan by a Participant or by a Provider on behalf of a Participant for the provision of a Covered Item or Service.
- 1.183. Single Case Agreement – An agreement established between the FIDA-IDD Plan and a Non-Participating Provider when Participants require care not available from a Participating Provider.
- 1.184. 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.
- 1.185. 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.

- 1.186. 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.
- 1.187. 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.
- 1.188. 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.
- 1.189. State – The New York State Department of Health (NYSDOH), is the Single State Medicaid Agency, and as such has ultimate authority for the Demonstration. Through a letter of agreement and as described in this three-way Contract, certain administrative and operational responsibilities are delegated to the New York State Office for People With Developmental Disabilities (OPWDD). Within this three-way Contract, each agency is identified individually where necessary.
- 1.190. State Plan – The New York Medicaid State Plan filed with Federal CMS, in compliance with Title XIX of the Social Security Act.
- 1.191. Support Brokerage - A 1915(c) HCBS Waiver approved service available for participants who may self-direct some or all of their services. The Support Broker provides assistance and practical skills training to the participant in the areas of: understanding and managing the responsibilities involved with self-direction; developing daily implementation of and managing the self-directed plan and budget; monitoring expenditures; negotiating terms and service arrangements with providers in the self-directed plan and budget; employer responsibilities such as recruiting, supervising, and training of participant-hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; risk assessment, planning and ensuring safeguards are identified and met; developing and maintaining the Circle of Support and facilitating Circle of Support meetings.

- 1.192. Third Party – Any Person other than CMS, OPWDD, NYSDOH, the FIDA-IDD Plan, or any of the FIDA-IDD Plan's intercompany affiliates within the same parent organization.
- 1.193. 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: accident-only coverage or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including auto insurance; workers compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; dental-only, vision-only, or long-term care insurance; specified disease coverage; hospital indemnity or other fixed dollar indemnity coverage; or prescription-only coverage.
- 1.194. Transformation Agenda -- The OPWDD-led system change initiative seeking to support people with intellectual and developmental disabilities enjoy meaningful relationships with friends, family, and others in their lives; experience personal health and growth; live in the home of their choice; and fully participate in their communities. The Transformation Agenda includes efforts to develop new service options to better meet the needs of individuals and families in a truly person-centered way, including allowing for more self-direction of services; create a specialized managed care system that recognizes the unique needs of people with disabilities, and is focused on a habilitative model of services and supports; ensuring that people live in the most integrated community settings; increasing the number of individuals who are competitively employed; focusing on a quality system that values personal outcome goals for people, such as an improved life or access to meaningful activities; and working to make funding in the system sustainable and transparent.
- 1.195. 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.
- 1.196. 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.

- 1.197. Voluntary Disenrollment – Disenrollment from a FIDA-IDD Plan or from the FIDA-IDD Demonstration initiated by a Participant or his/her Representative and/or Designee including all such individuals recognized by the laws of New York.
- 1.198. Welcome Packet – The first packet of materials sent to new Participants as described Section 2.3.2.7.

2. Section 2. FIDA-IDD Plan Responsibilities

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

- 2.1. **Compliance.** The FIDA-IDD Plan must, to the satisfaction of CMS and the State:
 - 2.1.1.1. 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 the State, and Demonstration terms and conditions, including the requirement to have and implement a compliance plan. The FIDA-IDD Plan must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. §§ 422, 423, and 438 except to the extent that waivers from these requirements are provided in the Memorandum of Understanding (MOU) signed by CMS and the State for this initiative.
 - 2.1.4. Comply with Other Laws
 - 2.1.4.1. No obligation imposed herein on the FIDA-IDD Plan shall relieve the FIDA-IDD 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. The State and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

2.1.4.3. The State or CMS will inform the FIDA-IDD Plan of any such report unless the appropriate agency to which the State or CMS has reported requests that the State or CMS not inform the FIDA-IDD 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-IDD 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-IDD 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-IDD Plan's standards of conduct;

2.1.5.3. Implement the operation of the compliance program;

- 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-IDD 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. The FIDA-IDD Plan will certify to the State and CMS initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual who has been debarred, excluded, revoked, or suspended by the Federal, State or local government, or otherwise excluded from participating in procurement activities:
- 2.1.6.1. As a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the FIDA-IDD Plan's equity; or
 - 2.1.6.2. As a party to an employment, consulting or other agreement with the FIDA-IDD Plan for the provision of items and services that are significant and material to the FIDA-IDD Plan's obligations in the Medicaid managed care program, consistent with requirements of SSA § 1932 (d)(1).
- 2.1.7. Pursuant to 42 C.F.R. § 455.101, the FIDA-IDD Plan is required to check against the Federal and State excluded Provider lists all staff, Participating Providers, or other contracted entities.
- 2.1.7.1. The US Department of Health and Human Services Office of Inspector General has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Similarly, the New York Office of the Medicaid Inspector General also has the authority to exclude, for good reason, medical professionals from participating in the New York Medicaid program. FIDA-IDD Plans are required to check both the List of Excluded Individuals and Entities (LEIE) (available at: <http://exclusions.oig.hhs.gov/>) and the Restricted, Terminated or Excluded Individuals or Entities List (available at: <http://www.omig.ny.gov/component/content/article/29-fraud/fraud-abuse/372-restricted-terminated-or-excluded-individuals-or-entities>). The

FIDA-IDD Plan must comply with applicable guidance on the treatment of excluded individuals and entities and notify CMS and the State immediately if the plan has discovered an excluded individual or entity. Additional guidance on the effects of an exclusion is provided in the Special Advisory Bulletin on the Effect of Exclusions from Participation in Federal Health Programs, available at: <https://oig.hhs.gov/exclusions/files/sab-05092013.pdf>.

- 2.1.8. The FIDA-IDD Plan shall report to the State and CMS documentation of the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the FIDA-IDD Plan, or with any subcontract(s) in which the FIDA-IDD Plan has a five percent (5%) or more ownership interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR § 455.100 through 455.104.
- 2.1.9. Pursuant to 42 CFR § 455.106, the FIDA-IDD Plan will disclose any criminal convictions of managing employees related to Medicare, Medicaid, or Title XX programs at the time the FIDA-IDD Plan applies or renews an application for participation in the Medicaid managed care program or Family Health Plus program or at any time on request. NYSDOH is required to notify the HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.
- 2.1.10. Pursuant to 42 CFR § 455.106, the FIDA-IDD Plan will require Providers to disclose health care related criminal conviction information from all parties affiliated with the Provider. Upon entering into an initial agreement or renewal of any agreement between the FIDA-IDD Plan and its Providers, the FIDA-IDD Plan must disclose any conviction of a criminal offense related to that Provider or Provider's managing employee involvement in any program under Medicare, Medicaid, or Title XX services program.
- 2.1.11. Comply with any developmental disability or behavioral health program changes that take effect during the Demonstration period.
- 2.1.12. Comply with all aspects of the joint Readiness Review.
- 2.1.13. Comply with requirements and recommendations as they are adopted by the Medicaid Redesign Team's Health Disparities Work Group and enacted by the State.
- 2.1.14. Adopt and implement policies ensuring Culturally Competent Care Management and service delivery, making oral interpretation services for any Participant that so requires or requests oral interpretation services, and making all written information available in Prevalent Languages.

2.1.15. Accreditation

2.1.15.1. To the extent that the FIDA-IDD Plan is accredited by NCQA, the FIDA-IDD Plan must report to the State 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.

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

2.1.16.1. The Program Integrity Plan must define how the FIDA-IDD 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-IDD Plan.

2.1.17. Ownership and Related Information Disclosure

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

2.1.17.2. Pursuant to 42 CFR § 455.104, the FIDA-IDD Plan will obtain a disclosure of complete ownership, control, and relationship information from all MCO Providers.

2.1.17.3. Pursuant to 42 CFR § 455.105, within 35 days of the date of a request by OPWDD, NYSDOH, OMIG or DHHS, the FIDA-IDD Plan will require from any First Tier, Downstream or Related Entity disclosure of ownership, with whom an individual Participating Provider has had a business transaction totaling more than \$25,000 during the 12 month period ending on the date of request.

2.1.18. Mergers and Acquisitions

2.1.18.1. In addition to the requirements at 42 C.F.R. § 422 subpart L, the FIDA-IDD Plan must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify the State 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.).

2.1.19. Financial Requirements.

2.1.19.1. General

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

2.1.19.1.2. Financial Viability

2.1.19.1.2.1. 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-IDD Plan shall meet all State and Federal financial soundness requirements. These must include: The FIDA-IDD 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 Items and Services provided to the Participants for which the State and/or CMS does not pay the FIDA-IDD Plan, or the State or CMS or the FIDA-IDD Plan does not pay the Participant or Provider that furnishes the health care services under a contractual or other arrangement.

2.1.19.1.2.2. The FIDA-IDD 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.

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

2.1.19.1.2.4. If the FIDA-IDD Plan becomes insolvent, the FIDA-IDD 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.

2.1.19.1.3. Financial Reports: The FIDA-IDD Plan shall submit financial reports, including certified annual and quarterly financial statements, and make available documents relevant to its financial condition to OPWDD, NYSDOH, CMS, and the New York State Department of Financial Services in a timely manner as required by State laws and regulations including, but not limited to, PHL §§

4403-a, 4404 and 4409, Title 10 NYCRR Part 98 and when applicable, State Insurance Law §§ 304, 305, 306, and 310.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirement

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

2.2.1.2. CMS and State Readiness Review Responsibilities:

2.2.1.2.1. CMS and the State will conduct a Readiness Review of each FIDA-IDD 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-IDD Plan. CMS and the State or their designee will conduct the Readiness Review to verify the FIDA-IDD Plan's assurances that the FIDA-IDD Plan is ready and able to meet its obligations under the Contract.

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

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

2.2.1.2.1.1.2. 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;

2.2.1.2.1.1.3. Capabilities of First Tier, Downstream, and Related Entities, in accordance with Section 2.7.2.3 and Appendix C;

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

2.2.1.2.1.1.5. Care Management capabilities, in accordance with Section 2.5;

2.2.1.2.1.1.6. Participant services capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.11;

2.2.1.2.1.1.7. Comprehensiveness of quality management / quality improvement and Utilization Management strategies, in accordance with Section 2.14;

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

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

2.2.1.2.1.1.10. Financial solvency requirements;

2.2.1.2.1.1.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.16 and Section 2.17, including IT testing and security assurances.

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

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

2.2.1.2.4. CMS or the State may, in its discretion, postpone the Contract Operational Start Date for the FIDA-IDD Plan if the FIDA-IDD Plan fails to satisfy all Readiness Review requirements. If, for any reason, the FIDA-IDD Plan does not fully demonstrate to CMS or the State that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and either CMS or the State 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 the State may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. FIDA-IDD Plan Readiness Review Responsibilities

2.2.1.3.1. The FIDA-IDD Plan must demonstrate to CMS and the State's satisfaction that the FIDA-IDD 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-IDD Plan engaging in marketing of its Demonstration product.

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

2.2.2. Contract Management

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

2.2.2.1.1. Ensure the FIDA-IDD 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-IDD Plan and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the FIDA-IDD 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 which Covered Items and Services are accessed at least thirty (30) calendar 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 the State in time frames and formats specified by CMS and the State;

2.2.2.1.5. Meet with representatives of CMS or the State, or both, on a periodic or as-needed basis to resolve issues within specified time frames;

2.2.2.1.6. Ensure the availability to CMS and the State upon either's request, of those members of the FIDA-IDD 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-IDD Plan, when requested, at the State and CMS meetings related to the FIDA-IDD Demonstration;

2.2.2.1.8. Coordinate requests and activities among the FIDA-IDD Plan, all First Tier, Downstream, and Related Entities, CMS, and the State;

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

2.2.2.1.10. Meet with CMS and the State at the time and place requested by CMS and the State, if CMS or the State, or both, determine that the FIDA-IDD Plan is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. The FIDA-IDD Plan shall establish and maintain the interdepartmental structures and processes to support the operation and management of its FIDA-IDD Demonstration line of business in a manner that fosters integration of physical health, OPWDD services, 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-IDD 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 the State or CMS, the FIDA-IDD Plan shall submit to the CMT an overall organizational chart that includes senior and mid-level managers for the FIDA-IDD Plan.

2.2.3.3. The FIDA-IDD 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-IDD Plan governance structure. After the first effective date of enrollment, the FIDA-IDD Plan must have individuals with disabilities, including Participants, within the

governance structure of the FIDA-IDD Plan. The FIDA-IDD Plan will also be encouraged to include Participant representation on its boards of directors.

2.3. FIDA-IDD Plan Role in Enrollment Activities

2.3.1. Enrollment Generally. Enrollment and Disenrollment transactions will be processed through the State Enrollment Broker. The State Enrollment Broker 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 the State identifying individuals who have elected to disenroll from a FIDA-IDD Plan, or have enrolled in or have selected another type of available Medicare coverage that is not a FIDA-IDD Plan. The State will share Enrollment and Disenrollment transactions with contracted FIDA-IDD Plans.

2.3.2. Enrollment

2.3.2.1. All Enrollment elections are processed through the Enrollment Broker consistent with the Effective Date of Enrollment requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. In the event that a Participant directly contacts the FIDA-IDD Plan to request Enrollment into the FIDA-IDD Plan, the FIDA-IDD 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-IDD Plan Enrollment.

2.3.2.2. Effective Date of Enrollment – The FIDA-IDD Plan will be required to accept Enrollments, as communicated by the Enrollment Broker, of Eligible Individuals no earlier than thirty (30) calendar days prior to the initial effective date of enrollment.

2.3.2.3. Effective Date of Coverage. If an Enrollment request is received by the Enrollment Broker and accepted by the State’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.

2.3.2.4. The FIDA-IDD Plan will be responsible for providing Covered Items and Services to Participants beginning on their Effective Date of Enrollment.

2.3.2.5. The FIDA-IDD Plan must have a mechanism for receiving timely information about all Enrollments in the FIDA-IDD Plan, including the Effective Date of Enrollment, from CMS, the State, and the Enrollment

Broker's systems consistent with the time frames outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

- 2.3.2.6. The FIDA-IDD 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 the State, without restriction, except that the FIDA-IDD Plan shall notify the State of any third party liability in accordance with Section 5.1.12. The FIDA-IDD Plan shall accept for Enrollment all Eligible Individuals identified by the State 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.
- 2.3.2.7. The FIDA-IDD Plan shall provide a Welcome Packet including the following materials for Participant receipt no later than eight (8) Business Days from receipt of confirmation of Enrollment or by the last calendar day of the month prior to the Effective Date of Enrollment, whichever occurs later:
 - 2.3.2.7.1. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the FIDA-IDD Plan;
 - 2.3.2.7.2. A combined Provider and Pharmacy Directory or a separate notice on how to access this information online and how to request a hard copy;
 - 2.3.2.7.3. A single ID card; and
 - 2.3.2.7.4. A Participant Handbook (Evidence of Coverage).
- 2.3.2.8. The number of Participants enrolled with FIDA-IDD Plan will be limited to a level that will not exceed FIDA-IDD Plan's physical and professional capacity.
- 2.3.2.9. The State and CMS, through the CMT, will review documentation provided by the FIDA-IDD Plan that sets forth the FIDA-IDD Plan's physical and professional capacity: (i) before the first Enrollment and as regularly provided subsequently; (ii) when the FIDA-IDD Plan requests a review and the State 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-IDD Plan's capacity; (iv) when there is a Change of Control, or a sale or transfer of the FIDA-IDD Plan; and, (v) when CMS and the State determine that the FIDA-IDD Plan's operating or financial performance reasonably indicates a lack of Provider or

administrative capacity. Such documentation must demonstrate that the FIDA-IDD 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-IDD 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 the State reasonably finds that the FIDA-IDD Plan has failed to restore Participating Provider and administrative capacity, the CMT may freeze Enrollment during the implementation phase or take other corrective actions.

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

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

2.3.2.12. For Participants who undergo Medicaid renewal requirements, the FIDA-IDD Plan shall timely assist these Participants in meeting the requirements for their Medicaid renewal. This shall include helping to obtain documentation necessary for renewal and helping to timely provide renewal documentation to the LDSS.

2.3.3. Disenrollment

2.3.3.1. Participants may request to be disenrolled from the FIDA-IDD 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.

2.3.3.2. In the event that a Participant directly contacts the FIDA-IDD Plan to request Disenrollment from the FIDA-IDD Plan, the FIDA-IDD Plan shall:

2.3.3.2.1. 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.

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

- 2.3.3.3. Voluntary Disenrollments are processed by the Enrollment Broker consistent with the Disenrollment Effective Date requirements set forth in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including the State-Specific Appendix 5, and the requirements set by the State for the Enrollment Broker.
- 2.3.3.4. The FIDA-IDD 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 the State and Enrollment Broker's systems.
- 2.3.3.5. Voluntary Disenrollment requests that are 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.
- 2.3.3.6. Any time an Eligible Individual requests to disenroll from the Demonstration, the State or its Enrollment Broker will send a notice confirming the Disenrollment Effective Date in addition to providing information on the benefits available to the Participant once they have disenrolled.
- 2.3.3.7. The FIDA-IDD Plan shall cease providing Covered Items and Services to a Participant upon the Effective Date of Disenrollment.
- 2.3.3.8. Within two (2) business days of receiving such information, the FIDA-IDD Plan shall notify the Enrollment Broker and CMT of any Participant who it knows or believes is no longer eligible to remain enrolled in the FIDA-IDD Plan per the eligibility provisions of this contract at 3.2 or the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance and include all supporting materials. This includes where the FIDA-IDD Plan has received notice that a Participant has permanently moved out of the service area or has been incarcerated according to Section 40.2.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. This also includes where the FIDA-IDD Plan has received notice (e.g. out of area claims, etc.) that a Participant is absent from the service area such that the Enrollment Broker must initiate researching and acting upon a change of address under Section 40.2.1.3 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.
- 2.3.3.9. Under no circumstances shall the FIDA-IDD Plan cease to provide services to a Participant until the Enrollment Broker informs the FIDA-IDD Plan that the Participant's coverage must be terminated because

the Participant has received appropriate notice and waived or exhausted all Appeal rights. Termination shall take effect on the Effective Date of Disenrollment indicated by the Enrollment Broker.

2.3.3.10. Discretionary Involuntary Disenrollments: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to the FIDA-IDD Plan on Discretionary Involuntary Disenrollment. This Contract and guidance provides both procedural and substantive requirements the FIDA-IDD Plan, the State, and CMS must follow prior to involuntarily disenrolling a Participant. If all of the procedural requirements are met, the State and CMS will decide whether to approve or deny each request for Discretionary Involuntary Disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements. The FIDA-IDD Plan must comply with the following requirements for the following three bases for Discretionary Involuntary Disenrollment: disruptive conduct, fraud or abuse, and necessary consent or release.

2.3.3.10.1. Disruptive conduct: The FIDA-IDD Plan may submit a request when the Participant engages in conduct or behavior that seriously impairs the FIDA-IDD Plan's ability to furnish Covered Items and Services to either this Participant or other Participants and provided the FIDA-IDD Plan made and documented reasonable efforts to resolve the problems presented by the Participant.

2.3.3.10.1.1. Procedural requirements: The FIDA-IDD Plan's request for Discretionary Involuntary Disenrollment for disruptive conduct must be in writing and include all of the supporting documentation outlined in the evidentiary requirements. The procedural requirements are:

2.3.3.10.1.1.1. Notices: The process requires 3 written notices. The FIDA-IDD Plan must include in the request submitted to the State and CMS evidence that the advance notice and notice of intent have already been sent to the Participant or their Representative and/or Designee. The planned action notice will be sent by the Enrollment Broker and may not be sent by the FIDA-IDD Plan. The notices are:

2.3.3.10.1.1.1.1. Advance notice: Inform the Participant that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include

a clear and thorough explanation of the disruptive conduct and its impact on the FIDA-IDD Plan's ability to provide services, examples of the types of reasonable accommodations the FIDA-IDD Plan has already offered the grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Participant receives notice and then later resumes, the FIDA-IDD Plan must begin the process again. This includes sending another advance notice.

2.3.3.10.1.1.1.2. Notice of intent: Informs the Participant that the FIDA-IDD Plan intends to request the State and CMS' permission to disenroll the Participant; and

2.3.3.10.1.1.1.3. Planned action notice: A notice, sent by the Enrollment Broker, advising that CMS and the State have approved the FIDA-IDD Plan's request. This notice is not a procedural prerequisite for approval and the FIDA-IDD Plan may not send it under any circumstances.

2.3.3.10.1.1.2. Information about the Participant: The FIDA-IDD Plan must provide information about the Participant, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.3.10.1.1.3. Provider statements: The FIDA-IDD Plan's submission must include statements from providers describing their experiences with the Participant (or refusal in writing, to provide such statements); and

2.3.3.10.1.1.4. Participant statements: The FIDA-IDD Plan's submission must include any information provided by the Participant or his or her Representative and/or Designee. The Participant can provide any information he/she wishes. If the Participant chose not to submit any information, the FIDA-IDD Plan must provide proof that the Participant was provided an opportunity to do so.

2.3.3.10.1.1.5. Future enrollments: If the FIDA-IDD Plan is requesting the ability to decline future enrollments for

this individual, the Plan must include this request explicitly in the submission.

2.3.3.10.1.2. Substantive Requirements: Prior to approval, the complete request shall be reviewed for procedural and evidentiary sufficiency by the State and CMS concluding with a review by representatives from the CMS Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.3.10.1.2.1. Evidentiary standards: At a minimum, the FIDA-IDD Plan's supporting documentation must demonstrate the following to the satisfaction of both State and CMS staff with appropriate clinical or medical expertise:

2.3.3.10.1.2.2. Pattern of disruptive conduct: The Participant is presently engaging in a pattern of disruptive conduct that is seriously impairing the FIDA-IDD Plan's ability to furnish Covered Items and Services to the Participant and/or other Participants.

2.3.3.10.1.2.3. Reasonable efforts: The FIDA-IDD Plan took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.3.10.1.2.3.1. A documented effort to understand and address the Participant's underlying interests and needs reflected in his/her disruptive conduct and provide efforts to address them. The State and CMS will determine whether the reasonable efforts offered are sufficient.

2.3.3.10.1.2.3.2. A documented provision of information to the Participant of his or her right to use the FIDA-IDD grievance procedures.

2.3.3.10.1.2.3.3. The FIDA-IDD Plan provided the Participant with a reasonable opportunity to cure his/her disruptive conduct.

2.3.3.10.1.2.4. Relationship to services: The FIDA-IDD Plan must provide evidence that the member's behavior is not related to the use, or lack of use, of FIDA-IDD Covered Items and Services.

2.3.3.10.1.2.5. Extenuating circumstances: The FIDA-IDD Plan may also provide evidence of other extenuating circumstances that demonstrate the Participant's disruptive conduct;

2.3.3.10.1.2.6. Limitations: The FIDA-IDD Plan shall not seek to terminate Enrollment under this section because of any of the following:

2.3.3.10.1.2.6.1. The Participant's uncooperative or disruptive behavior resulting from such Participant's special needs unless treating Providers explicitly document their belief that there are no reasonable efforts the FIDA-IDD Plan could provide that would address the disruptive conduct.

2.3.3.10.1.2.6.2. The Participant exercises the option to make treatment decisions with which the FIDA-IDD Plan or any health care professionals associated with the FIDA-IDD Plan disagree, including the option of declining treatment and/or diagnostic testing.

2.3.3.10.1.2.6.3. An adverse change in a Participant's health status or because of the Participant's utilization of Covered Items and Services.

2.3.3.10.1.2.6.4. The Participant's mental capacity is, has, or may become diminished.

2.3.3.10.2. Fraud or Abuse: When 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.

2.3.3.10.2.1. The FIDA-IDD Plan may submit a request that a Participant be involuntarily disenrolled if a Participant knowingly provides, on the election form, fraudulent information that materially affects the Participant's eligibility to enroll in the FIDA-IDD Plan; or if the Participant intentionally permits others to use his or her ID card to obtain services under the FIDA-IDD Plan.

2.3.3.10.2.2. Prior to submission, the FIDA-IDD Plan must have and provide to CMS/NYSDOH credible evidence substantiating the allegation that the Participant knowingly

provided fraudulent information or intentionally permitted others to use his or her ID card.

2.3.3.10.2.3. The FIDA-IDD Plan must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged Fraud and/or Abuse.

2.3.3.10.3. Necessary consent or release: When the Participant knowingly fails to complete and submit any necessary consent or release allowing the FIDA-IDD 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.

2.3.3.10.3.1. The FIDA-IDD Plan may request that a Participant be involuntarily disenrolled if the Participant knowingly fails to complete and submit any necessary consent or release allowing the FIDA-IDD 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. The FIDA-IDD Plan must provide notice to the Participant and or their Representative and/or Designee prior to submission of the request outlining the intent to request Disenrollment with an explanation of the basis of the FIDA Plan's decision and information on the Participant's access to Grievance procedures and a fair hearing.

2.3.3.11. Following any Disenrollment under this section, the FIDA-IDD Plan shall transfer the Participant's Comprehensive Health Record information promptly to a new Medicare or Medicaid health plan (if any), OPWDD and/or its designee. The information shall be provided no later than ten (10) calendar days from the receipt of the notice of Disenrollment to the FIDA-IDD Plan and no later than the effective date of transfer in the method and format specified by the State and CMS.

2.4. Covered Items and Services

2.4.1. Covered Items and Services must be available to all Participants twenty-four (24) hours a day, seven (7) days a week. All services must be provided, in accordance with the IDT policy.

2.4.2. Covered Items and Services will be managed and coordinated by the FIDA-IDD Plan through the Participant's Care Manager.

- 2.4.3. 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-IDD Plan shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.
- 2.4.4. The FIDA-IDD Plan must provide at least the full range of Behavioral Health Services covered by a Mainstream Managed Care Plan under the existing Partnership Plan demonstration under Social Security Act Section 1115(a).
- 2.4.5. The FIDA-IDD 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-IDD Plan must provide the most expansive set of services required by either program. The FIDA-IDD Plan may not limit or deny services to Participants based on Medicare or Medicaid providing a more limited range of items and services than the other program.
- 2.4.6. As described herein and in the IDT Policy, many Covered Items and Services are authorized by the IDT through the Participant's (LP).
- 2.4.7. Referrals from PCPs or other Providers are not necessary and may not be required by the FIDA-IDD Plan or any of its Participating Providers when a Participant is obtaining Covered Items or Services under the FIDA-IDD Demonstration.

2.5. Care Delivery Model

- 2.5.1. Care Management. The FIDA-IDD 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 conducted 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/or their Representative and/or or Designee and led by a Care Manager. As outlined in the IDT Policy, the IDT will ensure the integration of the Participant's OPWDD supports and services, medical

services, Behavioral Health Services, substance use disorder treatment services, 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 the Participant's 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.

2.5.2.2. As outlined in the IDT Policy, and subject to the limitations of the licensure of the IDT participants, the IDT's decisions serve as service authorizations, may not be modified by the FIDA-IDD Plan outside of the IDT, and are appealable by the Participant, his/her Providers, and his/her Representative and/or Designee. IDT service planning, coverage determinations, and Care Management will occur in accordance with the terms outlined in the IDT Policy.

2.5.2.3. Interdisciplinary Team Training: The FIDA-IDD Plan will offer training to all Participating Providers on the IDT process and other substantive subjects reflecting the core competencies of working with the FIDA-IDD population.

2.5.2.4. 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 OPWDD services, medical, social, Behavioral Health Services, prescription drugs and non-prescription drugs, Community-based or Facility-based LTSS, educational, financial and other services of the LP that support the Participant's psychosocial needs irrespective of whether such items and services are covered by the FIDA-IDD Plan. More detail about the Care Manager responsibilities is provided in the IDT Policy.

2.5.2.4.1. The FIDA-IDD Plan Care Manager is the IDT lead and facilitates all IDT activities. The Care Manager may request information from the FIDA-IDD Plan's Utilization Management (UM) staff, such as information about medical necessity, clinical guidelines, or evidence-based best practices. The UM staff, however, may not participate in IDT meetings, and should not be deemed members of the IDT.

2.5.2.4.2. For each Participant, the FIDA-IDD Plan's IDT shall consist of the Participant's Care Manager and specific other persons with relevant expertise and experience appropriate to address the needs of Participants. The Care Manager shall be the point of contact for

the Participant or be responsible for assigning and overseeing a point of contact.

2.5.2.5. Within thirty (30) calendar days of the Effective Date of Enrollment, the FIDA-IDD Plan shall provide to Participating and Non-Participating Providers who are identified as serving newly enrolled FIDA-IDD Participants a communication informing them that the FIDA-IDD Participant has just enrolled with the FIDA-IDD Plan. The communication shall also provide the name, telephone, and email contact information for the FIDA-IDD Participant's Care Manager. The FIDA-IDD Plan shall provide the most direct telephone contact possible for the Care Manager. The FIDA-IDD Plan shall send Participating and Non-Participating Providers updated Care Manager's name and contact information within thirty (30) calendar days of any change to this information.

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-IDD Plan must establish policies for appropriate assignment of Care Managers.

2.5.2.6.2. Care Managers must have knowledge of intellectual and developmental disabilities, 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.

2.5.2.6.3. Care Manager must be a licensed professional such as an RN, Licensed Social Worker, or Psychologist and have knowledge of physical health, developmental disability services, aging, appropriate support services in the community (e.g., Community-based and Facility-based LTSS), 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.

2.5.2.6.4. Care Managers in FIDA-IDD Plan are required to have one year experience working with individuals with IDD.

2.5.2.7. Care Management Assignment and Change Request

2.5.2.7.1. The FIDA-IDD 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-IDD Plan must have a process to ensure that a Participant and/or their Representative and/or Designee are able to request a change in his or her Care Manager at any time.

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

2.5.2.8.1. Care Manager Contact Standards. Care Managers shall maintain contact with Participants as frequently as outlined in the LP 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-IDD Plan will manage transitions of care and continuity of care for Participants moving from an institutional setting to a community living arrangement. The FIDA-IDD Plan's process for facilitating continuity of care will include ensuring that both the IDT and the FIDA-IDD Plan do the following:

2.5.3.2. Communicates with entities involved in Participants' transition.

2.5.3.3. Assures that the hospitals and Nursing Facilities are not imposing a requirement for a three (3) calendar day hospital stay prior to covering a Skilled Nursing Facility stay.

2.5.3.4. Makes arrangements to help insure that all community-based supports, including non-covered services such as 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.

2.5.3.5. Works with and ensures that each IDT and the FIDA-IDD Plan itself 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 and FIDA-IDD Plan staff must cooperate with the work of the MFP contractor as relates to the Participant. The FIDA-

IDD Plan must comply with any and all requirements of the Money Follows the Person (MFP) program set forth by the NYSDOH, including, but not limited to, requirements for referral and reporting.

- 2.5.3.6. Tracks the number of Participants who wish to move to the community and are referred to the MFP Program and reports this information to the OPWDD.
 - 2.5.3.7. Utilizes environmental adaptations and equipment and technology the Participant needs for a successful care setting transition.
 - 2.5.3.8. Provides stabilization and provision of uninterrupted access to Covered Items and Services for the Participant.
 - 2.5.3.9. Assesses Participants' ongoing care needs;
 - 2.5.3.10. Monitors continuity and quality of care, and services provided.
 - 2.5.3.11. Helps Participants transition to another Participating Provider if their Participating Provider leaves the FIDA-IDD Plan's network; and
 - 2.5.3.12. Transitions Participants to new Participating Providers, if needed, once the LP is completed.
- 2.5.4. Pre-existing Conditions. Upon the Effective Date of Enrollment, the FIDA-IDD Plan shall assume full responsibility for any Covered Items and Services received by the Participant as of the Effective Date of Enrollment that are necessary to treat medical conditions or address function impairments that may have existed prior to a Participant's Enrollment with the FIDA-IDD Plan. To ensure continuity of care in accordance with Section 2.6.6, the FIDA-IDD Plan shall support the continuation of any existing treatment plan provided that the Participant's treatment plan is current. Beyond the continuity of care period, the FIDA-IDD 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.
- 2.5.4.1. Health Promotion and Wellness Activities
 - 2.5.4.1.1.1. Participant Health Education. The FIDA-IDD 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 or their

Representative and/or Designees, about health and self-care and how to access FIDA-IDD Plan benefits and supports.

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

2.5.4.1.1.3. Health and Wellness Education and Outreach for Participants and/or their Representative and/ or Designee. The FIDA-IDD 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.

2.5.4.1.1.4. Flu Prevention Program. The FIDA-IDD 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.

2.5.4.1.1.5. Telehealth/Tele-Monitoring and Web-Phone Based Technology. The FIDA-IDD Plan must provide telehealth, tele-monitoring, and web-phone based technology 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. Assessments, Reassessments, LP, Participant Engagement, and Continuity of Care

2.6.1. OPWDD Approved Assessment (OAA): OPWDD shall provide to the FIDA-IDD Plan the most recent results from the prospective Participant's OAA. After this initial OAA is provided to the FIDA-IDD Plan, subsequent OAA Tools will be completed by a FIDA-IDD Plan QIDP who will be available to each Participant's IDT for any follow-up or clarifying questions regarding the OAA.

2.6.2. Comprehensive Service Planning Assessment (CSPA): Each Participant shall receive, and be an active participant in, a timely FIDA-IDD CSPA of medical, Behavioral Health Service, Community-based or Facility-based LTSS, strengths and social needs and validated for Individuals with Intellectual Disabilities, completed by a licensed professional consistent with applicable state and federal law. The FIDA-IDD CSPA must be completed in accordance with the timelines and requirements outlined in the IDT Policy.

2.6.3. Comprehensive Reassessment (CR): The FIDA-IDD Plan shall conduct a CR for each Participant in accordance with the timelines and requirements outlined in the IDT Policy.

2.6.4. Life Plan (LP): The FIDA-IDD Plan shall develop and implement a LP in accordance with the timelines and requirements outlined in the IDT Policy.

2.6.5. Participant Engagement and Education.

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

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

2.6.6.1. The FIDA-IDD Plan allows Participants receiving any Covered Item or Service at the time of Effective Date of Enrollment other than ICF IID- services or Behavioral Health Services to maintain current Providers, including with Providers who are currently out of the FIDA-IDD 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) calendar days after the Effective Date of Enrollment; or

2.6.6.1.2. Until the LP is finalized and implemented.

2.6.6.2. The FIDA-IDD Plan allows Participants who reside in an ICF-IID or other OPWDD-certified residential program to maintain current ICF-IID or residential providers as long as the Participant's LP continues to describe the need for the service. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. § 438.404 which clearly articulates the Participant's right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the FIDA-IDD Plan renders an adverse determination (either in whole or in part) on the Appeal.

2.6.6.3. The FIDA-IDD Plan allows Participants who are receiving non-residential OPWDD 1915(c) comprehensive waiver services to maintain current providers and service levels in place at the time of Enrollment for at least ninety (90) calendar days after Enrollment, or until the LP has been finalized and implemented, whichever is later.

2.6.6.4. The FIDA-IDD 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. This requirement will be in place for not to exceed two (2) years from the date of a Participant's Effective Date of Enrollment and applies only to Episodes of Care that were ongoing during the transition period from Medicaid Fee-For-Service (FFS) to Enrollment in a FIDA-IDD Plan.

2.6.6.5. The FIDA-IDD Plan assures that, within the first ninety (90) calendar days of coverage, it will provide:

2.6.6.5.1. In outpatient settings, up to ninety (90) calendar 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-IDD Plan's formulary but require Prior Authorization or step therapy under the FIDA-IDD Plan's Utilization Management rules) that otherwise meets the definition of a Part D drug during the first ninety (90) calendar days following Enrollment in the FIDA-IDD Plan; and

- 2.6.6.5.2. In long-term care settings, a temporary supply of at least ninety-one (91) calendar days and up to ninety-eight (98) calendar days of non-formulary drugs including drugs that are on the FIDA-IDD Plan's formulary but require Prior Authorization or step therapy under the FIDA-IDD 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
- 2.6.6.5.3. A ninety (90) calendar day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.
- 2.6.6.5.4. Except as otherwise stated in this Contract, Part D transition rules and rights will continue as provided for in current law and regulation.
- 2.6.6.6. During the transition period, for any Provider seen by the Participant within the previous six (6) months prior to transition and of whom the FIDA-IDD Plan is aware, the FIDA-IDD Plan will allow access to that Provider within the first ninety (90) calendar days of Enrollment, even on a Non-Participating Provider basis.
- 2.6.6.7. During the transition period, FIDA-IDD Plans will advise the Participants' IDTs if and when Participants have received care that would not otherwise be covered at an in-network level.
- 2.6.6.8. On an ongoing basis, and as appropriate, FIDA-IDD Plans must also contact Providers (i.e., Non-Participating) currently serving FIDA-IDD Participants, but who are not already members of their Provider Network with information on becoming credentialed as Participating Providers.
- 2.6.6.9. Any reduction, suspension, denial, or termination of previously authorized services shall trigger the FIDA-IDD Plan to issue the notice required under 42 CFR § 438.404 and as further described under Section 2.13 of this Contract.
- 2.6.6.10. The FIDA-IDD Plan shall have policies and procedures to:
 - 2.6.6.10.1. Expeditiously obtain, accept, and honor established service plans provided on paper or electronically transferred from Medicaid and/or Medicare Fee-for-Service 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;

2.6.6.10.2. Ensure transfer of CSPA, CR, LPs, contact information, and other pertinent information necessary to assure continuity of care for Participants going back to Medicaid fee-for-service.) OPWDD, NYSDOH or their Representative/Guardian or Designee for FIDA-IDD Participants that disenroll from the FIDA-IDD Plan back to Medicaid fee-for-service must work with the Developmental Disabilities Regional Office (DDRO) in the County in which the Participant lives. The information shall be provided no later than ten (10) calendar days from the receipt of the notice of Disenrollment to the FIDA-IDD Plan and no later than the effective date of transfer in the method and format specified by the State and CMS; and

2.6.6.11. Continuity of Care Exceptions

2.6.6.11.1. Unless requested by the Participant, the FIDA-IDD Plan may not transition Participants to a Participating PCP until:

2.6.6.11.2. The Participant chooses or is assigned a Participating PCP in accordance with Section 2.8.5 and the Participating PCP is capable of serving the Participant's needs appropriately;

2.6.6.12. A CSPA and LP are complete; and

2.6.6.12.1. A new LP has been drafted and implementation of the new LP has begun in accordance with the IDT Policy.

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

2.6.6.12.2.1. A CSPA and LP are complete;

2.6.6.13. Notwithstanding exceptions related to Behavioral Health Services in Section 2.6.6.3 and ICF- IID and other OPWDD certified residential services in Section 2.6, 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) calendar days after Enrollment and will not be terminated at the end of ninety (90) calendar days without advance notice to the Participant and transition to other services, if needed.

2.6.6.14. Out-of-Network Reimbursement Rules. For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined in this Contract and by 42 C.F.R. §§ 424.101 and 405.400 respectively, the health care professional is required to accept as payment in full by the FIDA IDD Plan the

amounts the health care professional could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS, However, the FIDA IDD Plan is not required to reimburse the health care professional more than the health care professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the FIDA-IDD Plan in writing that it is billing an amount less than such amount. Participants maintain improper/inappropriate billing (sometimes previously referred to as balance billing) protections.

- 2.6.6.15. If a Participant is receiving any Covered Item or Service that would not otherwise be covered by the FIDA-IDD Plan at an in-network level after the continuity of care period, the FIDA-IDD Plan must notify the Participant's IDT prior to 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.
- 2.6.6.16. Effective upon the termination of the continuity of care period, the FIDA-IDD 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-IDD Plan's formulary but require Prior Authorization or step therapy under the FIDA-IDD Plan's Utilization Management rules).
- 2.6.6.17. 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-IDD 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-IDD Plan must maintain documentation of such transfer of responsibility of medical care or treatment. For services traditionally covered by Medicare, the FIDA-IDD Plan must cover, through discharge, inpatient services if the individual was a Participant at the beginning of the inpatient stay.
- 2.6.6.18. 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-IDD Plan's Provider Network, the FIDA-IDD Plan will permit such Participant to continue an ongoing course of treatment with such Physician for up to ninety (90) calendar days as outlined in Section

2.6.6.1 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 reimbursement at the FIDA-IDD Plan's established rates based on a review of the level of items and services provided; (ii) adhere to the FIDA-IDD Plan's quality requirements; and (iii) adhere to the FIDA-IDD Plan's policies and procedures.

- 2.6.6.19. The FIDA-IDD 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-IDD 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-IDD Plan must ensure that there is no cost to the Participant as if the services were furnished within the Provider Network.
- 2.6.6.20. For Covered Items and Services that are part of the traditional Medicare (i.e., Medicare FFS) benefit package, the FIDA-IDD Plan will be required to pay Non-Participating Providers including health care professionals and section 1861(u) providers of services, the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) 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-IDD Plans will be required to pay Non-Participating Providers the Medicaid FFS rate. For Participating Developmental Disability service providers, the FIDA-IDD Plan will be required to pay these providers no less than Medicaid FFS rate for the first year of the Demonstration for services that are part of the traditional Medicaid fee for service benefit package.
- 2.6.6.21. For Covered Items and Services that are part of the traditional Medicaid benefit package, the FIDA-IDD 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-IDD Plan's Service Area. The State will consider approving alternative payment methods, consistent with State law, if both the Provider and FIDA-IDD Plan come to an agreement.
- 2.6.6.22. For Covered Items and Services delivered to residents of ICF- IID facilities, the FIDA-IDD Plan shall pay the rate established by the NYSDOH for the ICF-IID in accordance with Attachment 4.19-D Part II of the New York State Plan.

2.7. Provider Network

2.7.1. General.

- 2.7.1.1. The FIDA-IDD Plan must demonstrate annually that it has an adequate Provider Network, as approved by CMS and the State, to ensure adequate access to OPWDD services, 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-IDD Plan must maintain a Provider Network sufficient to provide all Participants with access to the full range of Covered Items and Services, including OPWDD services, 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-IDD Plan must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) Business Days after becoming aware of a change in the FIDA-IDD Plan's network of Participating Providers that renders the FIDA-IDD Plan unable to provide one (1) or more Covered Items and Services within the access to care standards set forth in this section, 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. The FIDA-IDD Plan is required to comply with the home care worker wage parity provisions of Section 3614-c of the Public Health Law.
- 2.7.1.3. Participating Provider Credentialing, Recredentialing, and Board Certification. The FIDA-IDD Plan shall have a uniform process for credentialing 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 of the FIDA-IDD Plan.
- 2.7.1.4. Recredentialing. Re-credentialing shall occur not less than every three years. At re-credentialing and on a continuing basis, the FIDA-IDD Plan shall verify minimum credentialing requirements and monitor Participant Grievances and Appeals, quality of care and quality of service events, and Medical Record review.
- 2.7.1.5. Delegated Credentialing. The FIDA-IDD 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-IDD Plan, NCQA, CMS, the State and applicable regulatory standards. The FIDA-IDD Plan shall

remain responsible for delegated Participating Provider credentialing and re-credentialing.

2.7.1.6. The FIDA-IDD 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, Medicaid, or the State Children's Health Insurance Program, except for Emergency Services. Section 2.17 of this Contract provides the FIDA-IDD Plan's obligations to check the excluded Provider lists.

2.7.1.7. The FIDA-IDD Plan may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

2.7.1.7.1. Furnished under the FIDA-IDD Plan by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);

2.7.1.7.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

2.7.1.7.3. Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments;

2.7.1.8. The FIDA-IDD Plan may not pay for an item or service:

2.7.1.8.1. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; and

2.7.1.8.2. With respect to home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.

2.7.1.9. The FIDA-IDD Plan shall establish, maintain and monitor a network supported by final 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:

2.7.1.9.1. The anticipated number of Participants;

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

2.7.1.9.3. The number and types of Providers required to furnish the Covered Items and Services;

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

2.7.1.9.5. 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.

2.7.1.9.5.1. Proximity Access Standards

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

2.7.1.9.5.1.2. The FIDA-IDD Plan must demonstrate annually for Medicare medical Providers and facilities and quarterly for all Medicaid services that its Provider Network meets the stricter of the following standards:

2.7.1.9.5.1.2.1. For Medicare medical Providers and facilities, time, distance and minimum number standards updated annually on the CMS website (<http://www.cms.hhs.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination->

Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html);

2.7.1.9.5.1.2.2. 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

2.7.1.9.5.1.3. Within the following State-specific standards:

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

2.7.1.9.5.1.3.2. Participants may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves. 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.

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

2.7.1.9.5.1.3.4. The FIDA-IDD Plan shall make reasonable accommodations, including access to Out-of-Network Providers, if necessary, so that no Participant that is too frail, as determined by the FIDA-IDD Plan to travel thirty (30) minutes or thirty (30) miles shall be required to do so to see a Participating Provider.

2.7.1.9.5.1.3.5. The FIDA-IDD Plan must contract with an adequate number of Community-based OPWDD service providers to allow Participants a choice of at least two (2) providers of each covered Community-based OPWDD service within a fifteen (15) mile radius or thirty (30) minutes from the Participant's ZIP code of residence.

2.7.1.10. The FIDA-IDD Plan's entire Provider Network must meet the existing applicable Medicare and Medicaid Provider Network requirements.

- 2.7.1.11. State Medicaid standards shall be utilized for Community-based and Facility-based LTSS, as described below, for Behavioral Health Services, for OPWDD 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).
- 2.7.1.12. 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-IDD Plan must meet the Medicare requirements.
- 2.7.1.13. 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-IDD Plan must meet the Medicaid requirements.
- 2.7.1.14. 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.
- 2.7.1.15. The State 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.
- 2.7.1.16. The FIDA-IDD Plan's Provider Network must meet all of the following requirements:
- 2.7.1.16.1. In no instance may the FIDA-IDD Plan's Provider Network have less than two (2) of any Provider type necessary to provide Covered Items and Services.
 - 2.7.1.16.2. All Participating Providers' physical sites must be accessible to all Participants as must all Participating Providers that deliver services in the Participants' locations.
 - 2.7.1.16.2.1. The FIDA-IDD Plan must collect completed Accessibility Attestation forms from new Participating Providers that join their networks during the Demonstration.
 - 2.7.1.16.2.2. All Participating Providers must submit to the FIDA-IDD Plan and the FIDA-IDD Plan must maintain on file a signed Accessibility Attestation Form indicating the

accessibility features available at the Participating Provider's location.

2.7.1.16.2.3. A Participating Provider's completion or non-completion of the ADA Accessibility Attestation Form, or responding in the affirmative to elements included in the ADA Accessibility Attestation Form does not alter existing obligations to comply with the ADA.

2.7.1.16.2.4. The FIDA-IDD Plan has discretion on how to address Participating Provider refusals to complete the ADA Accessibility Attestation Form.

2.7.1.16.2.5. All Participating Providers must notify the FIDA-IDD Plan within ten (10) Business Days of any any change in its ability to provide accommodations as outlined in the signed Accessibility Attestation Form.

2.7.1.16.3. The FIDA-IDD 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.

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

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

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

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

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

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

2.7.1.16.4.6. Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a

Participating Provider (as included in the FIDA-IDD Plan's Benefit Package): within five (5) Business Days of request, or sooner if clinically indicated.

2.7.1.16.4.7. Non-urgent mental health or substance abuse visits with a Participating Provider (as included in the FIDA-IDD Plan's Benefit Package): within two (2) weeks of request.

2.7.1.16.4.8. 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) Business Days of request.

2.7.1.16.4.9. Mental Health Clinics must provide a clinical assessment within five (5) Business Days of request for Participants in the following designated groups:

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

2.7.1.16.4.9.2. Participants in domestic violence shelter programs not currently receiving treatment;

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

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

2.7.1.16.4.9.5. Participants who have been discharged from an inpatient psychiatric facility within the last sixty (60) calendar days who are not currently receiving treatment;

2.7.1.16.4.9.6. Participants referred by rape crisis centers; and

2.7.1.16.4.9.7. Participants referred by the State court system.

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

2.7.1.16.5.1. 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 CSPA) within thirty (30) calendar days of Enrollment.

2.7.1.16.5.2. For Participants that are not New to Service but transitioning from Medicare and/or Medicaid FFS, FIDA-IDD Plan must provide continuity of Community-based LTSS immediately upon Enrollment, as further outlined in the continuity of care and transition policy in Section 2.6.6 and Section 2.5.3, respectively. The FIDA-IDD Plan must contract with an adequate number of Community-based LTSS Providers to allow Participants 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.

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

2.7.1.16.6.1. For New to Service Participants (meaning those not already receiving Facility-based LTSS), FIDA-IDD 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-IDD 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.

2.7.1.16.7. Each FIDA-IDD 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-IDD Plan must instruct Participants on what to do to obtain services after business hours and on weekends and may use an on call/physician answering service as appropriate.

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

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

- 2.7.1.16.10. Participants must be assured choice of all Participating Providers, including the Care Manager and others that will participate in their IDT.
- 2.7.1.16.11. Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.28(b)(5) and as described in the Section 1915(c) OPWDD Comprehensive Waiver.
- 2.7.1.16.12. The FIDA-IDD 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-IDD Plan and for which the FIDA-IDD Plan is accountable to the State, or directly through the FIDA-IDD Plan's Provider Network).
- 2.7.1.16.13. The State and CMS have developed transition requirements that specify continuation of existing Non-Participating Providers for Covered Items and Services. These are outlined in Section 2.6.6.
- 2.7.1.16.14. The FIDA-IDD 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 the State and CMS will monitor access to Covered Items and Services through survey, utilization, and Grievance and Appeal data to assess the need for FIDA-IDD Plan Provider Network corrective actions. The State and CMS will conduct reviews of FIDA-IDD Plans to ensure compliance with network adequacy standards. Participating Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.
- 2.7.1.16.15. The State and CMS will finalize the standards, based on administrative data and stakeholder input. The State 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-IDD Plan initiate further Provider Network expansion over the course of the Demonstration.
- 2.7.1.17. Provider Networks will be subject to confirmation through Readiness Reviews and on an ongoing basis. If access problems are detected, the FIDA-IDD 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, the State and/or CMS reserve the right to reassess the FIDA-IDD Plan Provider Network.

- 2.7.1.18. The FIDA-IDD Plan must make reasonable efforts to contact Out-of-Network Providers, including Providers and prescribers that are providing services to Participants after the FIDA-IDD Plan is notified of the prospective Enrollment and during the initial continuity of care period, and provide them with information on becoming Participating Providers. If the Provider does not become a Participating Provider, or if the Participant does not select a new Participating Provider by the end of continuity of care period, the FIDA-IDD Plan shall choose a Participating Provider for the Participant.
- 2.7.1.19. The FIDA-IDD 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-IDD 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-IDD Plan must ensure that cost to the Participant is no greater than it would be if the services were furnished within the Provider Network. Out-of-Network Providers must coordinate with the FIDA-IDD Plan in respect to payment.
- 2.7.1.20. The FIDA-IDD 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-IDD 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-IDD Plan shall authorize the Participant to access services from an appropriate Non-Participating Provider. The FIDA-IDD 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.
- 2.7.1.21. The FIDA-IDD Plan ensures that it contracts with or has a Payment Arrangement with all ICF-IID Facilities in which a newly enrolled or current Participant resides.

- 2.7.1.22. The FIDA-IDD Plan must maintain a complete and accurate Provider and Pharmacy Directory, including information collected by the ADA Accessibility Attestation Form.
- 2.7.1.22.1. Consistent with Chapter 4 of the Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance, the FIDA-IDD Plan shall update its online and hard copy Provider and Pharmacy Directory within thirty (30) days of receiving updated information, to include any changes in Participating Provider accessibility. The FIDA-IDD Plan must inform Participants of the availability of an online Provider and Pharmacy Directory, and upon a Participant's request, provide a paper copy of the Provider and Pharmacy Directory.
- 2.7.1.23. The FIDA-IDD Plan shall ensure that its Participating Providers are responsive to the linguistic, cultural, ethnic, national origin, racial, religious, age, sex, gender identity, sexual orientation, and other unique needs of any minority, homeless Participants, mentally or physically disabled Participants, or other special population served by the FIDA-IDD 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 or visually impaired.
- 2.7.1.24. The FIDA-IDD 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 the State's and CMS' discretion;
- 2.7.1.25. The FIDA-IDD Plan shall ensure that multilingual Participating Providers and, to the extent that such capacity exists within the FIDA-IDD 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.
- 2.7.1.26. The FIDA-IDD Plan shall ensure that Participating Providers and interpreters or translators are available for those Participants who are Deaf or hearing-impaired within the FIDA-IDD Plan's Service Area.
- 2.7.1.27. The FIDA-IDD 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-IDD Plan's Provider Network(s).

- 2.7.1.28. The FIDA-IDD 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.
- 2.7.1.29. The FIDA-IDD 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.
- 2.7.1.30. The FIDA-IDD Plan must demonstrate that it has made reasonable efforts to contract with American Indian Health Care Providers in the Network to ensure timely access to services available under the contract for American Indian Participants who are eligible to receive services from such Providers.
- 2.7.1.31. The FIDA-IDD Plan shall ensure that its Participating Providers have a strong understanding of disability culture and Community-based and Facility-based LTSS.
- 2.7.1.32. In the event that the FIDA-IDD Plan declines to include any given individuals or groups of Providers in its Provider Network, the FIDA-IDD Plan must give the affected Providers written notice of the reason for its decision.
- 2.7.1.33. The FIDA-IDD Plan must permit any American Indian who is enrolled in a non-American Indian demonstration and eligible to receive services from a participating American Indian Health Care Provider to choose to receive Covered Items and Services from that Indian Health Care Provider, and if that I/T/U Provider participates in the Provider Network as a PCP, to choose that Indian Health Care Provider as his or her PCP, as long as that Provider has capacity to provide the services.
- 2.7.1.34. The FIDA-IDD 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).

2.7.2. Provider Qualifications and Performance

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-IDD 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;

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-IDD Plan remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the FIDA-IDD Plan subcontracts for performance of any Contract responsibility. The FIDA-IDD 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-IDD Plan of its legal responsibilities under the Contract.

2.7.2.3.2. The FIDA-IDD 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-IDD Plan. The FIDA-IDD Plan is required to evaluate any potential First Tier, Downstream, or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.230. Additional information about subcontracting requirements is contained in Appendix C.

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

2.7.2.3.4. The FIDA-IDD 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. The FIDA-IDD Plan must 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-IDD Plan must provide Grievance and Appeal procedures and time frames, pursuant to 42 C.F.R. § 438.10(g) as modified by the FIDA-IDD 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-IDD Plan shall provide a detailed description of its risk arrangements with Providers under subcontract with the FIDA-IDD Plan. This description shall be made available to FIDA-IDD Plan Participants upon request. It will not be permissible for any incentive arrangements to 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. FIDA-IDD Plan Risk Arrangements

2.7.3.2.1. Except as otherwise specified in Section 2.6.9.2.2, by January 1, 2017, the FIDA-IDD Plan shall provide a detailed description of its risk arrangements, if any, with providers under subcontract with the FIDA-IDD Plan. This description shall be made available to FIDA-IDD Plan Participants upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical items or services to Participants.

2.7.3.2.2. For services other than Section 1915(c) Comprehensive OPWDD Waiver Services, the FIDA-IDD Plan is encouraged to implement an alternative payment system through which providers are paid on an alternative basis to traditional fee-for-service as soon as practicable (e.g., pay for performance, bundled payment).

2.7.3.2.3. To encourage the adoption of these methodologies, the FIDA-IDD Plan is required to develop and submit a plan for developing alternative payment systems addressing the full continuum of covered services, including Section 1915(c) Comprehensive OPWDD Waiver Services, for State and CMS review. After State and CMS approval, the FIDA-IDD Plan will be required to implement the approved plan, which will remain in effect throughout the duration of the Demonstration.

2.7.3.2.4. Once a plan is approved, the FIDA-IDD Plan must comply with its provisions or seek CMS and State approval of modifications.

2.7.3.2.5. CMS and the State have the authority to direct the FIDA-IDD Plan to make modifications to the alternative payment methodologies as warranted by reporting, grievances, appeals, stakeholder feedback, or other data.

2.7.3.2.6. These requirements notwithstanding, the FIDA-IDD Plan may not implement alternative payment methodologies for Section 1915(c) Comprehensive OPWDD Waiver services earlier than January 1, 2017 or without prior approval of the specific methodologies as described in the plan.

2.7.4. Non-Payment and Reporting of Provider Preventable Conditions

2.7.4.1. The FIDA-IDD Plan agrees to take such action as is necessary in order for the State 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-IDD 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. § 438.3(g), 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 on the www.health.ny.gov website. The FIDA-IDD Plan's policies and procedures shall also be consistent with the following:

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

2.7.4.2.2. The FIDA-IDD Plan shall require, as a condition of payment from the FIDA-IDD 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-IDD Plan and/or the State.

2.7.4.2.3. The FIDA-IDD 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-IDD 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-IDD 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-IDD Plan shall ensure that its non-payment for Provider Preventable Conditions does not prevent Participants from accessing items and services.

2.7.5. Participating Provider Education and Training

2.7.5.1. The FIDA-IDD Plan must ensure that all Participating Providers have access to 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

2.7.5.2. Cultural Competency. The FIDA-IDD Plan will provide access and encourage completion of Cultural Competency training.

- 2.7.5.3. Disability Training. The FIDA-IDD Plan must provide access to disability competent care 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;
 - 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., LPs) 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-IDD Plan must make 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. The FIDA-IDD Plan must provide clear information and access to training for Providers that improper/inappropriate billing (sometimes previously referred to as balance billing) is prohibited under the Demonstration.
- 2.7.5.6. All training will be made available for the Participant, Participant's Caregiver/Guardian or Designee and the Care Manager shall fully explain the IDT Policy to these IDT members as necessary.
- 2.7.5.7. The FIDA-IDD Plan will make available for all Participating Providers training materials on the IDT Policy including at a minimum:

- 2.7.5.7.1. IDT Policy and procedures;
- 2.7.5.7.2. The LP 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 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-IDD Plan shall:
 - 2.7.5.8.1. Provide access to Participating Providers to approved training including required provider training for providers of OPWDD services as outlined in 14 NYCRR Parts 633, 680, and 624; and in administrative guidance published by OPWDD in Administrative Memoranda 2012-06; 2012-04; 2012-03; 2012-02; 2010-02; 2008-01; and 2003-01. DSP Performance Requirements are described in Administrative Memorandum 2014-03.
 - 2.7.5.8.2. Document completion of the training by all Participating Providers, including both employed and contract personnel;
- 2.7.5.9. Training available for all Participating Providers. The FIDA-IDD Plan must make training available for all Participating Providers and IDT members including:
 - 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.
- 2.7.5.10. Training for PCPs. The training program for PCPs 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.
 - 2.7.5.10.5. How to assist the Participant in obtaining OPWDD services.
- 2.7.5.11. Participating Provider Manual. The FIDA-IDD Plan prepares an understandable, accessible Participating Provider Handbook (or handbooks for medical, OPWDD services, 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-IDD Plan contact information, including information on how to contact the Care Manager;
 - 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 improperly/inappropriately billed (sometimes previously referred to as balance billing);
 - 2.7.5.11.8. Reasonable accommodations;
 - 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 elements in the Accessibility Attestation Form; and
 - 2.7.5.11.15. A provision explaining that the FIDA-IDD Plan may not limit a Participating Provider's communication with Participants as provided in Section 5.1.10.
 - 2.7.5.11.16. The FIDA-IDD Plan's policies and procedures regarding advance directives.
- 2.7.5.12. Participating Provider and Pharmacy Directory. The FIDA-IDD Plan shall make its Participating Provider and Pharmacy Directory available to Participating Providers via the FIDA-IDD Plan's website or web portal and in paper copy upon request.
- 2.7.5.13. Provider-based Health Education for Participants. The IDT provides health education to Participants. The FIDA-IDD Plan shall ensure that Care Managers and Participating Providers have the preventive care, disease-specific, and FIDA-IDD 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-IDD 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 and OPWDD services in accordance with 14 NYCRR Parts 633 and 624.

2.8. Network Management

2.8.1. General Requirements

- 2.8.1.1. The FIDA-IDD Plan shall develop and implement a strategy to manage the Provider Network with a focus on access to items and 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 it's 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-IDD 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. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice 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 and if a contract termination involves a Primary Care Provider, all Participants who are patients of that Primary Care Provider must be notified; The FIDA-IDD 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-IDD 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-IDD 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-IDD Plan will arrange that such items and services be provided by a Non-Participating Provider. In such event, the FIDA-IDD Plan will promptly negotiate an agreement ("Single Case Agreement") with a Non-Participating Provider at the applicable Medicaid or Medicare Fee-For-Service rate to treat the Participant until a qualified Participating Provider is available. The FIDA-IDD 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-IDD Plan through site visits

to be accessible for Participants with disabilities. The FIDA-IDD Plan shall collect sufficient information from Participating Providers to assess compliance with the ADA. Compliance shall be confirmed through Provider attestation to the ADA Accessibility Attestation Form and a random sampling of on-site compliance review, in a manner that assures no conflict of interest throughout the Demonstration. As necessary to serve Participants, Participating Provider locations where Participants receive services shall be ADA compliant. All Participating Providers must meet their ongoing ADA compliance obligations.

2.8.2. Providers on OPWDD Early Alert.

- 2.8.2.1. The FIDA-IDD Plan shall check the list of entities on OPWDD Early Alert which is available at:
http://www.opwdd.ny.gov/opwdd_services_supports/service_providers/early_alert/letters_to_agencies.
 - 2.8.2.2. Pursuant OPWDD policy, although providers on OPWDD Early Alert will not be considered for expansion of services, OPWDD Early Alert does not affect the certification or funding of a provider or its current programs. As such, the FIDA-IDD Plan may enter into contracts or single case agreements with providers on OPWDD Early Alert to cover services under this Contract for Participants who were being served by the OPWDD Early Alert provider prior to Enrollment into the FIDA-IDD Plan.
 - 2.8.2.3. The FIDA-IDD Plan may not cover services, whether through a contract or case agreement, delivered by an entity on OPWDD Early Alert to a Participant who does not have a pre-enrollment relationship with that entity without the prior approval of The State and CMS.
 - 2.8.2.4. These limitations only apply while a provider is included on the OPWDD Early Alert list. If a provider is removed from the list pursuant the OPWDD Early Alert policy, this provision will no longer apply.
- 2.8.3. The FIDA-IDD 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-IDD 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-IDD Pharmacy Network is open, (e.g., a FIDA-IDD Plan whose Pharmacy Network includes at least one (1) twenty-four (24) hour pharmacy 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:

2.8.3.1.1. 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.

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

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

2.8.4. 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.

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

2.8.6. PCP Selection and Assignment.

2.8.6.1. Choice of Primary Care Provider. The FIDA-IDD 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-IDD Plan must assign a PCP to Participants who fail to select a PCP.

2.8.6.1.1. A PCP may only be assigned after written notification of the Participant by the FIDA-IDD Plan and only after the FIDA-IDD 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).

2.8.6.1.2. 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-IDD Plan; and iii) any special language needs, if known by the FIDA-IDD Plan.

2.8.6.1.3. In circumstances where the FIDA-IDD Plan operates or contracts with a multi-Provider clinic to deliver primary care services, the 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.

2.8.6.2. Participant Changes to PCP

2.8.6.2.1. The FIDA-IDD 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.

2.8.6.2.2. The FIDA-IDD 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.

2.8.6.2.3. The FIDA-IDD 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.

2.8.6.2.4. 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 2.8.5 of this Contract.

2.8.6.2.5. In addition to those conditions and circumstances under which the FIDA-IDD Plan may assign a Participant a PCP when the Participant fails to make an affirmative choice of a PCP, the FIDA-IDD Plan may initiate a PCP change for a Participant under the following circumstances:

2.8.6.2.5.1. The Participant requires specialized care for an acute or chronic condition and the Participant and FIDA-IDD Plan

agree that reassignment to a different PCP is in the Participant's interest;

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

2.8.6.2.5.3. The Participant's PCP ceases to participate in the FIDA-IDD Plan's Provider Network;

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

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

2.8.6.2.5.5.1. 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 360-6.4 and 42 C.F.R. § 431.54(e).

2.8.6.3. Whenever initiating a change, the FIDA-IDD Plan must offer affected Participants, except for Participants restricted in accordance with Section 2.8.5.2.5.5.1, the opportunity to select a new PCP in the manner described in this Section.

2.8.6.4. Specialists as PCPs. The FIDA-IDD 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 LP.

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

2.8.7. FQHC and RHC Reimbursements

2.8.7.1. The FIDA-IDD Plan shall ensure that its payments to FQHCs and RHCs for services to Participants are no less than the sum of:

2.8.7.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHCs and

2.8.7.1.2. The Medicare cost-share amount for FQHC and RHCs services, as required in New York's Medicaid State Plan for the Medicaid FFS program and reimbursed under Medicaid. This cost-share amount is the difference between eighty percent (80%) of the Medicare FFS rate for that FQHC and the Medicaid PPS amount for that FQHC, where the Medicaid PPS amount exceeds eighty percent (80%) of the Medicare rate.

2.9. Participant Access to Services

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

2.9.1.1. Except for services that do not required authorization as outlined in Section 2.9.3, the IDT, FIDA-IDD Plan, or specified specialist must authorize, arrange, coordinate and provide to Participants 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-IDD Plan shall offer adequate choice and availability of primary, specialty, acute care, OPWDD services, Behavioral Health Service, and Community-based and Facility-based LTSS Participating Providers that meet CMS and State standards as provided in Section 2.7;

2.9.1.3. The FIDA-IDD 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:

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

2.9.1.4.1.1. The FIDA-IDD Plan agrees to adhere to the member-to-PCP ratios shown below. These ratios are FIDA-IDD 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-IDD Plan):

- 2.9.1.4.1.2. No more than 1,500 Participants for each Physician or 2,400 Participants 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-IDD Plan agrees that these ratios will be prorated for Participating Providers who represent less than one FTE to the FIDA-IDD Plan.
- 2.9.1.4.1.5. The FIDA-IDD Plan agrees that ratios will be no more than at least one (1) primary care dentist for each 2,000 Participants.

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-IDD 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-IDD 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-IDD 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 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 and monitoring correction of deficiencies; and
- 2.9.1.6. When a PCP or any OPWDD, medical, Behavioral Health Service, Community-based or Facility-based LTSS Participating Provider is terminated from the FIDA-IDD Plan or leaves the Provider Network for any reason, the FIDA-IDD 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-IDD Plan must also report the termination to the State 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-IDD 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 Participating 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

2.9.3.1. The FIDA-IDD Plan will assure coverage of Emergency Medical Conditions and Urgent Care services. The FIDA-IDD 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 American Indian eligible to receive services from a participating American Indian Health Care Provider; covered services provided by that Indian Health Care 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. Palliative Care;

- 2.9.3.1.10. Other Preventive Services, not already listed herein;
- 2.9.3.1.11. Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services;
- 2.9.3.1.12. Dental Services through Article 28 Clinics Operated by Academic Dental Centers;
- 2.9.3.1.13. Cardiac Rehabilitation, first course of treatment (a Physician or RN authorization is required for subsequent courses of treatment);
- 2.9.3.1.14. Supplemental Education, Wellness, and Health Management Services; and
- 2.9.3.1.15. 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.
- 2.9.3.1.16. Prescription drugs:
 - 2.9.3.1.16.1. Which are on the formulary, or
 - 2.9.3.1.16.2. Which are not on the formulary, but where a refill request is made for an existing prescription within the ninety (90) calendar day transitional period.

2.9.4. Authorization of Services

- 2.9.4.1. 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 or the FIDA-IDD Plan in accordance with the IDT Policy. Except that:
 - 2.9.4.1.1. Preventive Dental X-rays and Comprehensive Dental shall be authorized by a dentist;
 - 2.9.4.1.2. Eye wear shall be authorized by an ophthalmologist or optometrist; and
 - 2.9.4.1.3. Hearing Aids shall be authorized by an audiologist.

- 2.9.4.2. For the processing of requests for initial and continuing authorizations of Covered Items and Services, the FIDA-IDD Plan shall, in accordance with the IDT Policy:
- 2.9.4.2.1. Have in place for its IDTs and ensure that they follow written policies and procedures for initial and continuing authorization of services;
 - 2.9.4.2.2. Have in place procedures to allow Participants to initiate requests for provisions of Covered Items and Services;
 - 2.9.4.2.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and
 - 2.9.4.2.4. Consult with the requesting Provider if the requesting Provider is not a member of the IDT.
- 2.9.4.3. 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. Denials of OPWDD services must be rendered by a QIDP.
- 2.9.4.4. The FIDA Plan shall ensure that all behavioral health authorization activities are in compliance with 42 U.S.C. § 1396u-2(b)(8).
- 2.9.4.5. The FIDA-IDD Plan must notify the requesting Provider, either orally or in writing, and give the Participant written notice of any decision by the FIDA-IDD 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:
- 2.9.4.5.1. Be produced in a manner, format, and language that can be easily understood;
 - 2.9.4.5.2. Be made available in Prevalent Languages, upon request; and

- 2.9.4.5.3. 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.
- 2.9.4.6. The FIDA-IDD Plan and IDT must make authorization decisions in the following time frames and provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.210(d) and Article 49 of NYS PHL:
 - 2.9.4.6.1. For a service that must be pre-authorized, the FIDA-IDD Plan or 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.
 - 2.9.4.6.1.1. Any service or item that is approved must be provided within three (3) Business days of the date of the coverage determination, except when more time is necessary to tailor an item to the specific needs or requirements of the Participant.
 - 2.9.4.6.2. For a determination involving 1) continued or extended health care or other 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-IDD 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 time frame 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.
 - 2.9.4.6.3. For a determination involving health care services which have been already delivered, within fourteen (14) calendar days of receipt of the necessary information.
 - 2.9.4.6.4. Failure by the FIDA-IDD Plan or 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 the integrated Appeals process.

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

2.9.4.6.5.1. The Participant or the Provider requests an extension, or

2.9.4.6.5.2. The FIDA-IDD Plan can justify (to the satisfaction of the State and CMS upon request) that:

2.9.4.6.5.2.1. The extension is in the Participant's interest; and

2.9.4.6.5.2.2. There is a need for additional information where:

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

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

2.9.4.6.5.3. The FIDA-IDD Plan must inform the Participant of the right to file a Grievance if he or she disagrees with the extension.

2.9.4.6.6. For expedited service authorization decisions, where the Provider indicates or the FIDA-IDD Plan or IDT determines that following the standard time frame in Section 2.9.4.6 could seriously jeopardize the Participant's life or health or ability to attain, maintain, or regain maximum function, the FIDA-IDD Plan or the IDT 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:

2.9.4.6.6.1. The Participant or the Provider requests an extension; or

2.9.4.6.6.2. The FIDA-IDD Plan or IDT can justify (to the State and CMS upon request) that:

2.9.4.6.6.3. The extension is in the Participant's interest; and

2.9.4.6.6.4. There is a need for additional information where:

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

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

2.9.4.6.6.5. In accordance with 42 C.F.R. §§ 438.3(i) 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, discontinue Medically Necessary Items or Services to any Participant, or provide incentives in violation of the fraud and abuse laws, including but not limited to the physician self-referral law or the anti-kickback statute.

2.9.5. Quality Assurance, Utilization Review, and Peer Review.

2.9.5.1. The FIDA-IDD 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., LPs), and certifications of need of care.

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

2.9.5.3. FIDA-IDD 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.
- 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 upon request.
- 2.9.5.4. The FIDA-IDD Plan requires Participating Providers to use evidence-based practices. In doing so, the FIDA-IDD 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 including the use of CQL Personal Outcome Measures interviews to assess the provision of person-centered planning.
 - 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 Participant-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 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 or services.
 - 2.9.5.5. The FIDA-IDD Plan shall comply with the quality assurance standards outlined in Section 2.14.
 - 2.9.5.6. The FIDA-IDD Plan shall comply with the utilization review standards outlined in the IDT Policy.
 - 2.9.5.7. The FIDA-IDD 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.
 - 2.9.5.8. The FIDA-IDD Plan shall not compensate individuals that conduct utilization review activities or members of 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.
 - 2.9.5.9. The FIDA-IDD 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
- 2.9.6.1. The FIDA-IDD Plan shall train all of the FIDA-IDD Plan's employees, Participating Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with the Participant or Participant's LP 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-IDD 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-IDD Plan, its Participating Providers, Affiliates or First Tier, Downstream, or Related Entities.
 - 2.9.6.2. The FIDA-IDD Plan shall provide the State 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-IDD Plan shall provide the State and CMS, upon request, with its protocols for protecting 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-IDD 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-IDD Plan staff is adequately trained to educate Participants to identify signs of Abuse, Neglect, and Financial Exploitation.

2.9.6.4.3. The FIDA-IDD 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-IDD Plan and, when required or otherwise appropriate, to the investigating authority.

2.9.6.4.4. The FIDA-IDD 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-IDD 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 in accordance with 14 NYCRR Parts 633 and 624.

2.9.6.4.5.1. The FIDA-IDD Plan shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The FIDA-IDD Plan shall require that events involving the use of restraint or seclusion are reported to the FIDA-IDD 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-IDD Plan shall make reasonable efforts to detect unauthorized use of restrictive interventions. The FIDA-IDD Plan shall require that events involving the use of restrictive interventions are reported to the FIDA-IDD 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-IDD 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-IDD 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-IDD Plan shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the FIDA-IDD Plan. The FIDA-IDD Plan shall pay a Non-Participating Provider of Emergency and Post-Stabilization Care an amount equal to or, if the FIDA-IDD 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-IDD Plan shall ensure that the Participant is not billed for the difference, if any, between such rate and the non-Participating Provider's charges.

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

2.9.7.1.5. The FIDA-IDD 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-IDD Plan shall require Providers to notify the Participant's PCP of a 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. A 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-IDD Plan if:

2.9.7.1.8.1. Such transfer or discharge order is consistent with generally accepted principles 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-IDD Plan, through the IDTs, shall provide ongoing education to Participants regarding the appropriate use of Emergency Services. The FIDA-IDD 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-IDD 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-IDD 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-IDD Plan shall cover Post-Stabilization Services provided by a Participating or Non-Participating Provider in any of the following situations: (i) the FIDA-IDD 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-IDD Plan for authorization of further Post-Stabilization Services; or (iii) the FIDA-IDD Plan does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, the FIDA-IDD Plan could not be contacted, or the FIDA-IDD Plan and the treating Provider cannot reach an agreement concerning the Participant's care and a

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-IDD 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-IDD 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-IDD Participant Ombudsman

2.9.9.1. The FIDA-IDD Plan must cooperate with the FIDA-IDD Participant Ombudsman. This requires:

2.9.9.1.1. The FIDA-IDD Plan shall make initial contact with the FIDA-IDD Participant Ombudsman receiving any FIDA-IDD Participant Ombudsman calls, emails, letters, or faxes within one (1) Business Day of the contact.

2.9.9.1.2. The FIDA-IDD Plan shall continue to be responsive to the FIDA-IDD Participant Ombudsman about a given Participant matter until such time as the matter is resolved.

2.9.9.1.3. The FIDA-IDD Plan shall designate a lead staff person to service as liaison between the FIDA-IDD Plan and the FIDA-IDD Participant Ombudsman.

2.9.9.1.4. The FIDA-IDD Plan shall provide the FIDA-IDD Participant Ombudsman with general FIDA-IDD Plan-specific information about coverage, policies, and procedures and also Participant-

specific information about the Participant's coverage, LP, IDT, and more.

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

2.9.9.1.6. The FIDA-IDD Plan shall document all interactions with the FIDA-IDD 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.

2.9.9.1.7. The FIDA-IDD 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-IDD 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-IDD 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.

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-IDD Plan Participants, Caregiver/Guardians or Designees;

2.10.2.2. The FIDA-IDD 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-IDD Plan must establish a process for the PAC to provide input to the FIDA-IDD Plan.

2.10.2.4. The FIDA-IDD 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-IDD 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-IDD Plan.
 - 2.10.2.7. The FIDA-IDD Plan must demonstrate that the PAC composition reflects the diversity of the FIDA-IDD Participant population, and participation of individuals with disabilities, including Participants, within the governance structure of the FIDA-IDD Plan.
 - 2.10.2.8. The PAC meetings must be open to all Participants and their family representatives and all Participants and family representatives should receive notice of the PAC meetings.
 - 2.10.2.9. The PAC meetings must be open to the Participant Ombudsman, and the FIDA-IDD Plan must invite the Participant Ombudsman.
- 2.10.3. The FIDA-IDD Plan must conduct at least two Participant Feedback Sessions in its Service Area each year. It is sufficient for the FIDA-IDD 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 Nassau, Rockland, Suffolk, and Westchester Counties, the FIDA-IDD Plan must hold at least two (2) Participant Feedback Sessions each year in each county.
- 2.10.3.1. Participants must be invited to raise problems and concerns and to provide positive feedback.
 - 2.10.3.2. The FIDA-IDD 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-IDD 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-IDD Plan must summarize each session, make the summary available to Participants and the public, and retain as a record pursuant the retention policies provided in Section 5.4 of this Contract.

2.10.3.5. The FIDA-IDD 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 the State and/or CMS

2.11. Participant Services

2.11.1. Participant Service Representatives (PSRs). The FIDA-IDD 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;

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, OPWDD services, 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-IDD Plan's Participant database, the FIDA-IDD 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 Intellectual Disabilities or cognitive impairments; for example, provide Marketing, Outreach, and Participant Communications in simple, 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-IDD 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-IDD 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 authorization;
 - 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-IDD Plans or to disenroll from the FIDA-IDD 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-IDD Plan.

2.11.2. Participant Service Telephone Responsiveness

2.11.2.1. The FIDA-IDD Plan must operate a call center during normal business hours, seven (7) days a week, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance. Live PSRs must be available Monday through Friday, during normal business hours, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance. The FIDA-IDD 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 Federal holidays (except New Year's Day).

2.11.2.2. The FIDA-IDD Plan's PSRs must answer eighty percent (80%) of all Participant telephone calls within thirty (30) seconds or less. The FIDA-IDD 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 response system, or recorded greeting and before reaching a live person. The FIDA-IDD Plan must limit the disconnect rate of all incoming calls to five percent (5%). The FIDA-IDD 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-IDD 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-IDD 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 specified in the Medicare Marketing Guidelines and the Medicare-Medicaid guidance. The FIDA-IDD 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 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 time frames provided in Section 2.13.1.1.1.

2.11.4. Nursing Hotline

- 2.11.4.1. The FIDA-IDD Plan operates a toll-free nursing hotline with live nurses available to answer health-related questions twenty-four (24) hours a day, seven (7) days a week.
- 2.11.4.2. Nursing Hotline nurses provide general health-related information as well as assistance in accessing services, IDT members and service authorizations outside of normal business hours.

2.11.4.3. Nursing hotline staff must have access to all FIDA-IDD Plan Participants' LPs as well as to contact information for members of all FIDA-IDD Plan Participants' IDTs.

2.12. Participant Grievance

2.12.1. Grievance Filing.

2.12.1.1. Timing of Grievance Filing.

2.12.1.2. All Grievances must be filed within sixty (60) calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident). Effective no sooner than July 1, 2017, the Participant may file the Grievance at any time as allowed in 42 C.F.R. § 438.202(c)(2)(i). Internal Grievance Filing. A Participant, or an Authorized Representative, may file an Internal Grievance with the FIDA-IDD Plan Provider by calling or writing to the FIDA-IDD Plan.

2.12.1.3. External Grievance Filing. The FIDA-IDD Plan shall inform Participants that they, or their Authorized Representative, may file an External Grievance through 1-800 Medicare. The FIDA-IDD Plan must display a link to the electronic Grievance form on the Medicare.gov Internet web site on the FIDA-IDD Plan's main web page. The FIDA-IDD Plan must inform Participants of the email address, postal address or toll-free telephone number where a Grievance may be filed. External grievances filed through 1-800-Medicare are automatically entered into the CMS complaints tracking module, which will be accessible to the FIDA-IDD Plan. External grievances filed with the State shall be forwarded to the Contract Management Team and also entered into the CMS Complaints tracking module.

2.12.2. Internal Grievance Administration Process

2.12.2.1. The FIDA-IDD Plan must have a formally structured Grievance system, consistent with this Contract, and 42 C.F.R. § 438 subpart F, in place for addressing Participant Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The FIDA-IDD Plan must maintain written records of all Grievance activities, and notify CMS and the State of all Internal Grievances.

2.12.2.2. The FIDA-IDD 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;
- 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-IDD 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. 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;
- 2.12.2.3.4. Provide every Participant with notice of the availability of the Participant Ombudsman to assist in filing Grievances or advising about the Grievance process; and
- 2.12.2.3.5. 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. Time Frame for Plan Decision and Notification on Grievance.

2.12.3.1. A FIDA-IDD 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: Upon a paper review, a 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:

2.12.3.1.1.1. The Grievance involves a FIDA-IDD Plan's decision to invoke an extension relating to a coverage determination.

2.12.3.1.1.2. The Grievance involves a FIDA-IDD 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 Time Frame: Notification of decision within thirty (30) calendar days of the FIDA-IDD Plan receiving the written or oral Grievance.

2.12.3.3. Extension. An extension of up to fourteen (14) calendar days may be requested by a Participant or Provider on a Participant's behalf (written or oral). The FIDA-IDD Plan may also initiate an extension of up to fourteen (14) calendar days 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-IDD Plan requests the extension it must notify the Participant in writing of the reasons for delay.

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:

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

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 the State 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 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-IDD Plan; 2) Appeal to the FIDA-IDD 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.

2.13.1.1.1.1. Appeal Filing. A Participant, or an Authorized Representative, may file an Appeal with the FIDA-IDD Plan by calling or writing to the FIDA-IDD Plan. A Non-Participating Provider may also file an Appeal on his/her own behalf with a FIDA-IDD Plan without any written authorization from the Participant and this Appeal shall be processed through the integrated Appeal process outlined in this section. To proceed with an Appeal, Non-Participating Providers must state they will hold the Participant harmless regardless of the outcome of the Appeal.

2.13.1.1.1.1.1. Acknowledgement of Appeal. The FIDA-IDD 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-IDD Plan will not send the written acknowledgement.

2.13.1.1.1.2. Appeal Filing Deadline. The FIDA-IDD 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 termination of authorized Medicare or Medicaid benefit coverage. This first level of Appeal is an internal Appeal, to be decided by the FIDA-IDD 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.

2.13.1.1.1.2.1. Time Frame for Plan Decision on Appeal. The FIDA-IDD Plan shall be required to decide the 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:

2.13.1.1.1.2.1.1. Expedited: FIDA-IDD Plan conducts a paper review unless a Participant requests in-person review and this must be completed as fast as the Participant's condition requires, but no later than within seventy-two (72) hours of the receipt of the Appeal.

2.13.1.1.1.2.1.2. Expedited Appeals shall be granted where a standard decision could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function.

2.13.1.1.1.2.1.3. If the FIDA-IDD 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-IDD 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. The written notice must include the reasons for the transfer to the standard timeframe, inform the Participant of the right to file an expedited Grievance if he or she disagrees with the FIDA-IDD Plan's decision to transfer to the standard timeframe, inform the Participant of his or her right to resubmit the request for an expedited Appeal with a provider's support, and include instruction about the Grievance process and its timeframes.

2.13.1.1.1.2.1.4. Standard: FIDA-IDD Plan conducts a paper review unless a Participant requests in-person

review and must complete this 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, for all other appeals, no later than thirty (30) calendar days from the date of the receipt of the Appeal.

2.13.1.1.1.2.1.5. Extension of Expedited or Standard Appeal.

An extension of up to fourteen (14) days may be requested by a Participant or Provider on a Participant's behalf (written or oral). The FIDA-IDD Plan may also initiate an extension of up to fourteen (14) days 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-IDD 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-IDD Plan's decision to grant an extension.

2.13.1.1.1.2.2. Benefits will continue pending an Appeal in accordance with Section 2.13.1.1.1.11.

2.13.1.1.1.3. Notification of Appeal Decision.

2.13.1.1.1.3.1. Contents of Notice: 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 (IAHO) at the FIDA-IDD Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). The notification must inform the Participant of the process and time frame 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-IDD Plan's Action is upheld, the Participant shall not be liable for the cost of any continued benefits. If the Participant is not already

receiving continuing benefits, the Notice will inform them how to request those benefits.

2.13.1.1.1.3.2. Timeline for notice: For expedited Appeals, the FIDA-IDD Plan must make a reasonable effort to provide prompt oral notice to the Participant and must document those efforts. The FIDA-IDD Plan must follow up with a written notice sent to the Participant within two (2) calendar days of attempting to provide oral notice. For standard appeals, the FIDA-IDD Plan must mail written notice of a decision to the Participant simultaneous with the decision, in accordance with the timelines specified in Section 2.13.1.1.1.3.2.

2.13.1.1.1.3.3. Automatic Administrative Hearing. Any wholly or partially adverse decision by the FIDA-IDD Plan is automatically forwarded along with the Appeal review record to the Integrated Administrative Hearing Officer at the FIDA-IDD Administrative Hearing Unit at OTDA.

2.13.1.1.1.3.4. The case must be auto-forwarded within two (2) Business Days of the adverse decision being reached.

2.13.1.1.1.3.5. This must be done electronically by secure and appropriate email to a designated mail box with a cover note that clearly indicates:

2.13.1.1.1.3.5.1. The name of the FIDA-IDD Plan;

2.13.1.1.1.3.5.2. The type of Appeal (i.e., expedited, Medicaid prescription drug, or other);

2.13.1.1.1.3.5.3. The name of the contact person at the FIDA-IDD Plan for use by the FIDA-IDD Administrative Hearing Unit; and

2.13.1.1.1.3.5.4. The Participant's name, address, phone number or other contact, social security number and Medicaid or CIN number.

2.13.1.1.1.3.6. This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed for matters before OTDA).

2.13.1.1.1.3.7. Benefits will continue pending an Appeal in accordance with Section 2.13.1.1.1.11.

2.13.1.1.1.3.8. The FIDA-IDD 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-IDD Plan, OTDA will contact the Participant regarding the 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:

2.13.1.1.1.3.8.1. Twenty-four (24) hours for the expedited Appeals;

2.13.1.1.1.3.8.2. Five (5) calendar days for the Medicaid prescription drug Appeals; and

2.13.1.1.1.3.8.3. Ten (10) calendar days for all other Appeals.

2.13.1.1.1.4. Notices of Automatic Administrative Hearing.

2.13.1.1.1.4.1. Acknowledgement. The FIDA-IDD 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 IAHO. If a decision is reached before the written acknowledgement is sent, the FIDA-IDD Plan will not send the written acknowledgement.

2.13.1.1.1.4.2. Hearing Notice. The IAHO shall provide the Participant and the FIDA-IDD Plan with a written Notice of Administrative Hearing at least ten (10) calendar days in advance of the hearing date.

2.13.1.1.1.5. Participation in the Administrative Hearing. The FIDA-IDD Plan must participate in the Administrative Hearing. The staff person participating must be knowledgeable in the Appeal decision reached by the FIDA-IDD Plan and the basis for the decision. The FIDA-IDD Plan shall follow all IAHO/OTDA processes and procedures that are not inconsistent with the integrated Appeal process outlined herein.

2.13.1.1.1.6. Administrative Record for Administrative Hearing. The IAHO 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.

2.13.1.1.1.7. TimeFrame for Decision on Administrative Hearing.

2.13.1.1.1.7.1. Standard Timeframe: The IAHO 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 of receipt of auto-forwarded Appeal for Medicaid drug coverage matters and for all other matters within ninety (90) calendar days from the date the Participant requests an appeal with the FIDA-IDD Plan.

2.13.1.1.1.7.2. Expedited Time Frame: The IAHO 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-IDD Plan's Appeal decision and the Appeal review record.

2.13.1.1.1.7.3. Decision: The IAHO 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 time frames stated in Sections 2.13.1.1.1.8.1 and 2.13.1.1.1.8.2. The FIDA-IDD Plan is bound by the decision of the IAHO and may not seek further review. The FIDA-IDD Plan must implement the decision of the IAHO immediately (within no more than one (1) Business Day).

2.13.1.1.1.8. Medicare Appeals Council. If a Participant disagrees with the Integrated Administrative Hearing Officer's decision, the Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the IAHO'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 IAHO. This must be done within sixty (60) calendar days of the date of the adverse decision by the IAHO. The IAHO will forward the Appeal and the record to the Medicare Appeals Council. These Appeals must be filed with the FIDA-IDD 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 2.13.1.1.1.11.

2.13.1.1.1.9. 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.

2.13.1.1.1.10. Continuation of Benefits Pending Appeal. Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA-IDD Plan Appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original Appeal is requested to the FIDA-IDD 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. In the case of an Appeal to the Medicare Appeals Council, the Participant must have received continuation of benefits during earlier level of Appeals and file the Appeal with the IAHO within ten (10) calendar days of IAHO decision in order to receive continuation of benefits during the Appeal to the Medicare Appeals Council. Even if the FIDA-IDD Plan's Action is upheld, the Participant shall not be liable for the cost of any continued benefits. The FIDA-IDD 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-IDD Plan or the Integrated Administrative Hearings Officer reverses a decision to deny, limit, or delay services. The FIDA-IDD Plan or the State must pay for the disputed services, in accordance with State policy and regulations, if the FIDA-IDD 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.

2.13.1.1.1.11. Validation of Integrated Administrative Hearing Officer Decisions. CMS and the State are establishing a quality oversight process for the integrated appeal system. As part of this quality review process, the FIDA-IDD plan shall forward all or a portion of adverse appeal decisions for quality oversight, as will be specified in forthcoming guidance. This quality oversight process will not alter the integrated appeals process set forth in this Section of this contract.

2.13.2. General. All FIDA-IDD 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-IDD Plan misses the applicable adjudication time frame. 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-IDD Plan. The Participant or Provider may file an expedited Appeal either orally or in writing; no additional Participant follow-up is required. The FIDA-IDD 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-IDD 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 and in compliance with 42 C.F.R. § 438.10.

2.13.2.3. The FIDA-IDD 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-IDD 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-IDD 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 Comprehensive Health Record and any other documents and records.
- 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. Ensure that the Participants are informed:
 - 2.13.2.5.5.1. That a Participant has a right to an Administrative Hearing;
 - 2.13.2.5.5.2. Of representation rules at Administrative Hearings; and
 - 2.13.2.5.5.3. That parties to Administrative Hearings include the FIDA-IDD Plan and the Participant and his or her representative or the representative of the deceased Participant's estate.
- 2.13.2.5.6. Maintain written records of all Appeal activities, consistent with this Contract, 42 C.F.R. § 431 subpart E, and 42 C.F.R. § 438

subpart F, and inform CMS and the State of all internal Appeals in a manner to be specified by CMS and the State.

2.13.3. Integrated Coverage Determination Notice - In accordance with 42 C.F.R. §§ 438.10(g)(xi), 438.404, 422.568 and 422.570, the FIDA-IDD 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). In particular, Participants will receive a written notice with coverage determinations and all of Participants' Appeal rights each time 1) there is a LP created or updated and 2) there is a coverage determination reached and a service or item authorized that is not reflected in the most recent LP. These notices will be developed jointly by CMS and the State and will delineate all Appeal rights under the FIDA-IDD Demonstration (including all applicable Demonstration Medicare and Medicaid Appeal rights).

2.13.3.1. The Integrated Coverage Determination Notice will explain:

2.13.3.1.1. The determination made and the Action the FIDA-IDD Plan intends to take;

2.13.3.1.2. The reasons for the decision or Action, including clinical rationale, if any;

2.13.3.1.3. The citation to the regulations supporting such Action;

2.13.3.1.4. The availability, upon request of the Participant, or the Participant's designee, of the clinical review criteria relied upon to make such determination;

2.13.3.1.5. The Participant's or authorized representative or the Provider's right to file an Appeal;

2.13.3.1.6. 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;

2.13.3.1.7. What, if any, additional necessary information should be provided in order for the FIDA-IDD Plan to render a decision on the Appeal.

- 2.13.3.1.8. The availability of the Participant Ombudsman to help the Participant in understanding his/her appeal rights and in exercising his/her Appeal rights;
- 2.13.3.1.9. Information on how to access the Participant Ombudsman;
- 2.13.3.1.10. Circumstances under which expedited resolution is available and how to request it; and
- 2.13.3.1.11. If applicable, the Participant's rights to have benefits continue pending the resolution of the Appeal; and
- 2.13.3.1.12. That the FIDA-IDD Plan must provide the services authorized within three (3) Business Days of the coverage determination, or as expeditiously as possible when more than three (3) Business Days is necessary to tailor an item to the specific needs or requirements of the Participant.

2.13.3.2. 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.

2.13.3.3. The notice must be translated for the individuals who speak Prevalent Languages.

2.13.3.4. The notice must include language clarifying that oral interpretation is available for all languages and how to access it.

2.13.3.5. The FIDA-IDD Plan shall ensure that:

- 2.13.3.5.1. Participants receive Integrated Coverage Determination Notices at least 15 days in advance of the date of its adverse Action.

- 2.13.3.5.2. The FIDA-IDD Plan and each IDT uses the required form notices provided by the State and CMS.

2.13.4. Appeal Process Notices

2.13.4.1. The State and CMS will provide the FIDA-IDD 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.

2.13.4.2. The FIDA-IDD Plan shall ensure that it uses the required form notices provided by the State and CMS.

2.13.5. Hospital Discharge Appeals

2.13.5.1. When a Participant is being discharged from the hospital, the FIDA-IDD Plan must comply with requirements in 42 C.F.R. §§ 422.620-422.622.

2.13.5.2. 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.

2.13.5.3. 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-IDD Plan Appeal if the Participant has missed the deadline for requesting the QIO review.

2.13.5.4. 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.

2.13.5.5. If the QIO agrees with the FIDA-IDD Plan's decision, the FIDA-IDD 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.

2.13.5.6. If the QIO overturns the FIDA-IDD Plan's decision, the FIDA-IDD Plan must pay for the remainder of the hospital stay.

2.13.6. 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.

2.14. Quality Improvement Program

2.14.1. The FIDA-IDD 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 OPWDD services;

2.14.1.1.3. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.14.1.1.4. Quality of Community-based and Facility-based LTSS outside the OPWDD service system;

2.14.1.1.5. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and Community-based and Facility-based LTSS Providers and services;

2.14.1.1.6. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.14.1.1.7. 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-IDD 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;

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-IDD Plan, the State 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-IDD Plan shall make the clinical and practice guidelines available via the FIDA-IDD Plan's website. The FIDA-IDD 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-IDD 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.

2.14.2.2. The FIDA-IDD 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-IDD 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-IDD Plan's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438 subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422 (subpart D), Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2.14.2.3. The FIDA-IDD Plan shall:

2.14.2.3.1. 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;

- 2.14.2.3.2. 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-IDD Plan's service delivery system;
- 2.14.2.3.3. Seek the input of Providers and medical professionals representing the composition of the FIDA-IDD Plan's Provider Network in developing functions and activities;
- 2.14.2.3.4. Establish internal processes to ensure that the Quality Management activities for Primary, Specialty, and Behavioral Health Services, OPWDD services and Community-based and Facility-based LTSS reflect utilization across the Provider Network and include all of the activities in this Section of this Contract and, in addition, the following elements:
 - 2.14.2.3.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), CQL Personal Outcome Measures interview data 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;
 - 2.14.2.3.4.2. 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-IDD Plan shall submit its process for Medical Record reviews and the results of its Medical Record reviews to the State and CMS;
 - 2.14.2.3.4.3. A process to measure Participating Providers and Participants, at least annually, regarding their satisfaction with the FIDA-IDD Plan. The FIDA-IDD Plan shall submit a survey plan to the State and CMS for approval and shall submit the results of the survey to the State and CMS;
 - 2.14.2.3.4.4. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

- 2.14.2.3.4.5. 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
- 2.14.2.3.4.6. In collaboration with and as further directed by the State, develop a customized Medical Record review process to monitor the assessment for and provision of Community-based and Facility-based LTSS. OPWDD will further develop a customized review process for the provisions of and outcomes of care management for individuals with IDD.
- 2.14.2.3.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the FIDA-IDD Plan's QI initiatives. Such description shall:
 - 2.14.2.3.5.1. 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 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;
 - 2.14.2.3.5.2. 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;
 - 2.14.2.3.5.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and
 - 2.14.2.3.5.4. Include organization-wide policies and procedures that document processes through which the FIDA-IDD 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;
- 2.14.2.4. The FIDA-IDD Plan shall submit to the State and CMS an annual QI Work Plan that shall include the following components or other components as directed by State and CMS:
 - 2.14.2.4.1. Planned clinical and non-clinical initiatives;

- 2.14.2.4.2. The objectives for planned clinical and non-clinical initiatives;
 - 2.14.2.4.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;
 - 2.14.2.4.4. The individual(s) responsible for each clinical and non-clinical initiative;
 - 2.14.2.4.5. Any issues identified by the FIDA-IDD Plan, CMS, the State, Participants, and Providers, and how those issues are tracked and resolved over time;
 - 2.14.2.4.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and
 - 2.14.2.4.7. Process for correcting deficiencies.
- 2.14.2.5. The FIDA-IDD Plan shall evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the State 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-IDD Plan's assessment of the quality of physical and behavioral health care rendered, OPWDD services, 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.
- 2.14.2.6. The FIDA-IDD Plan shall also maintain sufficient and qualified staff employed by or under contract with the FIDA-IDD Plan to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for Quality Management. QI staff shall include:
- 2.14.2.6.1. 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;
 - 2.14.2.6.2. A qualified individual to serve as the Demonstration QI Director who will be directly accountable to the FIDA-IDD Plan's New York Executive Director and, in addition, if the FIDA-IDD

Plan offers multiple products or services in multiple states, will have access to the FIDA-IDD Plan's executive leadership team. This individual shall be responsible for:

2.14.2.6.2.1. 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;

2.14.2.6.2.2. Maintaining an active role in the FIDA-IDD Plan's overall QI structure;

2.14.2.6.2.3. 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:

2.14.2.6.2.3.1. OPWDD services;

2.14.2.6.2.3.2. Physical and behavioral health care;

2.14.2.6.2.3.3. Pharmacy management;

2.14.2.6.2.3.4. Care management;

2.14.2.6.2.3.5. Community-based and Facility-based LTSS;

2.14.2.6.2.3.6. Financial;

2.14.2.6.2.3.7. Statistical/analytical;

2.14.2.6.2.3.8. Information systems;

2.14.2.6.2.3.9. Marketing, publications;

2.14.2.6.2.3.10. Enrollment; and

2.14.2.6.2.3.11. Operations management.

2.14.2.7. The FIDA-IDD 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 the State, or its designee, that may be attended by representatives of the State, the FIDA-IDD 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.

2.14.2.8. The FIDA-IDD 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-IDD Plan's Participating Providers. The QI Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate health care utilization, and Participant health status, per 42 C.F.R. § 438.242. The FIDA-IDD Plan shall ensure that data received from Participating Providers and included in reports are accurate and complete by:

2.14.2.8.1. Verifying the accuracy and timeliness of reported data;

2.14.2.8.2. Screening the data for completeness, logic, and consistency;
and

2.14.2.8.3. Collecting service information in standardized formats to the extent feasible and appropriate.

2.14.2.9. 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 the State on a quarterly basis or as requested by CMS and the State. CMS and the State, 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 Entity to the FIDA-IDD Plan who ceases to be a Participating Provider or First Tier, Downstream, or Related Entity to the FIDA-IDD Plan for a quality of care issue.

2.14.3. QI Activities

2.14.3.1. The FIDA-IDD 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-IDD 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. § 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-IDD 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-IDD 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-IDD Plan shall perform and report the quality and utilization measures identified by CMS and the State and in accordance with requirements in the Memorandum of Understanding between CMS and New York State of November 5, 2015 (MOU), Table 7-B Core Quality Measures, 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 Table 7-B of the MOU referenced above. 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-IDD Plan shall not modify the reporting specifications methodology prescribed by CMS and the State without first obtaining CMS and the State's written approval. The FIDA-IDD Plan must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and the State. CMS and the State (or designee) will perform an independent validation of at least a sample of FIDA-IDD Plan's findings.
- 2.14.3.7. The FIDA-IDD 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-IDD Plan of new Federal CMS requirements.
- 2.14.3.8. The FIDA-IDD 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-IDD Plan shall collect annual data and contribute to all Demonstration QI-related processes, as directed by the State and CMS, as follows:

2.14.3.9.1. Collect and submit to the State, CMS, and/or CMS' contractors, in a timely manner, data for the measures specified in Table 7-B of the MOU;

2.14.3.9.2. Contribute to all applicable the State 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 the State and rectifying those inadequacies, as directed by CMS and/or the State;

2.14.3.9.3. Contribute to the State and CMS data regarding the individual and aggregate performance of FIDA-IDD Plans with respect to the noted measures; and

2.14.3.9.4. Contribute to the State and CMS processes culminating in the publication of any additional technical or other reports by the State or CMS related to the noted measures.

2.14.3.10. The FIDA-IDD Plan shall demonstrate how to utilize results of the measures specified in Table 7-B of the MOU in designing QI initiatives.

2.14.3.11. Participant Experience Surveys

2.14.3.12. The FIDA-IDD Plan shall conduct Participant experience survey activities, as directed by the State and/or CMS, disclose the survey results to the State and CMS, disclose the identified CAHPS measurement set and the survey results to Participants upon request, and provide the State with access to the de-identified CAHPS response set upon request, as follows:

2.14.3.12.1. Conduct, as directed by the State 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 the State and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by the State and CMS and rectifying those inadequacies, as directed by the State and CMS; and

2.14.3.12.3. The FIDA-IDD 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-IDD Plan shall implement and adhere to all processes relating to the Quality Improvement Project Requirements, as directed by the State and CMS, as follows:

2.14.4.1.1. In accordance with 42 C.F.R. § 438.330(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 the State 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-IDD Plan and relate to at least one (1) of the OPWDD Transformation Agenda subject areas including; the promotion of self-direction, gainful employment and meaningful community engagement, more integrated living options. At least one (1) performance improvement project each year beginning in January 2017 will be selected as a priority and approved by the State. 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.

2.14.4.1.1.2. Implement the Quality Improvement Project Requirements, in a Culturally Competent manner;

2.14.4.1.1.3. Evaluate the effectiveness of QI interventions;

2.14.4.1.1.4. Plan and initiate processes to sustain achievements and continue improvements;

2.14.4.1.1.5. Submit to the State and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by the State and CMS. Such reports shall include information regarding progress on Quality Improvement Project Requirements, barriers encountered, and new knowledge gained. As directed by the State and CMS, the FIDA-IDD Plan shall present this information to the State and CMS at the end of the Quality Improvement Requirement Project cycle as determined by the State and CMS; and

2.14.4.1.1.6. 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-IDD Plan's population. Although the FIDA-IDD Plan has the flexibility to choose the design of their CCIPs, the State and CMS may require them to address specific topic areas.

2.14.4.1.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.14.4.1.2.1. The FIDA-IDD Plan shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.14.4.1.3. Risk Assessment

2.14.4.1.3.1. The FIDA-IDD 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, the State, CMS, and the FIDA-IDD Plan. The FIDA-IDD Plan is responsible for conducting (at least annually) a risk assessment of events that occur or could occur that impact the vulnerability of the Participant, the State, CMS, and the FIDA-IDD 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).

2.14.4.1.3.2. The risk assessment shall include input from staff throughout the FIDA-IDD Plan organization seeking input given the objectives about processes, resources and solutions.

2.14.4.1.3.3. The FIDA-IDD 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.

2.14.4.1.3.4. FIDA-IDD 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-IDD 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 the State and/or CMS as directed by the State and CMS, or calculated by the State or CMS;

2.14.5.1.2. Annual validation of quality improvement projects required by the State and CMS; and

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 E, and at the direction of the State, regarding access, structure and operations, and quality of care and services furnished to Participants. The FIDA-IDD 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

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-IDD 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;
- 2.14.5.1.3.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and NYSDOH;
- 2.14.5.1.3.5. 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
- 2.14.5.1.3.6. 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-IDD 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, 423.2260 et. seq., and 42 C.F.R. §438.10; the Medicare Marketing Guidelines, and the Medicare-Medicaid marketing guidance for the FIDA-IDD Demonstration with the following exceptions or modifications:

2.15.1.1.1. The FIDA-IDD Plan must refer Participants and Potential Participants who inquire about the Demonstration eligibility or Enrollment to the Enrollment Broker although the FIDA-IDD Plan may provide Participants and Potential Participants with factual information about the FIDA-IDD Plan’s Demonstration Plan and its benefits prior to referring a request regarding eligibility or Enrollment to the Enrollment Broker. This requirement does not preclude the FIDA-IDD Plan from engaging in Marketing activity to Potential Participants;

2.15.1.1.2. The FIDA-IDD Plan must make available to CMS and The State, upon request, current schedules of all educational events conducted by the FIDA-IDD Plan to provide information to Participants or Potential Participants;

2.15.1.1.3. The FIDA-IDD Plan must convene all educational and marketing events at sites within the FIDA-IDD 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-IDD Plan may not offer financial or other incentives other than nominal gifts or promotional items, including private insurance, to induce Potential Participants to enroll with the FIDA-IDD Plan or to refer a friend, neighbor, or other person to enroll with the FIDA-IDD Plan;

1.1.1.1.1. The FIDA-IDD Plan may not make unsolicited door-to-door contacts with Participants or Potential Participants.

1.1.1.1.2. The FIDA-IDD Plan may not make unsolicited marketing contacts with Potential Participants on a one-on-one basis, including telephone, or other unsolicited contacts, with the following exception:

2.15.1.1.5. The FIDA-IDD Plan may make one-on-one marketing contacts with a Potential Participant who proactively requests a one-on-one appointment and the FIDA-IDD Plan has a documented incoming request for the one-on-one appointment;

2.15.1.1.6. The FIDA-IDD Plan 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-IDD Plan may not use any Marketing, Outreach, or Participant Communications materials that contain any assertion or statement (whether written or oral) that:

2.15.1.1.7.1. The Participant or Potential Participant must enroll in the FIDA-IDD Plan in order to obtain benefits or in order not to lose benefits;

2.15.1.1.7.2. The FIDA-IDD Plan is endorsed by CMS, NYSDOH, OPWDD, Medicare, Medicaid, the Federal government, New York, or similar entity.

2.15.2. The FIDA-IDD Plan must develop and obtain State 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 2016 and any subsequent years.

2.15.3. The FIDA-IDD 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 and Developmental Disabilities; and

2.15.3.3. Translated into Prevalent Languages. The following materials must be translated into these languages:

1. Summary of Benefits (SB);
2. Annual Notice of Change (ANOC);
3. Evidence of Coverage (i.e., EOC / Participant Handbook);
4. Formulary;
5. Provider and Pharmacy Directory;
6. Part D Transition Letter;
7. OAA;
8. CSPA;
9. Life Plan;
10. Ad-hoc communications regarding payments / reimbursements; and
11. Integrated Coverage Determination Notice.

2.15.3.4. Updated by the FIDA-IDD 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 Section 1.156; and

2.15.3.6. Mailed with a multi-language insert that indicates that the Participant can access free interpreter services. This message shall be written in the languages required in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance; and

2.15.3.7. Distributed to the FIDA-IDD 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-IDD Plan must receive Prior Approval of all marketing and Participant Communications materials in categories of materials that CMS and the State 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-IDD 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 the State.
- 2.15.4.3. CMS and the State may agree to defer to one or the other Party for review of certain types of Marketing, Outreach, and Participant Communications, as agreed in advance by both Parties.
- 2.15.4.4. The FIDA-IDD 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 the State may conduct additional types of review of the FIDA-IDD 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 the State determines it is appropriate to investigate.
 - 2.15.4.5.4. "Secret shopper" activities where CMS or the State or delegated entity request the FIDA-IDD 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-IDD Plan may not begin Marketing, Outreach, and Participant Communications activities to new Eligible Individuals or Participants more than ninety (90) calendar days prior to the effective date of Enrollment for the following Contract year.

2.15.5. Requirements for Dissemination of Marketing, Outreach, and Participant Communications Materials

2.15.5.1. Welcome Calls. The FIDA-IDD Plan will make Welcome Calls to newly enrolled Participants. These calls include, but are not limited to:

2.15.5.1.1. Introducing Participants to the FIDA-IDD Plan;

2.15.5.1.2. Explaining the Comprehensive Service Planning Assessment CSPA and LP processes; and

2.15.5.1.3. Explaining the role of the Care Manager and the IDT.

2.15.5.2. Consistent with the timelines specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance, the FIDA-IDD Plan must provide new Participants with the following materials which, with the exception of the material specified in Section 2.15.5.43, must also be provided annually thereafter:

2.15.5.3. An Evidence of Coverage (EOC)/Participant Handbook document that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.111, 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 the State:

2.15.5.4. Participant rights and responsibilities (see Appendix B);

2.15.5.5. Eligibility requirements;

2.15.5.6. How the assessment and care planning processes work;

2.15.5.7. An explanation of the process by which clinical information, including diagnostic and medication information, may be available to key caregivers;

2.15.5.8. How to request and obtain a copy of the Participant's Medical Records, and to request that they be amended or corrected;

2.15.5.9. How to obtain OPWDD services;

- 2.15.5.10. How to obtain access to specialty, Behavioral Health Services, pharmacy, and long-term services and supports Participating Providers;
- 2.15.5.11. 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:
- 2.15.5.12. 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);
- 2.15.5.13. The fact that prior authorization is not required for Emergency Services;
- 2.15.5.14. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;
- 2.15.5.15. Which services require Prior Authorization;
- 2.15.5.16. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;
- 2.15.5.17. Access and network adequacy requirements;
- 2.15.5.18. That the Participant has a right to use any hospital or other setting for emergency care;
- 2.15.5.19. The Post-Stabilization Care Services rules at 42 C.F.R. § 422.113(c).
- 2.15.5.20. How to access the Provider and Pharmacy Directory, how to choose Providers, and how to change Providers;
- 2.15.5.21. The availability of self-directed services and how to begin accessing self-directed services;
- 2.15.5.22. How to access Services not subject to Prior Authorization;
- 2.15.5.23. 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-IDD 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-IDD 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-IDD Plan must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change;

- 2.15.5.24. How to obtain assistance from PSRs;
- 2.15.5.25. How to file Grievances and Appeals, including:
- 2.15.5.26. Grievance, Appeal, and fair hearing procedures and time frames;
- 2.15.5.27. Toll-free numbers that the Participant can use to file a Grievance or an Appeal by phone; and
- 2.15.5.28. A statement that continuation of benefits at the FIDA-IDD Plan level must be provided in accordance with Section 2.13.1.1.1.11 if the original appeal is requested 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; and
- 2.15.5.29. How the Participant can identify the person to whom the Participant wants the FIDA-IDD Plan to send written notices of denials, terminations, and reductions;
- 2.15.5.30. How to obtain assistance with the Appeals processes through the PSR and other assistance mechanisms as the State or CMS may identify, including the Participant Ombudsperson;
- 2.15.5.31. 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;
- 2.15.5.32. That Participants have the right to disenroll from the FIDA-IDD Plan and how to disenroll voluntarily;
- 2.15.5.33. Explanation that the FIDA-IDD Plan ID card replaces the Medicare and Medicaid cards;
- 2.15.5.34. How to contact the FIDA-IDD 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.
- 2.15.5.35. How to contact the Participant Ombudsman for any assistance.

- 2.15.5.36. How to obtain additional information in Alternative Formats or languages; and
- 2.15.5.37. The name of the FIDA-IDD Plan's parent company and any DBA (Doing Business As) that may be used.
- 2.15.5.38. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;
- 2.15.5.39. How to obtain information regarding Physician Incentive Plans;
- 2.15.5.40. How to obtain information on the Contractor's structure and operations;
- 2.15.5.41. A Summary of Benefits (SB) that that uses the model document developed by CMS and the State and contains a concise description of the important aspects of enrolling in the FIDA-IDD Plan, as well as the benefits offered under the FIDA-IDD 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 the State. The SB must provide sufficient detail to ensure that Participants understand the benefits to which they are entitled. The SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.
- 2.15.5.42. A combined Provider and Pharmacy Directory or a separate notice on how to access this information online and how to request a hard copy, as specified in Section 2.15.6, Chapter 4 of the Medicare Managed Care Manual, and the Medicare-Medicaid marketing guidance.
- 2.15.5.43. 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 the State;
- 2.15.5.44. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the State's outpatient prescription drug benefit and that uses the model document developed by CMS and the State.
- 2.15.5.45. The procedures for a Participant to disenroll from the Demonstration.
- 2.15.5.46. The FIDA-IDD Plan must provide Participants the following materials on an ongoing basis:
- 2.15.5.46.1. An ANOC that summarizes all major changes to the FIDA-IDD Plan's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the

State. The ANOC is a written notice of any significant change to the coverage or program, as required in 42 CFR § 422.1114 and

2.15.5.46.2. 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-IDD Plan.

2.15.5.47. The FIDA-IDD 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.

2.15.5.48. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the FIDA-IDD Plan must provide Participants with at least sixty (60) calendar days advance notice regarding changes to the comprehensive, integrated formulary. The requirement at 42 C.F.R. § 423.120(b)(5) that FIDA-IDD Plans provide at least sixty (60) calendar days advance notice regarding Part D formulary changes also applies to FIDA-IDD Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits;

2.15.5.49. The FIDA-IDD Plan must immediately remove from its formulary covered drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer and will not need to meet the advance notice requirements of 42 C.F.R. § 423.120(b)(5)(i). However, the FIDA-IDD Plan must provide retrospective notice of any such formulary changes to affected enrollees, CMS, and the State, members of the IDT and other authorized prescribers, network pharmacies, and pharmacists as provided at 42 C.F.R. § 423.120(b)(5)(iii).

2.15.5.50. The FIDA-IDD Plan must immediately remove from its formulary covered drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer and will not need to meet the advance notice requirements of 42 C.F.R. § 423.120(b)(5)(i). However, the FIDA-IDD Plan must provide retrospective notice of any such formulary changes to affected enrollees, CMS, and the State, members of the IDT and other authorized prescribers, network pharmacies, and pharmacists as provided at 42 C.F.R. § 423.120(b)(5)(iii).

2.15.5.51. When the FIDA-IDD Plan removes a drug from the formulary (List of Covered Drugs) for safety reasons, the FIDA-IDD Plan must notify affected Participants in writing and must also call to notify affected Participants about the change.

2.15.5.52. The FIDA-IDD 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:

2.15.5.52.1. Made available in large print (at least 16 point font) to Participants as an Alternative Format, upon request;

2.15.5.52.2. For vital materials, available in Prevalent Languages, as defined in Section 1.156;

2.15.5.52.3. Written with cultural sensitivity and at a fourth to sixth grade reading level; and

2.15.5.53. 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.

2.15.5.54. Provider Letters. The FIDA-IDD Plan shall send to existing Providers caring for FIDA-IDD Participants a letter stating:

2.15.5.54.1. The Participant has enrolled in the FIDA-IDD Plan;

2.15.5.54.2. A brief summary of the benefits of the FIDA-IDD Plan; and

2.15.5.54.3. Contact information for the FIDA-IDD Plan Care Manager assigned to the Participant, including but not limited to: Care Manager name, direct phone number, and hours of availability.

2.15.6. Provider and Pharmacy Directory

2.15.6.1. Maintenance and Distribution. The FIDA-IDD Plan must:

2.15.6.1.1. Maintain a combined Provider and Pharmacy Directory that uses the model document developed by CMS and the State and provide either a copy of or a separate notice on how to access this information online and how to request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance, to all new Participants at the time of Enrollment and annually thereafter;

2.15.6.1.2. When there is a significant change to the Provider Network, provide notice to Participants, as specified in Chapter 4 of the

Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance;

- 2.15.6.1.3. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice 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
- 2.15.6.1.4. Content of Provider and Pharmacy Directory. The Provider and Pharmacy Directory must include, at a minimum, the following information for all Providers in the FIDA-IDD Plan's Provider Network:
 - 2.15.6.1.5. The names, addresses, and telephone numbers of all current Participating Providers and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).
 - 2.15.6.1.6. As applicable, Participating Providers with training in and experience treating:
 - 2.15.6.1.7. Persons with IDD;
 - 2.15.6.1.8. Persons with physical disabilities, chronic illness, HIV/AIDS;
 - 2.15.6.1.9. Persons with serious mental illness;
 - 2.15.6.1.10. Persons who are Deaf or hard-of-hearing and blind or visually impaired;
 - 2.15.6.1.11. Persons with co-occurring disorders;
 - 2.15.6.1.12. Persons with ESRD; and
 - 2.15.6.1.13. Other specialties.
 - 2.15.6.1.14. As applicable, whether the health care professional or non-facility based Participating Providers has completed cultural competence training;
 - 2.15.6.1.15. Whether the Participating Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables,

lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

- 2.15.6.1.16. Whether the Participating Provider is accepting new patients as of the date of publication of the directory;
- 2.15.6.1.17. Whether the Participating Provider in on a public transportation route;
- 2.15.6.1.18. In accordance with Section 2.7.1.8.2, whether the Participating Provider or Pharmacy meets the ADA Accessibility Attestation Form requirements;
- 2.15.6.1.19. Any languages other than English, including ASL, spoken by Participating Providers or offered by skilled medical interpreters at the Provider's site;
- 2.15.6.1.20. For Behavioral Health Services Participating Providers, training in and experience treating trauma, child welfare, substance use;
- 2.15.6.1.21. As applicable, whether the Participating Provider has access to language line interpreters; and
- 2.15.6.1.22. A description of the roles of the PCP and IDT and the process by which Participants select and change PCPs.
- 2.15.6.1.23. The directory must include, at a minimum, the following information for all pharmacies in the FIDA-IDD Plan's pharmacy network:
 - 2.15.6.1.23.1. The names, addresses, and telephone numbers of all current network pharmacies; and
 - 2.15.6.1.23.2. Instructions for the Enrollee to the contact the FIDA-IDD Plan's toll free Participant Services telephone line (as described in Section 2.11) for assistance in finding a convenient pharmacy.

2.16. Data Submissions, Reporting Requirements, and Surveys

- 2.16.1. General Requirements for Data. The FIDA-IDD Plan must provide and require its First Tier, Downstream and Related Entities to provide:

- 2.16.1.1. All information CMS and the State require under the Contract related to the performance of the FIDA-IDD Plan's responsibilities, including non-medical information for the purposes of research and evaluation;
- 2.16.1.2. Any information CMS and the State require to comply with all applicable Federal or State laws and regulations; and
- 2.16.1.3. Any information CMS or the State 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-IDD Plan shall:

- 2.16.2.1.1. Submit to the State and CMS and/or their designee the applicable reports as required in this Contract and the CMS Core Reporting Requirements and subsequent revisions, 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, and 423.514.
- 2.16.2.1.3. Submit to CMS and NYSDOH all applicable FIDA-IDD Plan reporting requirements;
- 2.16.2.1.4. Submit to CMS and the State all required reports and data in accordance with the specifications, templates and time frames described in this Contract and the CMS Core Reporting Requirements and subsequent revisions, 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 State;
- 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 for HEDIS, plus additional Medicaid measures required by the State. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core

measures that the FIDA-IDD Plan must report to CMS and the State;

2.16.2.1.6. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by the State; and

2.16.2.1.7. Submit at the request of CMS or the State 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-IDD Plan shall:

2.16.3.1.1. Maintain Information Systems (Systems) that will enable the FIDA-IDD Plan to meet all of the State's requirements as outlined in this Contract. The FIDA-IDD 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.

2.16.3.1.1.4. Ensure a secure, HIPAA-compliant exchange of Participant information between the FIDA-IDD Plan and the State and any other entity deemed appropriate by the State. Such files shall be transmitted to the State through secure FTP, HTS, or a similar secure data exchange as determined by the State;

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-IDD Plan must establish appropriate links, as provided by the State, on the FIDA-IDD Plan's website that direct users back to the State's website portal; and

2.16.3.1.1.6. The FIDA-IDD Plan shall verify the accuracy of all FIDA-IDD Plan data submissions; the FIDA-IDD Plan shall screen the data for completeness, logic, and consistency; the

FIDA-IDD Plan shall collect service information from providers in standardized formats to the extent feasible and appropriate; and the FIDA-IDD Plan shall make all collected data available to the State and upon request to CMS.

2.16.3.1.2. Data Certification Requirements - Any information and/or data required by this Contract and submitted to CMS and/or the State shall be certified by the FIDA-IDD Plan as follows:

2.16.3.1.2.1. The information and/or data shall be certified by one of the following:

2.16.3.1.2.1.1. The FIDA-IDD Plan's Chief Executive Officer;

2.16.3.1.2.1.2. The FIDA-IDD Plan's Chief Financial Officer;

2.16.3.1.2.1.3. An individual who has delegated authority to sign for, and who reports directly to, the FIDA-IDD Plan's Chief Executive Officer or Chief Financial Officer.

2.16.3.1.2.2. Content of Certification: The FIDA-IDD Plan's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

2.16.3.1.2.3. Timing of Certification: The FIDA-IDD Plan shall submit the certification concurrently with the certified information and/or data.

2.16.3.1.2.4. The State will identify the specific data that requires certification.

2.16.3.2. Design Requirements

2.16.3.2.1. The FIDA-IDD Plan shall comply with the State's requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.16.3.2.2. The FIDA-IDD Plan's Systems shall interface with the State's Legacy MMIS system.

2.16.3.2.3. The FIDA-IDD Plan shall have adequate resources to support the MMIS interfaces. The FIDA-IDD 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.

2.16.3.2.4. The FIDA-IDD Plan shall conform to HIPAA compliant standards for data management and information exchange.

2.16.3.2.5. The FIDA-IDD Plan shall have controls to maintain information integrity.

2.16.3.2.6. The FIDA-IDD Plan shall maintain appropriate internal processes to determine the validity and completeness of data submitted to the State.

2.16.3.3. Participant Comprehensive Health Record. The FIDA-IDD Plan must maintain a Comprehensive Health Record to which all members of the IDT have swift and easy access. The FIDA-IDD 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 LP to be accessible to the IDT. The FIDA-

IDD 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 LP.

2.16.3.4. System Exchange of Encounter Data

2.16.3.4.1. The FIDA-IDD 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-IDD Plan shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in 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-IDD Plan shall make all systems and system information available to authorized CMS, State and other agency staff as determined by CMS or the State to evaluate the quality and effectiveness of the FIDA-IDD Plan's data and systems.

2.16.4.1.2. The FIDA-IDD Plan is prohibited from sharing or publishing CMS or State data and information without prior written consent from CMS or the State.

2.16.4.2. System Availability and Performance Requirements

2.16.5. The FIDA-IDD 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-IDD 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-IDD Plan's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to the State upon request. During routine maintenance and in the event of system failure or unavailability, the FIDA-IDD Plan shall notify the CMT upon discovery and implement the COOP immediately.

2.16.7. The FIDA-IDD Plan shall preserve the integrity of Participant-sensitive data that reside in both live and archived environments.

2.17. Encounter Reporting

2.17.1. For Medicare encounters, the FIDA-IDD 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. For Medicaid encounters, the FIDA-IDD Plan must meet any State and CMS diagnosis and/or Encounter reporting requirements that are in place, as may be updated from time to time. All encounters (Medicare and Medicaid) shall be sent to CMS and all encounters (Medicare and Medicaid) shall be submitted to the State. CMS and the State are exploring an integrated submission process. Should a process entailing submission of Encounter Data files to the State be determined that is deemed acceptable to State and CMS, and reduces burden on the FIDA-IDD Plan, the FIDA-IDD Plan may be directed to use that process. Furthermore, the FIDA-IDD Plan's Systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS or the State and updated from time to time. The FIDA-IDD 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 State will provide technical assistance to the FIDA-IDD Plan for developing the capacity to meet encounter reporting requirements.

2.17.2. Requirements. The FIDA-IDD 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 sub capitated sources. Such data must be able to be linked to the State's eligibility data;
- 2.17.2.2. Participate in site visits and other reviews and assessments by CMS and the State, or its designee, for the purpose of evaluating the FIDA-IDD Plan's collection and maintenance of Encounter Data;
- 2.17.2.3. Upon request by CMS, the State, 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 State, or their designee. Such Encounter Data shall include elements and level of detail determined necessary by CMS and the State. As directed by CMS and the State, such Encounter Data shall also include the National Provider Identifier (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 State on a monthly basis or within time frames specified by CMS and the State, including at a frequency determined necessary by CMS and the State to comply with any and all applicable statutes, rules, regulations and guidance;
- 2.17.2.6. Submit Encounter Data that meets minimum standards for accuracy as defined by CMS and the State. The FIDA-IDD Plan must also correct and resubmit denied encounters as necessary; and
- 2.17.2.7. If CMS, the State, or the FIDA-IDD Plan, determines at any time that the FIDA-IDD Plan's Encounter Data is not complete and accurate, the FIDA-IDD Plan shall:
- 2.17.2.7.1. Notify CMS and the State, 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 State approval, within a time frame established by CMS and the State, which shall in no event exceed thirty (30) calendar days from the day the FIDA-IDD Plan identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;
 - 2.17.2.7.3. Implement the CMS and the State -approved corrective action plan within a time frame approved by CMS and the State, which shall in no event exceed thirty (30) calendar days from the date that the FIDA-IDD Plan submits the corrective action plan to CMS and the State for approval; and
- Participate in a validation study to be performed by CMS, the State, 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-IDD 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-IDD Plan pays, and then later determines should not have paid.

3. Section 3. CMS and State Responsibilities

3.1. Contract Management

3.1.1. Administration. Contract Management. CMS and the State 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 State authorized and empowered to represent CMS and the State about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (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 State representatives will act as liaisons among the FIDA-IDD Plan and CMS and the State 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-IDD Plan;
- 3.1.1.1.3. Receive and respond to External Grievances;
- 3.1.1.1.4. Conduct regular meetings with the FIDA-IDD Plan;
- 3.1.1.1.5. Consider and decide FIDA-IDD Plan request for Discretionary Involuntary Disenrollments in accordance with the process outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance;
- 3.1.1.1.6. Coordinate requests for assistance from the FIDA-IDD Plan and assign CMS and State staff with appropriate expertise to provide technical assistance to the FIDA-IDD Plan;
- 3.1.1.1.7. Make best efforts to resolve any issues applicable to the Contract identified by the FIDA-IDD Plan, CMS, or the State;
- 3.1.1.1.8. Inform the FIDA-IDD Plan of any discretionary action by CMS or the State under the provisions of the Contract;
- 3.1.1.1.9. Coordinate review of marketing materials and procedures; and
- 3.1.1.1.10. Coordinate review of Grievance and Appeals data, procedures,

- 3.1.1.1.10.1. Review, approve, and monitor the FIDA-IDD Plan's Outreach and orientation materials and procedures;
 - 3.1.1.1.10.2. Review, approve, and monitor the FIDA-IDD Plan's Complaint and Appeals procedures;
 - 3.1.1.1.10.3. Monitor compliance with all applicable rules and requirements, and issue compliance notices, as appropriate;
 - 3.1.1.1.10.4. 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 State determine that the FIDA-IDD Plan is in violation of any of the terms of the Contract stated herein;
 - 3.1.1.1.10.5. Conduct site visits as determined necessary by CMS and the State to verify the accuracy of reported data; and
 - 3.1.1.1.10.6. Coordinate the FIDA-IDD 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 the State) shall review and provide written approval of any updates made by the updating Party (CMS or the State) to the 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 the State) shall be provided to the CMT.
- 3.1.2. Performance Evaluation
- 3.1.2.1. CMS and the State will, at their discretion:
 - 3.1.2.2. Evaluate, through inspection or other means, the FIDA-IDD 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-IDD Plan and its Provider Network. CMS and the State will provide the FIDA-IDD Plan with the written results of these evaluations;
 - 3.1.2.3. Conduct periodic audits of the FIDA-IDD Plan, including, but not limited to, an annual independent external review and an annual site visit;

3.1.2.4. Conduct annual Participant surveys and provide the FIDA-IDD Plan with written results of such surveys; and

3.1.2.5. Meet with the FIDA-IDD Plan at least semi-annually to assess the FIDA-IDD Plan's performance.

3.2. Eligibility and Enrollment Activities

3.2.1. Individuals are eligible for the FIDA-IDD Demonstration in accordance with Section C.1. of the Memorandum of Understanding between CMS and New York State November 5, 2015.

3.2.1.1.1.1. Enrollment Generally. Enrollment and Disenrollment transactions will be processed through the State Enrollment Broker. Individuals have the option to contact 1-800-MEDICARE to request Disenrollment. The State (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 the State identifying individuals who have elected to disenroll from a FIDA-IDD Plan, or have enrolled in or have selected another type of available Medicare coverage that is not the FIDA-IDD Plan. The State will share Enrollment and Disenrollment transactions with contracted FIDA-IDD Plans.

3.2.1.2. All Enrollments are processed through the Enrollment Broker consistent with the Effective Date of Enrollment requirements in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

3.2.1.2.1.1. Effective Date(s) of Enrollment – All Effective Dates of Enrollment are prospective. 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 Enrollment is entered by the Enrollment Broker and accepted by the State'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 Enrollments after the 20th will be effective the first day of the second month following the request. Prospective Participants have the option to cancel their Enrollment until the last day of the month prior to the effective date of Enrollment.

- 3.2.1.2.1.2. The State Enrollment broker will start accepting Enrollment requests for all nine (9) counties of operation as outlined in Appendix H no earlier than one (1) month prior to the first effective date of coverage.
- 3.2.1.2.1.3. The State and CMS must agree in writing to any changes to the Effective Dates of Enrollment.
- 3.2.1.2.1.4. CMS and the State will monitor Enrollments and Disenrollments 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.
- 3.2.1.2.1.5. Any FIDA-IDD 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-IDD Plan until the Medicaid Managed Care plan deficiencies are resolved or may be disqualified from the FIDA-IDD Demonstration.
- 3.2.1.2.1.6. Any FIDA-IDD 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-IDD Plan until the FIDA-IDD Plan is no longer under such sanction.
- 3.2.1.2.1.7. CMS and the State will monitor any unusual shifts in Enrollment by individuals enrolled in the FIDA-IDD 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 the State may discontinue further Enrollment into the FIDA-IDD Plan. Any illegal marketing practices will be referred to appropriate agencies for investigation.
- 3.2.1.2.1.8. Disenrollment
- 3.2.1.2.1.9. Voluntary Disenrollment. Participants may request to be disenrolled from the FIDA-IDD 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.

- 3.2.1.2.1.10. Types of Voluntary Disenrollment
- 3.2.1.2.1.11. Disenrollments from the FIDA-IDD Demonstration
- 3.2.1.2.1.12. When a Participant requests a new MA-PD plan through 1-800-Medicare and
- 3.2.1.2.1.13. When a Participant elects to receive his or her Medicare services through Medicare Fee-for-Service and a separate Medicare PDP.
- 3.2.1.2.1.14. 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 the State and the Enrollment Broker, and other guidance documents specifying State approved Enrollment Broker policies and procedures.
- 3.2.1.2.1.15. Voluntary Disenrollment requests submitted directly to the Enrollment Broker are confirmed orally and in writing by the Enrollment Broker.
- 3.2.1.2.1.16. Involuntary Disenrollments
- 3.2.1.2.1.17. Required Involuntary Disenrollments. The State 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 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.
- 3.2.1.2.1.18. 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.

- 3.2.1.2.1.19. When a Participant remains out of the Service Area or for whom residence in the FIDA-IDD Plan Service Area cannot be confirmed for more than six (6) consecutive months.
- 3.2.1.2.1.20. When a Participant no longer resides in the Service Area, except for a Participant living in the Service Area who is admitted to an ICF-IID or 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-IDD Plan under the provisions of this Section, the FIDA-IDD Plan must first provide documentation satisfactory to the State 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 the State and CMS determine that the Participant no longer resides in the Service Area. Termination may be retroactive if the State and CMS are able to determine the month in which the Participant moved from the Service Area.
- 3.2.1.2.1.21. When CMS or the State 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.
- 3.2.1.2.1.22. When the State is made aware that a Participant has resided in a Development Center for more than 90 days, the individual will be disenrolled from the FIDA-IDD Demonstration and will return to Medicaid FFS and Medicare FFS or a Medicare Advantage Plan. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month during which the 90th day fell.
- 3.2.1.2.1.23. When CMS or the State is made aware that the Participant is no longer eligible to participate in the FIDA-IDD Demonstration.

- 3.2.1.2.1.24. The termination or expiration of this Contract terminates coverage for all Participants with the FIDA-IDD 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.
- 3.2.1.2.1.25. When CMS and the State approve 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.
- 3.2.1.2.1.26. Discretionary Involuntary Disenrollments as described in Section 2.3.2.9.
- 3.2.1.2.1.27. 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.
- 3.2.1.2.1.28. The Enrollment Broker will process the Disenrollment and may provide assistance to the Participant in securing alternative coverage.
- 3.2.1.2.1.29. When a Participant requests to disenroll from the FIDA-IDD Demonstration entirely and was enrolled in the OPWDD 1915(c) comprehensive waiver the Plan is required to contact the DDRO to ensure a safe transition and the continuity of OPWDD 1915(c) comprehensive waiver services.
- 3.2.1.2.1.30. Enrollment and Disenrollment Systems
- 3.2.1.2.1.31. CMS and the State will maintain systems to provide:
- 3.2.1.2.1.32. Enrollment and Disenrollment information to the FIDA-IDD Plan; and
- 3.2.1.2.1.33. Continuous verification of eligibility status.
- 3.2.1.2.1.34. State Enrollment Broker. The State will utilize an independent third party entity (Enrollment Broker) to facilitate Enrollments and Disenrollments into the FIDA-IDD Plan.
- 3.2.1.2.1.35. The Enrollment Broker shall:

- 3.2.1.2.1.36. Develop generic materials to assist Eligible Individuals in choosing whether to enroll in the Demonstration. Said materials shall present the FIDA-IDD Plan in an unbiased manner to Eligible Individuals. The State may collaborate with the FIDA-IDD Plan in developing Demonstration Plan-specific materials for the Enrollment Broker to use;
- 3.2.1.2.1.37. Present the FIDA-IDD Plans in an unbiased manner to Eligible Individuals and Participants seeking to transfer from one FIDA-IDD Plan to another. Such presentation(s) shall ensure that Eligible Individuals and such Participants are informed prior to Enrollment of the following:
 - 3.2.1.2.1.38. The rights and responsibilities of participation in the Demonstration;
 - 3.2.1.2.1.39. The nature of the FIDA-IDD Plan's care delivery system, including, but not limited to, the Provider Network; and
 - 3.2.1.2.1.40. Orientation and other Participant services made available by the FIDA-IDD Plan.

- 3.2.1.3. Enroll and disenroll Participants in the FIDA-IDD Plan, including completion of the State's Enrollment and Disenrollment forms;
- 3.2.1.4. Ensure that Participants are informed at the time of Enrollment of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by Federal law or waiver; and
- 3.2.1.5. Be knowledgeable about the FIDA-IDD Plan's policies, services, and procedures; and

4. Section 4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments

- 4.1.1.1. CMS and the State will each contribute to the total Capitation payment. CMS and the State will each make monthly payments to the FIDA-IDD Plan for their respective portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth in Section 4 and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The FIDA-IDD 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 Section 4.2.1.

4.1.1.3. On a regular basis, CMS will provide the State with the FIDA-IDD Plan level payment information in the Medicare Plan Payment Report. The use of such information by the State will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the FIDA-IDD Plan. On a regular basis, the State will also provide to CMS FIDA-IDD Plan-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates

4.1.2.1. 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	April 1, 2016 - December 31, 2017
2	January 1, 2018 - December 31, 2018
3	January 1, 2019 - December 31, 2019
4	January 1, 2020 - December 31, 2020

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medicaid Component

4.2.1.1. The State shall pay the FIDA-IDD 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, by rate cell as described below. The State will continue to explore the need for additional rate cells for the target population.

4.2.1.2. The Rate Cells for the Medicaid Component are stratified by age, as follows:

4.2.1.2.1. Dual Eligible Adults, Age 21 to < 50. This rate cell will be paid for eligible individuals who are age 21 or older and less than 50. One rate cell for this age group will be determined for the entire Demonstration Area.

4.2.1.2.2. Dual Eligible Adults, Age 50 and Over. This rate cell will be paid for eligible individuals who are age 50 and older. One rate cell for this age group will be determined for the entire Demonstration Area.

4.2.2. Underlying Rate Structure for Medicare Component of the Capitation Rate

4.2.2.1. Medicare will pay the FIDA-IDD 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-IDD 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 based on 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. 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.

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 3.5% bonus county rate (benchmark) for the applicable county.

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. The FIDA-IDD Plan and Providers of hospice services would be required to coordinate these services with the rest of the Participant's care. The FIDA-IDD 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 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 Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and Medicaid Component of the capitated rate herein.

4.2.3.1.1. Demonstration Year 1: .25%

4.2.3.1.2. Demonstration Year 2: .5%

4.2.3.1.3. Demonstration Year 3: 1% unless changed as a result of the provisions outlined in Section 4.4.3.6

4.2.3.1.4. Demonstration Year 4: 1% unless changed as a result of the provisions outlined in Section 4.4.3.6

4.2.3.2. Except as otherwise specified, rate updates will take place on January 1st of each calendar year.

4.2.3.3. Aggregate 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 Aggregate Savings Percentages.

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 2016, 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 2016 with Medicare Advantage experience in 2015. 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.

4.2.4.2.1.1. In calendar year 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Participants in 2017 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2016.

4.2.4.2.1.2. After calendar year 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Participants.

4.2.4.2.1.3. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Participants with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.2.1.4. 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. Risk Mitigation Approaches

4.3.1. Enrollment Mix Adjustment: The Medicaid rate component paid under this Demonstration will reflect a blended rate for all levels of care (institutional and community-based). The enrollment mix adjustment will consider the actual enrolled mix of Participants receiving institutional and community-based services against the projected enrollment mix built into

the Medicaid component of the capitation rates. The adjustment will modify the Medicaid component of the capitation rate during Demonstration Year 1 within a pre-approved range and mitigate the cost risk presented by a population with higher or lower needs than what was built into the Medicaid component of the capitation rates. The modification will be made once representative enrollment data are available and will apply both retrospectively and prospectively to Demonstration Year 1.

4.3.2. Risk Corridors

- 4.3.2.1. Risk corridors will be established for Demonstration Years 1, 2 and 3.
- 4.3.2.2. The Demonstration will utilize a tiered Plan-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible costs.
- 4.3.2.3. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g., CMS-HCC).
- 4.3.2.4. The risk corridors will be reconciled as if the FIDA-IDD Plan had received the full quality withhold payment.
- 4.3.2.5. Process for collecting cost information
 - 4.3.2.5.1. CMS and the State will evaluate Encounter Data, cost data, and FIDA-IDD Plan financial reports to determine incurred costs.
 - 4.3.2.5.2. Risk corridor share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Part D, with the maximum Medicare payment/recoupment equaling one percent (1%) of the risk-adjusted Medicare baseline in Demonstration Year 1, .5% in Demonstration Year 2 and .25% in Demonstration Year 3.
 - 4.3.2.5.3. All remaining payments or recoveries once Medicare has reached its maximum shall be treated as Medicaid expenditures eligible for FMAP.
 - 4.3.2.5.4. For Demonstration Year 1, administrative costs will be limited to 7% of the FIDA-IDD Plan's non-Part D revenue. For Demonstration Years 2 and 3, administrative costs will be excluded from the risk corridor calculations. Activities to improve health care quality, as defined at 42 C.F.R. § 422.2430, including

care management expenses, will not be considered administrative costs.

4.3.2.5.5. Taxes and regulatory fees will be excluded for the purposes of the risk corridor gain/loss calculations. Offsets, such as reinsurance and third-party liability recoveries, will be netted out of any expense prior to the risk corridor gain/loss calculations.

4.3.2.5.6. Interim and final settlement amounts shall be calculated for each Demonstration Year; however, any Demonstration Year 1 payment will be contingent upon FIDA-IDD Plan participation in Demonstration Year 2, and any Demonstration Year 2 payment will be contingent upon FIDA-IDD Plan participation in Demonstration Year 3, unless otherwise permitted by the State and CMS.

4.3.2.5.7. Risk corridor tiers: CMS and NYSDOH will use the bands as described in Exhibit 4.1 to address potential FIDA-IDD Plan gains/losses in Demonstration Year.

4.3.3. Medical Loss Ratios (MLR)

4.3.3.1. For Medicaid rating period beginning on or after July 1, 2017, the FIDA-IDD Plan is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and NYSDOH requirements for the FIDA-IDD Plan.

4.3.3.2. Prior to the applicability of the requirements in Section 4.3.3.1, for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirement in Section 4.3.3.1, the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.3.3.3. Any remittances owed as a result of applying the prevailing Medicare Advantage MLR requirements would be shared between the NYSDOH and Medicare proportionally based on each payor's contribution to the total premiums subject to the MLR calculation. The MLR calculation shall include costs associated with Covered Services and care management.

Exhibit 4.1 – Risk Corridor Tiers

Demonstration Year 1:

Percentage of Gain/Loss	FIDA-IDD Plan Share	Medicare/State Share (Based on parameters in 4.3.2.5)
≤1.0%	100%	0%
>1.0% and ≤2.0%	50%	50%
>2.0%	0%	100%

Demonstration Year 2:

Percentage of Gain/Loss	FIDA-IDD Plan Share	Medicare/State Share (Based on parameters in 4.3.2.5)
≤1.5%	100%	0%
>1.5% and ≤3.0%	50%	50%
>3.0%	0%	100%

Demonstration Year 3:

Percentage of Gain/Loss	FIDA-IDD Plan Share	Medicare/State Share (Based on parameters in 4.3.2.5)
≤2.0%	100%	0%
>2.0% and ≤3.5%	50%	50%
>3.5%	0%	100%

4.4. Payment Terms

4.4.1. CMS will make monthly, prospective Capitation payments to the FIDA-IDD Plan. The NYSDOH will make monthly Capitation payments to the FIDA-IDD 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 3.5% bonus county rate (benchmark) 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.

4.4.2. Timing of Capitation Payments

4.4.2.1. Enrollments

4.4.2.1.1. CMS and the State will make monthly per member per month Capitation payments to the FIDA-IDD Plan. The per member per month (PMPM) Capitation payment for a particular month will reflect payment for the Participants with effective Enrollment into the FIDA-IDD Plan as of the first day of that month, as described in Section 2.3.1.

4.4.2.2. Disenrollments

4.4.2.2.1. The final per member per month Capitation payment made by CMS and the State to the FIDA-IDD 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 3.2.6).

4.4.2.3. Timing of Medicaid Component of the Rate

4.4.2.3.1. Capitation paid by the State for the Medicaid Component is due to the FIDA-IDD Plan within the service month. Payments due from the State, 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-IDD Plan's sole remedy against the State for late payments by the State. Payment terms contained on the FIDA-IDD Plan's invoices shall have no force and effect.

4.4.3. Modifications to Capitation Rates

4.4.3.1. CMS and the State will jointly notify the FIDA-IDD Plan in advance and in writing of any proposed changes to the Capitation rates, and the FIDA-IDD Plan shall accept such changes as payment in full as described in Section 4.5.

4.4.3.1.1. 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 Medicare Advantage and Part D rate announcement and the annual Medicaid rate update will be made only if and when CMS and the State 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 the State will make changes to baseline estimates within thirty (30) calendar 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.

- 4.4.3.2. 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.
- 4.4.3.3. 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 State 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.
- 4.4.3.4. 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 give the FIDA-IDD Plan the opportunity to review and comment on such adjustments and will then incorporate such adjustments into the Demonstration Year 3 baseline, as appropriate, on a prospective basis to prevent overpayments due to increased coding intensity.
- 4.4.3.5. Changes to the Aggregate Savings Percentages will be made if and when CMS and State 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. CMS and the State will give the FIDA-IDD Plan the opportunity to review and comment on any such proposed changes to the Aggregate Savings Percentages before they are implemented.
- 4.4.3.6. In the event that the FIDA-IDD Plan experiences 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 Years 3 and 4 will be reduced to (.75%) percent. CMS and the State will make such determination at least four months prior to the start of Demonstration Years 3. The annual loss determination will be prior to any payments or recoupments under the risk corridor as described in Section 4.3.2. Annual losses will be calculated as if the FIDA-IDD Plan had received the full

quality-withhold payment and any other offsets except any risk corridor payments or recoupments.

4.4.4. Quality Withhold Policy for Medicaid and Medicare A/B Components

4.4.4.1. Under the Demonstration, both CMS and the State 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-IDD Plan’s performance consistent with established quality thresholds.

4.4.4.2. CMS and the State will evaluate the FIDA-IDD Plan’s performance according to the specified metrics required in order to earn back the quality withhold for a given Demonstration Year.

4.4.4.3. Whether or not the FIDA-IDD Plan has met the quality requirements in a given year will be made public.

4.4.4.4. Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology will be made available in separate technical guidance.

4.4.4.5. Withhold Measures in Demonstration Year 1

4.4.4.5.1. Figure 4.1 below identifies core withhold measures for Demonstration Year 1. Additional details, including technical specifications, withhold methodology, and required benchmarks, is provided in separate guidance.

4.4.4.5.2. For Demonstration Year One, which crosses calendar years, the FIDA-IDD Plan will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2016 and at the end of CY 2017. The determination in CY 2016 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2016. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

Figure 4.1: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
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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 90 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	
Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure		X
Long Term Care Overall Balance	Reporting of the percent of Participants who did not reside in an ICF-IID at the time of enrollment and did not reside in an ICF-IID during the reporting period.	State defined measure		X

4.4.4.6. Withhold Measures in Demonstration Years 2, 3 and 4

4.4.4.6.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Years 3 and 4, and will be based on performance in the core Demonstration and State specified measures.

4.4.4.6.2. Payment will be based on performance on the quality withhold measures listed in Figure 4.2, below.

4.4.4.6.3. If the FIDA-IDD Plan is unable to report at least three (3) of the quality withhold measures listed in Figure 4.2 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.2: Quality Withhold Measures for Demonstration Years 2, 3 and 4

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Customer Service	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed:</p> <ul style="list-style-type: none"> • 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	<p>Percent of best possible score the plan earned on how quickly Participants get appointments and care:</p> <ul style="list-style-type: none"> • 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 	AHRQ/CAHPS	X	

	<p>get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <ul style="list-style-type: none"> • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? 			
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Plan All-cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either for 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	
Reducing the Risk of Falling	Percent of Participants with a problem falling,	NCQA/HEDIS HOS	X	

	walking or balancing who discussed it with their doctor and got treatment for it during the year.			
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) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	Percent of Participants with a prescription for 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	
Screening for Vision	Percentage of members who received an eye exam in the last year.	State-defined measure		X
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Diversion	Reporting of the number of Participants who lived outside the ICF-IID during the current measurement year as a proportion of all Participants who lived outside the ICF-IID during the previous year.	State-defined measure		X

4.4.5. American Recovery and Reinvestment Act of 2009

- 4.4.5.1. All payments to the FIDA-IDD Plan are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.
- 4.4.5.2. The FIDA-IDD Plan shall offer American Indian Participants the option to choose an American Indian Health Care Provider as a Primary Care Provider if the FIDA-IDD Plan has an American Indian Primary Care Provider in its Provider Network that has capacity to provide such services;
- 4.4.5.3. The FIDA-IDD Plan shall demonstrate that it has sufficient access to American Indian Health Care Providers to ensure access to Covered Items and Services for American Indian Participants;
- 4.4.5.4. The FIDA-IDD Plan shall make prompt payment to American Indian Health Care Providers;
 - 4.4.5.4.1.1. The FIDA-IDD Plan shall reimburse an American 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 a Participating Provider.
- 4.4.5.5. The FIDA-IDD Plan shall pay Non-Participating American Indian Health Care Providers that are FQHCs for the provision of services to an American Indian Participant at a rate equal to the rate that the FIDA-IDD Plan would pay to a network FQHC that is not an American Indian Health Care Provider.

4.4.6. Suspension of Payments

- 4.4.6.1. The State may suspend payments to the FIDA-IDD Plan in accordance with 42 C.F.R. § 455.23, et seq. and 130 CMR 450, et seq. as determined necessary or appropriate by the State.

4.5. Transitions between Rate Cells and Risk Score Changes

- 4.5.1. 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.
- 4.5.2. Medicaid changes will happen prospectively such that the next month's payment will reflect the change in status.

4.6. Reconciliation

- 4.6.1. Medicare

4.6.1.1. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

4.6.1.2. Final Medicare Reconciliation and Settlement: In the event the FIDA- IDD Plan terminates or non-renews this Contract, CMS' final settlement phase for a terminating contract applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality withholds, and MLRs as applicable, that are outstanding at the time of termination.

4.7. Payment in Full

4.7.1. The FIDA-IDD 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.

4.7.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, the State and the FIDA-IDD 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.

4.7.3. By signing this Contract, the FIDA-IDD Plan accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the FIDA-IDD Plan; and that while data is made available by the Federal Government and the State to the FIDA-IDD Plan, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

5. Section 5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The FIDA-IDD Plan must notify CMS and the State 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-IDD Plan must notify CMS and the State 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-IDD Plan must notify CMS and the State 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-IDD 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 State, which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors:

5.1.3.1. The FIDA-IDD 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 ventures with, the Federal government or State of New York.

5.1.3.2. The FIDA-IDD 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-IDD Plan must:

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-IDD 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-IDD 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-IDD Plan may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the FIDA-IDD Plan hereunder; and

5.1.4.2.2. Notify the FIDA-IDD Plan hereunder and authorize the FIDA-IDD Plan to make such investigations and take such action as the FIDA-IDD 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-IDD 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-IDD 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-IDD Plan's equity or be permitted to serve as a director, officer, or partner of the FIDA-IDD Plan. Federal financial participation (FFP) is not available for any amounts paid to the FIDA-IDD Plan if the FIDA-IDD Plan could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act.

5.1.6. Disclosure Requirements. The FIDA-IDD Plan must disclose to CMS and the State information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. § 455(b). The FIDA-IDD Plan must obtain 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 State, including but not limited to obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages. The FIDA-IDD Plan must maintain such disclosed information in a manner which can be periodically searched by the FIDA-IDD Plan for exclusions and provided to the State in accordance with this Contract and relevant State and Federal laws and regulations. In addition, the FIDA-IDD Plan must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the FIDA-IDD Plan is not a Federally qualified Health Maintenance Organization under the Public Health Service Act. In addition, the FIDA-IDD Plan shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Participants upon reasonable request.

5.1.7. Physician Incentive Plans

5.1.7.1. The FIDA-IDD 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, subdivision 438.3(i), and Part 1003. The FIDA-IDD Plan must submit all information required to be disclosed to CMS and the State in the manner and format specified by CMS and the State, which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The FIDA-IDD Plan shall be liable for any and all loss of Federal financial participation (FFP) incurred by New York State that results from the FIDA-IDD 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-IDD 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-IDD Plan's Demonstration Plan, and the FIDA-IDD Plan shall not be

liable if it can demonstrate, to the satisfaction of CMS and the State, that it has made a good faith effort to comply with the cited requirements.

5.1.8. Physician Identifier. The FIDA-IDD 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-IDD Plan must provide such unique identifier to CMS and the State for each of its PCPs in the format and time-frame established by CMS and the State in consultation with the FIDA-IDD Plan.

5.1.9. Timely Provider Payments.

5.1.9.1. As defined in 42 C.F.R. § 447.46, the FIDA-IDD Plan pays all clean electronic claims to Providers, including American Indian Health Care Providers, within thirty (30) calendar days of receipt and paper claims within forty-five (45) calendar days per NYS Insurance Law Section 3224a.

5.1.9.2. The FIDA-IDD 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) calendar days of receipt for electronic claims and within thirty (30) calendar days of receipt all other claims. The FIDA-IDD Plan or its PBM pays interest on clean claims that are not paid within fourteen (14) calendar days (electronic claims) or thirty (30) calendar days (all other claims).

5.1.9.3. The FIDA-IDD 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) calendar days, nor more than ninety (90) calendar days, to submit to the Part D sponsor claims for reimbursement.

5.1.9.4. The FIDA-IDD Plan's claims processing system checks claims payment logic to identify erroneous payments.

5.1.9.5. The FIDA-IDD 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-IDD Plan shall 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-

IDD 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 non-treatment; 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

5.1.11.1. The FIDA-IDD Plan must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold a Participant liable for:

5.1.11.1.2. Debts of the FIDA-IDD Plan, in the event of the FIDA-IDD Plan's insolvency;

5.1.11.1.3. Covered Items and Services provided to the Participant in the event that the FIDA-IDD Plan fails to receive payment from CMS or the State for such services; or

5.1.11.2. 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-IDD Plan had directly provided the services;

5.1.11.3. 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;

5.1.11.4. Not deny any service provided under this Contract to a Participant for failure or inability to pay any applicable charge;

5.1.11.5. 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 nor shall the FIDA-IDD Plan bear responsibility for the unpaid bill; and

5.1.11.6. Moral or Religious Objections. The FIDA-IDD 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-IDD Plan objects to the service on moral or religious grounds. If the FIDA-IDD 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 State and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

- 5.1.11.6.1. To the State
- 5.1.11.6.2. With its application for a contract;
- 5.1.11.6.3. Whenever it adopts the policy during the term of the Contract; and
- 5.1.11.6.4. The information provided must be:
 - 5.1.11.6.4.1. Consistent with the provisions of 42 C.F.R. § 438.10;
 - 5.1.11.6.4.2. Provided to Eligible Individuals before and during Enrollment; and
 - 5.1.11.6.4.3. Provided to Participants within ninety (90) calendar 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-IDD 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-IDD 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-IDD Plan). The FIDA-IDD 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-IDD Plan may use the Roster as one method to determine TPHI information.

5.1.12.2. Post Payment and Retroactive Recovery. The State, and/or its vendor, will also be vested with the responsibility to collect any reimbursement for FIDA-IDD Plan Benefit 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-IDD Plan's next roster and TPHI file. The FIDA-IDD Plan will have six months from the later of the date the TPHI has been posted (eMedNY transaction date) or the FIDA-IDD 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-IDD Plan in error, the FIDA-IDD Plan will refund the adjusted recovery to the State.

5.1.12.3. **TPHI Reporting.** The FIDA-IDD 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-IDD 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-IDD Plan, the State will assume there are no retroactive recoveries being pursued by the FIDA-IDD Plan and will initiate recovery processing.

5.1.13. **Other Insurance and Settlements.** The FIDA-IDD 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-IDD Plan cannot take actions to collect these funds. Pursuit of Worker's Compensation benefits and No-fault Insurance by the FIDA-IDD Plan is authorized, to the extent that they cover expenses incurred by the FIDA-IDD Plan.

5.1.13.1. **Medicaid Drug Rebate.** Non-Part D covered outpatient drugs dispensed to Participants shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.13.2. The FIDA-IDD Plan shall submit to NYSDOH, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Participants for which the FIDA-IDD Plan is responsible for coverage and other data as NYSDOH determines necessary.

5.1.14. **Non-Part D covered outpatient drugs dispensed to Participants shall be subject to the same rebate requirements as NYSDOH is subject under section**

1927 of the Social Security Act and that NYSDOH shall collect such rebates from pharmaceutical manufacturers.

5.1.15. The FIDA-IDD Plan shall submit to NYSDOH, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Participants for which the FIDA-IDD Plan is responsible for coverage and other data as NYSDOH determines.

5.2. Confidentiality

5.2.1. Statutory Requirements. The FIDA-IDD Plan understands and agrees that CMS and the State 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) and any other applicable State laws on confidentiality and disclosure. The FIDA-IDD 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-IDD 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-IDD 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.

5.2.3. Data Security. The FIDA-IDD 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-IDD 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-IDD 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-IDD 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-IDD 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 State in whatever form it is maintained by the FIDA-IDD Plan. Upon the termination or completion of this Contract, the FIDA-IDD 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 State, will destroy such data or material.

5.2.5. Destruction of Personal Data. For any PHI received regarding an Eligible Beneficiary referred to FIDA-IDD Plan by the State who does not enroll in FIDA-IDD Plan's plan, the FIDA-IDD 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 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-IDD 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-IDD Plan must seek and obtain prior written authorization from CMS and the State for the use of any data pertaining to this Contract for research or any other purposes not directly related to the FIDA-IDD 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 State as existing now or during the term of this Contract, except as modified by CMS and State pursuant to the MOU and this Contract. All applicable Federal and State laws, regulations, policies, and procedures are hereby incorporated into this

Contract by reference, pursuant to Section 5.6.1.3 of this Contract. Notwithstanding any provision to the contrary, however, the parties agree that clauses 4-13 and clauses 16-26 of Appendix I, the Standard Clauses for New York State Contracts, do not apply to CMS, HHS, or any other agency of the Federal government.

5.3.2. Sovereign Immunity. Nothing in this Contract will be construed to be a waiver by the State 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. If, at any time during the term of this Contract, the FIDA-IDD Plan or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the FIDA-IDD Plan's facilities or loss of necessary Federal or State approvals, the FIDA-IDD Plan must report such loss to CMS and the State. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification. The FIDA-IDD Plan shall indemnify and hold harmless CMS, the NYSDOH, OPWDD, 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-IDD Plan, any person employed by the FIDA-IDD Plan, or any of its First Tier, Downstream, or Related Entities provided that the FIDA-IDD 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-IDD Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider in the FIDA-IDD 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-IDD Plan from including Providers in its Provider Network to the extent necessary to meet the needs of the FIDA-IDD Plan's Participants or from establishing any measure designed to maintain

quality and control costs consistent with the responsibilities of the FIDA-IDD Plan.

5.3.6.1.1. The FIDA-IDD Plan shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, 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-IDD 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-IDD 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-IDD 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 this section, shall be construed to require the FIDA-IDD Plan to contract with Providers beyond the number necessary to meet the needs of its Participants; precludes the FIDA-IDD Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the FIDA-IDD Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Participants.

5.3.6.2. If a complaint or claim about discrimination against the FIDA-IDD Plan is presented to New York for handling discrimination complaints, the FIDA-IDD 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-IDD 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-IDD Plan agrees, as a material condition of the contract, that neither the FIDA-IDD 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-IDD Plan, or any of the aforesaid affiliates of FIDA-IDD 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-IDD 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 the State 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-IDD 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 Federal and State laws, the FIDA-IDD Plan must arrange for the transfer, at no cost to CMS, the State, 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, OPWDD, 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-IDD 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-IDD 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-IDD Plan must provide CMS and the State with a complete list of such plans and services, upon request.

CMS and the State will exercise discretion in disclosing information that the FIDA-IDD Plan may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or the State 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-IDD Plan and maintained on file by CMS or the State, 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 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 the State reasonably determine that the FIDA-IDD Plan is deficient in the performance of its obligations under the Contract, CMS and the State may require the FIDA-IDD Plan to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and the State 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-IDD Plan must promptly and diligently implement the corrective action plan, and demonstrate to CMS and the State that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan may subject the FIDA-IDD Plan to termination of the Contract by CMS and the State 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 the State 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 the State 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-IDD Plan:

5.3.14.1.1. Fails substantially to provide Covered Items and Services required to be provided under this Contract to Participants;

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, the State, 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 2.14;

5.3.14.1.9. Fails to comply with any corrective action plan required by CMS and the State;

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:

- 5.3.14.2.1. Intermediate sanctions and Civil Money Penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;
 - 5.3.14.2.2. The appointment of temporary management to oversee the operation of the FIDA-IDD Plan in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);
 - 5.3.14.2.3. Suspension of Enrollment (including assignment of Participants);
 - 5.3.14.2.4. Suspension of payment to the FIDA-IDD Plan;
 - 5.3.14.2.5. Disenrollment of Participants;
 - 5.3.14.2.6. Denial of payment as set forth in 42 C.F.R. § 438.730; and
 - 5.3.14.2.7. Suspension of marketing.
- 5.3.14.3. If CMS or the State have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the FIDA-IDD Plan has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and the State may:
- 5.3.14.3.1. Require the FIDA-IDD Plan to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and the State; or
 - 5.3.14.3.2. Require the FIDA-IDD Plan to change the manner or method in which the FIDA-IDD Plan ensures the performance of such contractual responsibility.
- 5.3.14.4. Before imposing any intermediate sanctions, the State and CMS must give the entity timely written notice that explains the basis and nature of the sanction and other due process protections that CMS and the State elect to provide.
- 5.3.15. Additional Administrative Procedures. CMS and the State may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The FIDA-IDD 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-IDD Plan certifies that neither the FIDA-IDD 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 the State, with the performance of services under the Contract. Without limiting the generality of the foregoing, CMS and the State require that neither the FIDA-IDD Plan nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing FIDA-IDD Plan enrollment functions for the State. The FIDA-IDD Plan further certifies that it will comply with Section 1932(d) of the Social Security Act.
- 5.3.18. Insurance for FIDA-IDD Plan's Employees. The FIDA-IDD Plan must agree to maintain at the FIDA-IDD Plan's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and the State with certification of same upon request. The FIDA-IDD Plan, and its professional personnel providing services to Participants, must obtain and maintain appropriate professional liability insurance coverage. The FIDA-IDD Plan must, at the request of CMS or the State, provide certification of professional liability insurance coverage.
- 5.3.19. Waiver. The FIDA-IDD Plan, CMS, or the State 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-IDD Plan, CMS, or the State 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 the State 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-IDD Plan shall comply with the Standard Terms and Conditions as specified in Appendix I.
- 5.3.22. The FIDA-IDD 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-IDD 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-IDD Plan becomes barred, suspended, or excluded from participation in this transaction, the FIDA-IDD Plan shall, within thirty (30) calendar days after becoming barred, suspended or excluded, provide to the State a written description of each offense causing the exclusion, the 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-IDD 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-IDD 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-IDD 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-IDD Plan's request from the Department's Bureau of Fiscal Operations.

5.3.24.3. The FIDA-IDD 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 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.

5.3.25. The FIDA-IDD Plan certifies that it has accurately completed the NY state anti-lobbying certification on Appendix I, #24.

5.3.26. The FIDA-IDD Plan certifies that funds provided pursuant to this Agreement shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

5.4. Record Retention, Inspection, and Audit

5.4.1. The FIDA-IDD 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-IDD Plan must make the records maintained by the FIDA-IDD Plan and its Provider Network, as required by CMS and the State and other regulatory agencies, available to CMS and the State and its agents, designees or FIDA-IDD Plans or any other authorized representatives of New York State or the United States Government, or their designees or FIDA-IDD 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-IDD Plan.

5.4.3. The FIDA-IDD 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-IDD Plan and its First Tier, Downstream and Related Entities that pertain to: the ability of the FIDA-IDD Plan to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The FIDA-IDD 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 the State may require, in a manner that meets CMS and the State's record maintenance requirements.

5.4.5. The FIDA-IDD Plan must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, the State 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 State or CMS Termination With Cause

5.5.1.1. In addition to the grounds for termination under 42 C.F.R. § 422.510(a), the State and CMS shall have the right to terminate this Contract, in whole or in part if the FIDA-IDD 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 credible 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-IDD Plan has its Certificate of Authority suspended, limited or revoked by the State;

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) calendar days, or to such longer period as the parties may agree, of the State'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-IDD Plan's equity, or has an employment, consulting, or other agreement with such a person for the provision of Covered Items and/or Services that are significant to the FIDA-IDD 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 State and CMS will notify the FIDA-IDD Plan of its intent to terminate this Contract for the FIDA-IDD Plan's failure to meet the requirements of this Contract and provide FIDA-IDD Plan with a hearing prior to the termination.
- 5.5.1.3. If State suspends, limits, or revokes FIDA-IDD Plan's Certificate of Authority under PHL Article 44, and:
- 5.5.1.3.1. If such action results in the FIDA-IDD Plan ceasing to have authority to serve the entire contracted Service Area, as defined by Appendix H of this Contract, this Contract shall terminate on the date the FIDA-IDD Plan ceases to have such authority; or
- 5.5.1.3.2. If such action results in the FIDA-IDD Plan retaining authority to serve some portion of the contracted Service Area, the FIDA-IDD 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-IDD Plan ceases to have authority to serve.
- 5.5.1.4. No hearing will be required if this Contract terminates due to State suspension, limitation, or revocation of the FIDA-IDD Plan's Certificate of Authority.
- 5.5.1.5. Prior to the effective date of the termination, the State shall notify Participants of the termination or delegate responsibility for such notification to the FIDA-IDD Plan, and such notice shall include a statement that Participants may disenroll immediately from the FIDA-IDD Plan's Demonstration Plan.
- 5.5.1.6. The State reserves the right to terminate this Contract in the event it is found that the certification filed by the FIDA-IDD 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-IDD Plan in accordance with the written notification terms of this Contract.

5.5.2. FIDA-IDD Plan and the State/CMS Initiated Termination

5.5.2.1. The FIDA-IDD Plan and the State/CMS each shall have the right to terminate this Contract in the event that the State/CMS and the FIDA-IDD Plan fail to reach agreement on the monthly Capitation Rates.

5.5.3. FIDA-IDD Plan Initiated Termination

5.5.3.1. All FIDA-IDD 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-IDD Plan shall have the right to terminate this Contract in the event that the State or CMS materially breaches the Contract or fails to comply with any term or condition of this Contract that is not cured within twenty (20) calendar days, or to such longer period as the Parties may agree, of the FIDA-IDD Plan's written request for compliance. The FIDA-IDD Plan shall give the State and CMS 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-IDD Plan.

5.5.3.3. The FIDA-IDD 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 the State and CMS. In such event, FIDA-IDD Plan shall give the State and CMS written notice within ninety (90) calendar 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-IDD Plan.

5.5.3.4. The FIDA-IDD Plan shall have the right to terminate this Contract in its entirety or in specified counties of the FIDA-IDD Plan's Service Area if the FIDA-IDD Plan is unable to provide the Combined Medicare Advantage and FIDA-IDD Plan Benefit 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-IDD Services within the FIDA-IDD Plan's organization, and, after diligent efforts, the FIDA-IDD Plan cannot make other provisions for the delivery of such services. The FIDA-IDD Plan shall give the State written notice of any such termination that specifies:

5.5.3.4.1. 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;

5.5.3.4.2. The FIDA-IDD Plan's attempts to make other provision for the delivery of FIDA-IDD Covered Items and Services; and

5.5.3.4.3. The effective date of the termination, which shall be at least ninety (90) calendar days after CMS and the State receive the FIDA-IDD 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-IDD 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) calendar days after the FIDA-IDD Plan receives written notice of the reduction in payment, unless available funds are insufficient to continue payments in full during the ninety (90) calendar day period, in which case the State shall give the FIDA-IDD 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-IDD Plan on or before the effective date of the termination of the Contract.

5.5.5. Termination without Prior Notice

5.5.5.1. In the event the FIDA-IDD 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 the State may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or the State 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 the State determine that participation of the FIDA-IDD 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 State, without prior notice, may immediately terminate this Contract, suspend the FIDA-IDD Plan from participation, withhold any future payments to the FIDA-IDD 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 State that the FIDA-IDD 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 the State may terminate this Contract without cause upon no less than ninety (90) calendar days prior written notice to the other Party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the FIDA-IDD 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 and the State 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 the State 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 the State 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-IDD 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-IDD 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) calendar days' notice due to a material breach of a provision of this Contract unless CMS or the State determines that a delay in termination would pose an imminent and serious risk to the health of the Participants enrolled with the FIDA-IDD Plan or the FIDA-IDD 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 the State 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-IDD Plan may request a pre-termination hearing or develop and implement a corrective action plan. CMS or the State must:

5.5.8.2.1. Give the FIDA-IDD 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-IDD 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 the State may terminate this Contract upon thirty (30) calendar 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-IDD Plan otherwise withdraws from the Medicare or New York State Medicaid programs, the FIDA-IDD 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-IDD Plan's Demonstration Plan; provided, however, that CMS and the State 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 the State, or both, elect to terminate or not renew this Contract, CMS and the State will be responsible for notifying all Participants covered under this Contract of the date of termination and the process by which those Participants will continue to receive care. If the FIDA-IDD Plan elects to terminate or not renew the Contract, the FIDA-IDD 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-IDD Plan must promptly return to CMS and the State all payments advanced to the FIDA-IDD Plan for Participants after the effective date of their disenrollment; and

5.5.10.2.3. The FIDA-IDD Plan must supply to CMS and NYSDOH all information necessary for the payment of any outstanding claims

determined by CMS and the State to be due to the FIDA-IDD 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-IDD Plan shall comply with the phase-out plan that the FIDA-IDD Plan has developed and that the State and CMS have approved.
- 5.5.11.2. The FIDA-IDD 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-IDD Plan shall assist Participants by referring them, and by making their Comprehensive Health Record available as appropriate to health care Providers and/or programs;
- 5.5.11.4. The FIDA-IDD 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-IDD 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-IDD Plan shall provide such other reasonable assistance as the State or CMS may request affecting that transaction.
- 5.5.11.7. Upon completion of LPs 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-IDD 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-IDD Plan's Service Area, and in the event that it is not scheduled for renewal, the FIDA-IDD Plan shall comply with close-out procedures that the FIDA-IDD Plan develops in conjunction with LDSS, and the State, and CMS has approved. The close-out procedures shall include the following:

- 5.5.12.1.1. The FIDA-IDD Plan shall promptly account for and repay funds advanced by the State and CMS for coverage of Participants for periods subsequent to the effective date of termination;
- 5.5.12.1.2. The FIDA-IDD Plan shall give the State and CMS, and other authorized Federal, state or local agencies access to all books, records, and other documents and upon request, portions of such books, records, or documents that may be required by such agencies pursuant to the terms of this Contract;
- 5.5.12.1.3. The FIDA-IDD Plan shall submit to the State and CMS, and other authorized Federal, State or local agencies, within ninety (90) calendar days of termination, a final financial statement and audit report relating to this Contract, made by a certified public accountant, unless the FIDA-IDD Plan requests of the State and CMS and receives written approval from the State 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. The State and CMS shall promptly pay all claims and amounts owed to the FIDA-IDD 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, NYSDOH, and OPWDD Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Participants (signed on 11.05.2015); and
 - 5.6.1.3. Any State or Federal Requirements or Instructions or updates thereto released to FIDA-IDD Plans. Examples 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. Appendix I, the Standard Clauses for New York State Contracts.
Notwithstanding any provision to the contrary, however, the parties agree that clauses 4-13 and clauses 16-26 of Appendix I, the Standard Clauses for New York State Contracts, do not apply to CMS, HHS, or any other agency of the Federal government;
 - 5.6.2.2. The Contract terms and conditions, including all other appendices.
 - 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.
 - 5.6.2.6. Notwithstanding the foregoing, if there is any conflict in any of the documents listed above between the federal requirements regarding this agreement and any State requirements, the federal requirements shall prevail.
- 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**

- 5.7.1. This Contract shall be in effect from January 1, 2018, and, so long as the FIDA-IDD Plan has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the FIDA-IDD 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 December 31, 2020. This contract will terminate, or its effectuation will be delayed, unless NYSDOH receives all necessary approvals from CMS, including but not limited to Section 1115(a) demonstration authority, and unless the FIDA-IDD Plan is deemed ready to participate in the FIDA-IDD Demonstration, as provided for in Section 2.2.1 of this Contract. Funds must not be expended or awarded until the State 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

5.8.1. 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.

5.8.2. 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

To: State of New York, Department of Health
Jason A. Helgeson
Medicaid Director, OHIP
One Commerce Plaza, Suite 1211
Albany, NY 12210

Copies to:

Andrew Segal, Director, DLTC
One Commerce Plaza, Room 1620
Albany, NY 12210

To:

Electronic copies to:

CONTRACT NO.:

IN WITNESS WHEREOF, CMS, the NYSDOH, and the FIDA-IDD Plan hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

[Health Plan Name], SIGNATURE

STATE AGENCY SIGNATURE

By: _____

By: _____

Printed Name

Printed Name

Title: _____

Title: _____

Date: _____

Date: _____

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

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

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

Notary
Approved:

Approved:

ATTORNEY GENERAL

Thomas P. DiNapoli
STATE COMPTROLLER

Title: _____

Title: _____

Date: _____

Date: _____

In Witness Whereof, CMS, the State, and [Health Plan Name], have caused this Contract to be executed by their respective authorized officers:

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

Kathryn Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

In Witness Whereof, CMS, the State, and [Health Plan Name], have caused this Contract to be executed by their respective authorized officers:
United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

Section 6: Appendices

APPENDIX A - COVERED ITEMS AND SERVICES

1.1. Amendments

1.1.1. 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.

1.1.2. Any Amendment must be approved by the New York State Attorney General and Comptroller.

1.2. Medical Necessity. The FIDA-IDD Plan shall provide services to Participants as follows:

1.2.1. The FIDA-IDD 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 and the IDT Policy.

1.2.2. The FIDA-IDD Plan must provide all Covered Items and Services that are Medically Necessary, including but not limited to, those Covered Items and Services that:

1.2.3. 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.

1.2.4. Notwithstanding this definition, the FIDA-IDD Plan will provide coverage in accordance with the more favorable of the current Medicare and State coverage rules, as outlined in the State and Federal rules and coverage guidelines.

1.2.5. All care must be provided in accordance and compliance with the ADA, as specified by the Olmstead decision.

1.2.6. The FIDA-IDD 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 Items or Services.

- 1.2.7. The FIDA-IDD Plan and IDT 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.
- 1.2.8. The FIDA-IDD Plan and IDT shall not deny authorization for a Covered Item or Service that the Participant or the Provider demonstrates is Medically Necessary.
- 1.2.9. The FIDA-IDD Plan or the IDT may place appropriate limits on a Covered Item or Service, as relates to a given Participant. Any limits must be made 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-IDD Plan's Medical Necessity guidelines must, at a minimum, be:
 - 1.2.9.1. Developed with input from practicing Physicians in the Demonstration Plan's Service Area;
 - 1.2.9.2. Developed in accordance with standards adopted by national accreditation organizations;
 - 1.2.9.3. Developed in accordance with the definition of Medical Necessity in this Appendix;
 - 1.2.9.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
 - 1.2.9.5. Evidence-based, if practicable; and
 - 1.2.9.6. Applied in a manner that considers the individual health care needs of the Participant.
- 1.2.10. The FIDA-IDD Plan's Medical Necessity guidelines, program specifications and service components for Behavioral Health Services must, at a minimum, be submitted to the State 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.
- 1.2.11. Community-based LTSS 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 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 LP, 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.

1.2.12. Covered Items and Services. The FIDA-IDD Plan agrees to provide Participants access to the following Covered Items and Services:

- 1.2.12.1. 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.
- 1.2.12.2. All Home and Community Based Waiver Services as Specified in Appendix A
- 1.2.12.3. All Items and Services provided under Medicare Part A
- 1.2.12.4. All Items and Services provided under Medicare Part B
- 1.2.12.5. All Items and Services provided under Medicare Part D
- 1.2.12.6. 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 MOU or the Contract, Part D requirements will continue to apply.
- 1.2.12.7. All other items and services identified in this Appendix and this Contract.
- 1.2.12.8. As a term and condition of this Demonstration, the FIDA-IDD 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 A-1 provides a list of FIDA-IDD Demonstration Covered Item and Services. Table A-1 will be updated to address any changes due to State Plan Amendments, 1115(a) demonstration amendments, and 1915(c) waiver amendments during the Demonstration.

- 1.2.12.9. The FIDA-IDD Plan must provide Medicaid coverage for all items and services that are covered by Medicare Parts A and B except as noted here or in the annual FIDA-IDD 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.
- 1.2.12.10. All Covered Items and Services must be covered in accordance with current State 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-IDD Plan shall comply with any changes made during the Demonstration. The FIDA-IDD Plan is required to maintain compliance with all applicable State and Federal policies around applicable Covered Items and Services definitions and coverage rules.
- 1.2.12.11. All Medically Necessary physical, OPWDD, and Behavioral Health Services and all necessary long-term supports and services are to be provided at no cost to the Participant.
- 1.2.12.12. Supplemental Benefits in Addition to Required Covered Items and Services. The FIDA-IDD Plan may request State and CMS approval to provide supplemental benefits in addition to all required Covered Items and Services listed in Table A-1. The approval must be sought annually and must apply to a full calendar year of the Demonstration. If approval is granted, the FIDA-IDD Plan must cover the approved Supplemental Benefits in Addition to Required Covered Items and Services as approved for the calendar year.
- 1.2.12.13. Court-Ordered Services. The FIDA-IDD 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-IDD Plan at the Medicaid fee schedule. The FIDA-IDD 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, DISCO, and Medicaid Advantage Plus covered services.

1.2.12.14. All required Covered Items and Services are listed in Table A-1.

1.2.12.15. All Covered Items and Services definitions are provided in Table A-2.

Table A-1 FIDA-IDD Demonstration Covered Items and Services

Abdominal Aortic Aneurism Screening	Medicaid Pharmacy Benefits as Allowed by State Law
Adult Day Health Care	Medical Nutrition Therapy
AIDS Adult Day Health Care	Medication Therapy Management
Ambulance	Medicare Part B Prescription Drugs
Ambulatory Surgical Centers	Medicare Part D Prescription Drug Benefit as Approved by CMS
Assertive Community Treatment (ACT)	Mobile Mental Health Treatment (Medicare)
*Assistive Technology/ Adaptive Technology	Non-Emergency Transportation
Bone Mass Measurement	+Nursing Facility (Medicaid)
Breast Cancer Screening (Mammograms)	Nursing Hotline
Cardiac Rehabilitation Services	Nutrition (includes Nutritional Counseling and Educational Services)
Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)	Obesity Screening and Therapy to Keep Weight Down
Cardiovascular Disease Screening and Testing	Opioid Treatment
+Care Management	OPWDD Certified Outpatient Clinic
Cervical and Vaginal Cancer Screening	Other Health Care Professional Services
Chemotherapy	Other Supportive Services the Interdisciplinary Team Determines Necessary

Chiropractic	Outpatient Blood Services
Colorectal Screening	Outpatient Hospital Services
*Community Habilitation Agency Purchased Agency Supported	Outpatient - Medically Supervised Withdrawal- Substance Abuse
*Community Transition	Outpatient Mental Health
Consumer Directed Personal Assistance Services	Outpatient Rehabilitation (OT, PT, Speech)
*Day Habilitation	Outpatient Substance Abuse Care
Day Treatment (Continuing)	Outpatient Surgery
	Palliative Care
Day Treatment (OPWDD)	Pap Smear & Pelvic Exams
Defibrillator (implantable automatic)	Partial Hospitalization (Medicaid)
Dental	Partial Hospitalization (Medicare)
Depression Screening (Medicare)	*Pathways to Employment
+Developmental Center	Personal Care Services
Diabetes Monitoring (Self-Management Training)	Personal Emergency Response Services (PERS)
Diabetes Screening	Personalized Recovery Oriented Services (PROS)
Diabetes Supplies	Podiatry
Diabetic Therapeutic Shoes or Inserts	Primary Care Physician
Diagnostic Testing	*Pre-Vocational Services
Directly Observed Therapy for Tuberculosis	Preventive Services
Durable Medical Equipment (DME)	Private Duty Nursing
Emergency Care	Prostate Cancer Screening
*Environmental Modification	Prosthetics
Family Planning Services +	Pulmonary Rehabilitation Services
*Fiscal Intermediary	Remote Access Technology
Health/Wellness Education	*Residential Habilitation Supervised IRA Supportive IRA Family Care Home
Hearing Services	Respiratory Care Services
HIV Screening	*Respite Free Standing Hourly Agency Purchased

	Agency Supported
Home Health	Routine Physical Exam 1/year
Home Infusion Bundled Services	*Self-Direction (Managed by Fiscal Intermediary) Fiscal Intermediary Support Brokerage Live-In-Caregiver Individual Directed Goods and Services Community Habilitation Supported Employment (Intensive & Extended) Respite Community Transition Services
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs	Sexually Transmitted Infections (STIs) Screening and Counseling
Home Visits by Medical Personnel	Skilled Nursing Facility
ICF/IID	Smoking and Tobacco Cessation
Immunizations	Specialist Office Visits
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Substance Abuse Therapy
Inpatient Mental Health Care	*Supported Employment Intensive One to One Agency Purchased Agency Supported Group *Supported Employment Extended One to One Agency Purchased Agency Supported Group
Inpatient Mental Health over 190-day Lifetime Limit (Medicare)	Telehealth

Inpatient Services during a Non-covered Inpatient Stay	Transportation
*Intensive Behavioral Services	Urgent Care
Kidney Disease Services (including End Stage Renal Disease services)	*Vehicle Adaptation/Modification
Lung cancer screening	"Welcome to Medicare" Preventive Visit
Mammograms	Wellness Counseling
Medical Social Services	

Table A-2 FIDA-IDD 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.
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

	<p>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.</p>
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

	<p>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 meaningful way. All ACT referrals per regulation are received through the local single point of access process (SPOA).</p>
Assistive Technology - Adaptive Devices	<p>Assistive Technology - Adaptive Devices means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive Device - Adaptive Device service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. The devices and services must be documented in the participant's LP as being essential to the person's habilitation, ability to function, or safety and essential to avoid or delay institutionalization.</p>
Bone Mass Measurement	<p>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.</p>
Breast Cancer Screening (Mammograms)	<p>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.</p>
Cardiac Rehabilitation Services	<p>Comprehensive programs that include exercise, education, and counseling are</p>

	covered for members who meet certain conditions with a doctor's 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):	One visit per year with Participant's primary care doctor to help lower Participant's risk for cardiovascular disease. During this visit, Participant's doctor may discuss aspirin use (if appropriate), check Participant's blood pressure, and provide tips to make sure Participant is 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.
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 Participant is at high risk for cervical or vaginal cancer, or if Participant is 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 Participant is 50 or over and once every 24 months if Participant is at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy), colonoscopy (once every 24 months if Participant is at high risk for colorectal cancer. If Participant 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 Participant is 50 or older), or flexile sigmoidoscopy (once every 48 months for most people 50 or older. If the Participant isn't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy).
Community Transitional Services	Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those

	<p>reasonable and necessary to enable a person to establish a basic household. Items purchased are the property of the individual receiving the service. The service must be identified in the Life Plan.</p>
<p>Consumer Directed Personal Assistance Services</p>	<p>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 in a Participant directed manner. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Participants who choose CDPAS 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. Participants 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 Participant 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.</p>
<p>Day Treatment Continuing</p>	<p>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</p>

	<p>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.</p>
Day Treatment OPWDD	<p>A combination of diagnostic and treatment services provided to persons with developmental disabilities in need of a broad range of clinically supported and structured habilitation services</p>
Defibrillator (implantable automatic)	<p>Defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.</p>
Dental (Preventive Dental and Comprehensive Dental)	<p>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.</p>
Depression Screening	<p>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.</p>
Diabetes Monitoring (Self-Management Training)	<p>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.</p>

Diabetes Screening	<p>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.</p>
Diabetes Services and Supplies	<p>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).</p>
Diabetic Therapeutic Shoes or Inserts	<p>Diabetic therapeutic shoes or 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 provided with such shoes). It also includes fitting the therapeutic custom-molded shoes or depth shoes and training to help Participants manage their diabetes, in some cases.</p>
Diagnostic Testing	<p>Diagnostic testing diagnostic tests, like CT scans, MRIs, EKGs, and X-rays, when a doctor or health care Provider orders</p>

	<p>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.</p>
<p>Durable Medical Equipment (DME)</p>	<p>Durable Medical Equipment and Medical-Surgical Supplies must be ordered by a qualified practitioner. 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.</p> <p>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 is imposed and benefit includes non-Medicare covered DME (e.g. tub stool, grab bars, over toilet commodes, shower chairs). DME for short term or trial use must be rented.</p> <p>Medical-Surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical</p>

	<p>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 is fed via nasogastric, gastrostomy or jejunostomy tube and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. 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.)</p>
<p>Emergency Care</p>	<p>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.</p>
<p>Environmental Modifications and Adaptive Devices</p>	<p>Those physical adaptations to the participant's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and without which the person would require</p>

institutionalization and/or more restrictive and expensive living arrangement. Adaptations include: installation of ramps, hand rails and grab-bars, widening of doorways, modifications of bathroom facilities, installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient, lifts and related equipment, elevators when no feasible alternative is available, automatic or manual door openers/bells, modifications of the kitchen necessary for the participant to function more independently in his home, medically necessary air conditioning, braille identification systems, tactile orientation systems, bed shaker alarm devices, strobe light smoke detection and alarm devices, small area drive-way paving for wheel-chair entrance/egress from van to home, safe environment modifications for behaviorally challenged participants including window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems and shatter-proof shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

<p>Family Planning Services</p>	<p>Includes: all types of birth control: pills, condoms, diaphragms, IUDs, Depo Provera, Norplant, and contraceptive foams; emergency contraception; 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. Termination of pregnancy may be provided only as allowed by applicable state and federal law and regulation, and sterilization services may be provided only as allowed by State and federal law (42 C.F.R. Part 441, Subpart E). *As part of a family planning visit</p>
<p>Fiscal Intermediary (FI)</p>	<p>An entity that has a contract with the FIDA-IDD 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 for Participants receiving DDPAS services. See also OPWDD FI for self-directed services through the Section 1915 (c) OPWDD Comprehensive Waiver</p>
<p>Health/Wellness Education/ Health Education</p>	<p>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</p>

	Participant; and 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 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. 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 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 LP.
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-IDD Plan as a medical benefit.
Home Visits by Medical Personnel	<p>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.</p> <p>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</p>

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 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

	<p>provided to the Participant and increases the efficiency of medication management, all of which promote the Participant's ability to remain at home.</p> <p>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.</p> <p>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 to meet the Participant's medical needs and/or other significant findings. The IDT will utilize this information in revising the Participant's LP.</p>
<p>Immunizations</p>	<p>Flu (one shot per flu season in the fall or winter), hepatitis B vaccine for people who are at risk, Pneumonia vaccine.</p>
<p>Inpatient Hospital Care Acute - Including Substance Abuse and Rehabilitation Services</p>	<p>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.</p>

	<p>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 and under the supervision of the IDT and/or FIDA-IDD Plan.</p>
<p>Inpatient Hospital Psychiatric/ Inpatient Mental Health and Inpatient Mental Health Over 190-Day Lifetime Limit</p>	<p>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.</p> <p>All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190-Day Lifetime Limit. The FIDA-IDD Plan may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the New York State P.H.L.</p>
<p>Intensive Psychiatric Rehabilitation Treatment Programs</p>	<p>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</p>

	technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR, Part 587.
Intermediate Care Facility-IID	A facility for individuals who 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).
Inpatient Services during a Non-covered Inpatient Stay	<p>If Participant has exhausted Participant's inpatient benefits or if the inpatient stay is not Medically Necessary such that FIDA-IDD Plan will not cover Participant's inpatient stay, in some cases, FIDA-IDD Plan will cover certain services received while in the hospital or the skilled nursing facility (SNF) stay. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> 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 Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and

	<p>replacements required because of breakage, wear, loss, or a change in the Participant's physical condition</p> <p>Physical therapy, speech therapy, and occupational therapy</p>
Kidney Disease Services (including ESRD)	<p>Covered services include:</p> <p>Kidney disease education services to teach kidney care and help Participants make informed decisions about their care. For Participants with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</p> <p>Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area)</p> <p>Inpatient dialysis treatments (if Participant is admitted as an inpatient to a hospital for special care)</p> <p>Self-dialysis training (includes training and helping with Participant's home dialysis treatments)</p> <p>Home dialysis equipment and supplies</p> <p>Certain home support services (such as, when necessary, visits by trained dialysis workers to check on Participant's home dialysis, to help in emergencies, and check Participant's dialysis equipment and water supply)</p> <p>Certain drugs for dialysis.</p>
Lung cancer screening	<p>The plan will pay for lung cancer screening every 12 months for Participants ages 55-77 if the Participant</p> <p>1) smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer <i>or</i> smoke now or have quit within the last 15 years and 2) has a counseling and shared decision-making visit with the Participant's doctor or other qualified provider. After the first screening, the</p>

	plan will pay for another screening each year with a written order from the Participant's doctor or other qualified provider.
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 as identified on the State Specific ADD File.
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 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 order. A physician must prescribe these services and renew the 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

	<p>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</p> <p>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.</p>
<p>Medicare Part B Prescription Drugs</p>	<p>These drugs are covered under Part B of Medicare, including the following drugs:</p> <ul style="list-style-type: none"> Drugs injected or infused while getting doctor, hospital outpatient, or ambulatory surgery center services 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

	<p>Certain oral anti-cancer drugs and anti-nausea drugs</p> <p>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents</p> <p>IV immune globulin for the home treatment of primary immune deficiency diseases.</p>
Medicare Part D Prescription Drug Benefit	Drugs defined in 42 C.F.R. § 423.100.
Medication Therapy Management	Medication therapy management services provided to Participants in accordance with subpart D of 42 C.F.R. § 423.
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.
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-IDD Plan. The individuals staffing the nursing hotline have access to all FIDA-IDD Plan Participants' PCSPPCLPs as well as to members of all FIDA-IDD Plan Participants' IDTs. These can be used in assisting Participants access care after hours.

<p>Nutrition</p>	<p>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.</p>
<p>Obesity Screening and Therapy to Keep Weight Down</p>	<p>Intensive counseling is provided to assist with weight loss for a Participant with a body mass index of 30 or more.</p>
<p>Opioid Treatment Services- Substance Abuse</p>	<p>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</p>

	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 that Participant needs and storage and administration.
Outpatient Hospital Services	We cover medically-necessary services Participant gets 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 Participant can't self-administer Provider

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 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 directly access one assessment from a network Provider in a twelve (12) month period without requiring prior authorization.
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 directly access one assessment from a network Provider in a twelve (12) month period without requiring prior authorization.
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	See Cervical and Vaginal Cancer Screening
Partial Hospitalization (Medicaid)	Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient

	<p>hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention. These services are certified by OMH under NYCRR Part 587.</p>
Partial Hospitalization (Medicare)	<p>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 Participant's doctor's or therapist's office and is an alternative to inpatient hospitalization.</p>
PCP Office Visits	<p>Primary care doctor office visits.</p>
Personal Care Services	<p>Personal care services (PCS) include 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.</p>
Personal Emergency Response Services (PERS)	<p>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</p>

	<p>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.</p>
<p>Personalized Recovery Oriented Services (PROS)</p>	<p>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.</p>
<p>Podiatry</p>	<p>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 Participants with conditions affecting the legs, such as diabetes</p>
<p>Preventive Services</p>	<p>Medicare and Medicaid preventive services including those specified in this Appendix A and any others that Medicare and Medicaid cover or may begin to cover during the Demonstration.</p>
<p>Private Duty Nursing</p>	<p>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 the IDT or a qualified practitioner but approved by the IDT or FIDA-IDD Plan and incorporated into the LP. Additional</p>

	<p>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.</p>
<p>Prostate Cancer Screening</p>	<p>Prostate Cancer Screening exams once every 12 months for men age 50 and older.</p>
<p>Prosthetics</p>	<p>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; interferes 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</p>

	<p>benefit limits noted below (no override). Prior authorization is required for some high cost or high utilization items.</p> <p>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 and support during pregnancy.</p> <p>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 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.</p> <p>Prosthetic appliances and devices are appliances and devices, (other than artificial eyes and dentures) which replace any missing part of the body.</p>
Pulmonary Rehabilitation Services	Comprehensive programs of pulmonary rehabilitation are covered for Participants who have moderate to very

	severe chronic obstructive pulmonary disease (COPD) and 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	Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences. Respite services are provided in the following locations: individual's home or place of residence; Family Care home; Medicaid certified ICF/DD; Individualized Residential Alternative (IRA) or Community Residence (CR); and free-standing Respite facility under the auspices of OPWDD.
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

	<p>must be ordered by a primary care doctor 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.</p>
Skilled Nursing Facility	<p>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-IDD 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.</p>
Smoking and Tobacco Cessation Counseling	<p>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.</p>
Specialist Office Visits/Specialty Care	<p>Specialist office visits</p>

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.

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

	<p>programs to provide ongoing supports to individuals with traumatic brain injury.</p> <p>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.</p> <p>All Substance Abuse Programs Services must be documented in the LP 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).</p>
<p>Telehealth/Tele-Monitoring and Web-Phone Based Technology</p>	<p>Coverage of 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.</p>
<p>Transportation Services - Emergency and Non-Emergency Transportation</p>	<p>Transportation provided by an ambulance service, including air ambulance. Emergency transportation if</p>

	<p>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”.</p> <p>Transportation essential for a Participant to obtain necessary medical care and services under the FIDA-IDD 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.</p> <p>Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets to obtain services and goods. Includes State Plan transport.</p>
Urgent Care	<p>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</p>

	<p>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.</p>
<p>Vehicle Adaptation/Modification</p>	<p>Modifications 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.</p> <p>These modifications are approved only when the vehicle is used to improve the Participant's independence and inclusion in the community.</p>
<p>Vision Care Services/Eye Exams and Eye Wear</p>	<p>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.</p>

	<p>If the FIDA-IDD 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-IDD 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-IDD 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). However, the Participant may pay for upgraded lenses as a private customer and have the FIDA-IDD Plan pay for the frames or pay for upgraded frames as a private customer and have the FIDA-IDD 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.</p>
<p>“Welcome to Medicare” Preventive Visit</p>	<p>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.</p>
<p>Wellness Counseling</p>	<p>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</p>

	<p>episodes of disease and utilize health care resources efficiently and effectively. This service differs from Medicaid State Plan Nursing Service as the wellness counseling is provided as a discrete service to medically stable individuals.</p> <p>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.</p> <p>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 State Plan services.</p>
Community Habilitation	<p>Community Habilitation is similar in scope to residential habilitation supports and day habilitation supports, however, the focus of this service is directed towards service delivery occurring in the community (non-certified) settings to facilitate and promote independence and community integration. Community Habilitation is defined as a face to face service in the waiver and in all guidance issued by OPWDD. Therefore, in order for a service to be billed, the staff must be with the individual.</p>

Day Habilitation	Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational or speech therapies in the service plan. In addition, Day Habilitation services may serve to reinforce skills, behaviors or lessons taught in other settings
Directly Observed Therapy for Tuberculosis	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-IDD 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-IDD Plan remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT Provider.
OPWDD Fiscal Intermediary	The Fiscal Intermediary (FI) service is evolved from the Financial Management Services (FMS) from the previous waiver. Any individual eligible for HCBS waiver services may self-direct some or all of their services. The person self-directing receives an individualized portable budget that is directed by the individual pursuant to an approved plan. If an individual chooses to self-hire their own staff, the employer of record must be either the individual or family or the Fiscal Intermediary. An individual must

	<p>choose an FI agency if the following services are included in their budget in order to provide for appropriate billing and claiming: Individual Directed Goods and Services, Live-in Caregiver, Support Brokerage, Community Transition Services, or any type of 100% State-paid items. The most typical set of tasks that the FI supports the individual self-directing is with billing and payment of approved goods and services, fiscal accounting and reporting, ensuring Medicaid and corporate compliance, and general administrative supports. The FI must be approved to provide services for individuals in the 1915 (c) OPWDD Comprehensive Waiver.</p>
<p>Support Brokerage</p>	<p>Support Brokerage is a service available for participants who may self-direct some or all of their services. Start-up Support Brokerage services may be provided to:</p> <ul style="list-style-type: none"> (a) individuals who wish to self-direct some services and request assistance in identifying the supports and services they choose to receive, or (b) individuals who wish to learn about alternatives for residing in and receiving services in the most integrated settings. <p>Support Brokers assist waiver participants (or the participant's family or representative as appropriate) to self-direct and manage some or all of their waiver services and/or to experience the greatest degree of community integration possible.</p>
<p>Live-In-Caregiver</p>	<p>Live-in Caregiver is an unrelated care provider who resides in the same household as the waiver participant and provides as needed supports to address the participant's physical, social, or</p>

	<p>emotional needs in order for the participant to live safely and successfully in his or her own home. The Live-in Caregiver must be unrelated to the participant by blood or marriage to any degree.</p>
<p>Individual Directed Goods and Services</p>	<p>Individual Directed Goods and Services (IDGS) are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses an identified need in an individual’s service plan, which includes improving and maintaining the individual’s opportunities for full membership in the community. Individuals who choose to self-direct their services may receive IDGS as a waiver service. Individuals may manage their IDGS budget, as described in their individualized service plan, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the following criteria:</p> <ul style="list-style-type: none"> • Are related to a need or goal identified in the State-approved person-centered care plan; • Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance; • Promote opportunities for community living and inclusion; • Are able to be accommodated without compromising the participant’s health or safety; and, • Are provided to, or directed exclusively toward, the benefit participant. <p>Service Eligibility Criteria:</p>

	<ul style="list-style-type: none"> • Available for individuals who are self-directing services
<p>Supportive Employment</p>	<p>Supported Employment (SEMP) services are the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage. The outcome of this service is paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided through many different service models. Some of these models can include evidence based supported employment or customized employment for individuals with significant disabilities.</p>
<p>Pathways to Employment</p>	<p>The Pathway to Employment is a person-centered, comprehensive career planning and support service that provides assistance for participants to obtain, maintain or advance in competitive employment or self-employment. The Pathway to Employment service will be available to individuals expressing an interest in competitive employment or self-employment including (but not limited to) individuals who receive Day Habilitation, Pre-Vocational and Supported Employment services, as well as students leaving high school</p>

<p>Residential Habilitation</p>	<p>Residential Habilitation services include activities that are described in the habilitation plan to be implemented and support the waiver participant. The habilitation plans include activities or supports that are designed to help the person pursue or maintain the outcomes in his or her life that have value to the participant. Residential Habilitation services are available to individuals who live at home, in their own home or residence, a family care home, provider managed residential setting, or OPWDD certified residence. The service may be implemented by para-professional and/or professional staff in accordance with the needs of the participant.</p>
<p>Intensive Behavioral Services</p>	<p>Intensive Behavioral Services is a new waiver service, which will be available under the following circumstances:</p> <ul style="list-style-type: none"> (1) For individuals who reside in a non-certified residential location, their own home or family home, or a family care home; and (2) The individual or a party acting on behalf of the individual certifies through written documentation that the individual is at risk of imminent placement in a more restrictive living environment due to challenging behavioral episodes. <p>Intensive Behavioral Services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions and are focused on developing effective behavioral management strategies to ensure health and safety and/or improve quality of life. Intensive Behavioral Services differ from services available through the State Plan as follows: the service will be</p>

	available in the person's home; the service is short-term designed to achieve community stabilization; the service is of high intensity; the intent is to develop effective behavioral strategies that will be maintained, if necessary, through transitioning to other appropriate services to help the person to sustain the behavioral strategies long-term.
Pre-Vocational Services	Prevocational Services are those services that provide learning and work experiences, including volunteering, where participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and their service and supports planning team through an ongoing person-centered planning process.

+ Family Planning - In accordance with 42 C.F.R. § 431.51(b)(2), a Participant can choose any doctor or clinic that offers family planning services in or out of the FIDA-IDD Plan's provider network.

Nursing Facility (Medicaid) - Benefit available once enrolled in the FIDA-IDD Plan

Developmental Center - Benefit available once enrolled in the FIDA-IDD Plan for up to ninety (90) continuous days. Participant then must be disenrolled.

Care Management - A benefit provided by the FIDA-IDD Plan for Participants

*Waiver service

1.2.12.16. A.3 Description of Non-Covered Items and Services.

1.2.12.16.1. The following services are excluded from the FIDA-IDD Demonstration Covered Items and Services but, are covered by Medicare or Medicaid fee-for-service. The IDT and FIDA-IDD Plan

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 LP:

1.2.12.16.2. Hospice Services

- 1.2.12.16.2.1. Hospice services provided to FIDA-IDD 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.
- 1.2.12.16.2.2. 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 LP and reflect the changing needs of the Participant/family.
- 1.2.12.16.2.3. If a Participant in the FIDA-IDD Plan becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access the FIDA-IDD Plan's Benefit Package while Hospice costs are paid for by Medicare fee-for-service.
- 1.2.12.16.2.4. The FIDA-IDD 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 LP and determined by the IDT. The FIDA-IDD Plan will have the flexibility to cover Items or Services that are not traditionally included as Medicare or Medicaid Covered Items and Services but that are necessary and appropriate for the Participant.

1.2.12.16.2.5. Free - Standing Birth Centers – 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 provided services by the facility.

APPENDIX B – PARTICIPANT RIGHTS AND RESPONSIBILITIES

The FIDA-IDD 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:

- 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;
- To receive timely access to care and services;
- To request and receive written and oral information about the FIDA-IDD Plan, it's Participating Providers, its benefits and services and the Participants' rights and responsibilities in a manner the Participant understands.
- To receive materials and/or assistance in a foreign language and in Alternative Formats, if necessary.
- To be provided qualified interpreters, free of charge, if a Participant needs interpreters during appointments with Providers and when talking to the FIDA-IDD Plan;
- To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;
- To not be discriminated against on the basis of and to get care without regard to sex, race, ethnicity, health status, disability, color, age, national origin, culture, language, sexual orientation, gender identity, marital status or religion;
- 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-IDD Plan network;
- To complain to the State 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;
- To be advised in writing of the availability of the State 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.

- To appoint someone to speak for him/her about the care he/she needs.
- To be informed of all rights, and the right to exercise such rights, in writing prior to the Effective Date of Enrollment;
- To participate in his/her care planning and participate in any discussions around changes to the Person-Centered Life Plan, if/when they are warranted;
- To recommend changes in policies and services to agency personnel, the State or any outside representative of the Participant choice;
- To have telephone access to a nursing hotline and on-call Participating Providers 24/7 in order to obtain any needed emergency or urgent care or assistance;
- 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;
- To receive reasonable accommodations in accessing care, in interacting with the FIDA-IDD Plan and Providers, and in receiving information about one's care and coverage;
- To see a specialist and request to have a specialist serve as Primary Care Provider;
- 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.
- 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.
- To receive a written explanation if Covered Items or Services were denied, without having to request a written explanation.
- 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-IDD Plan be sent by alternative means or to an alternative address;
- Participant is provided a copy of the FIDA-IDD 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-IDD Plan;
- To seek and receive information and assistance from the independent, conflict free Participant Ombudsman;
- To make decisions about Providers and coverage, which includes the right to choose and change Providers within the FIDA-IDD 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-IDD Plan or making other changes in coverage);
- To be informed at the time of enrollment and at LP 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-IDD Plan and its Participating Providers honor it; and
- To access information about the FIDA-IDD Plan, its network of Providers, and Covered Items and Services including:
 - information about the FIDA-IDD 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.
- The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
- 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.
- The right to have a voice in the governance and operation of the FIDA-IDD Plan system, Provider or health plan, as detailed in this Contract.
- 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:

- Receive an in-person upon enrollment in the FIDA-IDD Plan and to participate in the development and implementation of a LP. Participants, or their designated representative, also have the right to request a CR by the FIDA-IDD Plan, and to be fully involved in any such CR.
- Receive complete and accurate information on his or her health and Functional Status by the Interdisciplinary Team.
- 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:
 - Before Enrollment.
 - At Enrollment.
 - At the time an Eligible Individual's or Participant's needs necessitate the disclosure and delivery of such information in order to allow the Eligible Individual or Participant to make an informed choice.
- Be encouraged to involve caregivers or family members in treatment discussions and decisions.
- 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.
- 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-IDD Plan and its Providers or the State Agency or CMS provide, or arrange for the provision of, medical services to the Participant.
- The right to receive timely information about FIDA-IDD 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(g) and (h).
- The right to be protected from liability for payment of any fees that are the obligation of the FIDA-IDD Plan.
- The right not to be charged any cost sharing for Medicare Parts A and B services.

FIDA-IDD Participants have the following responsibilities:

- To try to understand Covered Items and Services and the rules around getting Covered Items and Services;
- To tell Providers that they are enrolled in a FIDA-IDD Plan and show their FIDA-IDD Plan ID card;
- To treat Providers and employees of the FIDA-IDD Plan with respect;
- To communicate problems immediately to the FIDA-IDD Plan;
- To keep appointments or notify the Interdisciplinary Team if an appointment cannot be kept;
- To supply accurate and complete information to the FIDA-IDD Plan's employees;
- To actively participate in LP development and implementation;
- To notify the State and the FIDA-IDD 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;
- To ask questions and request further information regarding anything not understood;
- To use the FIDA-IDD Plan's Participating Providers for services included in the FIDA-IDD Plan Benefit Package;
- To notify the FIDA-IDD Plan of any change in address or lengthy absence from the area;
- To comply with all policies of the FIDA-IDD Plan as noted in the Participant Handbook;
- If sick or injured, to call their doctors or care coordinators for direction right away;
- In case of emergency, to call 911; and
- If Emergency Services are required out of the service area, to notify the FIDA-IDD Plan as soon as possible

APPENDIX C: RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

- The FIDA-IDD Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on the FIDA-IDD 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 438.3(j).
- The FIDA-IDD Plan shall specifically ensure:
 - HHS, the Comptroller General, NYSDOH, OPWDD, 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
 - HHS's, the Comptroller General's, NYSDOH, OPWDD, 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.
- The FIDA-IDD Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
 - Participant protections that include prohibiting Providers from holding a Participant liable for payment of any fees that are the obligation of the FIDA-IDD Plan or any balances unpaid by the FIDA-IDD Plan, as improper/inappropriate billing (sometimes previously referred to as balance billing) is prohibited;
 - Language that any services or other activity performed by a First Tier, Downstream and Related Entities must be in accordance with the FIDA-IDD Plan's contractual obligations to CMS and the State;
 - Language that specifies the delegated activities and reporting requirements;
 - Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, the State or the FIDA-IDD Plan determine that such parties have not performed satisfactorily;

- Language that specifies the performance of the parties is monitored by the FIDA-IDD Plan on an ongoing basis and the FIDA-IDD Plan must impose corrective action as necessary;
 - Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Participant Privacy and confidentiality of Participant health records; and
 - Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.
- The FIDA-IDD 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:
 - The credentials of medical professionals affiliated with the party or parties will be reviewed by the FIDA-IDD Plan; or
 - The credentialing process will be reviewed and approved by the FIDA-IDD Plan and the FIDA-IDD Plan must audit the credentialing process on an ongoing basis.
- The FIDA-IDD 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-IDD Plan retains the right to approve, suspend, or terminate any such arrangement.
- The FIDA-IDD Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that neither the FIDA-IDD 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-IDD 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-IDD Plan or Participant.
- The FIDA-IDD Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the FIDA-IDD Plan shall provide a written statement to a Provider of the reason or reasons for termination with cause.
- The FIDA-IDD 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:
 - Language that the FIDA-IDD Plan is obligated to pay contracted medical Providers under the terms of the contract between the FIDA-IDD 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-IDD Plan and the relevant medical Provider in compliance with 42 C.F.R. § 447.45(d);

- Language that services must be 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;
- Language that services must be accessible to all Participants and that reasonable accommodations must be provided to all Participants who require them;
- 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;
- Language describing to the Participant Ombudsman and the rights of the Participants to contact the Participant Ombudsman for information and assistance;
- Language describing the Participants' Rights;
- Language describing required training for Providers;
- Language describing criminal background checks for Providers;
- Language describing mandatory reporting requirements and procedures for Providers as pertains to known or suspected abuse and neglect of Participants;
- 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;
- 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;
- Language that medical Providers maintain Participant records and information in an accurate and timely manner;
- Language that medical Providers ensure timely access by Participants to the records and information that pertain to them;
- 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;
- Language that clearly state the medical Providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA;
- 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;

- Language that prohibits the FIDA-IDD 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:
 - 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-IDD Plan's health benefit plans as they relate to the needs of such Provider's patients; or
 - 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-IDD Plan for services provided to the patient;
- Language that states the Provider is not required to indemnify the FIDA-IDD 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-IDD Plan based on the FIDA-IDD Plan's management decisions, utilization review provisions or other policies, guidelines or actions;
- Language that states the FIDA-IDD Plan shall require Providers to comply with the FIDA-IDD Plan's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
- Language that states the FIDA-IDD Plan shall notify Providers in writing of modifications in payments, modifications in Covered Items and Services or modifications in the FIDA-IDD 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-IDD Plan and the Provider or unless such change is mandated by CMS or the Department without 30 days prior notice;
- 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-IDD 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

- The Provider shall not profit from provision of Covered Items and Services that are not Medically Necessary or medically appropriate.
- The FIDA-IDD Plan shall not profit from denial or withholding of Covered Items and Services that are Medically Necessary or medically appropriate.
- Language that states that no payment shall be made by the FIDA-IDD Plan to a Provider for a Provider Preventable Condition; and
- 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-IDD Plan. The Provider shall comply with such reporting requirements to the extent the Provider directly furnishes services.
- Language that states the FIDA-IDD 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.
- 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-IDD Plan to assist Participants in keeping their appointments.
- 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.
- 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 this section.
- The FIDA-IDD Plan shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers includes language that prohibits the FIDA-IDD 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:
 - Stop-loss protection;
 - Minimum patient population size for the Physician or Physician group;
 - and

- Identification of the health care services for which the Physician or Physician group is at risk.
- The FIDA-IDD 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.
- Nothing in this section shall be construed to restrict or limit the rights of the FIDA-IDD 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.

**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 [Health Plan Name], the State of New York, acting by and through the State of New York Department of Health (State/NYSDOH), and a Medicare-Medicaid Managed Care Organization (hereinafter referred to as FIDA-IDD Plan) agree to incorporate as part of the contract [] governing FIDA-IDD 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-IDD 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.

**Article I
Voluntary Medicare Prescription Drug Plan**

FIDA-IDD Plan agrees to operate one or more Medicare Voluntary Prescription Drug Plan 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-IDD 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.

CMS agrees to perform its obligations to FIDA-IDD 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.

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-IDD Plan. This provision does not apply to new requirements mandated by statute

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-IDD Plan, New York State, and CMS.

Article II

Functions to be Performed by FIDA-IDD Plan

A. ENROLLMENT

1. FIDA-IDD 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-IDD Plan's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. FIDA-IDD 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-IDD Plan also agrees to provide Part D benefits as described in FIDA-IDD Plan Benefit Package approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).
2. FIDA-IDD 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-IDD Plan agrees to provide the information required in 42 C.F.R. § 423.48.
2. FIDA-IDD 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-IDD 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-IDD 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.
2. FIDA-IDD Plan agrees to address complaints received by CMS against the FIDA-IDD 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-IDD 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-IDD Plan acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to FIDA-IDD Plan through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO FIDA-IDD PLAN

FIDA-IDD 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-IDD Plan intends to participate in the Part D program for the next program year, FIDA-IDD Plan agrees to submit the next year's Part D FIDA-IDD 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-IDD Plan may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. FIDA-IDD Plan acknowledges that

failure to submit a timely FIDA-IDD Plan Benefit Package under this section may affect the FIDA-IDD 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

1. FIDA-IDD 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-IDD 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-IDD Plan agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and the State (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 State that meet the requirements of 42 C.F.R. § 423.120.
2. FIDA-IDD Plan agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. § 423.124.
3. FIDA-IDD 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-IDD Plan agrees to contract with any pharmacy that meets FIDA-IDD 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-IDD 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-IDD 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.

L. BENEFICIARY FINANCIAL PROTECTIONS

FIDA-IDD Plan agrees to afford its Participants protection from liability for payment of fees that are the obligation of FIDA-IDD Plan in accordance with 42 C.F.R. § 423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. FIDA-IDD Plan agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. FIDA-IDD Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on FIDA-IDD 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-IDD Plan must provide certifications in accordance with 42 C.F.R. § 423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. FIDA-IDD Plan shall submit prescription drug event data in accordance with 42 C.F.R. § 423.329(b)(3).

P. FIDA-IDD PLAN REIMBURSEMENT TO PHARMACIES

1. If FIDA-IDD Plan uses a standard for reimbursement of pharmacies based on the cost of a drug, FIDA-IDD 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-IDD 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 or within 30 days of receipt of a claim submitted otherwise.
3. FIDA-IDD 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-IDD Plan for reimbursement.

Article III Record Retention and Reporting Requirements

RECORD MAINTENANCE AND ACCESS

FIDA-IDD Plan agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

GENERAL REPORTING REQUIREMENTS

FIDA-IDD 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.

CMS AND NEW YORK STATE LICENSE FOR USE OF FIDA-IDD PLAN FORMULARY

FIDA-IDD Plan agrees to submit to CMS and the State the FIDA-IDD Plan's formulary information, including any changes to its formularies, and hereby grants to CMS and the State, and any person or entity who might receive the formulary from CMS and the State, 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-IDD Plan agrees to comply with the confidentiality and Participant record accuracy requirements specified in 42 C.F.R. § 423.136.
- B. FIDA-IDD 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

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.

QUALIFICATION TO RENEW ADDENDUM

In accordance with 42 C.F.R. §423.507, FIDA-IDD Plan will be determined qualified to renew this addendum annually only if:

FIDA-IDD 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

CMS or the Department has not provided FIDA-IDD Plan with a notice of intention not to renew.

Although FIDA-IDD Plan may be determined qualified to renew its addendum under this Article, if FIDA-IDD Plan, CMS, and the Department cannot reach agreement on the Part D FIDA-IDD 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-IDD PLAN

FIDA-IDD Plan may non-renew this addendum in accordance with 42 C.F.R. § 423.507(a).

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-IDD Plan

- A. FIDA-IDD 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-IDD 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

- 1. FIDA-IDD Plan acknowledges that, if it is a Capitated Financial Alignment FIDA-IDD Plan, the termination or nonrenewal of this addendum by any Party may require CMS to terminate or non-renew the FIDA-IDD Plan's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents FIDA-IDD Plan from meeting the requirements of 42 C.F.R. § 422.4(c), in which case the FIDA-IDD Plan must provide the notices specified in this contract, as well as the notices specified under subpart K of 42 C.F.R. Part 422.
- 2. 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.
- 3. In the event that FIDA-IDD 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-IDD 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-IDD 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**

Section 1. 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.

Section 2. ALTERATION TO ORIGINAL ADDENDUM TERMS

FIDA-IDD Plan agrees that it has not altered in any way the terms of the FIDA-IDD Plan addendum presented for signature by CMS. FIDA-IDD Plan agrees that any alterations to the original text FIDA-IDD Plan may make to this addendum shall not be binding on the Parties.

Section 3. ADDITIONAL CONTRACT TERMS

FIDA-IDD Plan agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. § 423.505(j).

Section 4. CMS AND NEW YORK STATE APPROVAL TO BEGIN
MARKETING AND ENROLLMENT ACTIVITIES

FIDA-IDD 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-IDD 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-IDD Plan's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, FIDA-IDD 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.

Section 5. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), FIDA-IDD 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.

Section 6. FIDA-IDD 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.

APPENDIX E: DATA USE ATTESTATION

The FIDA-IDD Plan shall restrict its use and disclosure of Medicare and Medicaid data obtained from CMS and State 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 the State to administer. The FIDA-IDD Plan shall only maintain data obtained from CMS and the State information systems that are needed to administer the Demonstration that it has contracted with CMS and the State to administer. The FIDA-IDD Plan (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS or the State information systems, or data obtained from the CMS or the State information systems, to support any line of business other than the Demonstration for which the FIDA-IDD Plan contracted with CMS and the State.

The FIDA-IDD 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-IDD Plan acknowledges two exceptions to this limitation. First, the FIDA-IDD Plan may provide its Participants information about non-health related services after obtaining consent from the Participants. Second, the FIDA-IDD Plan may provide information about health-related services without obtaining prior Participant consent, as long as the FIDA-IDD Plan affords the Participant an opportunity to elect not to receive such information.

CMS may terminate the FIDA-IDD Plan's access to the CMS data systems, and the State may terminate the FIDA-IDD Plan's access to the State data systems, immediately upon determining that the FIDA-IDD 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 the State have authorized under this Appendix E (herein, data use agreement). A termination of this data use agreement may result in CMS or the State terminating the FIDA-IDD 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-IDD Plan is a Demonstration Plan. This data use agreement excludes any public use files or other publicly available reports or files that CMS or the State make available to the general public on their respective websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS and State information systems to which the Data Use Attestation applies. CMS and the State will update the list periodically as necessary to reflect changes in CMS' and the State'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 (E CRS)
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 the State deems necessary including but not limited to WMS and MMIS.

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, the State or NYSDOH), and ([Health Plan Name]), hereafter referred to as the FIDA-IDD Plan, governing the operations of the following health plan: [Health Plan Name] ([]), the FIDA-IDD 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 Plan and the Medicare Marketing Guidelines.

I agree that CMS or the State may inspect any and all information, including those held at the premises of the FIDA-IDD Plan, to ensure compliance with these requirements. I further agree to notify CMS and the State 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-IDD Plan.

APPENDIX G: MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter “Licensor”),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

[Health Plan Name] (hereinafter “Licensee”),
with offices located at [Health Plan Address].

CMS Contract ID: []

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 January 1, 2018.

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 on January 1, 2018 through December 31, 2018, concurrent with the 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, 2018, 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.

APPENDIX H: SERVICE AREA

The Service Area outlined below is contingent upon the FIDA-IDD Plan meeting all Readiness Review requirements in each county. CMS and the State 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 the State.

Bronx
Kings
Nassau
New York
Queens
Richmond
Rockland
Suffolk
Westchester

APPENDIX I: STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licensor, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.
2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.
3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6-a).

However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

4. **WORKERS' COMPENSATION BENEFITS.** In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. **NON-DISCRIMINATION REQUIREMENTS.** To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex (including gender identity or expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin:

(a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. **WAGE AND HOURS PROVISIONS.** If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes,

except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a

term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY

NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or

(iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.

In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job

assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. **CONFLICTING TERMS.** In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix I, the terms of this Appendix I shall control.

14. **GOVERNING LAW.** This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern

Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development Division for Small Business

Albany, New York 12245 Telephone: 518-292-5100

Fax: 518-292-5884

email: opa@esd.ny.gov

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development

Division of Minority and Women's Business Development 633 Third Avenue

New York, NY 10017 212-803-2414

email: mwbecertification@esd.ny.gov

<https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for

the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. **PROCUREMENT LOBBYING.** To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. **CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.**

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. **IRAN DIVESTMENT ACT.** By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at:

<http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an

opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.