STATE MEDICAID AGENCY CONTRACT

BETWEEN

[PLAN NAME]

AND

NEW YORK STATE DEPARTMENT OF HEALTH

This AGREEMENT ("Agreement") is made and entered into as of the 1st day of January 2025 (the "Effective Date") by and between the New York State Department of Health ("SDOH") and [PLAN NAME] ("Health Plan"). Health Plan and SDOH collectively are referred to herein as the "Parties," and each individually as a "Party."

RECITALS

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

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

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

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

WHEREAS, Health Plan and SDOH desire to enter into an arrangement regarding the provision of such benefits by Health Plan's D-SNP(s) within the State of New York in an effort to improve and expand the integration and coordination of such benefits, better educate Dual Eligible Beneficiaries into

New York's D-SNP products, and thereby improve the quality of care to Dual Eligible Beneficiaries by coordinating care and reducing the costs and administrative burden.

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

I. DEFINITIONS

A. "Applicable Integrated Plan" (AIP) means a FIDE or HIDE D-SNP that operates with exclusively aligned enrollment limited to only full-benefit dually eligible individuals who receive coverage of Medicaid benefits through the D-SNP or a Medicaid managed care plan owned and operated by the same parent company as the D-SNP in accordance with CMS regulations at 42 CFR §422.561.

B. "Coinsurance" is the percentage of the total amount of the cost of medical services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage.

C. "Coordination Only D-SNP" (formerly referred to as a standalone D-SNP) means a D-SNP that does not have a Medicaid managed care contract with the State to offer Medicaid benefits. The Coordination Only D-SNP does not meet a FIDE or HIDE definition in accordance with CMS regulations at 42 CFR § 422.2

D. "Co-payment" is that portion of the total cost of covered services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage.

E "Cost-Sharing" means the portion of the cost of covered services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage. Cost-Sharing includes: Deductibles, Coinsurance, and Co-payments.

F. "Cost-Sharing Obligations" mean those financial payment obligations to be paid by SDOH in satisfaction of Deductibles, Coinsurance, and Co-payments for Medicare Part A and Medicare Part B services with respect to certain Dual Eligible Beneficiaries and as defined for certain Dual Eligible Beneficiaries with full Medicaid benefits, as defined in New York's Medicaid Plan. Such financial payment obligations shall not include premiums or Cost-Sharing relating to Medicare Part D benefits.

G. "Deductible" means the fixed dollar amount for which an individual would normally be financially responsible pursuant to his or her Medicare coverage before the costs of services are covered.

H. "Dual-Eligible Medicare Advantage Special Needs Plan(s)" or "D-SNP" as defined in 42 CFR § 422.2, means a specialized Medicare Advantage Plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that (1) coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services that include primary and acute care and for plan year 2025 and subsequent years including Medicare cost-sharing as defined in Section 1905(p)(3)(B), (C) and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries; and (2) may provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services; (3) has a contract with SDOH consistent with 42 CFR § 422.107 that meets the minimum requirements in paragraph (c) of such section; and (4) beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits: (i) meets the additional requirement specified in 42 CFR § 422.107(d) in its contract with SDOH; (ii) is a Highly Integrated Dual Eligible Special Needs Plan; (iii) is a Fully Integrated Dual Eligible Special Needs Plan.

I. "Dual Eligible Beneficiary" or "Dual Eligible Beneficiaries" or "Dual Eligibles" are those categories of individuals indicated in Attachment A that are eligible for Medicare benefits as well as for Medicaid under the New York's Medicaid Plan. Medicaid includes coverage of medical services, assistance in paying Medicare Part A and/or Part B premiums, and Cost-Sharing Obligations for Medicare-covered services.

J. "Exclusively Aligned" shall mean a D-SNP enrolling only full benefit Dual-Eligible Beneficiaries who are also enrolled in an Integrated Medicaid Product offered by SDOH, including but not limited to Medicaid Advantage Plus ("MAP"), that is offered by the Medicare Advantage Organization, its parent organization (directly or indirectly), or another entity owned and controlled by its parent organization.

K. "Fee-for-Service" means that the State pays a doctor, other healthcare professional, provider or hospital directly for each service that is provided to a Medicaid enrollee.

L. "Fully Integrated Dual Eligible Special Needs Plan" or "FIDE SNP" means a D-SNP (1) that provides Dual-Eligible Beneficiaries access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Social Security Act with SDOH; (2) whose capitated contract with SDOH provides coverage, consistent with SDOH policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; and (3) for plan year 2025 and subsequent years, including Medicare cost-sharing as defined in section 1905 (p)(3)(B), (C) and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries; and (4) for plan year 2025 and subsequent years, home health services as defined in Sec. 440.70; and (5) medical supplies, equipment and appliances as described in Sec. 440.70(b)(3); (6) that coordinates

the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (7) that employs policies and procedures approved by CMS and SDOH to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement; and (8) has received CMS designation as a FIDE SNP.

M. "Highly Integrated Dual Eligible Special Needs Plan" or "HIDE SNP" means a D-SNP that provide coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid managed care plan), including coverage of LTSS, behavioral health benefits, or both, under a capitated contract with SDOH. The capitated contract with SDOH may be executed directly with the D-SNP, with the D-SNP's parent organization, or with another entity that is owned and controlled by the D-SNP's parent organization. Additionally, the HIDE SNP's capitated contract with SDOH (for coverage of the required Medicaid benefits) must cover the entire service area of the D-SNP.

N. "Integrated Benefits for Dually Eligible Enrollees Program or "IB-Dual" means a program that provides Medicaid and Medicare services for Dual Eligibles enrolled in Mainstream or HARP, who are not required to enroll in a Managed Long-Term Care plan and also enrolled in an aligned D-SNP of the same organization.

O. "Integrated Medicaid Product" means a plan that provides and/or arranges coverage of Medicare and Medicaid services for Dual Eligible Beneficiaries contracted through CMS-approved D-SNP and a companion Medicaid plan offered by SDOH, including but not limited to Integrated Benefits for Dually Eligible Enrollees (IB-Dual) and Medicaid Advantage Plus.

P. "MA Contract" means the contract between Health Plan and CMS pursuant to which Health Plan sponsors Medicare Advantage.

Q. "Medicaid Benefits" means those items and services that are (i) covered by New York's Medicaid Plan for certain individuals identified in Attachment A, (ii) not eligible for coverage as basic benefits under the Medicare Program, and (iii) not covered by Health Plan's D-SNP(s) as a Supplemental Benefit.

R. "Medicaid Managed Care" refers to one or all the following health care plans authorized and contracted by New York to manage a specified benefit package of Medicaid benefits for a defined group of eligible enrollees: Mainstream Managed Care Plan (MMCP), Health and Recovery Plan (HARP), Medicaid Advantage Plus (MAP), or Managed Long Term Care Partial Capitation (MLTCP).

S. "Medicare Laws" means any and all laws, rules, regulations, statutes, orders and standards, instructions and guidance applicable to the Medicare Advantage Program and Medicare Advantage Organizations, as the term is defined in 42 CFR § 422.4, including Health Plan

in its capacity as the sponsor of Health Plan's D-SNP(s).

T. "Medicaid Advantage Plus Plan Integrated Appeals and Grievances Demonstration" means a Federal-State partnership established by CMS and SDOH to implement a demonstration that integrates appeals and grievance processes for MAP plans and FIDE SNPs with exclusively aligned enrollment participating in the MAP program sponsored by the same offeror. The demonstration began January 1, 2020, and will continue until December 31, 2025.

U. "Medicare Advantage Premium" means the amount Medicare Advantage plans may charge a Member for mandatory benefits and/or optional Supplemental Benefits beyond basic Medicare services.

V. "Member" shall mean an individual eligible to enroll in, and who has enrolled in, Health Plan's D-SNP.

W. "Model of Care" shall mean the program designed by Health Plan and approved by CMS to meet the specialized needs of a Dual Eligible population that includes (i) an appropriate network of providers and specialists available through Health Plan's D-SNP, and (ii) care management services, which include assessment, individualized plan of care and interdisciplinary team.

X. "Partial Dual Eligible" beneficiary means those categories of individuals indicated in Attachment A that are eligible for Medicare benefits as well as Medicaid coverage of assistance in paying Medicare Part A and/or Part B premiums, and Cost-Sharing Obligations for Medicare-covered services.

Y. "Premium" shall mean the amount SDOH pays for Medicare Part A and/or Part B on behalf of certain Dual Eligible beneficiaries pursuant to Section 1905 of the Social Security Act.

Z. "Service Area" means the counties identified in Attachment B in which Health Plan's D-SNP(s) operate(s) pursuant to Health Plan's MA Contract and certificate of authority issued by SDOH.

AA. "Subcontract" shall mean an agreement between Health Plan and a third-party under which the third-party agrees to accept payment for providing services to Health Plan's members.

BB. "Subcontractor" shall mean a third party with which Health Plan has an agreement.

CC. "Supplemental Benefit" means Medicare Advantage D-SNP benefits beyond basic Medicare Part A and Part B services described in 42 CFR § 422.101, including limits on out-of-pocket spending, reduction in premiums, or optional healthcare services.

II. HEALTH PLAN RESPONSIBILITIES

A. Coordination of Benefits Health Plan shall coordinate the delivery of all benefits covered by both Medicare and New York's Medicaid Plan as administered by SDOH. Health Plan is further responsible for coordinating care of all of its Members with other managed care organizations as applicable. In furtherance of these obligations, Health Plan shall specifically:

1. Identify for its Members the benefits they may be eligible for under New York's Medicaid Plan that are not covered by the D-SNP;

2. Assist in the coordination and access to needed Medicaid services, and arrange for the provision of such Medicaid services, to its Members by identifying participating Medicaid providers in the D-SNP's provider network; and

3. Develop and apply care coordination policies describing services Health Plan will provide or arrange, including, without limitation, care management, disease management, and discharge planning.

B. Plan Management. Health Plan shall administer D-SNP and provide coordinated care and benefits for dual eligible Members per the terms as described.

1. Medicare Benefits. Health Plan shall provide to its Members the benefits set out in Health Plan's D-SNP benefit package, including basic benefits and Supplemental Benefits, pursuant to Health Plan's MA Contract and applicable Medicare Law.

2. Compliance with Medicare Laws. Health Plan's administration of Health Plan's D-SNP(s), including, without limitation, plan benefit package design, provider network adequacy, provider credentialing, utilization management programs, quality improvement programs, and payment processes and procedures (collectively, "Administrative Services"), shall be subject to and in compliance with Medicare Laws.

3. Care Coordination. In accordance with the Model of Care approved by CMS, Health Plan shall develop individualized care plans that include communication and coordination with providers that render services covered under New York's Medicaid Plan. Health Plan will use its care management process to manage the Member's health status and assist the Member in obtaining or accessing Medicare and/or Medicaid benefits and services. Health Plan shall coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries. Health Plan shall employ policies and procedures to coordinate or integrate beneficiary

communication materials, enrollment, communications, grievance and appeals and quality improvement.

4. Comprehensive Written Statement of Benefits. Prior to enrolling any eligible individual into Health Plan's D-SNP, Health Plan shall provide such individual with a comprehensive written statement describing the Medicare and Medicaid benefits and Cost-Sharing protections the individual would receive as a Member of Health Plan's D-SNP. Such written statement shall include such information and be formatted in accordance with the requirements established by CMS. The Medicaid benefits that Health Plan will provide to Members are those benefits set forth in the model contract of the companion product designated in Attachment B.

5. Social Determinants of Health and Special Needs Plan Health Risk Assessment. CMS requires Health Plan to complete Member health risk assessment at enrollment and annually. Health Plan must also include specific standardized questions on housing stability, food security, and access to transportation in its health risk assessment surveys. The Health Plan shall act on any unmet needs identified from the screening by providing referrals to services as part of care plan development for its Members.

6. Summary of Benefits. Health Plan shall integrate into a single Summary of Benefits all Medicare and Medicaid benefits a Member may be eligible to receive upon enrollment in Health Plan's D-SNP(s).

7. Prompt Pay. Health Plan shall pay all claims for items and services in accordance with federal and state law and regulation, including, as applicable, Section 3224-a of the New York Insurance Law and 42 CFR § 422.520.

C. Medicare Advantage Supplemental Benefits. Services that are covered as Supplemental Benefits under Health Plan's D-SNP(s) and overlap with Medicaid Benefits under New York's Medicaid Plan shall be first adjudicated by Health Plan as claims for services under the Supplemental Benefit offered by Health Plan's D-SNP(s) before treating such claims as SDOH responsibility under the State Medicaid Plan.

D. Maximum Out-of-Pocket (MOOP) Limit. Health Plan shall ensure calculation of the maximum out-of-pocket limit is based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance, or remains unpaid (including when the cost-sharing is not paid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing).

E. Categories of Dual Eligible Beneficiaries to be Served. The categories of Dual Eligible Beneficiaries are defined in **Attachment A.**

1. Health Plan's D-SNP serving Medicaid Fee-For-Service (FFS) beneficiaries and/or MLTC partial capitation members may enroll the following categories of Dual Eligible Beneficiaries into the D-SNP:
   - QMB
   - QI
   - QDWI
   - QMB-Plus
   - FBDE

2. Health Plan's D-SNP aligned with the Integrated Benefits for Dually Eligible Enrollees Program (IB-Dual) for MMC/HARP is permitted to also enroll Medicaid FFS beneficiaries and may enroll the categories of Dual Eligible Beneficiaries listed above in E.1.

3. Health Plan's D-SNP that is Exclusively Aligned with a Medicaid Advantage Plus (MAP) product or other integrated program such as IB-Dual is solely limited to enrollment of the following categories of Dual Eligible Beneficiaries:
   - QMB-Plus
   - FBDE

4. Health Plan shall complete **Attachment B** to fully describe alignment of the Health Plan's D-SNP(s) and categories of Dual Eligible Beneficiaries served for each integrated/non-integrated product type including service area and ownership/affiliation as appropriate. Health Plan shall describe any application submissions and/or service area expansion counties that may be pending DOH approval at time of SMAC completion.

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

G. Provider Network.

1. Identification of Providers. Health Plan shall verify a provider's participation in New York's Medicaid Plan before inclusion in its D-SNP Provider Directory. Health Plan shall identify in its provider directory those participating providers that accept both Medicare and Medicaid.

2. Network Congruency Standards. Where the D-SNP organization offers an Integrated Medicaid Product (includes FIDE and HIDE D-SNPs), Health Plan shall

augment the more narrow network (either Medicare or Medicaid) to develop an acceptable level of network congruency between its Medicare and Medicaid participating providers to ensure access and availability of services, such that a minimum percentage of providers in a Health Plan's participating provider network shall participate in both Medicare and Medicaid managed care. Health Plan shall not terminate network provider participation for the sole purpose of achieving network congruency.

Health Plan shall ensure that its Medicare and Medicaid participating provider networks are congruent. Health Plan's provider networks shall maintain congruency whereby at least 85% of the Medicaid provider network overlaps with the Medicare provider network.

Health Plan will provide an attestation to DOH demonstrating network congruency in a format and timeframe to be determined by the Department.

H. Claims Crossover Agreement. In accordance with 42 CFR § 438.3(t), Health Plan shall enter into a signed agreement with CMS for the coordination of benefits and participate in the automated Medicare claims crossover process to receive Medicare fee-for-service claims.

I. Integrated Medicaid Product Offerings.

1. To further SDOH efforts to provide integrated care and benefits for New York's Dual Eligible Beneficiaries, Health Plan shall submit a complete application to SDOH to offer an Integrated Medicaid Product where Health Plan does not currently contract with the State to provide a managed care plan for dual eligibles.

   The submission timeline shall be as follows:
   - Health Plan shall send a letter of intent to SDOH on or before November 1, 2024, to propose an integrated product offering effective January 1, 2026.
   - Health Plan shall submit a completed application for an Integrated Medicaid Product to SDOH in accordance with State's published submission schedule. This can be found at: https://www.health.ny.gov/health_care/managed_care/plans/

2. Applications submitted for Coordination Only D-SNP products will not be accepted by SDOH, unless SDOH determines in its sole discretion that extenuating circumstances exist that are based on access or preservation of choice for Dual Eligible Beneficiaries.

3. Health Plans that currently offer a Coordination Only D-SNP, may continue to provide such option. However, the Coordination Only D-SNP may not further expand into new service area counties.

J. Supplemental Benefits.

1. Health Plan shall ensure its Supplemental Benefits will coordinate with Medicaid benefits covered by New York's Medicaid Plan during the next Medicare bid filing cycle, effective for the 2025 contract year and thereafter as outlined below.

   - Health Plan must use its rebate amount to fully cover Medicaid dental services as a Medicare supplemental benefit.
   - Dental care includes preventive, prophylactic and other routine dental care, services and dental prosthetics required to alleviate a serious health condition. Health Plan's D-SNP benefit design will cover the full scope of Medicaid dental services. The benefit design may not include a limited allowance amount for covered services.
   - D-SNPs must cover the Medicaid dental benefits available in the 2024 package as of January 1, 2025. Dental benefits added by DOH after the start of the new budget year (April 1st) would continue to be covered by Medicaid. Health Plan's D-SNP shall cover any newly added Medicaid dental services under the Medicare supplemental benefit beginning on January 1st of the following year.
   - Health Plan's D-SNP supplemental dental benefit will provide coverage for all partial and full dual eligibles.
   - Health Plan's D-SNP shall allow enrollees to self-refer to Article 28 clinics operated by academic medical centers to obtain covered dental services.
   - All D-SNP types (FIDE, HIDE and Coordination-Only) are subject to this supplemental benefit requirement.
   - The Medicare appeals and grievances process will apply to supplemental benefits as required. However, for FIDE D-SNPs (ie. MAP) shall continue to follow the integrated appeals and grievances demonstration process as outlined in Section O (2)(b) of this document.

2. Health Plan (both FIDE and HIDE D-SNPs) shall ensure its Supplemental Benefits (ie. dental, vision, hearing.) will coordinate with Medicaid benefits covered by New York's Medicaid Plan to develop an acceptable level of network congruency between its Medicare and Medicaid participating providers to ensure access and availability of supplemental services, such that a minimum percentage of providers in a Health Plan's participating provider network shall participate in both Medicare and Medicaid managed care. Health Plan shall meet network congruency standards of 85% beginning January 1, 2025.

   - Health Plan shall provide an attestation to DOH demonstrating network congruency in a format and timeframe to be determined by the Department.

3. Coordination Only D-SNPs shall ensure a level of network adequacy that complies

with CMS regulations found at 42 CFR Sec. 422.116.

K. D-SNP Offered with Companion Managed Long Term Care Partial Capitation Plan - Where the Health Plan's D-SNP with a Managed Long Term Care Partial Capitation Plan (MLTCP) is designated a HIDE-SNP, the Health Plan must comply with the following additional requirements to ensure care coordination for dual eligibles:

- Health Plan must ensure that the care managers on the D-SNP's interdisciplinary care team are the same care managers providing care coordination and care management services to the enrollee that provide such services through the MLTCP.

- The Health Plan must coordinate its D-SNP and affiliated MLTCP care plans by ensuring integrated care coordination and management, including but not limited to:
  - Assisting enrollees with accessing needed services identified under the care plans~~;~~ including referral, assistance in or coordination of services for the Enrollee to obtain needed services not included in the Benefit Package of the Health Plan;
  - Ongoing care management and communication across the care teams; and
  - Complying with the elements outlined under sections II (A) and II (B) per this agreement;

- The Health Plan shall continue to submit reporting for all hospital and skilled nursing facility admissions.

L. Notifications. Health Plan shall provide SDOH with the following notifications within ten (10) business days, unless a different time period is specified for a particular notification requirement:

1. Medicare Advantage Bid Filing. Health Plan shall provide SDOH with copy of: (i) its annual bid filing submitted to CMS, and (ii) CMS approval of its bid filing final submission.

2. Notice of Intent. Health Plan shall provide SDOH with a copy of its Medicare Notice of Intent describing its proposed Medicare product offerings, service area expansions and/or any other changes it intends to apply for to be effective in the next bid filing submission.

3. Service Area.

   a. Health Plan shall submit its Service Area, as approved by CMS, to SDOH. In order for Health Plan to offer benefits in such Service Area, it must also be authorized by SDOH.

b. Health Plan shall notify SDOH of any CMS approval of an update to its Service Area.

4. Summary of Benefits. Health Plan shall submit an annual Summary of Benefits of Health Plan's D-SNP benefits offered under the plan benefit packages, including Supplemental Benefits, for the counties identified in Attachment B, by January 1 each year, and within 15 calendar days of any update or modification.

5. Model of Care (MOC). Health Plan shall submit to DOH upon request a copy of its CMS-approved Model of Care. The MOC shall include policies and procedures incorporating care coordination and Medicaid quality of care for dual eligibles.

6. Quality Reporting.

   a. Health Plan shall submit to SDOH copies of all quality reports, measures, and findings generated from Health Plan's D-SNP(s) quality management programs as required by and submitted to CMS.

   b. Health Plan shall notify SDOH in the event Health Plan receives less than 3.0 Medicare Star rating on either its Part C or Part D scores for any D-SNP. Health Plan shall provide SDOH with a copy of any document submitted to CMS outlining the steps proposed or implemented to improve the low score.

7. Information Sharing about Hospital and SNF Admissions. In accordance with 42 CFR § 422.107(d), D-SNPs that do not meet a FIDE or HIDE designation, shall provide timely notification of all admissions to a hospital or skilled nursing facility ("SNF") to the Member's Medicaid health plan, or SDOH for fee-for-service Medicaid beneficiaries. Such information must include, but may not be limited to
   - Member Name
   - Subscriber ID
   - Date of Birth
   - Facility Member admitted to
   - Attending Physician
   - Admission Type/Diagnosis
   - Date of Admission
   - Primary Care Physician (PCP)

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

Health Plans shall enter into business associate agreements and any other agreements governing the legally compliant sharing of data in accordance with HIPAA, and/or any other applicable state and federal privacy laws, and/or pursuant to the terms of any agreements between Health Plans and SDOH. Health Plan shall provide SDOH with proof of documentation upon request by SDOH. Where notification must be provided to SDOH, Health Plan shall submit or transmit such notifications and data pursuant to instructions provided by SDOH.

M. Marketing. Health Plan shall comply with all applicable State and Medicare Laws relating to marketing of its D-SNP(s). In connection therewith, Health Plan shall submit its D-SNP(s) marketing and/or member communications materials to SDOH and/or CMS (as applicable) for approval and agrees to only use approved marketing material in New York.

N. Product Offerings. For each D-SNP offered by Health Plan and covered under this agreement, Health Plan shall complete all information required by **Attachment B**.

O. Exclusively Aligned D-SNP Requirements. The following are applicable only to Health Plan's operation of Exclusively Aligned D-SNPs.

1. Service Area. The counties within an Exclusively Aligned D-SNP's Service Area shall be aligned with the service area of its Integrated Medicaid Product.

2. Integrated Appeals and Grievances

a. *Unified Appeals and Grievance Process*. Health Plan's Exclusively Aligned FIDE or HIDE D-SNP shall implement a unified grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§ 422.629 – 634, 438.210, 438.400 & 438.402. This requirement includes:

- Grievances and appeals systems that meet the standards described in 42 CFR § 422.629;
- An integrated grievance process that complies with 42 CFR § 422.630;
- A process for making integrated organization determinations consistent with 42 CFR § 422.631;
- Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR § 422.632;
- A process for making integrated reconsiderations consistent with 42 CFR § 422.633; and a process for effectuation of decisions consistent with 42 CFR § 422.634. Implement a process to ensure that enrollees are provided reasonable assistance in completing forms and taking other procedural steps related to integrated appeals and grievances. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD

and interpreter capability.

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

(i) Health Plan's Exclusively Aligned FIDE D-SNPs shall comply with an integrated appeals and grievance process at both the internal Health Plan and fair hearing levels for Medicare and Medicaid services, consistent with the requirements outlined under the MAP Integrated Appeals and Grievances Process Demonstration established per Federal and State partnership for certain Medicaid Integrated Plans.

(ii) Integrated Appeals and Grievances Process Reporting Requirements.

The following appeals and grievances reporting requirements shall be submitted within 15 business days of the close of each quarter:

A quarterly summary of integrated appeals including:

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

(iii) Effectuation of Decisions

The Contractor must authorize or provide the disputed services immediately (within no more than one (1) Business Day), and as expeditiously as the Enrollee's health condition requires, if the services were not furnished while pending Contractor, OAH, or MAC decision on the appeal.

3. MAP Integrated Appeals and Grievances Demonstration Closeout. Upon conclusion of the MAP Integrated Appeals and Grievances Demonstration, the Health Plan shall comply with any required closeout procedures related to appeals administration and/or reporting in accordance with the MAP Memorandum of Understanding (MOU).

Health Plan's FIDE D-SNP shall implement unified appeals and grievances process established for applicable integrated plans (AIP) per CMS regulations.

P. IB-Dual D-SNP Requirements.

a. Any Health Plan that offers IB-Dual to MMC/HARP Members and is designated as a HIDED-SNP shall comply with the following requirements in accordance with CMS regulations no later than January 1, 2025:
   - The Health Plan's HIDE SNP capitated contract with the State (for coverage of required Medicaid benefits) must cover the entire service area of the D-SNP.

b. IB-Dual Service Area Expansion Requirements. Health Plan shall ensure any expansion of the approved D-SNP aligns with its Medicaid service area by submitting a mini-application to SDOH to expand the IB-Dual offering.

c. Medicaid Fee-for-Service (FFS) Duals Transition into IB-Dual. The Health Plan's D-SNP may continue to enroll both IB-Dual and FFS Dual members. Upon SDOH approval, the Health Plan may extend enrollment into IB-Dual to its FFS Dual members. FFS Duals may voluntarily enroll into the Medicaid Managed Care Plan (MMCP) aligned with the IB-Dual approved D-SNP.

Q. Default Enrollment Process.

a. On behalf of Members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and such Medicare eligibility results in full benefit Dual Eligible Beneficiary status for such Members, Health Plan shall perform the default enrollment process as provided by 42 CFR §§ 422.66 & 422.68.

b. Through this Agreement, and in conformance with 42 CFR § 422.66(c)(2)(i)(B) and 42 CFR § 422.107, SDOH approves Health Plan's implementation of the default enrollment process for its D-SNP subject to CMS' prior approval as per the requirements of 42 CFR §§ 422.66(c)(2)(i)(E), (F), & (G) inclusive; 42 CFR § 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable.

c. Health Plan shall be responsible for timely obtaining initial default enrollment process approval from CMS. Health Plan shall coordinate with SDOH regarding those activities necessary to obtain such CMS prior approval. Health Plan shall forward to SDOH a copy of CMS' default enrollment process prior approval notification or correspondence to Health Plan within 10 calendar days of receipt.

d. Health Plan shall be responsible for coordination and continuity of care to ensure that, for each Member enrolled in Health Plan's D-SNP through the default enrollment process (and who is thus also enrolled in a managed care organization operated by the Health Plan), Health Plan shall be responsible for continuing to

provide covered services authorized by the Member's managed care organization, without regard to whether such services are being provided by participating or non-participating providers for at least sixty (60) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the Health Plan's D-SNP plan or the Member's transition to a participating provider and any needed actions to mitigate potential negative consequences related to transition of providers.

e. Health Plan shall be responsible for coordinating those activities necessary to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR § 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. Health Plan shall coordinate with SDOH regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. Health Plan shall forward to SDOH copies of its default enrollment process renewal notification and materials, and CMS' renewal approval(s) notification or correspondence, within 10 calendar days of receipt.

f. Health Plan shall maintain a minimum 3.0 overall plan star rating as assigned by CMS to implement the default enrollment process.

g. Through implementation of the default enrollment process, SDOH shall provide Health Plan with information necessary to prospectively identify those members eligible for default enrollment.

R. Ownership and/or Affiliation with Medicaid Managed Care plan. Health Plan shall demonstrate that the entity holding the capitated contract with SDOH is the same legal entity as that which CMS has designated as a FIDE SNP, by providing SDOH with a copy of the notice from CMS attesting to such entity's status as a FIDE SNP.

III. SDOH RESPONSIBILITIES

A. Financial Responsibilities. Pursuant to New York's Medicaid Plan, SDOH will remain financially responsible for Cost-Sharing Obligations and Medicaid Benefits for certain Dual Eligible Beneficiaries, as set forth in Attachment A, who are Members of Health Plan's D-SNP(s) that enroll Fee-For-Service Medicaid enrollees. SDOH may have financial responsibility for Medicare Part A and/or Part B premiums for select categories of Dual Eligible Beneficiaries, as set forth in Attachment A. SDOH is not responsible for payment of Medicare Advantage premiums for mandatory or optional Supplemental Benefits, unless specifically prescribed in New York's Medicaid Plan.

SDOH is not financially responsible for Cost-Sharing Obligations and Medicaid Benefits for those Dual Eligible Beneficiaries enrolled in an Integrated Medicaid Product which may include Medicaid Advantage Plus, IB-Dual and certain Managed Long Term Care Partial programs.

B. Claims Processing. SDOH shall receive, process, and adjudicate claims for Cost-Sharing Obligations and Medicaid Benefits from Health Plan providers through the fee-for-service payment system, in accordance with SDOH's processes and procedures for claims administration. Health Plan shall receive, process and adjudicate claims for basic Medicare services and Supplemental Benefits.

C. Electronic Data Format. SDOH shall provide Health Plan with an electronic data file containing Medicaid participating providers in a generally accepted format on or about April 1 and October 1 of each year, or at such other time as determined by SDOH.

D. Educational and Marketing Materials. SDOH shall retain responsibility for developing and distributing materials and conducting educational activities relating to New York's Medicaid Plan and benefits and services covered under New York's Medicaid Plan.

IV. MEMBER PROTECTIONS

A. No Balance Billing by Providers. With respect to its Members who are eligible for Medicaid payment of Cost-Sharing, Health Plan agrees that it shall include in its contracts with Health Plan providers that they shall not bill or charge ("balance bill") such individuals the balance for any services such individuals are not liable in accordance with Section 1902(n)(3) of the Social Security Act.

B. Limitation on Out-of-Pocket Costs. Notwithstanding any provision in this Agreement to the contrary, Dual Eligible Beneficiaries enrolled in Health Plan's SNP(s), Health Plan shall not impose Cost-Sharing that exceeds the amount of Cost-Sharing that would be permitted with respect to such individual pursuant to the State Medicaid Plan if the individual were not enrolled in the Health Plan's SNP(s).

C. Member /Hold Harmless. Notwithstanding any provision in this Agreement to the contrary, Health Plan shall prohibit providers, under any circumstance including but not limited to non-payment by Health Plan or SDOH, insolvency of Health Plan or breach of Health Plan's agreement with a provider, from billing, charging, collecting a deposit from, seeking compensation or remuneration from or having any recourse against any Member for fees that are the responsibility of Health Plan or SDOH.

V. PRIVACY AND SECURITY

The Parties agree that any data or other information transmitted pursuant to this Agreement shall comply with all applicable State and Federal laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA"), Sections 367b(4) and 369 of the New York Social Services Law, Article 27-F of the New York Public Health Law and its implementing regulations, and 42 USC § 1396a and its implementing regulations.

VI. TERM AND TERMINATION

A. Term. This Agreement commences on the Effective Date and shall be in effect until December 31, 2025.

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

VII. MISCELLANEOUS

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

B. Sanctions. Health Plan may be subject to a CMS enrollment sanction of the D-SNP where an integrated Medicaid product offering (as indicated in Attachment B) has not been approved by the start of the calendar year. This applies but is not limited to any new or service area expansion plans. An enrollment sanction shall be lifted by CMS upon approval of an integrated Medicaid product application that meets all DOH requirements. CMS statutory authority to sanction remains in place through 2025 only.

C. Attachments.

1. The following attachments are incorporated by reference into this Agreement and attached hereto:

    a. Attachment A, "Categories of Dual-Eligible Beneficiaries"
    b. Attachment B, "Product Offerings"

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

CONTRACTOR SIGNATURE	STATE AGENCY SIGNATURE
By: _____	By: _____
_____ 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.

_____
(Signature and office of the individual taking acknowledgement)

ATTACHMENT A

CATEGORIES OF DUAL ELIGIBLE BENEFICIARIES

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

A. Full-benefit Dual Eligible Beneficiaries where the D-SNP is Exclusively Aligned:

1. A "Full Medicaid Only" is an individual who is enrolled in Medicare Part A and/or Part B, and eligible for Medicaid benefits under New York's Medicaid Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the eligibility criteria for QMB.

2. A "QMB-Plus" is an individual who meets all of the Qualified Medicare Beneficiary (QMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York's Medicaid Plan.

B. The following categories of Dual Eligible Beneficiaries and/or partial Dual Eligible Beneficiaries are recognized within the scope of this Agreement where the D-SNP is not Exclusively Aligned and enrolls full benefit Dual Eligible Beneficiaries and/or partial Dual Eligible Beneficiaries:

1. "Full Medicaid Only" is an individual who is enrolled in Medicare Part A and/or Part B, and eligible for Medicaid benefits under New York's Medicaid Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the eligibility criteria for QMB.

2. A "QMB-Plus" is an individual who meets all of the Qualified Medicare Beneficiary (QMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York's Medicaid Plan.

3. Qualified Disabled and Working Individual (QDWI) is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in the purchase of Medicare Part A. The individual must meet federal income and resource criteria and may not be otherwise eligible for Medicaid. A QDWI is eligible only for Medicaid payment of Part A premiums.

4. Qualified Medicare Beneficiary (QMB) Only is an individual who is entitled to Medicare Part A and has income that does not exceed 138% of the Federal Poverty Level (FPL). A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments.

5. Qualifying Individual (QI) is an individual who is in receipt of Medicare Part A, has income greater than 138% of the FPL but less than or equal to 186% FPL, and who is not otherwise eligible for Medicaid. A QI is eligible only for Medicaid payment of Medicare Part B premiums.

ATTACHMENT B

PRODUCT OFFERINGS

Health Plan shall complete all information below for each D-SNP under this Agreement. Health Plan shall attach copy of Medicaid benefits coverage as outlined in the specific appendix of the model contract when submitting to CMS. Health Plan shall indicate if any D-SNP counties are currently pending DOH approval for any integrated Medicaid product offerings listed below.

D-SNP WITH COMPANION MEDICAID ADVANTAGE PLUS (MAP)

Health Plan shall complete all information below and attach copy of Appendix K in its entirety when submitting this agreement to CMS. See link below.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm

Health Plan operates a MAP with Exclusively Aligned enrollment into the D-SNP. Health Plan shall meet designation for FIDE SNP as defined in this agreement and outlined in the Appendix K link to the model contract. The MAP plan coverage includes both behavioral health and long term services and supports. MAP behavioral health coverage (eff. 1/1/23) is described in Appendix A at the link below.

https://health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/2022/docs/2022-08-16_mltc_22-03.pdf

Health Plan has a fully executed MAP contract with SDOH :
Yes ___ No____

If the answer above is “No”, indicate expected date Health Plan will have a fully executed MAP contract: _____.

Health Plan has received CMS approval for default enrollment for its MAP contract:
Yes ___ No____

CMS Contract Code (H#):_____

Contract Name: _____

DSNP Plan Benefit Package: _____

Plan Name: _____

Service Area -
Check all approved counties that apply. For counties awaiting DOH approval, check the county box and indicate as "pending".

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

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

☐ FBDE
☐ QMB-Plus

Appeals and Grievances:

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

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

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

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

Full name of legal entity offering MAP: _____

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

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

Health Plan is seeking HIDE SNP designation as defined in this agreement. Yes ____ No_____

Health Plan shall attach copy of Appendix G of the model contract in its entirety when submitting to CMS. See the link below.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm

Health Plan operates an MLTCP with both Aligned and FFS enrollment into the D-SNP . Health Plan shall meet designation for HIDE SNP as defined in this agreement and outlined in the Appendix G link to the model contract. The MLTCP plan coverage includes long term services and supports.

CMS Contract Code H#): _____

Contract Name: _____

D-SNP Plan Benefit Package: _____

Plan Name: _____

Service Area-
Check all approved counties that apply. For counties awaiting DOH approval, check the county box and indicate as "pending".

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

☐ Essex	☐ Niagara	☐ Schoharie	

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

☐ QMB
☐ QI
☐ QDWI
☐ QMB-Plus
☐ FBDE

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

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

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

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

Full name of legal entity offering partial capitation MLTC plan: _____

D-SNP WITH COMPANION MMC/HARP (Integrated Benefit for Dually Eligible Enrollees Program -IB-Dual) –

Health Plan shall attach copy of Appendix K of the model contract in its entirety when submitting to CMS. See the link below.

https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

Health Plan that operates an IB-Dual with both Aligned and FFS dual eligible enrollees into the D-SNP. Health Plan shall meet designation for HIDE SNP as defined in this agreement and outlined in the Appendix K link to the model contract. The IB-Dual coverage includes behavioral health and/or long term services and supports.

Health Plan is seeking HIDE SNP designation as defined in this agreement. Yes _____ No_____

CMS Contract Code (H#): _____

Contract Name: _____

D-SNP Plan Benefit Package: _____

Plan Name: _____

Health Plan has received SDOH approval to offer IB-Dual in all counties indicated below:
Yes ___ No___

If the answer is "no" to the above, please identify which counties are awaiting SDOH approval.

Health Plan has received CMS approval for default enrollment for its MMC/HARP (IB-Dual) contract:
Yes ___ No____

Service Area –
Check all approved counties that apply. For counties awaiting DOH approval, check the county box and indicate as "pending".

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga

☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins
☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

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

In IB-Dual:
☐ QMB-Plus
☐ FBDE

In Fee-For-Service (FFS):
☐ QMB
☐ QI
☐ QDWI
☐ QMB-Plus
☐ FBDE

Ownership and Affiliation: Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion IB-Dual:

☐ The legal entity offering Health Plan is the same legal entity offering the IB-Dual program under which SDOH provides capitated payments for provision of the services in Appendix A.

☐ The legal entity offering Health Plan is a separate legal entity under the same parent organization from the legal entity offering the IB-Dual program under which SDOH provides capitated payments for the provision of the services.

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

Full name of legal entity offering IB-Dual: _____

COORDINATION ONLY D-SNP (1) –

CMS Contract Code (H#): _____

Contract Name: _____

D-SNP Plan Benefit Package: _____

Plan Name: _____

Service Area – check all approved counties that apply:

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

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

☐ QMB
☐ QI
☐ QDWI
☐ QMB-Plus
☐ FBDE

COORDINATION ONLY D-SNP (2) –

CMS Contract Code (H#): _____

Contract Name: _____

D-SNP Plan Benefit Package: _____

Plan Name: _____

Service Area – check all approved counties that apply:

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

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

☐ QMB
☐ QI
☐ QDWI
☐ QMB-Plus
☐ FBDE