

**DRAFT 2014 DISCO MODEL CONTRACT**  
**MISCELLANEOUS/CONSULTANT SERVICES**  
**(Non-Competitive Award)**

**STATE AGENCY (Name and Address):**

Office for People with Developmental  
Disabilities

Contract Management  
44 Holland Avenue  
Albany, NY 12228

**NYS Comptroller's Number:**

Originating Agency Codes: 12000  
51000

New York State Department of Health  
Office of Health Insurance Programs  
Division of Long Term Care  
ESP – Corning Tower Building 19th Floor  
Albany, NY 12237

**CONTRACTOR (Name and Address):**

**TYPE OF PROGRAM:**

Developmental Disability Individual Support and Care  
Coordination Organization

**CHARITIES REGISTRATION NUMBER:**

**CONTRACT TERM:**

CONTRACTOR HAS  HAS NOT  TIMELY  
FILED WITH THE ATTORNEY GENERAL'S  
CHARITIES BUREAU ALL REQUIRED  
PERIODIC OR ANNUAL WRITTEN REPORTS

**FROM:**  
**TO:**

**FEDERAL TAX IDENTIFICATION NUMBER:**

**FUNDING AMOUNT FOR CONTRACT TERM:**

Based on approved capitation rates

**MUNICIPALITY NUMBER (if applicable):**

**STATUS:**

CONTRACTOR IS  IS NOT   
A SECTARIAN ENTITY

CONTRACTOR IS  IS NOT   
A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS  IS NOT   
A NY STATE BUSINESS ENTERPRISE

(X) IF MARKED HERE, THIS CONTRACT IS  
RENEWABLE FOR TWO ADDITIONAL ONE YEAR  
PERIODS SUBJECT TO THE APPROVAL OF THE  
NEW YORK STATE DEPARTMENT OF HEALTH  
AND THE OFFICE OF THE STATE  
COMPTROLLER

**BID OPENING DATE:** N/A – Contractor is legislatively named in accordance with §4403-g.



## TABLE OF CONTENTS

### **Article I Term of Contract, Renewal and Termination**

- A. Term
- B. Renewal
- C. Termination of the Contract by the Department
- D. Termination of the Contract by the Contractor
- E. Other Termination Reasons
- F. Contract Expiration and Contractor Termination/Phase-out Plan
- G. Effect of Termination on New Enrollments

### **Article II Statutory and Regulatory Compliance**

### **Article III Contractor Service Area and Ages of Population to Be Served**

### **Article IV Eligibility for Developmental Disability Individual Support And Care Coordination Organization**

### **Article V Obligations of the Contractor**

- A. Provisions of Benefits
- B. Eligibility Activities of Contractor
- C. Enrollment Process
- D. Disenrollment Policy and Process
- E. Enrollee Protections
- F. Quality Assurance and Performance Improvement Program
- G. Outreach
- H. Information For Potential Enrollees, Applicants and Enrollees
- I. Member and Provider Services
- J. Care Management
- K. Advance Directives
- L. Duplicate CINs
- M. Contractor Responsibilities in Relation to Public Health

### **Article VI Payment**

- A. Capitation Payments
- B. Modification of Rates during Contract Period
- C. Rate-Setting Methodology
- D. Payment of Capitation
- E. Denial of Capitation Payments
- F. Department Right to Recover Premiums
- G. Third Party Health Insurance Determination
- H. Other Insurance and Settlements
- I. Contractor Financial Liability
- J. Spenddown and Net Available Monthly Income
- K. No Recourse Against Enrollees
- L. Notification Requirements to LDSS/RSFO (Revenue Support Field Office) Regarding Enrollees
- M. Contractor's Fiscal Solvency Requirements
- N. Prohibition on Payments to Institutions or Entities Located Outside of the United States
- O. DISCO Risk Corridor

## **Article VII Contractor Relationship with Subcontractors**

- A. Subcontractor/Provider Relations
- B. Full Responsibility Retained
- C. Required Provisions
- D. List of Covered Services and Subcontractors
- E. Provider Termination Notice
- F. Recovery of Over Payments to Providers
- G. Optometry Services Provided by Article 28 Clinics Affiliated with the College of Optometry of the State University of New York
- H. Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers not Participating in Contractor's Network

## **Article VIII Records, Reporting and Certification Requirements**

- A. Maintenance of Contractor Performance Records, Records Evidencing Enrollment Fraud and Documentation Concerning Duplicate CINs
- B. Maintenance of Financial Records and Statistical Data
- C. Access to Contractor Records
- D. Retention Periods
- E. Reporting Requirements
- F. Data Certifications
- G. Notification of Changes in Reporting Due Dates Requirements or Formats
- H. Ownership and Related Information Disclosure
- I. Role of Compliance Officer and Compliance Committee
- J. Public Access to Records
- K. Professional Discipline
- L. Certification Regarding Individuals Who have been Debarred or Suspended Federal or State Government
- M. Conflict of Interest Disclosure
- N. OMIG's Right to Audit and Recover Overpayments Caused by Contractor Submission of Misstated Reports
- O. OMIG's Right to Audit and Recover Overpayments Which Were Caused by the Contractor's Misstated Encounter Data
- P. OMIG Audit Authority

## **Article IX Intermediate Sanctions**

### **Article X General Requirements**

- A. Authorized Representative With Respect to Contract
- B. Confidentiality
- C. Additional Actions and Documents
- D. Relationship of the Parties, Status of the Contractor
- E. Nondiscrimination
- F. Employment Practices
- G. Dispute Resolution
- H. Assignment
- I. Binding Effect
- J. Limitation on Benefits of this Contract
- K. Entire Contract
- L. Conflicting Provisions
- M. Modification
- N. Headings
- O. Pronouns

**P.** Notices  
**Q.** Partial Invalidity  
**R.** Force Majeure  
**S.** Survival  
**T.** State Standard Appendix A  
**U.** Indemnification  
**V.** Environmental Compliance  
**W.** Energy Conservation  
**X.** Prohibition on Use of Federal Funds for Lobbying  
**Y.** Waiver of Breach  
**Z.** Choice of Law  
**AA.** Executory Provision and Federal Funds  
**BB.** Renegotiation  
**CC.** Affirmative Action  
**DD.** Omnibus Procurement Act of 1992  
**EE.** Fraud and Abuse  
**FF.** Nondiscrimination in Employment in Northern Ireland  
**GG.** Contract Insurance Requirements  
**HH.** Minority And Women Owned Business Policy Statement  
**II.** Provisions Related to New York State Information Security Breach and Notification Act  
**JJ.** Accessibility of State Agency Web-based Intranet and Internet Information and Applications  
**KK.** New York State Tax Law Section 5-a  
**LL.** Provisions Related to New York State Procurement Lobbying Law  
**MM.** Piggybacking  
**NN.** Lead Guidelines  
**OO.** Payment  
**PP.** M/WBE Utilization Plan for Subcontracting and Purchasing  
**QQ.** On-going Vendor Responsibility

## APPENDICES

APPENDIX A	Standard Clauses for New York State Contracts
APPENDIX B	New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act
APPENDIX C	Certification Regarding Lobbying
APPENDIX D	Standard Form LLL Disclosure of Lobbying Activities
APPENDIX E-1	Proof of Workers' Compensation Coverage
APPENDIX E-2	Proof of Disability Insurance Coverage
APPENDIX F	Service Area and Ages of Population Served
APPENDIX G	DISCO Covered and Non-Covered Services
APPENDIX H	Schedule of Capitation Rates
APPENDIX I	Quality Plan Guidelines for DISCOs
APPENDIX J	Definitions
APPENDIX K	Grievance System, Member Handbook Language and Service Authorization Requirements
APPENDIX L	DISCO Enrollee Rights
APPENDIX M	DISCO Information Requirements
APPENDIX N	DISCO Risk Corridor (illustration purposes only)
APPENDIX O	Disco Requirements for Cultural Competence Plan
APPENDIX X	Modification Agreement Form (to accompany modified appendices for Changes in term or consideration on an existing period or for renewal periods.)

**DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT  
AND CARE COORDINATION  
CONTRACT**

This CONTRACT is hereby made by and between the State Office of People With Developmental Disabilities (OPWDD), hereinafter called the "Office" and the State of New York Department of Health, hereinafter called the "Department" and the "Contractor" identified on the face page.

WHEREAS, the Department is the single State agency charged with the responsibility for administration of the New York State Medical Assistance Program (Medicaid), Title 11 of Article 5 of the Social Services Law; The Office has responsibility for services provided to individuals with intellectual and developmental disabilities in accordance with Article 16 of New York State Mental Hygiene Law.

WHEREAS, the Contractor has been certified as a Developmental Disability Individualized Services Care Coordination Organization (DISCO) pursuant to Section 4403-g of Article 44 of the Public Health Law;

WHEREAS, the Contractor represents that the Contractor is able and willing to provide and arrange for health and long-term care services on a capitated basis in accordance with New York State Public Health Law Section 4403-g;

NOW, THEREFORE, in consideration of the foregoing and of the covenants and agreements hereinafter set forth, the Parties hereto agree as follows:

## ARTICLE I

### TERM OF CONTRACT, RENEWAL AND TERMINATION

#### A. Term of Contract

Term: The Contract shall begin on and, unless terminated sooner as permitted by the terms of this Contract, end on the dates identified on the face page hereof.

#### B. Renewal

The Office, with the approval of the Department and the State Comptroller or his designee, may extend the term of the Contract for up to two (2) additional one (1) year terms. Standard Appendix X is the form to be used in extension of this Contract. The Department will provide written notice to the Contractor of extension of the term of the Contract at least ninety (90) days prior to the end of the term.

#### C. Termination of the Contract by the State

1. The Office or the Department shall have the right to terminate this Contract, if the Contractor, in the Office or the Department's determination:

- (a.) Takes any action that threatens the health, safety, or welfare of any Enrollee;
- (b.) Has engaged in an unacceptable practice under 18 NYCRR PART 515;
- (c.) Has failed to substantially comply with applicable standards of the Public Health Law and regulations or Mental Hygiene Law and regulations, or has had its certificate of authority suspended, limited, or revoked;
- (d.) Materially breaches the Contract or fails to comply with any term or condition of this Contract and such breach or failure is not cured within twenty (20) days, or such longer period as the Office may allow, of the Office's notice of breach or noncompliance;
- (e.) Becomes unable to meet its obligations in the normal course of business including but not limited to circumstances beyond its control and changes to the provider network affecting Enrollee access; or
- (f.) Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under Title 11 of the U.S. Code (the Bankruptcy Code) and the petition is not vacated within thirty (30) days of its filing.

2. The Office shall give the Contractor written notice of termination of this Contract, specifying the applicable termination provision(s) and the effective date of termination.

#### **D. Termination of the Contract by the Contractor**

1. The Contractor shall have the right to terminate this Contract, if the Office and/or the Department:
  - (a.) fails to make agreed-upon payments in a timely and accurate manner;
  - (b.) materially breaches the Contract or fails to comply with any material term or condition of this Contract.
2. Contractor shall allow thirty (30) days, or such longer period as the Contractor may permit, from the time of the Contractor's written notice of deficiency, for the Department or Office to cure the identified deficiency.
3. The Contractor shall give the Office and the Department written notice specifying the reason(s) for and the effective date of the termination, which shall not be less time than will permit an orderly disenrollment of Enrollees to the Medicaid fee-for-service program or transfer to another managed long-term care plan, but no more than ninety (90) days.

#### **E. Other Termination Reasons**

1. This Contract may be terminated by the Contractor, the Office or the Department as of the last day of any month upon no more than ninety (90) days prior written notice to the other Party so as to ensure an orderly transition. Notwithstanding this provision, the Contractor agrees to comply with Sections F and G of this Article.
2. This Contract shall be terminated immediately if federal financial participation in the costs hereof becomes unavailable or if State funds sufficient to fulfill the obligation of the Department and Office hereunder are not appropriated by the State Legislature. The Department will give the Contractor prompt written notice of such termination of this Contract.
3. This Contract may be terminated in accordance with the provisions of Article X Section BB, Renegotiation.

#### **F. Contract Expiration and Contractor Termination/Phase-Out Plan**

1. The Contractor hereby agrees that in the event this Contract is terminated by either Party that the Contractor will continue to provide Covered Services to Enrollees until Enrollees are reinstated to fee-for-service care or transferred to another managed long-term care plan. To the extent that such services are provided by the Contractor to Enrollees prior to their disenrollment into a fee-for-service program, the Contractor will continue to be reimbursed a premium for such Enrollee. Upon expiration and non-

renewal, or termination of this Contract, the Contractor shall comply with the termination plan that the Contractor has developed and that the Office and the Department have approved.

2. In the event that Contractor gives notice to terminate this Contract, the Contractor shall submit a termination plan for Office and Department approval with the Contractor's notice of termination.
3. In the event that the Office or Department gives notice to terminate this Contract, the Contractor shall submit within fifteen (15) days of notice or such longer period as the Department may allow a termination plan for Office and Department approval.
4. Sixty (60) days prior to the date of termination, the Contractor shall advise all current Enrollees of the termination by regular first class mail. In the event that the termination date is established less than sixty (60) days in advance, letters shall be mailed by regular first class mail within five (5) days of the establishment of the termination date.
5. The Contractor shall communicate with Office's Revenue Support Field Office (RSFO) within fifteen (15) days of the establishment of the termination date to offer the RSFO assistance and information necessary to reinstate each Enrollee's Medicaid benefits through the fee-for-service system or through enrollment in another managed care plan.
6. As soon as a termination date has been established and appropriate notice given pursuant to this Contract by either the Contractor or the Office:
  - a. the Contractor shall contact other community resources to determine the availability of other programs to accept the Enrollees into their programs;
  - b. the Contractor shall coordinate with the RSFO to assist Enrollees by referring them, and by making their care management record and other Enrollee service records available as appropriate to health care providers and/or programs;
  - c. the Contractor shall establish a list of Enrollees that is prioritized according to those Enrollees requiring the most skilled care, and
  - d. based upon the Enrollee's established priority and a determination of the availability of alternative resources, individual care plans shall be developed by the Contractor for each Enrollee in collaboration with the Enrollee, the Enrollee's family and appropriate community resources.
7. In conjunction with such termination and disenrollment, the Contractor shall provide such other reasonable assistance as the Office may request in affecting that transition.

Upon completion of individual care plans and reinstatement of the Enrollee's Medicaid benefits through the fee-for-service system or enrollment in another managed care plan, an Enrollee shall be disenrolled from the Contractor's DISCO.

8. Within sixty (60) days of the date of termination of the Contract, an accounting shall be

prepared and submitted to the Office and the Department by or on behalf of the Contractor for the establishment of a sum to be repaid to the Office or the Department by the Contractor of funds advanced by the Office or the Department, if any, for coverage of Enrollees for periods subsequent to the date of termination.

9. The Contractor shall maintain all books, records and other documents that may be required pursuant to this Contract regarding the DISCO and make such records available to the Office and the Department and all authorized representatives of the State and federal government throughout the period that such records are required to be maintained pursuant to this Contract.

#### **G. Effect of Termination on New Enrollments**

Once either Party has given notice of its intentions to terminate this Contract, enrollment into the DISCO will be suspended.

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## ARTICLE II

### STATUTORY AND REGULATORY COMPLIANCE

- A. The Contractor agrees to operate in compliance with the requirements of this Contract, legislative and regulatory requirements including, but not limited to 42 Code of Federal Regulation (CFR) parts 434 and 438, New York State Public Health Law Section 4403-g, and other applicable provisions of Article 44 and Article 49 of New York State Public Health Law and implementing regulations. The Contractor shall also meet the requirements of Article 16 of New York State Mental Hygiene Law and implementing regulations.
- B. Covered services provided by the Contractor under this Contract shall comply with all standards of the New York State Medicaid Plan established pursuant to Section 363-a of the State Social Services Law and the 1915c comprehensive waiver agreement and satisfy all other applicable requirements of the Social Services Law, Mental Hygiene Law and Public Health Law.
- C. The Contractor agrees to comply with all applicable laws, regulations, and rules including
1. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80;
  2. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
  3. The Rehabilitation Act of 1973, as implemented by regulations at 45 CFR part 84;
  4. The Americans with Disabilities Act;
  5. The Health Insurance Portability and Accountability Act, and
  6. Other laws applicable to recipients of Federal funds.
- D. The Contractor must comply with Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 for program accessibility, and must develop an ADA Compliance Plan consistent with the New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act set forth in Appendix B, which is hereby made a part of this Agreement as if set forth fully herein. Said plan must be approved by the Office and the Department, be filed with the Department, and be kept on file by the Contractor.
- E. The Contractor is receiving federal payments under this Contract. The Contractor and subcontractors paid by the Contractor to fulfill its obligations under this Contract are subject to certain laws that are applicable to individuals and entities receiving federal funds. The Contractor agrees to inform all subcontractors that payments that they receive are, in whole or in part, from federal funds.
- F. In the event that any provisions of this Contract conflicts with the provisions of any statute or regulations applicable to a Contractor, the provisions of the statute or regulations shall have control.

### **ARTICLE III**

#### **CONTRACTOR SERVICE AREA AND AGES OF POPULATION TO BE SERVED**

- A. For purposes of this Contract, the Contractor's service area shall consist of the geographic area described in Appendix F of this Contract, which is hereby made a part of this Contract as if set forth fully herein.

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## ARTICLE IV

### ELIGIBILITY FOR DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND AND CARE COORDINATION ORGANIZATION

A. Except as specified in Sections B and C of this Article, an Applicant who completes an enrollment agreement shall be eligible to enroll under the terms of this Contract if he or she:

1. is determined eligible for Medicaid by the Local Department of Social Services or an entity designated by the Department of Health, AND;
2. is a resident in the Contractor's service area, AND;
3. is determined by the Office to have a developmental disability as defined in Mental Hygiene Law section 1.03(22);

B. Persons NOT eligible for enrollment:

1. Individuals with developmental disabilities who would otherwise qualify for enrollment in a DISCO will NOT be eligible to enroll while they reside in the following:

1. OPWDD Developmental Center,
2. Skilled Nursing Facility,
3. Office of Alcohol and Substance Abuse (OASAS) Inpatient (where eligible for Medicaid Reimbursement),
4. Office of Mental Health Institutional Program (Psychiatric Units operated by Article 28 General Hospitals),
5. Article 31 Private Psychiatric Hospitals,
6. Residential Treatment Facilities for children and youth, and State Psychiatric Centers operated by the New York State Office of Mental Health).

However, if an individual who is already enrolled with a DISCO enters one of these settings, the DISCO will be expected to pay for the service when the service is eligible for Medicaid-funding, while working with the individual to ensure that he or she lives in the most integrated setting possible.

2. Persons receiving services in the following settings are also NOT eligible to enroll:

1. an OFCS childcare institution,
2. a adult home or assisted living facility licensed by NYS DOH,
3. a residential setting licensed by the New York State Department of Mental Health, including OMH Community Residences, Family Based Treatment Homes, Training Family Homes, etc.
4. enrolled in an OPWDD Care-At-Home waiver, or
5. enrolled in a Home and Community Based Services (HCBS) waiver program overseen by a New York State Agency, other than OPWDD.

## ARTICLE V

### OBLIGATIONS OF THE CONTRACTOR

#### A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42 CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.
2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the Comprehensive OPWDD Home and Community Based Services waiver and the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the Mental Hygiene Law (MHL), Public Health Law (PHL) and Social Services Law (SSL). Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid on a fee-for-service basis directly to the provider of service.
3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.
4. The Contractor shall maintain and demonstrate to the Offices' satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through a network of contracted providers that meets the requirements in section D of Article VII of this Contract. The Contractor shall meet the standards required by 42 CFR 438.206 for availability of services; 42 CFR 438.207 for assurances of adequate capacity; and applicable sections of MHL, PHL and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.
5. The contractor agrees to furnish all information requested by the Office related to *Money Follows the Person* reporting, and to cooperate with outreach activities related to this program.

#### B. Eligibility Activities of Contractor

In areas where mandatory enrollment is not approved and/or implemented, an individual Applicant's decision to enroll shall be voluntary. In all areas of the Contractor's service area, The Contractor shall accept applications and enrollment agreement forms in the order they are received, without selecting among forms and without regard to the capitation rate the Contractor will receive for such person. The Contractor shall not discriminate against eligible Applicants on the basis of health status or need for health care services.

### **C. Enrollment Process**

1. The Contractor shall comply with enrollment procedures developed by the state's enrollment broker and the Office. Such written procedures will be transmitted in writing to the Contractor by the Office, including procedures and policies for working with the Office's contracted enrollment broker consistent with the requirements of Mental Hygiene and Public Health Law.
2. The Contractor shall maintain copies of, completed assessment and reassessment instruments, a plan of care and any other necessary information to enable the Office to assess care coordination and enrollment activities of the Contractor.
3. An Enrollee shall be entitled to receive Covered Services as provided for herein as of the effective date of enrollment in the Contractor's Plan. For a list of services covered for DISCO enrollees (including DISCO enrollees also enrolled in the 1915(c) DD Waiver), please see Appendix G.
4. The Department or the Department's designee will provide to the Contractor a WMS/eMedNY "Exception Report" or an alternate electronic report for any approved applications that are not accepted by WMS/eMedNY, when WMS/eMedNY does not show the Applicant as Medicaid eligible.
5. The Contractor will request written permission from the Office and the Department to suspend enrollment when the Contractor determines that it lacks access to sufficient or adequate resources to provide or arrange for the safe and effective delivery of Covered Services to additional Enrollees. Resumption of enrollment will occur only with the Office and Department approval, not to be unreasonably delayed, after written notice from the Contractor that adequately describes how the situation precipitating the suspension was corrected.
6. OPWDD and the Department may establish enrollment limits based either on a determination of readiness or on limits established pursuant to Public Health Law.
7. The surplus amount (spend-down or NAMI amount) to be billed to an Enrollee by the Contractor must be the amount for which the Enrollee is responsible as determined by the RSFO or the LDSS. The method of collection of NAMI must be included in the terms of the Contractor's agreement with the Nursing Facility or ICF/DD.

### **D. Disenrollment Policy and Process**

#### **1. Disenrollment Policy**

- (a.) The Contractor shall comply with disenrollment procedures developed by the Office. Such written procedures will address all aspects of disenrollment

processing and the Office audit process, consistent with the requirements of the Mental Hygiene Law and Public Health Law.

- (b.) The effective date of disenrollment shall be the first day of the month following the month in which the disenrollment is processed through eMedNY, unless directed by the OTDA Office of Administrative Hearings or the Medicaid Inspector's Office.
- (c.) Disenrollment may not be based in whole or in part on an adverse change in the Enrollee's health, or the Enrollee's residential or institutional placement, or on the capitation rate payable to the Contractor. Disenrollment may not be initiated because of the Enrollee's high utilization of covered medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except as may be established under subsection 5 (a) of this Section.
- (d.) The Contractor shall continue to provide and arrange for the provision of covered services until the effective date of disenrollment. The Department will continue to pay capitation fees for an Enrollee until the effective date of disenrollment.
- (e.) In consultation with the Enrollee, prior to the Enrollee's effective date of disenrollment, the Contractor shall make all necessary referrals to alternative services, for which the plan is not financially responsible, to be provided subsequent to disenrollment, when necessary, and advise the Enrollee in writing of the proposed disenrollment date.

## 2. Enrollee-Initiated Disenrollment

- (a.) An Enrollee may initiate voluntary disenrollment at any time for any reason upon oral or written notification to the DDRO or the contracted enrollment broker.
- (b.) An Enrollee who elects to join and/or receive services from another managed care option authorized by NYS Medicaid, is considered to have initiated disenrollment from Contractor's DISCO.
- (c.) If an Enrollee is transferring from the Contractor's DISCO to another DISCO, a long term managed care plan, or Medicaid Managed Care plan, the Contractor must provide the receiving plan with the individual's current person centered service plan in order to ensure a smooth transition
- (d.) For Enrollees who have elected hospice, the Contractor shall continue to provide covered services during the month following admission to hospice if the Enrollee requires services covered by the plan in addition to services provided through hospice. The Contractor must reevaluate its plan of care and coordinate service plans with the hospice to avoid duplication and conflict.
- (e.) The Enrollee has been a resident of a Developmental Center for sixty (60) days, and has elected to disenroll.

### 3. Involuntary Disenrollment by a Contractor

- (a.) An involuntary disenrollment is a disenrollment initiated by the Contractor without agreement from the Enrollee.
- (b.) An involuntary disenrollment requires approval by OPWDD.
- (c.) The Contractor agrees to transmit information pertinent to the disenrollment request to OPWDD in sufficient time to permit OPWDD to review the request for disenrollment and effect the disenrollment pursuant to the requirements of 42 CFR 438.56 (e)(1).

A Contractor May Request Approval from OPWDD for an Involuntary Disenrollment if:

- (a.) The Enrollee knowingly fails to complete and submit any necessary consent or release.
- (b.) The Enrollee refuses to allow the Contractor to complete necessary reassessments and level of care eligibility redeterminations.

### 4. Reasons the Contractor Must Initiate Disenrollment

If an Enrollee does not request voluntary disenrollment, the Contractor must initiate involuntary disenrollment within five (5) business days from the date:

- (a.) the Contractor knows the Enrollee no longer resides in the service area; or
- (b.) the Enrollee has been absent from the service area for more than ninety (90) consecutive days and the enrollee and the enrollee's authorized representative have been non-responsive to requests for contact. Prior to the effective date of the disenrollment the Contractor must arrange and provide all necessary Covered Services, or
- (c.) the Enrollee is hospitalized or enters an OMH or OASAS inpatient program for sixty (60) days or longer, or
- (d.) the Enrollee clinically requires nursing home care but is not eligible for such care under the Medicaid Program's institutional rules, or
- (e.) the enrollee-is no longer eligible to receive Medicaid benefits, or
- (e.) the Enrollee is no longer eligible for ICF/DD level of care as determined at the last comprehensive assessment of the calendar year using the assessment tool prescribed by OPWDD. The Contractor shall provide OPWDD the results of its reassessment and recommendations regarding continued enrollment or disenrollment within five (5) business days of the comprehensive assessment, or

- (f.) the Enrollee is incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration, or
- (g.) the Enrollee has placed in an adult home, an assisted living facility, a non-institutional residential program licensed by OMH, or and OCFS childcare facility, or
- (h.) the Enrollee is enrolled in an HCBS Medicaid waiver, other than the OPWDD Comprehensive HCBS waiver, or
- (i.) the Enrollee is no longer deemed eligible to receive OPWDD services under the NYS Mental Hygiene law, or
- (j.) the enrollee has died.

#### **E. Enrollee Protections**

1. The Contractor shall have and comply with Office and Department-approved written policies and procedures regarding internal grievances, grievance appeals and appeals processes, that are consistent with the Department and Office's grievance, grievance appeals and appeals policies contained in Appendix K of this Agreement. These include notifying Enrollees who receive an adverse appeal resolution about their right to a Medicaid Fair Hearing and/or an External Appeal, where applicable. The Contractor agrees to submit any proposed material revisions to the approved policies and procedures for Department approval prior to implementation of the revised policies and procedures.
2. The Contractor agrees to adopt and maintain arrangements satisfactory to OPWDD to protect its Enrollees from incurring liability for payment of any fees that are the legal obligation of the Contractor. To meet this requirement the Contractor must:
  - (a.) ensure that all contracts with providers prohibit the Contractor's providers from holding any Enrollee liable for payment of any fees that are the legal obligation of the Contractor; and
  - (b.) indemnify the Enrollee for payment of any fees that are the legal obligation of the Contractor for services furnished by providers that have been authorized by the Contractor to serve such Enrollee, as long as the Enrollee follows the Contractor's rules for accessing services described in the approved member handbook.
3. The Contractor shall develop and implement written policies and procedures regarding Enrollee rights which fulfill the requirements of 42 CFR 438.100 and applicable State law and regulation.
4. The Contractor will distribute and otherwise make available information about Enrollee rights contained in Appendix L of this Agreement to all Potential Enrollees, Applicants and Enrollees.

## **F. Quality Assurance and Performance Improvement Program**

1. The DISCO Contractor shall have in place a fully operational Quality Assurance and Performance Improvement Program that is based upon a written Quality Plan for the ongoing monitoring, review, and evaluation of:
  - a. the care coordination and person centered planning function; and,
  - b. the quality of care, services and supports furnished to enrollees through the DISCO's network.
2. The written Quality Plan describes how the DISCO contractor will ensure:
  - a. the effectiveness of the care coordination and person centered planning function, and;
  - b. that care, supports, and services provided by network providers are of high quality and are delivered according to established regulations, standards, and evidence based practices where applicable; and meets individual member needs and personal outcomes.
3. The Contractor's written quality plan must meet the requirements of Article 44 of Public Health Law and implementing regulations; applicable CMS/federal regulations; OPWDD mental hygiene law, regulations, and guidelines including the information specified in the QUALITY ASSURANCE AND IMPROVEMENT PLAN ATTACHMENT; and address the standards in 42 CFR 438.240 regarding quality assurance and performance improvement
4. The Contractor's Quality Assurance and Performance Improvement Program and written Quality Plan must include and incorporate the following minimum standards:
  - a. Board level accountability for the overall oversight of DISCO program activities and an
  - b. Annual review and approval of the Quality Assurance and Performance Improvement (QA/PI) program (and written plan) by the Board, including that its implementation is designed to result in improved care coordination person centered care planning, service delivery, and outcomes for individuals served.
  - c. Involvement of enrollees (and family members, advocates, and others of importance to enrollees) in the quality assurance and performance improvement activities. Evaluation of the quality and appropriateness of the assessment function and the linkages between the assessment and the care coordination, care planning, and service delivery process including the incorporation of performance indicators that review the quality and appropriateness of enrollee assessment. Evaluation of changes in the enrollee's clinical and functional capacity and individual outcomes/progress towards goals as a result of the delivery of supports and services. This can be accomplished through the care coordination function, sampling by QI, or other appropriate methodologies outlined in the Quality Plan.
  - d. Evaluation of the quality and appropriateness of the assessment function and the linkages between the assessment and the care coordination and care planning process.
  - e. Incorporation of performance indicators that review the quality and appropriateness of the enrollee assessment.
  - f. Evaluation of changes in the enrollee's clinical and functional capacity and individual outcomes as a result of the delivery of supports and services. For

example, the Quality Plan could incorporate this review by sampling.

- g. Enrollee satisfaction with services and supports.
  - h. Review of the standards for access, availability and continuity of services against OPWDD, DOH and/or DISCO established requirements, standards and performance measures including, but not limited to:
    - (i) length of time to respond to requests for referrals,
    - (ii) timeliness of receipt of covered services,
    - (iii) timeliness of implementation of care plan,
    - (iii) telephone consultation to assist Enrollees in obtaining health information and, on a 24 hour basis, urgent care, and
    - (iv) other measures required and/or published by OPWDD/DOH for this purpose.
5. Annually, the identification of specific and measurable quality improvement activities including the required quality improvement project(s) that will be undertaken by the Contractor. Identification of how specific performance measures required by the Centers for Medicare and Medicaid Services (CMS), DOH, and/or OPWDD (See Appendix I) will be integrated into/implemented within the Contractor's Quality Plan.
  6. Meets other requirements specified in Appendix I, Quality Plan Guidelines for DISCOs incorporated as part of this DISCO Contract and/or published by OPWDD for the purpose of DISCO adherence.
  7. The Contractor agrees to cooperate with any external quality review conducted by or at the direction of CMS, OPWDD and/or the Department of Health and act on the recommendations provided through this external quality review.
  8. The Contractor agrees to submit any required quality improvement reports and data including the data outlined in the Attachment and/or published by OPWDD for this purpose.
  9. The Contractor agrees to submit any proposed material revisions to the approved quality plan for OPWDD approval prior to implementation of the revised plan.

#### **G. Outreach**

1. The Contractor shall conduct indirect marketing activities/outreach for Potential Enrollees consistent with 42 CFR 438.104, applicable State Law and its implementing regulation.
2. Outreach materials include any information produced by or on behalf of the Contractor that references managed care concepts, is intended for general distribution and is produced in a variety of print or broadcast mechanisms.
3. The Contractor shall comply with a outreach plan which has received written prior approval by the Office. If there are any material changes to the outreach plan, they must be submitted to the Office before implementation. The outreach plan shall describe outreach

and enrollment goals, the specific activities to be undertaken to achieve the enrollment goals and identify the personnel who will carry out the outreach functions. The outreach plan should address each of the following:

- (a.) a description of how the Contractor will distribute outreach material in its service area approved by the Office;
  - (b.) a listing and copies of the specific outreach formats to be used ( e.g. radio announcements, letters, posters, brochures, handbooks) and the forums for distribution or presentation (e.g. health fairs, provider offices, community events);
  - (c.) evidence that the material is written in 12 point type at a minimum and prose written in clear, simple, understandable language at the 4<sup>th</sup> to 6<sup>th</sup> grade reading level;
  - (d.) a description of how the Contractor will outreach to Potential Enrollees who speak other than English as a primary language;
  - (e.) the methods of making alternate formats available to persons who are visually and hearing impaired, who have a cognitive impairment, or who require the use of a communication device;
  - (f.) the method and timetable for updating and disseminating the list of Participating Providers available to Potential Enrollees;
  - (g.) a description of how the Contractor will assure that its Participating Providers comply with these provisions;
  - (h.) a discussion as to if or how the Contractor plans to provide nominal gifts for the target population;
  - (i.) a description of the personnel qualifications, the training content, methods and mechanisms for evaluation, supervision and reimbursement of outreach personnel; and
  - (j.) a description of the methods to be used by the Contractor to monitor and assure compliance with the approved outreach plan.
4. The Contractor shall conduct outreach activities consistent with the following provisions:
- (a.) The Contractor may use radio, television, billboards, newspapers, leaflets, brochures, the Internet, yellow page advertisements, letters, and posters as well as health fairs and other appropriate events to market its product.
  - (b.) The Contractor shall not mislead, confuse, defraud Potential Enrollees or misrepresent itself, the State or the Centers for Medicare and Medicaid Services.
  - (c.) The Contractor may place outreach materials in local community centers, pharmacies, hospitals, nursing homes, home care agencies, doctors' offices and

other areas where Potential Enrollees are likely to gather or receive long-term care services.

- (d.) The Contractor may not directly or indirectly engage in door to door, telephone or other “Cold Call” outreach activities.
  - (e.) The Contractor shall ensure, through its agreements with subcontractors, compliance with the provisions of this Section.
  - (f.) The Contractor, in its outreach materials, shall offer only benefits or services that are clearly specified in this Contract and available for the full contract period being outreached.
  - (g.) The Contractors shall not offer monetary incentives to Medicaid recipients to join the plan. Nominal gifts of no more than \$5.00 fair market value may be offered as part of promotional activities to stimulate interest in the plan as long as such gifts are made available to everyone regardless of whether they enroll.
  - (h.) Outreach staff shall be trained in the concepts of managed long-term care, DISCO benefits, and all facets of the plan using the subject outline of the member handbook as a minimal basis for the training curriculum.
  - (i.) The Contractor may not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
5. All written materials used in carrying out the functions of this Section, including but not limited to outreach materials and the member handbook, must be reviewed and approved by the Office prior to use. The Contractor shall comply with all requests from the Office for periodic reports on the performance of the Contractor’s responsibilities pursuant to this Section. The Contractor shall submit these reports within thirty (30) days of receiving the request from the Department.

#### **H. Information For Potential Enrollees, Applicants and Enrollees**

- 1. The Contractor shall provide information to all Potential Enrollees, Applicants and Enrollees consistent with 42 CFR 438.10, applicable State Law and its implementing regulation, and Appendix M of this Agreement.
- 2. The Contractor must submit to the Office and the Department for prior approval a description of how the Contractor will provide information and annual notification to its Enrollees as required by this Section, including:
  - (a.) evidence that the material is written in 12 point type at a minimum and prose written in clear, simple, understandable language at the 4<sup>th</sup> to 6<sup>th</sup> grade reading level;
  - (b.) the methods the Contractor will use to provide information to Applicants and Enrollees who speak other than English as a primary language;

- (c.) the methods of making alternate formats available to persons who are visually and hearing impaired who have a cognitive impairment, or who require the use of a communication device; and
  - (d.) the method and timetable for updating and disseminating the list of Participating Providers.
3. The Contractor shall provide Potential Enrollees, Applicants and Enrollees information consistent with the following provisions.
- (a.) The Contractor shall comply with the Office and Department's requirements for language and format standards for information pursuant to 42 CFR 438.10 (c) and (d).
  - (b.) The Contractor shall provide the member handbook and the provider network to all Applicants prior to enrollment and to Enrollees.
  - (c.) The Contractor shall give Enrollees prior written notice of significant changes to the information identified in subsection H (3)(b) of this Section. Such notice shall be at least thirty (30) days prior to the effective date of the change pursuant to 42 CFR 438.10(f)(4).
  - (d.) The Contractor shall annually notify Enrollees in writing of their disenrollment rights and their right to request the information specified in 42 CFR 438.10 (f) (6) and (g).

## **I. Member Services**

1. The Contractor is responsible to provide the following member services:
- (a.) develop a Person-Centered Service Plan with the person as defined in Appendix J and outlined in Section J. 8 below.
  - (b.) explaining the Contractor's rules for obtaining services and assisting Enrollees in making appointments;
  - (c.) fielding and responding to Enrollee questions and grievances, and advising Enrollees of the option to complain to the SDOH and/or RSFO at any time;
  - (d.) clarifying information in the member handbook for Enrollees;
  - (e.) advising Enrollees of the Contractor's grievance and appeals system, the service authorization process, and Enrollee's rights to a fair hearing and/or external review;
  - (f.) accommodating Applicants and Enrollees who require language translation and communications assistance;

- (g.) conducting post enrollment orientation activities, including orientation of Enrollees, Enrollees' families or representatives, employees, management principles and operating practices;
  - (h.) health promotion and wellness initiatives; and
  - (i.) assisting Enrollees with the renewal of their Medicaid benefits.
3. The Contractor shall develop and implement a cultural competence plan as further described in Appendix O with written protocols and procedure to assure that services are inclusive of culturally diverse member and provider services. Such a plan at a minimum should address:
- a. Effective communication for enrollee and members that speak a language other than English, deaf or hard-of-hearing that require interpretation and/or translation
  - b. Integrating culturally responsive approaches into assessments, planning, or other services.
  - c. A process to for training employees on a regular basis for cultural competence best requirements and best practices.
  - d. Outreach and engagement efforts should include collaborations with multicultural providers, religious groups, peer organizations, and family members.
  - e. Data collection should include race, ethnicity, language and disability for quality assurance and outcomes.
3. The Contractor shall develop and implement written procedures and protocols that assist enrollees to access independent advocacy services through the following means:
- a) Assistance for enrolled individuals to understand their right to request an advocate
  - b) Information regarding the availability of independent advocates and/or agencies and to connect individuals to independent advocates if they so request
  - c) Internal procedures for tracking the status/progress of individual requests for advocacy;
  - d) A commitment to cooperate with advocates, provide advocates access to records, files, facilities and personnel as needed.
4. The Contractor shall develop and implement written procedures and protocols to ensure that the minimum requirements for Willowbrook Class members are met as per the Willowbrook Permanent Injunction.

## **J. Care Management**

1. Care management entails the establishment and implementation of a comprehensive, holistic, person-centered written care plan and assisting enrollees to access services authorized under the care plan. Care management includes referral to and coordination of other necessary medical, and social, educational, psychosocial, financial and other

services of the care plan irrespective of whether such services are covered by the plan.

2. The Contractor shall comply with policies and procedures consistent with 42 CFR 438.210, 42 CFR 438.208 and Appendix K of this Agreement that have received prior written approval from the Office. The Contractor agrees to submit any proposed material revisions to the approved coverage and authorization of services policies and procedures for Office approval prior to implementation of the revised procedures.
3. The Contractor's care management system shall ensure that care provided is adequate to meet the needs of individual Enrollees and is appropriately coordinated, and shall consist of both automated information systems and operational policies and procedures.
4. The Contractor shall be responsible for the management, coordination, and continuity of care for all its members and shall develop and maintain policies and procedures to address this responsibility. The contractor shall:
  - a. Provide for the member's enrollment in the plan through an Intake Process that includes:
    - i. Assessment of a member's habilitative, physical, behavioral, functional, and psychosocial needs
    - ii. identifying the physical health, behavioral health and long-term support services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs;
  - b. Develop with the person, a person-centered plan of care plan. For enrollees living in an Intermediate Care Facility (ICF/DD) the plan of care is known as the Comprehensive Functional Assessment (CFA) and is developed in accordance with federal and state statute and regulations (42 U.S.C. §§ 1320a-7j, 1395hh, 1396d; Mental Hygiene Law Art. 16; Social Services Law §§ 364, 364-a; 42 CFR Parts 456, 483; 14 NYCRR Part 681). All other enrollees will have a care plan that is known as a LIFE PLAN. Both plans are developed based upon a formal assessment of the person's needs and goals and outline supports and services to be delivered in the most integrated settings appropriate to each individual
  - c. Provide On-Going Coordination of Care that includes:
    - i. Monitoring the health and safety of the enrollee;
    - ii. Coordination of care among waiver providers, specialists, behavioral health providers, and long-term care providers;
    - iii. Performance of reasonable preventive health case management services, and have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;
    - iv. Coordination of hospital and/or institutional discharge planning that includes post-discharge care, as appropriate
  - d. Monitor members' Outcomes in the following areas:
    - i. attainment of personal outcomes and for those members with ongoing medical or behavioral health conditions monitor the management of these specialized needs;

- ii. timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term support services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and
  - iii. the person served is being supported in the most integrated setting appropriate to his/her individual circumstances
- 5. The Contractor shall provide care coordination to all members enrolled in the DISCO in accordance with this Agreement. Care coordination shall not be available to individuals who are not in enrolled in the People First Waiver.
- 6. Lead Care Coordinator and the Care Coordination Team
  - a. The Contractor shall assign to each member a specific care coordinator who shall have primary responsibility for performance of care coordination activities as specified in this Agreement, and who shall be responsible for coordination of all of a member's habilitative, physical health, behavioral health, and long-term support services and natural (unfunded) supports. In addition, the care coordinator shall be the point of contact for the member or be responsible for assigning and overseeing a point of contact
  - b. The Contractor shall ensure that lead care coordinators meet the education and experience requirements. Lead care coordinators must have a bachelor's degree and one year of experience working with individuals with developmental disabilities.
  - c. The Contractor may use a care coordination team approach to performing care coordination activities. For each member, the Contractor's care coordination team shall consist of the member's lead care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of members. The Contractor shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams.
  - d. The care coordinator may use resources and staff from the Contractor's case management programs or from clinical programs included within the Contractor network, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team
- 7. Intake Activities
  - a. Within ten business days (or two weeks) of notice of the member's enrollment into the DISCO, the care coordinator shall conduct a face-to-face meeting with the member, review any existing assessments and perform any additional needed assessments.
    - i. As part of the face-to-face meeting, the care coordinator shall review with members the option to self-direct any or all of his/her services and supports

- and obtain written confirmation of the member's decision
- ii. The care coordinator shall also provide member education regarding choice of contract providers for services, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers
  - b. The Contractor may elect to use specialized intake coordinators or intake teams for initial care planning activities. All activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator. Should the contractor elect to utilize specialized intake coordinators or teams, the contractor shall develop policies and procedures which specify how the contractor will coordinate a seamless transfer of information from the intake coordinator or team to the member's care coordinator.
  - c. The Contractor shall ensure that, upon enrollment with the DISCO the person's current Medicaid Service Coordination or other case management activities are integrated within the care coordination provided by the Contractor

#### 8. Development of a Person-Centered Care Plan

- a. The member and the member's care coordinator/care coordination team shall be responsible for coordination of the member's physical health, behavioral health, and long-term support service needs.
- b. The care coordinator shall coordinate and facilitate a care planning meeting that includes, at a minimum, the member and the member's care coordinator and anyone else that the member wants to participate in the planning process. As appropriate, the care coordinator shall include or seek input from other individuals such as the member's representative or other persons authorized by the member to assist with care planning activities.
- c. The care coordinator shall verify that the decisions made by the care planning team reflect the person's informed choices and are based upon the assessment of the individual and are documented in a written, comprehensive plan of care.
- d. The Plan of Care must be developed using a Person Centered Planning Process as described in Appendix ?, (pending)
- e. Within 20 business days of enrollment, a member's plan of care developed with the member shall at a minimum include:
  - i. description of the person (e.g. skills, strengths, interests)
  - ii. desired health, functional, and quality of life outcomes for the member
  - iii. the observable/measurable action steps taken to achieve the member's outcomes that will be taken by the person, and paid and unpaid service providers and other persons who support the enrollee.
  - iv. pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term support services) related information and to assist with

- assessment, planning, and/or implementation of health care (including long-term support services) related services and supports;
- v. A safeguard description that includes an assessment of the participant's level of skills, the dignity of risk, and the supports needed to keep the participant safe from harm and actions to be taken when the health or welfare of the person is at risk. For enrollees residing in an Individualized Residential Alternatives (IRA) a plan for protective oversight that includes an assessment of the enrollee's ability to evacuate in case of fire.
  - vi. The person's employment status (competitively employed, volunteer, paid work at less than minimum wage )
  - vii. supports, including specific tasks and functions, that will be performed by family members and other caregivers;
  - viii. services the member will receive;
  - ix. HCBS waiver services that will be authorized by the Contractor, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the purpose and outcome of the service, and the intended schedule at which such care is needed, as applicable; Authorization for placement in an OPWDD certified residence is contingent upon DDRO review and prior approval
  - x. detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the DISCO shall assess the adequacy of the back-up plan;
  - xi. Relevant information from the member's individualized treatment plan for any member with behavioral support plan that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of services (14 NYCRR § 633.16);
  - xii. Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care;
  - xiii. Frequency of planned care coordinator contacts needed, which shall include consideration of the member's individualized needs and circumstances. Unplanned care coordinator contacts shall be provided as needed);
  - xiv. Additional information for members who elect self-direction of services.
  - xv. Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;
- f. The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any updates. The care

coordinator shall also sign and date the plan of care, along with any updates. The plan of care shall be reviewed at least twice annually for the purpose of reviewing the results and/or effect of the delivered supports and services on the person's satisfaction; functional/clinical status; and quality of life outcomes and determining whether any changes are needed to the plan and the person's supports and services to effectuate desired outcomes and results.

- g. The member's care coordinator/care coordination team shall provide a copy of the member's completed plan of care, including any updates, to the member, the member's representative, as applicable
- h. Long-term support services identified through care coordination and provided by the contractor shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.
- i. The Contractor's failure to meet requirements, including timelines, for care coordination set forth in this Agreement, except for good cause, constitutes non-compliance with this Agreement. Such failure shall not affect services if the individual is already receiving services.

#### 9. On-going Coordination of Care

- a. The Contractor's responsibility for on-going coordination of care include:
  - i. Identification and addressing service needs gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The contractor shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;
  - ii. Maintenance of appropriate on-going communication with community and natural supports to monitor and support their ongoing participation in the member's care;
  - iii. Coordination with community organizations that provide services that are important to the health, safety and well-being of members. This may include but shall not be limited to referrals to other agencies for assistance and assistance as needed with applying for programs.
  - iv. Provision of ongoing information regarding self-direction of services
- b. The Contractor shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that shall be performed directly by the care coordinator as specified in this Agreement, including development of the plan of care, all minimum care coordination contacts; the tasks that may be performed by the care coordinator or the care coordination team; measures taken to ensure that the care coordinator remains the member's primary point of contact; escalation procedures to alleviate issues to the care coordinator in

a timely manner; and measures taken to ensure if a member needs to reach his/her care coordinator specifically,.

- c. The Contractor shall have systems in place to facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding his/her members. The care coordinator shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

#### 10. Changes in Care Coordinator Staffing

- a. The Contractor shall develop policies and procedures regarding notice to members of care coordinator changes initiated by either the Contractor or the member, including advance notice of planned care coordinator changes initiated by the Contractor.
- b. The Contractor shall ensure continuity of care when care coordinator changes are made whether initiated by the member or by the Contractor. The Contractor shall demonstrate use of best practices by encouraging newly assigned care coordinators to attend a face-to-face transition visit with the member and the out-going care coordinator when possible.

#### 11. Outcome measurement & Quality Assurance

- a. The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination processes. The DISCO shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. At a minimum, the Contractor shall ensure that:
  - i. Care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;
  - ii. Level of care reassessments occur on schedule;
  - iii. Needs assessments and reassessment, as applicable, occur on schedule and in compliance with this Agreement;
  - iv. Service plan reviews occur at least twice annually and result in the review of the person's satisfaction; outcomes; and any necessary changes to the plan and supports and services to effectuate outcome achievement
- b. The contractor must utilize the system of measurement required by the state to determine the effectiveness of the supports in place through a determination of the outcomes achieved for the individual in the areas identified in the Personal Outcome Measures identified below.

- i. My Self: People are connected to natural supports. People have intimate relationships. People are safe. People have the best possible health. People exercise rights. People are treated fairly. People are free from abuse and neglect. People experience continuity and security. People decide when to share personal information.
- ii. My World: People choose where and with whom they live. People choose where they work. People use their environments. People live in integrated environments. People interact with other members of the community. People perform different social roles. People choose services.
- iii. My Dreams: People choose personal goals. People realize goals. People participate in the life of the community. People have friends. People are respected.

#### **K. Advance Directives**

The Contractor must provide all directives and information to Enrollees with respect to their rights under Public Health Law Articles 29-B and 29-C. The Contractor shall, in compliance with 42CFR 438.6(i) and 422.128, maintain written policies and procedures for advance directives and provide written information to Enrollees with respect to their rights under Public Health Law Articles 29-B and 29-C to formulate advance directives and of the Contractor's policies regarding the implementation of such rights. The Contractor shall include in such written notice to the Enrollee materials relating to Advance Directives and health care proxies as specified in 10 NYCRR 98-1.14 (f) and 700.5.

#### **L. Duplicate CINs**

The Contractor, within five (5) business days of identifying cases where a person may be enrolled in the Contractor's DISCO under more than one Client Identification Number (CIN), or has knowledge of an Enrollee with more than one active CIN, must convey that information in writing to the RSFO (for District 98) or the LDSS (Non-District 98) for appropriate follow-up. In circumstances where the duplicate CIN continues to exist after 90 days from notification to the RSFO and/or LDSS, the Contractor must report the duplicate CIN to the OFFICE.

Notwithstanding the foregoing, the SDOH always has the right to recover MCO premiums paid for persons who have concurrent enrollment in one or more MCO products under more than one Client Identification Number (CIN).

#### **M. Contractor Responsibilities Related to Public Health**

The Contractor shall provide the Department of Health with information as requested to facilitate epidemiological investigations.

The Contractor shall make reasonable efforts to assure timely and accurate compliance by Providers with public health reporting requirements related to communicable diseases and conditions mandated in PHL Article 21 and, for Contractors operating in New York City, the New York City Health Code (24 RCNY 11.03 – 11.07).

The Contractor shall make reasonable efforts to assure timely and accurate compliance by Providers with other mandated reporting requirements.

## ARTICLE VI

### PAYMENT

#### A. Capitation Payments

1. Compensation to the Contractor shall consist of a monthly capitation payment for each Enrollee.
2. In compliance with Section 4403-g of Public Health Law, monthly capitation rates shall be cost-neutral to both state and local governments when compared to costs which would be incurred by such programs if Enrollees were to receive comparable health and long-term care services on a fee-for-service basis in the geographic region for which services are provided.
3. The monthly Capitation Rates are attached hereto as Appendix H and shall be deemed incorporated into this Contract without further action by the parties.
4. The monthly capitation payment to the Contractor shall constitute full and complete payments to the Contractor for all services that the Contractor provides pursuant to this Contract.
5. Capitation Rates shall remain in effect until such time as modifications are made pursuant to Sections B and C of this Article.

#### B. Modification of Rates during Contract Period

1. Any technical modification to Capitation Rates, during the term of the Contract as agreed to by the Contractor, including but not limited to changes in Premium Groups, shall be deemed incorporated into this Contract without further action by the parties upon approval of such modifications by the Department and, when required, the Division of Budget.
2. Any other modification to Capitation Rates, as agreed to by the Department and the Contractor during the term of the Contract shall be deemed incorporated into this Contract without further action by the parties upon approval of such modifications by the Department and the State Division of Budget.
3. In the event that the Department and the Contractor fail to reach agreement on modifications to the monthly Capitation Rates, the Department will provide formal written notice to the Contractor of the amount and effective date of the modified Capitation Rates approved by the State Division of the Budget. The Contractor shall have the option of terminating this Contract if such approved modified Capitation Rates are not acceptable. In such case, the Contractor shall give written notice to the Department and the Office within thirty (30) days of the date of the formal written notice of the modified Capitation Rates from the Department specifying the reasons for and effective date of termination. The effective date of termination shall be ninety (90) days from the date of the Contractor's written notice, unless the Department determines that an orderly disenrollment to Medicaid fee-for-service or transfer to another managed long-term care

plan can be accomplished in fewer days. The terms and conditions in the Contractor's phase-out plan specified in Article I must be accomplished prior to termination. During the period commencing with the effective date of the Department's modified Capitation Rates through the effective date of termination of the Contract, the Contractor shall have the option of continuing to receive capitation payments at the expired Capitation Rates or at the modified Capitation Rates approved by the Department and the State Division of the Budget for the rate period.

4. If the Contractor fails to exercise its right to terminate in accordance with this Section, then the modified Capitation Rates, approved by the Department and the State Division of the Budget, shall be deemed incorporated into this Contract without further action by the parties as of the effective date of the modified Capitation Rates as established by the Department and approved by the State Division of the Budget.

### **C. Rate-Setting Methodology**

1. Capitation rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual Medicaid fee-for-service data or Contractor experience for the time period covered by the rates. Capitated rates shall be certified to be actuarially sound in accordance with 42 CFR § 438.6(c).
2. Notwithstanding the provisions set forth in Section C.1 above, the Department and the Office reserves the right to terminate this Agreement, in its entirety pursuant to Article I Section C of this Contract, upon determination by the Department that the aggregate monthly Capitation Rates are not cost effective pursuant to section 4403-g of Public Health Law.

### **D. Payment of Capitation**

1. The monthly capitation payment for each Enrollee is due to the Contractor from the Effective Date of Enrollment until the Effective Date of Disenrollment of the Enrollee or termination of this Contract, whichever occurs first. The Contractor shall receive a full month's capitation payment for the month in which disenrollment occurs. The Rosters generated by the Department, along with any modification communicated electronically or in writing by the Department or the Office or its designee prior to the end of the month in which the First Roster is generated, shall be the enrollment list for purposes of eMedNY premium billing and payment. The Contractor and the Department or the Office or its designee may develop protocols for the purpose of resolving roster discrepancies that remain unresolved beyond the end of the month.
2. Upon receipt by the fiscal agent of a properly completed claim for monthly capitation payments submitted by the Contractor pursuant to this Contract, the fiscal agent will promptly process such claim for payment through eMedNY and use its best efforts to complete such processing within thirty (30) business days from date of receipt of the claim

by the fiscal agent. Processing of Contractor claims shall be in compliance with the requirements of 42 CFR 447.45. The fiscal agent will also use its best efforts to resolve any billing problem relating to the Contractor's claims as soon as possible. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this Contract to the Contractor or anyone else beyond funds appropriated and available for payment of Medical Assistance care, services and supplies.

#### **E. Denial of Capitation Payments**

1. In the event that CMS denies payment for new or existing Enrollees based upon a determination that the Contractor failed to comply with federal statutes and regulatory requirements, the Department will deny capitation payments to the Contractor for the same Enrollees for the period of time for which CMS denies payment.

#### **F. Department Right to Recover Premiums**

1. The parties acknowledge and accept that the Department has a right to recover premiums paid to the Contractor for Enrollees listed on the monthly roster who are later determined, for the entire applicable payment month, to have been incarcerated; to have moved out of the Contractor's service area; or to have died. In any event, the State may only recover premiums paid for Medicaid Enrollees listed on a roster if it is determined by the Department that the Contractor was not at risk for provision of benefit package services for any portion of the payment period. Notwithstanding the foregoing, the Department always has the right to recover duplicate premiums paid for persons enrolled under more than one Client Identification Number (CIN) in the Contractor's plan whether or not the Contractor has made payments to providers. All recoveries will be made pursuant to Guidelines developed by the State.
2. The parties acknowledge and accept that the Department has the right to recover premiums paid to the Contractor for Enrollees listed on the monthly roster where the Contractor has failed to initiate involuntary disenrollment in accordance with the timeframes and requirements contained in Section D.4.(b)-(g) of Article V. The Department may recover the premiums effective on the first day of the month following the month in which the Contractor was required to initiate the involuntary disenrollment.
3. The Department and Office shall have the right to recover any portion of a capitation premium associated with services authorized or reimbursed by the Contractor in a manner contrary to policies of the Department and/or Office. If provided for in its network contracts, the Contractor may, in turn, seek equivalent recovery from those network providers it reimbursed in violation of Department and/or Office policy. In no case, however, may the Contractor seek such recovery from an Enrollee. This shall include, but is not limited to:
  - (a) the reimbursement of HCBS waiver services for an individual not approved and enrolled in the HCBS waiver by OPWDD, and
  - (b) the reimbursement of ICF/DD services to an individual not meeting the appropriate level of care standard for that service, and

- (c) separate, additional, or stand-alone reimbursement of a service included in the service model or service definition of another reimbursed service (e.g., separate reimbursement of transportation services to or from a day habilitation program, when the day habilitation service rate already includes the cost of such transportation), and
- d) the reimbursement of service combination not permitted by Department or Office policy (e.g., reimbursement of respite services for an individual enrolled in a certified residential program).

## **G. Third Party Health Insurance Determination (including Medicare)**

### **1. Point of Service (POS)**

The Contractor will make diligent efforts to determine whether Enrollees have third party health insurance (TPHI). The LDSS/RSFO is also responsible for making diligent efforts to determine if Enrollees have TPHI and to maintain third party information on the WMS/eMedNY Third Party Resource System. If TPHI coverage is known at the POS, the 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 Plan).

The Contractor shall make good faith efforts to coordinate benefits and must inform the LDSS/RSFO of any known changes in status of TPHI insurance eligibility within five (5) business days of learning of a change in TPHI. The Contractor may use the Roster as one method to determine TPHI information.

### **2. Post Payment and Retroactive Recovery**

The State, and/or its vendor, will also be vested with the responsibility to collect any reimbursement for Benefit Package services obtained from TPHI. In no instances may an Enrollee 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 Contractor's next roster and TPHI file. The Contractor will have six months from the later of the date the TPHI has been posted (eMedNY transaction date) or the Contractor'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 Contractor in error, the Contractor will refund the adjusted recovery to the State.

### **3. TPHI Reporting**

The Contractor shall report TPHI activities through the Medicaid Encounter Data System (MEDS) , or any replacement encounter data reporting system, and Medicaid Managed Care Operating Report (MMCOR) in accordance with instructions provided by SDOH. To prevent duplicative efforts, the Contractor shall, on a quarterly basis, share claim specific

TPHI disposition (paid, denied, or recovered) information with the State.

#### **H. Other Insurance and Settlements**

The Contractor is not allowed to pursue cost recovery against personal injury awards or settlements that the Enrollee has received. Any recovery against these resources is to be pursued by the Medicaid program and the Contractor cannot take action to collect these funds. Pursuit of Worker's Compensation benefits and No-fault Insurance by the Contractor is authorized, to the extent that they cover expenses incurred by the Contractor.

#### **I. Contractor Financial Liability**

The Contractor shall not be financially liable for any services rendered to an Enrollee prior to his or her effective date of enrollment or subsequent to disenrollment.

#### **J. Spenddown and Net Available Monthly Income**

Capitation rates are adjusted to exclude Enrollee spenddown and NAMI as determined by the Local Department of Social Services. The surplus amount (spend down or NAMI amount) to be billed to an Enrollee by the Contractor must be the amount for which the Enrollee is responsible as determined by the LDSS/RSFO. The method of collection of NAMI is subject to the terms of Contractor's agreement with the Nursing Facility. The Contractor's inability to collect funds from Enrollees or a facility will not change the plan's spenddown or NAMI adjustment. The Contractor shall report the gross amount of spenddown and NAMI for each Enrollee in accordance with current Medicaid policy and within the timeframes and in the format prescribed by the Department.

#### **K. No Recourse Against Enrollees**

1. Except for the rates and payments provided for in this Contract, the Contractor hereby agrees that in no event, including but not limited to nonpayment by the Medicaid agency, insolvency of the Contractor, loss of funding for this program, or breach of this Contract, shall the Contractor or a subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Enrollee or person acting on his behalf for covered services furnished in accordance with this Contract.
2. This Section K. shall not prohibit the Contractor or the subcontractors as specified in their agreements from billing for and collecting any applicable surplus amounts, Net Available Monthly Income (NAMI), Medicare billable expenses, commercial insurance, worker's compensation benefits, no-fault insurance, and coordination of benefit amounts. This Section K. supersedes any oral or written contrary agreement now existing or hereinafter entered into between the Contractor and any Enrollee or persons acting on his behalf. This provision shall survive termination of this Contract for any reason.

#### **L. Notification Requirements to LDSS Regarding Enrollees**

1. The Contractor agrees to notify the LDSS in writing when an Enrollee with a monthly spenddown is admitted to an inpatient facility so the spenddown can be recalculated and a determination made regarding the amount, if any, of the spenddown owed to the inpatient facility. The notification will include the Enrollee's name, Medicaid number, hospital name and other information as directed by the Department.
2. The Contractor agrees to notify the LDSS in writing prior to admission of an Enrollee to a nursing facility, to allow Medicaid eligibility to be redetermined using institutional eligibility rules. The notification will include the Enrollee's name, Medicaid number, nursing facility name and other information as directed by the Department. If such an Enrollee is determined by the LDSS to be ineligible for Medicaid nursing facility services, the LDSS shall notify the Contractor of such determination.

#### **M. Contractor's Fiscal Solvency Requirements**

1. The Contractor, for the duration of this Agreement, shall remain in compliance with all applicable state requirements for financial solvency for MCOs participating in the Medicaid Program. The Contractor shall continue to be financially responsible as defined in PHL §4403(1)(c) and shall comply with the contingent reserve fund and escrow deposit requirements of 10 NYCRR Part 98 and must meet minimum net worth requirements established by the Department and the State Insurance Department. The Contractor shall make provision, satisfactory to the Department, for protections for the Department and the Enrollees in the event of MCO or subcontractor insolvency, including but not limited to, hold harmless and continuation of treatment provisions in all provider agreements which protect the Department and Enrollees from costs of treatment and assures continued access to care for Enrollees.

#### **N. Prohibition on Payments to Institutions or Entities Located Outside of the United States**

The Contractor is prohibited under section 6505 of the Affordable Care Act (ACA), which amends section 1902(a) of the Social Security Act, from making or directing payments for Medicaid covered items or services to any financial institution or entity, such as provider bank accounts or business agents, located outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

#### **O. DISCO Risk Corridor**

For all enrollments into a DISCO effective October 1, 2015 through September 30, 2016, the Contractor and the Office and the Department will participate in a risk sharing arrangement. The risk sharing between the Office, Department and the Contractor will be an aggregate test of the cost (excluding administration costs) to the Contractor versus the Medicaid premium (excluding administration costs) paid by the Department to the Contractor. The chart attached to this Contract as Appendix N represents an example of the possible structure for the risk corridor for risk sharing. The calculation of the monies owed to the Contractor by the Department (if any) or monies owed to the Department by the Contractor (if any) will be calculated approximately ninety

(90) days following the end of the calendar year 2012 to allow for sufficient runout of claims. An assessment tool for all new Enrollees must be submitted on a monthly basis by the Contractor to the Department under the risk sharing arrangement. The Department will provide any applicable fee-for-service data on new Enrollees to the Contractor. The risk sharing arrangement may be renewed for an additional one (1) year if mutual interest exists.

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## ARTICLE VII

### CONTRACTOR RELATIONSHIP WITH SUBCONTRACTORS

#### A. Subcontractor/Provider Relations

1. Pursuant to 42 CFR 438.206, the Contractor must maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract.
2. The Contractor agrees to comply with applicable sections of New York State Public Health Law and regulation and Mental Hygiene Law regarding subcontract requirements, provider relations and termination and federal requirements at 42 CFR 434.6 and 438.6(l) regarding required subcontract provisions, 438.12 regarding provider discrimination prohibitions, 438.102 regarding provider-Enrollee communications, 438.214 regarding provider selection, 438.230 regarding subcontractual relationships and delegation.
3. Provider Services  
The Contractor is responsible to provide the following provider services:
  - (a.) assisting providers with prior authorization and referral protocols;
  - (b.) assisting providers with claims payment procedures;
  - (c.) fielding and responding to provider questions and complaints;
  - (d.) orientation of providers and subcontractors to program goals, and;
  - (e.) provider training to improve integration and coordination of care.
  - (f.) assisting providers with third party insurance reporting
4. Payment of subcontractors of services overseen or certified by OPWDD  
The Contractor will accept electronic claims from providers of OPWDD services that identify such services in manner consistent with fee-for-service Medicaid. This shall include, but is not limited to, the use of NYS Medicaid rate codes and provider location codes. Any deviation must be approved by the Commissioner of the Office or his/her designee.
5. Communication with Enrollee

The Contractor shall instruct its Participating Providers regarding the following requirements applicable to communications with their patients about the DISCOs or other managed care plans with which the Participating Providers may have contracts:

- a. Participating Providers who wish to let their enrollees know of their affiliations with one or more managed care plans must list each managed care plan with whom they have contracts.
- b. Participating Providers who wish to communicate with their patients about managed care options must advise patients taking into consideration ONLY the managed care options that best meet the needs of the enrollees. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one managed care plan over another.

- c. Participating Providers may display the Contractor's outreach materials provided that appropriate material is conspicuously posted for all other managed care plans with which the Participating Provider has a contract.
- d. Upon termination of a Provider Agreement with the Contractor, a provider that has contracts with other managed care plans may notify the people it serves of the change in status and the impact of such change on the patient.

**B. Full Responsibility Retained**

- 1. Notwithstanding any relationship(s) that the Contractor may have with subcontractors, the Contractor shall maintain full responsibility for adhering to and otherwise fully complying with all applicable laws and regulations, this Contract, all standards and procedures approved by the Office and the Department for the plan and the written instructions of the Office and the Department.
- 2. The Contractor shall oversee and is accountable to the Office and the Department for all functions and responsibilities that are described in this Contract.
- 3. The Contractor may only delegate activities or functions to a subcontractor in a manner consistent with requirements set forth in this Contract, 42CFR 434 and 438 and applicable State law and regulations.
- 4. The Contractor may only delegate management responsibilities as defined by State regulation by means of a Office or the Department approved management services agreement. Both the proposed management services agreement and the proposed management entity must be approved by the Office and the Department pursuant to the provisions of 10 NYCRR 98-1.11 before any such agreement may be implemented.

**C. Required Provisions**

- 1. Subcontracts shall require the approval of the Office and the Department as set forth in PHL 4402 and in 10 NYCRR Part 98.
- 2. The Contractor shall impose obligations and duties on its subcontractors, including its Participating Providers, that are consistent with this Contract, and that do not impair any rights accorded to the Department or DHHS.
- 3. No subcontract, including any provider subcontract, shall limit or terminate the Contractor's duties and obligations under this Contract.
- 4. Nothing contained in this Contract between the Office/Department and the Contractor shall create any contractual relationship between any subcontractor of the Contractor, including Participating Providers, and the Office or the Department.
- 5. Any subcontract entered into by the Contractor shall fulfill the requirements of 42 CFR Parts 434 and 438 that are appropriate to the service or activity delegated under such subcontract.

6. The Contractor shall also ensure that, in the event the Contractor fails to pay any subcontractor, including any Participating Provider, in accordance with the subcontract or provider agreement, the subcontractor or Participating Provider will not seek payment from the Office or the Department, the Enrollees, or their eligible dependents.
7. No contract between the Contractor and a health care provider shall contain any clause purporting to transfer to the health care provider, other than a medical group, by indemnification or otherwise, any liability relating to activity, actions or omissions of the Contractor as opposed to those of the health care provider.
8. All subcontracts with providers of covered services (including management agreements, if applicable), shall include the following provisions:
  - (a.) Any services or other activities performed by a subcontractor in accordance with a contract between the subcontractor and the Contractor will be consistent and comply with the Contractor's obligations under this Contract and applicable state and federal laws and regulations.
  - (b.) A provision that the Contractor will provide, no less than thirty (30) days prior to implementation, any new rules or policies and procedures regarding quality improvement, service authorizations, member appeals and grievances and provider credentialing, or any changes thereto, to a provider of covered services that is a subcontractor.
  - (c.) No provision of the subcontract is to be construed as contrary to the provisions of Article 44 of the Public Health Law and Article 16 of the Mental Hygiene Law and implementing regulations to the extent they do not conflict with federal law and 42 CFR Parts 434 and 438.
  - (d.) Specific delegated activities and reporting responsibilities, including the amount, duration and scope of services to be provided.
  - (e.) Satisfactory remedies, including termination of a subcontract when the Department or the Contractor determines that such parties have not performed adequately which includes but is not limited to egregious patient harm, significant substantiated complaints, submitting claims to the plan for services not delivered, and refusal to participate in the plan's quality improvement program.
  - (f.) Provision for ongoing monitoring of the subcontractor's compliance with the subcontract by the Contractor. Such monitoring provision shall specify requirements for corrective action, revocation of the subcontract or imposing sanctions if the subcontractor's performance is inadequate.
  - (g.) Specification that either:
    - (i.) the credentials of affiliated professionals or other health care providers will be reviewed directly by the Contractor; or

- (ii.) the credentialing process of the subcontractor will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

(h.) A procedure for the resolution of disputes between the Contractor and its subcontractors, or providers. Any and all such disputes shall be resolved using the Department's interpretation of the terms and provisions of this Contract, and portions of subcontracts executed hereunder that relate to services pursuant to this Contract. If a subcontract provides for arbitration or mediation, it shall expressly acknowledge that the Commissioner of the Department of Health and the Commissioner of the Office for People with Developmental Disabilities is not bound by arbitration or mediation decisions. Arbitration or mediation must occur within New York State, and the subcontract shall provide that the Commissioner will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

(i.) A provision specifying how the subcontractor shall participate in the Contractor's quality assurance, service authorization and grievance and appeals processes, and the monitoring and evaluation of the Contractor's plan.

(j.) A provision specifying how the subcontractor will insure that pertinent contracts, books, documents, papers and records of their operations are available to the Department, the Office, HHS, Comptroller of the State of New York, Comptroller General of the United States and/or their respective designated representatives, for inspection, evaluation and audit, through six (6) years from the final date of the subcontract or from the date of completion of any audit, whichever is later.

- 10. The Contractor agrees to comply with Section 3224-a of State Insurance Law pertaining to prompt payment to providers of covered services.

#### **D. Network Requirements for Covered Services**

- 1. The Contractor must demonstrate and maintain, to the Office and the Department's satisfaction, a sufficient and adequate network for delivery of all covered services.

The Contractor shall provide documentation to demonstrate capacity to serve the expected enrollment in its service area. The documentation shall be submitted quarterly through the Health Commerce System (HCS) in such format specified by the Office and the Department which will permit the review of accessibility compliance. Such submission must comply with the requirements of 42 CFR 438.207 and applicable sections of state law and implementing regulations.

- 2. The Contractor shall provide reasonable assurance that the applicant will provide high quality services to an enrolled population, that the applicant's network of providers is adequate and that such providers have demonstrated sufficient competency to deliver high quality services to the enrolled population and that policies and procedures will be in place to address the cultural and linguistic needs of the enrolled population.

3. The Contractor shall have a minimum of two (2) providers that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Office and the Department. Access to services provided in a OPWDD-certified residence is contingent upon OPWDD prior-review and approval.
4. Providers of covered services to which an Enrollee must travel must be geographically accessible for the enrolled population. Travel times must not exceed:
  - a. Thirty (30) minutes from the Enrollee's residence in metropolitan areas; or
  - b. Thirty (30) miles from the Enrollee's residence in non-metropolitan areas.

Exceptions may be allowed in cases where the needs of the person require service delivery from a provider with specialized skills and that provider is not located in the service area.

5. If the Contractor is unable to provide necessary services through its contracted network for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractors' network for as long as the Contractor is unable to provide them within the network.
6. Contractor shall post its provider directory on the Contractor's website to enable Prospective Enrollees, Enrollees, family members and supports, or others providing guidance and assistance to Prospective Enrollees and Enrollees to review the contracted network.
7. Provider contracts and material amendments thereto shall require the approval of the Department as set forth in PHL § 4402 and 10 NYCRR Part 98, and consistent with guidelines issued by the Office and the Department.

#### **E. Provider Termination Notice**

The Contractor shall provide the Office at least sixty (60) days notice prior to the termination of any subcontract, the termination of which would preclude an Enrollee's access to a covered service by provider type under this Contract, and specify how services previously furnished by the subcontractor will be provided. In the event a subcontract is terminated on less than sixty (60) days notice, the Contractor shall notify the Office immediately but in no event more than seventy-two (72) hours after notice of termination is either issued or received by the Contractor.

#### **F. Recovery of Overpayments to Providers**

Consistent with the exception language in Section 3324-b of the Insurance Law, the Contractor shall have and retain the right to audit participating providers' claims for a six year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This six year limitation does not apply to situations in which fraud may be involved or in which the provider or an agent of the provider prevents or obstructs the Contractor's auditing.

**G. Optometry Services Provided by Article 28 Clinics Affiliated with the College of Optometry of the State University of New York.**

1. Consistent with Chapter 37 of the Laws of 2010 amending SSL § 364-j, optometry services provided by Article 28 clinics affiliated with the College of Optometry of the State University of New York may be accessed directly by Enrollees without the Contractor's prior approval and without regard to network participation.
2. The Contractor will reimburse non-participating Article 28 clinics affiliated with the College of Optometry of the State University of New York for covered optometry services provided to Enrollees at Article 28 Medicaid fee-for-service clinic rates.

**H. Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers not Participating in Contractor's Network.**

1. Consistent with Chapter 697 of the Laws of 2003 amending SSL § 364-j, dental services provided by Article 28 clinics operated by academic dental centers may be accessed directly by Enrollees without prior approval and without regard to network participation.
2. The Contractor will reimburse non-participating Article 28 clinics operated by academic dental centers for covered dental services provided to Enrollees at approved Article 28 Medicaid clinic rates in accordance with the protocols issued by the Department.

## ARTICLE VIII

### RECORDS REPORTING AND CERTIFICATION REQUIREMENTS

#### **A. Maintenance of Contractor Performance Records, Records Evidencing Enrollment Fraud and Documentation Concerning Duplicate CINs**

1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data that meets the requirements of 42 CFR 438.242 and Article 44 of the Public Health Law.
2. The Contractor agrees to maintain for each Enrollee a care management record. The Contractor shall maintain, and shall require its subcontractors to maintain:
  - (a.) appropriate records related to services provided to Enrollees;
  - (b.) all financial records and statistical data that the LDSS/RSFO, the Office, the Department and any other authorized governmental agency may require including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received, any reserves related thereto and expenses incurred under this Contract;
  - (c.) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of the Contractor or its subcontractors, including its Participating Providers, if relevant, to bear the risk of potential financial losses;
  - (d.) all documents concerning enrollment fraud or the fraudulent use of any CIN; and
  - (e.) all documents concerning duplicate CINs.
3. Credentials for subcontractors and providers used by subcontractors shall be maintained on file by or in a manner accessible to the Contractor and furnished to the Department, upon request.

#### **B. Maintenance of Financial Records and Statistical Data**

The Contractor shall maintain all financial records and statistical data according to generally accepted accounting principles and/or Statutory accounting principles where applicable.

#### **C. Access to Contractor Records**

The Contractor shall provide the DDRO, the Office, the Department, The Comptroller of the State of New York, the Attorney General of the State of New York, DHHS, the Comptroller General of the United States, and their authorized representatives with access to all records relating to Contractor performance under this Contract for the purposes of examination, audit, and copying (at reasonable cost to the requesting party) of such records. The Contractor shall give access to such records on two (2) business days prior written notice, during normal business hours,

unless otherwise provided or permitted by applicable laws, rules, or regulations. Notwithstanding the foregoing, when records are sought in connection with a “fraud” or “abuse” investigation, as defined respectively in 10 NYCRR 98.1.21(a)(1) and (a)(2), all costs associated with the production and reproduction shall be the responsibility of the Contractor.

#### **D. Retention Periods**

The Contractor shall preserve and retain all records relating to Contractor performance under this Contract in readily accessible form during the term of this Contract and for a period of six (6) years thereafter. All provisions of this Contract relating to record maintenance and audit access shall survive the termination of this Contract and shall bind the Contractor until the expiration of a period of six (6) years commencing with termination of this Contract or if an audit is commenced, until the completion of the audit, whichever occurs later.

#### **E. Reporting Requirements**

1. The Contractor shall be responsible for fulfilling the reporting requirements of this Contract. Reports shall be filed in a format specified by the Office or the Department and according to the time schedules required by the Department.
2. The Contractor shall furnish all information necessary for the Office to assure adequate capacity and access for the enrolled population and to demonstrate administrative and management arrangements satisfactory to the Office. The Contractor shall submit periodic reports to the Office and the Department in a data format and according to a time schedule required by the Office to fulfill the Office’s administrative responsibilities under Section 4403-g of Article 44 of Public Health law and other applicable State and federal laws or regulations. Reports may include but are not limited to information on: availability, accessibility and acceptability of services; enrollment; Enrollee demographics; disenrollment; Enrollee health and functional status (including the Developmental Disabilities Profile (DDP) or any other such instrument the Office may request); service utilization; encounter data, Enrollee satisfaction; outreach; grievance and appeals; and fiscal data. The Contractor shall promptly notify the Office of any request by a governmental entity or an organization working on behalf of a governmental entity for access to any records maintained by the Contractor or a subcontractor pursuant to this Contract.
3. The Contractor shall submit the following specific reports to the Office and the Department.
  - (a.) Annual Financial Statements:  
In accordance with 10 NYCRR 98-1.16, the Contractor shall file in duplicate with both the Commissioner and the Superintendent of the Department of Insurance (SID) a financial statement each year in the form prescribed by the Commissioner known as the Medicaid Managed Care Operating Report (MMCOR). The MMCOR shows the condition at last year-end and contains the information required by Section 4408 of

the Public Health Law. The due date for annual statements shall be April 1 following the report closing date.

(b.) Quarterly Financial Statements:

The Contractor shall submit Quarterly Financial Statements to the Department and SID. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter.

(c.) Other Financial Reports:

Contractor shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the Department and SID in a timely manner as required by State laws and regulations including but not limited to Public Health Law § 4403-g, 4404 and 4409, Title 10 NYCRR 98-1.11, 98-1.16, and 98-1.17 and applicable Insurance Law §§ 304, 305, 306, and 310.

(d.) Encounter Data:

The Contractor shall prepare and submit encounter data on at least a monthly basis to Office and the Department or its designee. Healthcare service providers shall be identified by National Provider Identifiers (NPIs). Covered non-healthcare services shall be identified in encounter data using provider identifiers and location codes equivalent to Medicaid fee-for-service. Encounter records for covered non-healthcare services shall include the NYS rate code identifying the service paid. Submissions shall be comprised of encounter records or adjustments to previously submitted records which the Contractor has received and processed from provider encounter or claim records of any contracted or directly provided services rendered to the Enrollee in the current or any preceding months. All submissions shall be transmitted in accordance with the Department's published timeframes and shall be in the form and format specified by the Department.

The Contractor shall submit an annual notarized attestation that the encounter data submitted through the designated Fiscal Agent is, to the best of the Contractor's information, knowledge and belief, accurate and complete.

(e.) Grievance and Appeal Reports:

i) The Contractor must provide the Office on a quarterly basis, and within fifteen (15) business days of the close of the quarter, a summary of all grievance and appeals received during the preceding quarter using a data transmission method that is determined by the Office and the Department.

ii) The Contractor also agrees to provide on a quarterly basis, within fifteen (15) business days of the close of the quarter, the total number of grievance or appeals that have been unresolved for more than thirty (30) days. The Contractor shall maintain records on these and other grievances or appeals, which shall include all correspondence related to the grievance or appeal, and an explanation of disposition. These records shall be readily available for review by the Office or the Department upon request.

iii) Nothing in this Section is intended to limit the right of the Office, the Department or the DDRO to obtain information immediately from a Contractor pursuant to investigating a particular Enrollee grievance or appeal, or provider complaint.

(f.) Fraud and Abuse Reporting Requirements:

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

1. The name of the individual or entity that committed the fraud or abuse;
  2. The source that identified the fraud or abuse;
  3. The type of provider, entity or organization that committed the fraud or abuse;
  4. A description of the fraud or abuse;
  5. The approximate dollar amount of the fraud or abuse;
  6. The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
  7. Other data/information as prescribed by the Department.
- (ii) Such report shall be submitted when cases of fraud and abuse are confirmed, and shall be reviewed and signed by an executive officer of the Contractor.
- (g.) Performance Improvement Projects:  
The Contractor will be required to conduct performance improvement projects that focus on clinical and non-clinical areas consistent with the requirements of 42 CFR 438.240. The purpose of these studies will be to promote quality improvement within the DISCO. At least one (1) performance improvement project each year will be selected as a priority and approved by the Office. Results of each of these annual studies will be provided to the Office in a required format. Results of other performance improvement projects will be included in the minutes of the quality committee and reported to the Office upon request.
- (h.) Enrollee Health and Functional Status:  
The Contractor shall submit Enrollee outcome, health and functional status data for each of their Enrollees in the format and according to the timeframes specified by the Office. The data shall consist of the Developmental Disability Profile (DDP) or any other such instrument the Department may request. The data shall be submitted at least annually or on a more frequent basis if requested by the Office.
- (i.) Additional Reports:  
Upon request by the Office, the Contractor shall prepare and submit other operational data reports. Such requests will be limited to situations in which the desired data is considered essential and cannot be obtained through existing Contractor reports. Whenever possible, the Contractor will be provided with ninety (90) days notice and the opportunity to discuss and comment on the proposed requirements before work is begun. However, the Office reserves the right to give thirty (30) days notice in circumstances where time is of the essence.

## **F. Data Certification**

The Contractor shall comply with the data certification requirements in 42 CFR 438.604 and 438.606.

1. The types of data subject to certification include, but are not limited to, enrollment information, encounter data, the premium proposal, contracts and all other financial data. The certification shall be in a format prescribed by the Office and the Department and must be sent at the time the report or data are submitted.
2. The certification shall be signed by the Plan's Chief Executive Officer, the Chief Financial Officer or an individual with designated authority; and, the certification shall attest to the accuracy, completeness and truthfulness of the data.

## **G. Notification of Changes in Reporting Due Dates Requirements or Formats**

The Office or the Department may extend due dates, or modify report requirements or formats upon a written request by the Contractor to the Office or the Department, where the Contractor has demonstrated a good and compelling reason for the extension or modification. The Office or the Department will issue a written response to the request for a modification or extension of the due date.

## **H. Ownership and Related Information Disclosure**

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

## **I. Role of Compliance Officer and Compliance Committee:**

It is the obligation of the plan to designate a compliance officer and establish a compliance committee pursuant to 42 CFR 438.608 (b) (2). It is the obligation of the compliance officer and compliance committee to:

1. monitor the plan reporting obligations and ensure that the required reports are accurate and submitted in a timely manner;
2. develop written policies, procedures and standards of conduct that articulate the plan commitment to adhere to all applicable Federal and State Standards;
3. conduct appropriate staff training activities in an atmosphere of open communication;
4. establish provisions for internal monitoring and auditing; and,
5. have provisions for prompt responses to detected offenses with provisions for corrective action initiatives where appropriate.

## **J. Public Access to Reports**

Any data, information, or reports collected and prepared by the Contractor and submitted to New York State authorities in the course of performing their duties and obligations under this Contract will be deemed to be records of the Office and the Department and may be disclosed subject to and consistent with the requirements of Freedom of Information Law.

## **K. Professional Discipline**

1. Pursuant to Public Health Law Section 4405-b, the Contractor shall have in place policies and procedures to report to the appropriate professional disciplinary agency within thirty (30) days of occurrence, any of the following:
  - i) the termination of a health care provider contract pursuant to Section 4406-d of the Public Health Law for reasons relating to alleged mental and physical impairment, misconduct or impairment of enrollee safety or welfare;
  - ii) the voluntary or involuntary termination of a contract or employment or other

- affiliation with such contractor to avoid the imposition of disciplinary measures; or
  - iii) the termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to enrollee health and welfare.
2. The Contractor shall make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Articles 130 and 131 (a) of the State Education Law.

#### **L. Certification Regarding Individuals Who Have Been Debarred or Suspended By Federal or State Government**

The Contractor will certify to the Office and the Department initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual who has been debarred or suspended by the federal or state government, or otherwise excluded from participating in procurement activities:

1. as a director, officer, partner or person with beneficial ownership of more than 5% of the Contractor's equity; or
2. as a party to an employment, consulting or other agreement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations in the DISCO consistent with requirements of SSA §1932 (d)(1).

#### **M. Conflict of Interest Disclosure**

The Contractor shall report to the Office and Department in a format specified by the Department documentation, including but not limited to the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the managed long-term care plan or with any subcontract(s) in which the managed long-term care plan has a 5% or more ownership and interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR 455.100 and 455.104.

#### **N. OMIG's Right to Audit and Recover Overpayments Caused by Contractor Submission of Misstated Reports**

The OMIG can perform audits of financial reports filed by Contractors after the Department and/or Office reviews and accepts the Contractor's report. If the audit determines that the Contractor's filed report contained misstatements of fact, causing the Contractor and/or other Contractors to receive an inappropriate capitation rate, the OMIG will recover any and all overpayments. The Contractor will be entitled to the audit rights afforded to providers in 18 NYCRR 517, 518 and 519. Nothing in this section shall limit the Department and/or Office, OMIG, or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the Contract period, during the Contract period, or subsequent to the Contract period, or limit other remedies or rights available to the Department and/or Office, OMIG, or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.

**O. OMIG’s Right to Audit and Recover Overpayments Which Were Caused by the Contractor’s Misstated Encounter Data**

The OMIG can perform audits of the Contractor’s submitted encounter data after the Department has reviewed and accepted the Contractor’s encounter data submission. If the audit determines the Contractor’s encounter data was incorrectly submitted and the Contractor received additional or higher Medicaid managed care capitation rate payments due to the incorrect encounter data, OMIG can recover from the Contractor the additional Medicaid funds that the Contractor received because of the encounter data misstatement. The Contractor will be entitled to the audit rights afforded to providers in 18 NYCRR 517, 518 and 519. Nothing in this section shall limit the Department, OMIG or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the Contract period, during the Contract period, or subsequent to the Contract period or limit other remedies or rights available to the Department, OMIG or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor’s reporting submission.

**P. OMIG Audit Authority**

In accordance with PHL §30 through 36, and as authorized by federal or state laws and regulations, the OMIG may review and audit contracts, cost reports, claims, bills and all other expenditures of medical assistance program funds to determine compliance with federal and state laws and regulations and take such corrective actions as are authorized by federal or state laws and regulations.

**ARTICLE IX  
INTERMEDIATE SANCTIONS**

- A. The Contractor is subject to the imposition of sanctions as authorized by State law and regulation, including the Office and Department's right to impose sanctions for unacceptable practices as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) Part 515 and civil and monetary penalties pursuant to 18 NYCRR Part 516, and in Title 14 NYCRR Part 635 and 633, and 42 CFR 438.700 and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted services.
- B. Unacceptable practices for which the Contractor may be sanctioned include, but are not limited to:
1. Failing to provide medically necessary services that the Contractor is required to provide under its contract with the State.
  2. Imposing premiums or charges on Enrollees.
  3. Discriminating among Enrollees on the basis of their health status or need for health care or long term support services.
  4. Misrepresenting or falsifying information that it furnishes to an Enrollee, Applicant, Potential Enrollee, health care provider, the State or to CMS.
  5. Distributing directly or through any agent or independent contractor, Outreach materials that have not been approved by the State or that contain false or materially misleading information.
  6. Failure to conduct criminal background checks of deemed employees.
  7. Violating any other applicable requirements of SSA §§ 1903(m) or 1932 and any implementing regulations.
  8. Violating any other applicable requirements of 18 NYCRR, 14 NYCRR or 10 NYCRR Part 98.
  9. Failing to comply with the terms of this Agreement.
- C. Intermediate Sanctions may include but are not limited to:
1. Civil monetary penalties.
  2. Suspension of all new enrollment after the effective date of the sanction.
  3. Termination of the contract, pursuant to Article I of this Agreement.
- D. The Office or the Department shall have the right, upon notice to the LDSS/RSFO, to limit, suspend or terminate enrollment activities by the Contractor and/or enrollment into the DISCO upon ten (10) days written notice to the Contractor. The written notice shall specify the action(s) contemplated and the reason(s) for such action(s) and shall provide the Contractor with an opportunity to submit additional information that would support the conclusion that limitation, suspension or termination of enrollment activities or Enrollment in the Contractor's managed long term-care plan is unnecessary. The Office and the Department reserves the right to suspend enrollment immediately in situations involving imminent danger to the health and safety of Enrollees. Nothing in this paragraph limits other remedies available to the Office and the Department under this Agreement.
- E. The Contractor will be afforded due process pursuant to Federal and State Law and Regulations 42 CFR § 438.710, 18 NYCRR Part 516, and Article 44 of the PHL.

**ARTICLE X  
GENERAL REQUIREMENTS**

**A. Authorized Representatives With Respect to Contract**

Upon commencement of performance under this Contract, the Office and the Department and the Contractor shall each designate a contract representative under this Contract and shall promptly so notify the other Party in writing. The contract representative shall be the contact person for all matters arising under this Contract. Each Party shall notify the other Party if it designates a new contract representative.

**B. Confidentiality**

1. All individually identifiable information relating to Applicants and Enrollees that is obtained by the Contractor shall be safeguarded pursuant to 42 CFR 431, subpart F and applicable sections of 45 CFR Parts 160 and 164, 42 CFR Part 2, 42 U.S.C. Section 1396a(a)(7) (Section 1902(a)(7) of the Federal Social Security Act), and regulations promulgated thereunder, and applicable sections of State law and regulation including but not limited to Section 27-F of Public Health Law, Section 369 of the Social Services Law, and Section 33.13 of Mental Hygiene Law. Information shall be used or disclosed by the Contractor pursuant to appropriate consent only for a purpose directly connected with performance of Contractor obligations under this Contract.
2. Medical records of Applicants and Enrollees shall be confidential and shall be disclosed to and by other persons within the Contractor's organization, including subcontractors, only as necessary to provide health care and quality, peer, or complaint and appeal review of services under the terms of this Contract.
3. The provisions of this Section shall survive the termination of this Contract and shall bind the Contractor so long as the Contractor maintains any individually identifiable information relating to Applicants or Enrollees.

**C. Additional Actions and Documents**

Each Party hereby agrees to use its good faith and best efforts to cooperate with the other and to take or cause to be taken such further actions to execute, deliver, and file or cause to be executed, delivered, and filed such further documents and instrument, and to use best efforts to obtain such waivers and consents as may be necessary or as may be reasonably requested in order to effectuate fully the purposes, terms, and conditions of this Contract and the purposes of the plan.

#### **D. Relationship of the Parties, Status of the Contractor**

The Parties agree that the relation of Contractor to the Office and the Department will be that of an independent Contractor. The Parties also agree and acknowledge that Contractor is authorized to operate and to perform its obligations under this Contract pursuant to the provisions of Article 44 of New York State Public Health Law, Article 43 of State Insurance Law and Section 402 of the Social Security Amendments of 1967, as amended by Section 222(b) of the Social Security Amendments of 1972, 42 U.S.C. 1395b-1. The Parties further agree and acknowledge that Contractor will not, by virtue of its operation, of its performance of its obligations hereunder, of its compensation hereunder, or of any other provisions of this Contract: (1) be deemed to be an agent or instrumentality of the State of New York, the United States, or any agency of either, or (2) be deemed to be a preferred provider organization, third party administrator, or an independent practice association.

#### **E. Nondiscrimination**

The Contractor shall not unlawfully discriminate on the basis of age, race, color, gender, creed, religion, disability, sexual orientation, source of payment, type of illness or condition or place of origin. The Contractor shall operate the program in compliance with all applicable State and Federal non-discrimination laws.

#### **F. Employment Practices**

1. The Contractor shall comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relating to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, the implementing rules and regulations prescribed by the Secretary of Labor at 41 CFR Part 60 and with the Executive Law of the State of New York, Section 291-299 thereof and any rules or regulations promulgated in accordance therewith. The Contractor shall likewise be responsible for compliance with the above-mentioned standards by subcontractors with whom the Contractor enters into a contractual relationship in furtherance of this Contract.
2. The Contractor shall comply with regulations issued by the Secretary of Labor of the United States in 20 CFR Part 741, pursuant to the provisions of Executive Order 11758, and with the Federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Contractor shall likewise be responsible for compliance with the above mentioned standards by subcontractors with whom the Contractor enters into a contractual relationship in furtherance of this Contract.

#### **G. Dispute Resolution**

The Contractor and the Office shall jointly develop and use a process for resolving disputes with regard to the accuracy of assessments performed for enrollment, involuntary

disenrollments and for continued stay decisions when the Enrollee no longer meets the intermediate care facility level of care as determined at the last comprehensive assessment of the calendar year.

#### **H. Assignment**

This Contract shall not be assignable by the Contractor without the prior written consent of the Commissioners of the Department and the Office.

#### **I. Binding Effect**

Subject to any provisions hereof restricting assignment, this Contract shall be binding upon and shall inure to the benefit of the Parties and their respective successors and permitted assignees.

#### **J. Limitation on Benefits of this Contract**

It is the explicit intention of the Parties that no Enrollee, person or other entity, other than the Parties, is or shall be entitled to bring any action to enforce any provision of this Contract against the other Party, and that the covenants, undertakings, and agreements set forth in this Contract shall be solely for the benefit of, and shall be enforceable only by the Parties, or their respective successors and assignees, as permitted hereunder; provided, however, that the covenants, undertakings, and agreements set forth in Article VI, Section K hereof shall be construed for the benefit of the Enrollees.

#### **K. Entire Contract**

This Contract (including the Schedules and Appendices hereto) constitutes the entire Contract between the Parties with respect to the subject matter hereof, and it supersedes all prior oral or written agreements, commitments, or understandings with respect to the matters provided for herein. This Contract shall not be deemed to apply to individuals who are not Enrollees.

#### **L. Conflicting Provisions**

In the event of any conflict between the provisions of the main body of this Contract and the provisions of any Appendix or Schedule(s) attached hereto, the provisions of the main body of this Contract shall govern, unless a provision of an Appendix or a Schedule explicitly states that it shall supersede the main body of this Contract.

#### **M. Modification**

This Contract is subject to amendment or modification only upon mutual consent of the Parties reduced to writing. Attached Appendix X is the form to be used in modification of this Contract. Any such amendment or modification is not binding on the Parties unless and until approved by the Comptroller of the State of New York.

## **N. Headings**

Article and Section headings contained in this Contract are inserted for convenience of reference only, shall not be deemed to be a part of this Contract for any purpose, and shall not, in any way, define or affect the meaning, construction, or scope of any of the provisions hereof.

## **O. Pronouns**

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural as the identity of the person or entity may require.

## **P. Notices**

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- (a) via certified or registered United States mail, return receipt requested;
- (b) by facsimile transmission;
- (c) by personal delivery;
- (d) by expedited delivery service; or
- (e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

### **State of New York Department of Health**

Division of Long Term Care  
Address: Division of Long Term Care  
Office of Health Insurance Programs  
Corning Tower, Room 1415  
Empire State Plaza  
Albany, NY 12237

Telephone Number:

Facsimile Number:

#### **[Insert Contractor Name]**

Name:

Title:

Address:

Telephone Number:

Facsimile Number:

E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the

date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or e-mail, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

#### **Q. Partial Invalidity**

Should any provision of this Contract be declared or found to be illegal, invalid, ineffective, unenforceable or void, then each Party shall be relieved of any obligation arising from such provision; the balance of this Contract, if capable of performance, shall remain in full force and effect.

#### **R. Force Majeure**

Each Party shall use all efforts to perform its obligations under this Contract but shall be excused for failure to perform or for delay in performance hereunder due to unforeseeable circumstances beyond its reasonable control or which could not have been prevented by it, including but not limited to acts of God, floods, hurricanes, earthquakes, acts of war, civil unrest, or embargoes; provided, that acts of any governmental body shall be deemed not to be a force majeure.

#### **S. Survival**

The termination or expiration of this Contract shall not affect vested or accrued rights or obligations of the Parties existing as of the date of such termination or expiration or other obligations expressly intended to survive the termination or expiration hereof. Without limiting the generality of the foregoing, the following provisions of this Contract shall survive any expiration or termination of this Contract: entire Article VI; entire Article VIII; Section V. D.; Sections I.E. I.F. and I.G; Sections X.B, X.E, X.H, X.K, X.L, X.M, X.V, X.AA, Appendix A and all definitional provisions of this Contract to the extent that they pertain to any other surviving provisions or obligations.

#### **T. State Standard Appendix A**

The Parties agree to be bound by the terms and conditions of “Standard Clauses for New York State Contracts, January 2014” attached hereto and incorporated herein as Appendix A.

#### **U. Indemnification**

##### **1. Indemnification by Contractor**

- (a) The Contractor shall indemnify, defend and hold harmless the Office, the Department, the State, its officers, agents and employees and the Enrollees and their eligible dependents from:
- (i) any and all claims and losses incurred by or accruing or resulting from the acts or omissions of all Contractors, subcontractors, material men, laborers and any other person, firm or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract;
  - (ii) any and all claims and losses incurred by, accruing, or resulting to any person, firm or corporation who may be injured or damaged by the acts or omissions of the Contractor, its officers, agents and employees or subcontractors, including Participating Providers, in connection with the performance of this Contract; and
  - (iii) against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use or disposition of any data furnished by the Contractor under this Contract or based on any libelous or otherwise unlawful matter contained in such data.
- (b) The Department and/or Office shall provide the Contractor with prompt written notice of any claim made against the Department and/or Office and the Contractor, at its sole option, shall defend or settle said claim. The Department and/or Office shall cooperate with the Contractor, to the extent necessary for the Contractor to discharge its obligations hereunder. Notwithstanding the foregoing, the State reserves the right to join any such claim, at its sole expense, when it determines there is an issue of significant public interest.
- (c) The Contractor shall have no obligation hereunder with respect to any claim or cause of action for damages to persons or property to the extent caused by the Department and/or Office, its employees or agents, when acting within the course and scope of their employment.

## 2. Indemnification by the Department and/or Office

Subject to the availability of lawful appropriations as required by State Finance Law §41 and consistent with §8 of the State Court of Claims Act, the Department shall hold the Contractor harmless from and indemnify it for any final judgment of a court of competent jurisdiction to the extent attributable to the negligence of the Department or its officers or employees when acting within the course and scope of their employment. Provisions concerning the Department's responsibility for any claims for liability as may arise during the term of this Contract are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

## **V. Environmental Compliance**

The Contractor shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. The Contractor shall report violations to the Department, Department of Health and Human Services (DHHS) and to the appropriate Regional Office of the Environmental Protection Agency.

## **W. Energy Conservation**

The Contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy conservation plan issued in compliance with the Energy Policy and Conservation Act of 1975, Pub. L. 94-163 42 U.S.C. 6321 et seq., and any amendment thereto.

## **X. Prohibition on Use of Federal Funds for Lobbying**

1. The Contractor agrees, pursuant to Section 1352, Title 31, United States Code, and 45 CFR Part 93 not to expend federally appropriated funds received under this Contract to pay any person for influencing or attempting to influence an officer or employee of an 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 grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or
2. Modification of any federal contract, grant, loan or cooperative agreement. The Contractor agrees to complete and submit the "Certification Regarding Lobbying", attached hereto as Appendix C and incorporated herein, if this Contract exceeds \$100,000.
3. 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 an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Contract or the underlying Federal grant and the agreement exceeds \$100,000 the contractor agrees to complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities", attached hereto as Appendix D and incorporated herein, in accordance with its instructions.
4. The Contractor shall include the provisions of this Section in all subcontracts under this Contract and require that all subcontractors whose contract exceeds \$100,000 certify and disclose accordingly to the Contractor.

## **Y. Waiver of Breach**

No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. Any consent by a Party to, or waiver of, a breach under this Contract shall not constitute consent to, a waiver of, or excuse for any other, different or subsequent breach.

## **Z. Choice of Law**

This Contract shall be interpreted according to the laws of the State of New York, without reference to choice of law principles. The Contractor shall be required to bring any legal proceeding against the Department or the State arising from this Contract in New York State courts.

## **AA. Executory Provision and Federal Funds**

The State Finance Law of the State of New York, Section 112, requires that any contract made by a State Department which exceeds fifteen thousand dollars (\$15,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that this Contract is wholly executory and not binding until and unless approved by the Comptroller of the State of New York. The Parties also agree that the effectiveness of this Contract is conditioned upon receipt of any approval required pursuant to federal law to permit full Federal financial participation in the costs hereof. Contractor agrees to comply with all applicable federal audit requirements including but not limited to OMB Circular A-87 and other applicable federal rules and procedures concerning use of federal funds.

## **BB. Renegotiation**

In the event any part of this Contract is found to be invalid or unenforceable under applicable law and alters the general scope of contractual performance or a change occurs in applicable State or Federal law, rules or regulations or federal or State interpretations thereof which requires alteration of the general scope of contractual performance to remain in compliance therewith, or the Department obtains a waiver of such applicable Federal law, rule or regulation, either Party may initiate re-negotiation of the terms and conditions of this Contract to preserve the benefit bargained for. If the Parties are unable to agree on a revision of contractual terms and conditions consistent with the altered scope of contractual performance, either Party may terminate this Contract as of the last day of the month following the month in which written notice of termination is given, subject to the provisions of Article I, Sections F and G.

## **CC. Affirmative Action**

The Contractor agrees to comply with all applicable Federal and State nondiscrimination statutes including:

1. The Civil Rights Acts of 1964, as amended; Executive Order No. 11246 entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor Regulation 41 CFR Part 60; Executive Law of the State of New York, Sections 290-299 thereof, and any rules or regulations promulgated in accordance therewith; Section 504 of the Rehabilitation Act of 1973 and the Regulations issued pursuant thereto contained in 45 CFR Part 84 entitled "Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial

Assistance”; and the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. Section 12116, and regulations issued by the Equal Employment Opportunity Commission which implement the employment provisions of the ADA, set forth at 29 CFR Part 1630.

2. The Contractor is required to demonstrate effective affirmative efforts and to ensure employment of protected class members. The Contractor must possess and may upon request be required to submit to the Department or Office a copy of an Affirmative Action Plan which is in full compliance with applicable requirements of federal and State statutes.
3. Contractors and subcontractors shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, religion, color, national origin, sex, age, disability or marital status. For these purposes, affirmative action shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
4. Prior to the award of a State contract, the Contractor shall submit an Equal Employment Opportunity (EEO) Policy Statement to the Department within the time frame established by the Department.
5. The Contractor’s EEO Policy Statement shall contain, but not necessarily be limited to, and the Contractor, as a precondition to entering into a valid and binding State contract, shall, during the performance of the State contract, agree to the following:
  - (a.) The Contractor will not discriminate against any employee or Applicant for employment because of race, creed, religion, color, national origin, sex, age, sexual orientation, disability or marital status, will undertake or continue existing programs or affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and 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.
  - (b.) 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, religion, color, national origin, sex, age, disability or marital status.
  - (c.) 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 of 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, religion, color, national origin, sex, age, sexual orientation, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor’s obligations herein.

- (d.) Except for construction contracts, prior to an award of a State contract, the Contractor shall submit to the contracting agency a staffing plan of the anticipated work force to be utilized on the State contract or, where required, information on the Contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency. The form of the staffing plan shall be supplied by the contracting agency.
- (e.) After an award of a State contract, the Contractor shall submit to the contracting agency a work force utilization report, in a form and manner required by the agency, of the work force actually utilized on the State contract, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency.
- (f.) In the event that the Contractor is found through an administrative or legal action, whether brought in conjunction with this Contract or any other activity engaged in by the Contractor, to have violated any of the laws recited herein in relation to the Contractor's duty to ensure equal employment to protected class members, the Department may, in its discretion, determine that the Contractor has breached this Contract.
- (g.) Additionally, the Contractor and any of its subcontractors shall be bound by the applicable provisions of Article 15-A of the Executive Law, including Section 316 thereof, and any rules or regulations adopted pursuant thereto. The Contractor also agrees that any goal percentages contained in this Contract are subject to the requirements of Article 15-A of the Executive Law and regulations adopted pursuant thereto. For purposes of this Contract the goals established for subcontracting/purchasing with Minority and Women-Owned business enterprises are 0% to 5%. The employment goals for the hiring of protected class persons are 5% to 10%.

The Contractor shall be required to submit reports as required by the Department, in a format determined by the Department, concerning the Contractor's compliance with the above provisions, relating to the procurement of services, equipment and or commodities, subcontracting, staffing plans and for achievement or employment goals. The Contractor agrees to make available to the Department upon request, the information and data used in compiling such reports.

It is the policy of the Department to encourage the employment of qualified applicants/recipients of public assistance by both public organizations and private enterprises who are under contractual agreement to the Department for the provision of goods and services. The Department may require the Contractor to demonstrate how the Contractor has complied or will comply with the aforesaid policy.

## **DD. 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 Contractors, subcontractors, and suppliers on its procurement contracts. The Omnibus Procurement Act of 1992 requires that by signing this Contract, the Contractor certifies that whenever the total contract is greater than \$1 million:

1. The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors on this project, and has retained the documentation of these efforts to be provided upon request to the State;
2. The Contractor has complied with the Federal Equal Opportunity Act of 1972 (Pub. L. 92-261), as amended;
3. 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 such documentation upon request;
4. The Contractor acknowledges notice that New York 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.

#### **EE. Fraud and Abuse**

The Contractor shall comply with the program integrity requirements of 42 CFR 438.608 and operate in a manner as to ensure a prompt organizational response to detect offenses and development of corrective action initiatives. The Contractor shall also establish and adhere to a process for reporting to the Department credible information of violations of law by the Contractor subcontractors or Enrollees for a determination as to whether criminal, civil or administrative action may be appropriate. With respect to Enrollees, this reporting shall be restricted to credible information on violations of law with respect to enrollment in the plan or the provision of, or payment for, health services.

#### **FF. Nondiscrimination in Employment in Northern Ireland**

In accordance with Chapter 807 of the Laws of 1992, the Contractor agrees that, if it or any individual or legal entity in which the Contractor holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership in the Contractor, has business operations in Northern Ireland, the Contractor, or such individual or legal entity, shall take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity, and shall permit independent monitoring of its compliance with such Principles.

## **GG. Contract Insurance Requirements.**

The Contractor must, without expense to the State, procure and maintain, for the full term of the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this Contract, whether performed by it or by subcontractors. Before commencing the work, the Contractor shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to said Department, showing that it has complied with the requirements of this Section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty (30) days written notice has been given to said Department. The kinds and amounts of required insurance are:

1. A policy covering the obligations of the Contractor in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the Contract shall be void and of no effect unless the Contractor procures such policy and maintains it for the full term of the Contract.
2. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.
  - (a.) Contractor's Liability Insurance issued to and covering the liability of the Contractor with respect to all work performed by it under this proposal and the contract.
  - (b.) Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its subcontractors, including omissions and supervisory acts of the State.
  - (c.) Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its subcontractors, including omissions and supervisory acts of the State.

## **HH. Minority and Women Owned Business Policy Statement**

The New York State Department of Health and the OPWDD recognize the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and

economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Order-21 and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the Contractor agrees to file with the Department of Health within 10 days notice of award, a staffing plan of the anticipated work force to be utilized on this Contract or, where required, information on the Contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing shall be supplied by the Department, after an award of this Contract, the Contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this Contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories or other appropriate categories specified by the Department.

## **II. Provisions Related to 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). Contractor shall be liable for the costs associated with such breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of agents, officers, employees or subcontractors.

### **JJ. Accessibility of State Agency Web-based Intranet and Internet Information and Applications**

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract will comply with NYS Office for Technology Policy PO4-002, "Accessibility of New York State Web-based Intranet and Internet Information and Applications", and NYS Mandatory Technology Standard SO4-001, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to NYS Mandatory Technology Standard SO4-00, as determined by quality assurance testing. Such quality assurance testing will be conducted by Department of Health, contractor or other, and the results of such testing must be satisfactory to the Department of Health before web content will be considered a qualified deliverable under the contract.

### **KK. New York State Tax Law Section 5-a**

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than

\$100,000 to certify to the New York State Department of Taxation and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Department of Taxation and Finance, Contractor Certification Form ST-220-TD. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with the DTF. If the information changes for the contractor, its affiliates(s), or its subcontractors(s), a new form (ST-220-TD) must be filed with the DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

#### **LL. Provisions Related to New York State Procurement Lobbying Law**

The State reserves the right to terminate this Contract in the event it is found that the certification filed by the Contractor 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 Contractor in accordance with the written notification terms of the Contract.

#### **MM. Piggybacking**

New York State Finance Law Section 163(10)(e) [see also <http://www.ogs.state.ny.us/procurecounc/pgbguidelines.asp>] allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

#### **NN. Lead Guidelines**

All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

## **OO. Payment**

Payment for claims/invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments.

Authorization forms are available at the State Comptroller's website at [www.osc.state.ny.us/epay/index.htm](http://www.osc.state.ny.us/epay/index.htm), by email at [epunit@osc.state.ny.us](mailto:epunit@osc.state.ny.us) or by telephone at 518-474-6019. The Contractor acknowledges that it will not receive payment on any claims/invoices submitted under this Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller  
Bureau of Accounting Operations  
Warrant & Payment Control Unit  
110 State Street, 9th Floor  
Albany, NY 12236

## **PP. M/WBE Utilization Plan for Subcontracting and Purchasing**

The Office encourages the use of Minority and/or Women Owned Business Enterprises (M/WBEs) for any subcontracting or purchasing related to this contract. Contractors who are not currently a New York State certified M/WBE must define the portion of all consumable products and personnel required for this proposal that will be sourced from a M/WBE. The amount must be stated in total dollars and as a percent of the total cost necessary to fulfill the Agreement requirements. Supportive documentation must include a detailed description of work that is required including products and services.

The goal for usage of M/WBEs is at least 10% of monies used for contract activities. In order to assure a good-faith effort to attain this goal, the STATE requires that Contractors complete the M/WBE Utilization Plan and submit this Plan.

Contractors that are New York State certified MBEs or WBEs are not required to complete this form. Instead, such Contractors must simply provide evidence of their certified status.

Failure to submit the above referenced Plan (or evidence of certified M/WBE status) will result in disqualification of the vendor from consideration for award.

## **QQ. On-going Vendor Responsibility**

### **1. General Responsibility Language**

The Contractor shall at all times during the Contract term remain responsible. The

Contractor agrees, if requested by the Commissioner(s) of Health and/or the Office or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility)

The Commissioner(s) of Health and/or the Office or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner(s) of Health and/or the Office or his or her designee issues a written notice authorizing a resumption of performance under the Contract.

3. Termination (for Non-Responsibility)

Upon written notice to the Contractor, and a reasonable opportunity to be heard with appropriate Department of Health and/or the Office officials or staff, the Contract may be terminated by the Commissioner(s) of Health and/or the Office or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner(s) of Health and/or the Office or his or her designee to be nonresponsible. In such event, the Commissioner(s) of Health and/or the Office or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

**APPENDIX A**

**STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS**

**PLEASE RETAIN THIS DOCUMENT FOR  
FUTURE REFERENCE.**

# STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

**PLEASE RETAIN THIS DOCUMENT FOR FUTURE REFERENCE.**

STANDARD CLAUSES FOR NYS CONTRACTS

APPENDIX A

## TABLE OF CONTENTS

	Page
1. Executory Clause	3
2. Non-Assignment Clause	3
3. Comptroller’s Approval	3
4. Workers’ Compensation Benefits	3
5. Non-Discrimination Requirements	3
6. Wage and Hours Provisions	3
7. Non-Collusive Bidding Certification	4
8. International Boycott Prohibition	4
9. Set-Off Rights	4
10. Records	4
11. Identifying Information and Privacy Notification	4
12. Equal Employment Opportunities For Minorities and Women	4-5
13. Conflicting Terms	5
14. Governing Law	5
15. Late Payment	5
16. No Arbitration	5
17. Service of Process	5
18. Prohibition on Purchase of Tropical Hardwoods	5-6
19. MacBride Fair Employment Principles	6
20. Omnibus Procurement Act of 1992	6
21. Reciprocity and Sanctions Provisions	6
22. Compliance with New York State Information Security Breach and Notification Act	6
23. Compliance with Consultant Disclosure Law	6
24. Procurement Lobbying	7
25. Certification of Registration to Collect Sales and Compensating Use Tax by Certain State Contractors, Affiliates and Subcontractors	7
26. Iran Divestment Act	7

**STANDARD CLAUSES FOR NYS CONTRACTS****APPENDIX A****STANDARD CLAUSES FOR NYS 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, licenser, 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

Page 3

January 2014

**STANDARD CLAUSES FOR NYS CONTRACTS**

**APPENDIX A**

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,

Page 4

January 2014

**STANDARD CLAUSES FOR NYS CONTRACTS**

**APPENDIX A**

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, upgradings, 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

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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 A, the terms of this Appendix A 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.

Page 5

January 2014

**STANDARD CLAUSES FOR NYS CONTRACTS**

**APPENDIX A**

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](mailto: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](mailto: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.

## **APPENDIX B**

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

#### **I. OBJECTIVES**

Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include State and local government and ADA and Section 504 requirements extend to all programs and services provided by State and local government. Since Medicaid is a government program, health services provided through Medicaid Managed Care, including Managed Long Term Care and the OPWDD DISCOs, must be accessible to all that qualify for them.

MCO responsibilities for compliance with the ADA are imposed under Title II and Section 504 when, as a contractor in a Medicaid program, a plan is providing a government service. If an individual provider under contract with the MCO is not accessible, it is the responsibility of the MCO to make arrangements to assure that alternative services are provided. The MCO may determine it is expedient to make arrangements with other providers, or to describe reasonable alternative means and methods to make these services accessible through its existing Participating Providers. The goals of compliance with ADA Title II requirements are to offer a level of services that allows people with disabilities access to the program in its entirety, and the ability to achieve the same health care results as any Enrollee.

MCO responsibilities for compliance with the ADA are also imposed under Title III when the MCO functions as a public accommodation providing services to individuals (e.g. program areas and sites such as Outreach, education, member services, orientation, Complaints and Appeals). The goals of compliance with ADA Title III requirements are to offer a level of services that allows people with disabilities full and equal enjoyment of the goods, services, facilities or accommodations that the entity provides for its customers or clients. New and altered areas and facilities must be as accessible as possible. Whenever MCOs engage in new construction or renovation, compliance is also required with accessible design and construction standards promulgated pursuant to the ADA as well as State and local laws. Title III also requires that public accommodations undertake “readily achievable barrier removal” in existing facilities where architectural and communications barriers can be removed easily and without much difficulty or expense.

The State uses Plan Qualification Standards to qualify MCOs for participation in the OPWDD DISCO managed care program pursuant to the State’s responsibility to assure program access to all Enrollees, the Plan Qualification Standards require each MCO to submit an ADA Compliance Plan that describes in detail how the MCO will make services, programs and activities readily accessible and useable by individuals with disabilities. In the event that certain program sites are not readily accessible, the MCO must describe reasonable alternative methods for making the services or activities accessible and usable.

The objectives of these guidelines are threefold:

- To ensure that MCOs take appropriate steps to measure access and assure program accessibility for persons with disabilities;
- To provide a framework for MCOs as they develop a plan to assure compliance with the Americans with Disabilities Act (ADA); and
- To provide standards for the review of the MCO Compliance Plans.

These guidelines include a general standard followed by a discussion of specific considerations and suggestions of methods for assuring compliance. Please be advised that, although these guidelines and any subsequent reviews by State and local governments can give the Contractor guidance, it is ultimately the Contractor's obligation to ensure that it complies with its Contractual obligations, as well as with the requirements of the ADA, Section 504, and other federal, state and local laws. Other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and may impose requirements in addition to those established under ADA. For example, while the ADA covers those impairments that "substantially" limit one or more of the major life activities of an individual, New York City Human Rights Law deletes the modifier "substantially".

## **II. DEFINITIONS**

- A. "Auxiliary aids and services" may include qualified interpreters, note takers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for Enrollees who are deaf or hard of hearing (TTY/TDD), video text displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments; qualified readers, taped texts, audio recordings, Braille materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.
- B. "Disability" means a mental or physical impairment that substantially limits one or more of the major life activities of an individual; a record of such impairment; or being regarded as having such an impairment.

## **III. SCOPE OF CONTRACTOR COMPLIANCE PLAN**

The MCO Compliance Plan must address accessibility to services at MCO's program sites, including both Participating Provider sites and MCO facilities intended for use by Enrollees.

## **IV. PROGRAM ACCESSIBILITY**

Public programs and services, when viewed in their entirety must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-discrimination in policies and procedures and communication. Communications with individuals with disabilities are required to be as effective as communications with others. The MCO Compliance Plan must include a detailed description of how MCO services, programs, and activities are readily accessible and usable by individuals with disabilities. In the event that full physical accessibility is not readily available for people with disabilities, the MCO Compliance Plan will describe the steps or actions the

MCO will take to assure accessibility to services equivalent to those offered at the inaccessible facilities.

**A. PRE-ENROLLMENT OUTREACH AND EDUCATION STANDARD FOR COMPLIANCE**

Outreach staff, activities and materials will be made available to persons with disabilities. Outreach materials will be made available in alternative formats (such as Braille, large print, and audiotapes) so that they are readily usable by people with disabilities.

**SUGGESTED METHODS FOR COMPLIANCE**

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes training and information regarding attitudinal barriers related to disability
4. Activities and fairs that include sign language interpreters or the distribution of a written summary of the outreach script used by plan outreach representatives
5. Enrollee health promotion material/activities targeted specifically to persons with disabilities (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
6. Policy statement that Outreach Representatives will offer to read or summarize to blind or vision impaired individuals any written material that is typically distributed to all Enrollees
7. Staff/resources available to assist individuals with cognitive impairments in understanding materials

**COMPLIANCE PLAN SUBMISSION**

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

**B. MEMBER SERVICES DEPARTMENT**

Member services functions include the provision to Enrollees of information necessary to make informed choices about treatment options, to effectively utilize the health care resources, to assist Enrollees in making appointments, and to field questions and Complaints, to assist Enrollees with the Complaint process.

**B1. ACCESSIBILITY  
STANDARD FOR COMPLIANCE**

Member Services sites and functions will be made accessible to and usable by, people with disabilities.

**SUGGESTED METHODS FOR COMPLIANCE** (include, but are not limited to those identified below):

1. Exterior routes of travel, at least 36" wide, from parking areas or public transportation stops into the Contractor's facility
2. If parking is provided, spaces reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs
3. Routes of travel into the facility are stable, slip-resistant, with all steps > ½" ramped, doorways with minimum 32" opening
4. Interior halls and passageways providing a clear and unobstructed path or travel at least 36" wide to bathrooms and other rooms commonly used by Enrollees
5. Waiting rooms, restrooms, and other rooms used by Enrollees are accessible to people with disabilities
6. Sign language interpreters and other auxiliary aids and services provided in appropriate circumstances
7. Materials available in alternative formats, such as Braille, large print, audio tapes
8. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
9. Availability of activities and educational materials tailored to specific conditions/illnesses and secondary conditions that affect these populations (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
10. MCO staff trained in the use of telecommunication devices for Enrollees who are deaf or hard of hearing (TTY/TDD) as well as in the use of NY Relay for phone communication
11. New Enrollee orientation available in audio or by interpreter services
12. Policy that when member services staff receive calls through the NY Relay, they will offer to return the call utilizing a direct TTY/TDD connection

### **COMPLIANCE PLAN SUBMISSION**

1. A description of accessibility to the member services department or reasonable alternative means to access member services for Enrollees using wheelchairs (or other mobility aids)
2. A description of the methods the member services department will use to communicate with Enrollees who have visual or hearing impairments, including any necessary auxiliary aid/services for Enrollees who are deaf or hard of hearing, and TTY/TDD technology or NY Relay service available through a toll-free telephone number
3. A description of the training provided to the member services staff to assure that staff adequately understands how to implement the requirements of the program, and of these guidelines, and are sensitive to the needs of persons with disabilities

### **B2. IDENTIFICATION OF ENROLLEES WITH DISABILITIES**

## **STANDARDS FOR COMPLIANCE**

The Contractor must have in place satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services etc. The Contractor may not discriminate against a Prospective Enrollee based on his/her current health status or anticipated need for future health care. The Contractor may not discriminate on the basis of disability, or perceived disability of an Enrollee or their family member.

## **SUGGESTED METHODS FOR COMPLIANCE**

1. Appropriate post Enrollment health screening for each Enrollee, using an appropriate health screening tool
2. Patient profiles by condition/disease for comparative analysis to national norms, with appropriate outreach and education
3. Process for follow-up of needs identified by initial screening; e.g. referrals, assignment of case manager, assistance with scheduling/keeping appointments
4. Enrolled population disability assessment survey
5. Process for Enrollees who acquire a disability subsequent to Enrollment to access appropriate services

## **COMPLIANCE PLAN SUBMISSION**

A description of how the Contractor will identify special health care, physical access or communication needs of Enrollees on a timely basis, including but not limited to the health care needs of Enrollees who:

- are blind or have visual impairments, including the type of auxiliary aids and services required by the Enrollee
- are deaf or hard of hearing, including the type of auxiliary aids and services required by the Enrollee
- have mobility impairments, including the extent, if any, to which they can ambulate
- have other physical or mental impairments or disabilities, including cognitive impairments
- have conditions which may require more intensive case management

## **B3. NEW ENROLLEE ORIENTATION STANDARD FOR COMPLIANCE**

Enrollees will be given information sufficient to ensure that they understand how to access medical care through the plan. This information will be made accessible to and usable by people with disabilities.

## **SUGGESTED METHODS FOR COMPLIANCE**

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
4. Activities and fairs that include sign language interpreters or the distribution of a written summary of the Outreach script used by plan outreach representatives
5. Include in written/audio materials available to all Enrollees information regarding how and where people with disabilities can access help in getting services, for example help with making appointments or for arranging special transportation, an interpreter or assistive communication devices
6. Staff/resources available to assist individuals with cognitive impairments in understanding materials

### **COMPLIANCE PLAN SUBMISSION**

1. A description of how the MCO will advise Enrollees with disabilities, during the new Enrollee orientation on how to access care
2. A description of how the MCO will assist new Enrollees with disabilities (as well as current Enrollees who acquire a disability) in arranging appointments
  - This should include a description of how the MCO will assure and provide notice to Enrollees who are deaf or hard of hearing, blind or who have visual impairments, of their right to obtain necessary auxiliary aids and services during appointments and in scheduling appointments and follow-up treatment with Participating Providers
  - In the event that certain provider sites are not physically accessible to Enrollees with mobility impairments, the MCO will assure that reasonable alternative site and services are available
3. A description of how the MCO will determine the specific needs of an Enrollee with or at risk of having a disability/chronic disease, in terms of specialist physician referrals, durable medical equipment (including assistive technology and adaptive equipment), medical supplies and home health services and will assure that such contractual services are provided
4. A description of how the MCO will identify if an Enrollee with a disability requires on-going mental health services and how the MCO will encourage early entry into treatment
5. A description of how the MCO will notify Enrollees with disabilities as to how to access transportation, where applicable

### **B4. COMPLAINTS, COMPLAINTS AND APPEALS STANDARDS FOR COMPLIANCE**

The MCO will establish and maintain a procedure to protect the rights and interests of both Enrollees and the DISCO plans by receiving, processing, and resolving

Complaints and Appeals in an expeditious manner, with the goal of ensuring resolution of Complaints/Appeals and access to appropriate services as rapidly as possible.

All Enrollees must be informed about the Grievance System within their plan and the procedure for filing Complaints and/or Appeals. This information will be made available through the Member Handbook, the Department's toll-free Complaint line [1-(800) 206-8125] and the plan's Complaint process annually, as well as when the MCO denies a benefit or referral. The MCO will inform Enrollees of: the MCO's procedures; Enrollees' right to contact the Office or the Department with a Complaint, and to file an Appeal or request a fair hearing; the right to appoint a designee to handle a Complaint or Appeal; and the toll free Complaint line. The MCO will maintain designated staff to take and process complaints, and be responsible for assisting Enrollees in complaint resolution.

The MCO will make all information regarding the Grievance System available to and usable by people with disabilities, and will assure that people with disabilities have access to sites where Enrollees typically file Complaints and requests for Appeals.

#### **SUGGESTED METHODS FOR COMPLIANCE**

1. Toll-free Complaint phone line with TDD/TTY capability
2. Staff trained in Complaint process, and able to provide interpretive or assistive support to Enrollee during the Complaint process
3. Notification materials and Complaint forms in alternative formats for Enrollees with visual or hearing impairments
4. Availability of physically accessible sites, e.g. member services department sites
5. Assistance for individuals with cognitive impairments

#### **COMPLIANCE PLAN SUBMISSION**

1. A description of how the MCO's Complaint and Appeal procedures shall be accessible for persons with disabilities, including:
  - procedures for Complaints and Appeals to be made in person at sites accessible to persons with mobility impairments
  - procedures accessible to persons with sensory or other impairments who wish to make verbal Complaints or Appeals, and to communicate with such persons on an ongoing basis as to the status or their Complaints and rights to further appeals
  - description of methods to ensure notification material is available in alternative formats for Enrollees with vision and hearing impairments
2. A description of how the Contractor monitors Complaints and Appeals related to people with disabilities.

#### **C. CASE MANAGEMENT STANDARD FOR COMPLIANCE**

MCOs must have in place adequate case management systems to identify the service needs of all Enrollees, including Enrollees with chronic illness and Enrollees with disabilities, and

ensure that medically necessary covered benefits are delivered on a timely basis. These systems must include procedures for standing referrals, specialists as PCPs, and referrals to specialty centers for Enrollees who require specialized medical care over a prolonged period of time (as determined by a treatment plan approved by the MCO in consultation with the primary care provider, the designated specialist and the Enrollee or his/her designee), out-of-network referrals and continuation of existing treatment relationships with out-of-network providers (during transitional period).

#### **SUGGESTED METHODS FOR COMPLIANCE**

1. Procedures for requesting standing referrals to specialists and/or specialty centers, out-of-network referrals, and continuation of existing treatment relationships
2. Procedures to meet Enrollee needs for, durable medical equipment, medical supplies, home visits as appropriate
3. Appropriately trained MCO staff to function as case managers for special needs populations, or sub-contract arrangements for case management
4. Procedures for informing Enrollees about the availability of case management services

#### **COMPLIANCE PLAN SUBMISSION**

1. A description of the MCO case management program for people with disabilities, including case management functions, procedures for qualifying for and being assigned a case manager, and description of case management staff qualifications
2. A description of the MCO's notice procedures to Enrollees regarding the availability of case management services, standing referrals to specialists and specialty centers, out-of-network referrals and continuing treatment relationships

#### **D. PARTICIPATING PROVIDERS STANDARD FOR COMPLIANCE**

MCO's networks will include all the provider types necessary to furnish the Benefit Package, to assure appropriate and timely health care to all Enrollees, including those with chronic illness and/or disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, e.g. exam tables and medical equipment.

#### **SUGGESTED METHODS FOR COMPLIANCE**

1. Process for the MCO to evaluate provider network to ascertain the degree of provider accessibility to persons with disabilities, to identify barriers to access and required modifications to policies/procedures

2. Model protocol to assist Participating Providers, at their point of service, to identify Enrollees who require case manager, audio, visual, mobility aids, or other accommodations
3. Model protocol for determining needs of Enrollees with mental disabilities
4. Use of Wheelchair Accessibility Certification Form
5. Submission of map of physically accessible sites
6. Training for providers re: compliance with Title III of ADA, e.g. site access requirements for door widths, wheelchair ramps, accessible diagnostic/treatment rooms and equipment; communication issues; attitudinal barriers related to disability, etc. [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212) 788-2838].
7. Use of ADA Checklist for Existing Facilities and NYC Addendum to OAPD ADA Accessibility Checklist as guides for evaluating existing facilities and for new construction and/or alteration.

## **COMPLIANCE PLAN SUBMISSION**

1. A description of how the MCO will ensure that its Participating Provider network is accessible to persons with disabilities. This includes the following:
  - Policies and procedures to prevent discrimination on the basis of disability or type of illness or condition
  - Identification of Participating Provider sites which are accessible by people with mobility impairments, including people using mobility devices. If certain provider sites are not physically accessible to persons with disabilities, the MCO shall describe reasonable, alternative means that result in making the provider services readily accessible.
  - Identification of Participating Provider sites which do not have access to sign language interpreters or reasonable alternative means to communicate with Enrollees who are deaf or hard of hearing; and for those sites describe reasonable alternative methods to ensure that services will be made accessible
  - Identification of Participating Providers which do not have adequate communication systems for Enrollees who are blind or have vision impairments (e.g. raised symbol and lettering or visual signal appliances), and for those sites describe reasonable alternative methods to ensure that services will be made accessible
2. A description of how the MCO's specialty network is sufficient to meet the needs of Enrollees with disabilities
3. A description of methods to ensure the coordination of out-of-network providers to meet the needs of the Enrollees with disabilities
  - This may include the implementation of a referral system to ensure that the health care needs of Enrollees with disabilities are met appropriately
  - MCO shall describe policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when in the best interest of the Enrollee with a disability
4. Submission of the ADA Compliance Summary Report or MCO statement that data submitted to the Department is an accurate reflection of each network's physical accessibility

**E. POPULATIONS WITH SPECIAL HEALTH CARE NEEDS  
STANDARD FOR COMPLIANCE**

MCOs will have satisfactory methods for identifying persons at risk of, or having, chronic disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. MCOs will have satisfactory systems for coordinating service delivery and, if necessary, procedures to allow continuation of existing relationships with out-of-network provider for course of treatment.

**SUGGESTED METHODS FOR COMPLIANCE**

1. Procedures for requesting standing referrals to specialists and/or specialty centers, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships with out-of-network providers for course of treatment
2. Linkages with behavioral health agencies, disability and advocacy organizations, etc.
3. Adequate network of providers and sub-specialists and contractual relationships with tertiary institutions
4. Procedures for assuring that these populations receive appropriate diagnostic work-ups on a timely basis
5. Procedures for assuring that these populations receive appropriate access to durable medical equipment on a timely basis
6. Procedures for assuring that these populations receive appropriate allied health professionals (Physical, Occupational and Speech Therapists, Audiologists) on a timely basis

**COMPLIANCE PLAN SUBMISSION**

A description of arrangements to ensure access to specialty care providers and centers in and out of New York State, standing referrals, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships (out-of-network) for diagnosis and treatment of rare disorders

**F. ADDITIONAL ADA RESPONSIBILITIES FOR PUBLIC ACCOMMODATIONS**

Please note that Title III of the ADA applies to all non-governmental providers of health care. Title III of the Americans with Disabilities Act prohibits discrimination on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation. A public accommodation is a private entity that owns, leases or leases to, or operates a place of public accommodation. Places of public accommodation identified by the ADA include, but are not limited to, stores (including pharmacies) offices (including doctors' offices), hospitals, health care providers, and social service centers.

New and altered areas and facilities must be as accessible as possible. Barriers must be removed from existing facilities when it is readily achievable, defined by the ADA as easily accomplishable

without much difficulty or expense. Factors to be considered when determining if barrier removal is readily achievable include the cost of the action, the financial resources of the site involved, and, if applicable, the overall financial resources of any parent corporation or entity. If barrier removal is not readily achievable, the ADA requires alternate methods of making goods and services available. New facilities must be accessible unless structurally impracticable.

Title III also requires places of public accommodation to provide any auxiliary aids and services that are needed to ensure equal access to the services it offers, unless a fundamental alteration in the nature of services or an undue burden would result. Auxiliary aids include but are not limited to qualified sign interpreters, assistive listening systems, readers, large print materials, etc. Undue burden is defined as “significant difficulty or expense”. The factors to be considered in determining “undue burden” include, but are not limited to, the nature and cost of the action required and the overall financial resources of the provider. “Undue burden” is a higher standard than “readily achievable” in that it requires a greater level of effort on the part of the public accommodation.

Please note also that the ADA is not the only law applicable for people with disabilities. In some cases, State or local laws require more than the ADA. For example, New York City’s Human Rights Law, which also prohibits discrimination against people with disabilities, includes people whose impairments are not as “substantial” as the narrower ADA and uses the higher “undue burden” (“reasonable”) standard where the ADA requires only that which is “readily achievable”. New York City’s Building Code does not permit access waivers for newly constructed facilities and requires incorporation of access features as existing facilities are renovated. Finally, the State Hospital code sets a higher standard than the ADA for provision of communication (such as sign language interpreters) for services provided at most hospitals, even on an outpatient basis.

## APPENDIX C

### CERTIFICATION REGARDING LOBBYING

The undersigned certified, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the awarding of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative.
2. If any funds other than Federal 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, in connection with the award of any Federal contract, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative agreement, and the Agreement exceeds \$100,000, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The Contractor shall include the provisions of this section in all provider Agreements under this Agreement and require all Participating Providers whose provider agreements exceed \$100,000 to certify and disclose accordingly to the Contractor.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed pursuant to U.S.C. 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than \$10,000 and no more than \$100,000 for each such failure.

Date: \_\_\_\_\_  
\_\_\_\_\_ (Signature)

Name (Printed): \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

APPENDIX D

Standard Form LLL Disclosure of Lobbying Activities

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## APPENDIX E-1

### Requirements for Proof of Workers' Compensation Coverage

Unless the Contractor is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the Contractor's insurance carrier and/or the Workers' Compensation Board, of coverage for:

Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

- o **CE-200**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- o **C-105.2** – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
- o **SI-12** – Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** – Certificate of Participation in Workers' Compensation Group Self-Insurance.

**NOTE: ACORD forms are NOT acceptable proof of coverage.**

## APPENDIX E-2

### Requirements for Proof of Disability Insurance Coverage

Unless the Contractor is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the Contractor's insurance carrier and/or the Workers' Compensation Board, of coverage for:

Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

- o **CE-200**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- o **DB-120.1** – Certificate of Disability Benefits Insurance; OR
- o **DB-155** – Certificate of Disability Benefits Self-Insurance

**NOTE: ACORD forms are NOT acceptable proof of coverage.**

## APPENDIX F

### SERVICE AREA AND AGES OF POPULATION TO BE SERVED

1. The Contractor shall list the specific New York State counties in which it will enroll eligible individuals. The Contractor will not define a service area to be anything less than the entirety of each named county. The service area of the Contractor is:

2. The Contractor acknowledges that it must service individuals of all ages from birth to death. The Contractor acknowledges that it may not enroll any individual prior to birth, irrespective of Medicaid eligibility:

\_\_\_\_\_ Agree

\_\_\_\_\_ Disagree

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## APPENDIX G - DRAFT DISCO Covered/Non-Covered Services

Eligibility for benefit package services as outlined in this section:

Persons who are coded in the Medicaid eligibility system by the Office to have a developmental disability as defined in Mental Hygiene Law section 1.03(22); OR are eligible for Intermediate Care Facility/Developmental Disabilities (ICF/DD) level of care (as of the time of enrollment), may be eligible for Part A of the benefit package in this section.

Persons who are eligible for and enrolled in the OPWDD 1915c Home and Community Based Services (HCBS) Waiver are eligible to receive Part A of the benefit package and in addition can receive those services included in section B of the benefit package (OPWDD Comprehensive HCBS Waiver Services).

The list below identifies Medicaid services that are included in the DISCO Benefit Package (DISCO COVERED = Y) and Medicaid Services that are not included in the DISCO Benefit Package (DISCO COVERED = N). As is describe is Article IV, there are certain services that the DISCO is responsible for financially for a limited time period should an enrollee have need of the service, but individuals receiving these services cannot opt into a DISCO while receiving these services. These services have a “DISCO Covered Code” of “F” and include psychiatric inpatient stays and Developmental Center enrollments.

COS Detail Based on SVC_DESC and SVC_SUBDIV Fields	DISCO Covered Service <sup>1</sup>	
<b>ADULT DAY HEALTH CARE</b>	Y	<b>PART A</b>
<b>ASSISTED LIVING PROGRAM</b>	N	
<b>AUDIOLOGY &amp; HEARING AIDS</b>	Y	
<b>CASE MANAGEMENT</b>	Y	
<b>CHILD CARE FACILITY</b>	N	
<b>DRUGS (Prescription and over-the-counter)</b>	N	
<b>FREE-STANDING CLINIC</b>		
AMBULATORY SURGERY - ALL OTHER	N	
CLINIC/OPD - ALL OTHER	N	
CLINIC/OPD - AUDIOLOGY	Y	
CLINIC/OPD - DENTAL	Y	
CLINIC/OPD - NUTRITION	Y	
CLINIC/OPD - OPTOMETRY & EYEGLASSES	Y	
CLINIC/OPD - PODIATRY	Y	
CLINIC/OPD - PSYCHOLOGY, SOCIAL WORK & COUNSELING	Y	
CLINIC/OPD - THERAPY	Y	
DAY TREATMENT	Y	
INTENSIVE PSYCH REHAB TREATMENT	Y	
PARTIAL HOSPITALIZATION	Y	
<b>HOME HEALTH CARE</b>	Y	
<b>HOSPICE</b>	N	

<b>HOSPITAL OPD</b>	
AMBULATORY SURGERY - ALL OTHER	N
AMBULATORY SURGERY - DENTAL	Y
AMBULATORY SURGERY - PODIATRY	Y
CLINIC/OPD - ALL OTHER	Y
CLINIC/OPD - AUDIOLOGY	Y
CLINIC/OPD - DENTAL	Y
CLINIC/OPD - NUTRITION	Y
CLINIC/OPD - OPTOMETRY & EYEGLASSES	Y
CLINIC/OPD - PODIATRY	Y
CLINIC/OPD - PSYCHOLOGY, SOCIAL WORK & COUNSELING	Y
CLINIC/OPD - THERAPY	Y
DAY TREATMENT	Y
EMERGENCY ROOM	N
INTENSIVE PSYCH REHAB TREATMENT	Y
PARTIAL HOSPITALIZATION	Y
<b>INPATIENT</b>	
ALL OTHER	N
ALL OTHER (G.M.E.)	N
DENTAL	Y
DENTAL (G.M.E.)	Y
PSYCHIATRIC	F
PSYCHIATRIC (AWC DAYS)	N
PSYCHIATRIC (G.M.E.)	F
RESIDENTIAL TREATMENT FACILITY	F
SPECIALTY HOSPITAL - OPWDD (Not Applicable)	N
SUBSTANCE ABUSE	F
SUBSTANCE ABUSE (G.M.E.)	F
<b>INTERMEDIATE CARE FACILITY</b>	
COMM ICF/DD	Y
DEVELOPMENTAL CENTER	F
SMALL RESIDENTIAL UNIT	F
<b>LABORATORY</b>	N
<b>MEDICAL SUPPLIES &amp; D.M.E.</b>	Y
<b>NON-OPWDD WAIVER</b>	N
<b>OPTOMETRY &amp; EYEGLASSES</b>	Y
<b>ORDERED AMBULATORY</b>	
ALL OTHER	N
AUDIOMETRY	Y

NUTRITION	Y	
PSYCHOLOGY, SOCIAL WORK & COUNSELING	Y	
THERAPY	Y	
<b>PERSONAL CARE</b>	Y	
<b>PERSONAL EMERGENCY RESPONSE</b>	Y	
<b>PRACTITIONER</b>		
DENTAL	Y	
OTHER	N	
PHYSICIAN/NP/PA	N	
PODIATRY	Y	
PSYCHOLOGY, SOCIAL WORK & COUNSELING	Y	
THERAPY	Y	
<b>PRIVATE DUTY NURSING</b>	Y	
<b>REHABILITATION SERVICES</b>		
ASSERTIVE COMMUNITY TREATMENT	Y	
OMH LIC RESID PGMS (CR,FBT,TFH)	N	
PERSONALIZED RECOVERY ORIENTED SERVICES	Y	
<b>SKILLED NURSING FACILITY</b>	F	
<b>EARLY INTERVENTION</b>	N	
<b>SCHOOL SUPPORTIVE HEALTH SVCS</b>	N	
TRANSPORTATION EMERGENCY	N	
TRANSPORTATION NON-EMERGENCY	Y	

<b>OPWDD CAH WAIVER (NOT APPLICABLE)</b>		<b>PART B</b>
ADAPTIVE TECHNOLOGIES	N	
CASE MANAGEMENT	N	
ENVIRONMENTAL MODIFICATIONS	N	
<b>OPWDD COMPREHENSIVE HCBS WAIVER</b>		
ADAPTIVE TECHNOLOGIES	Y	
COMMUNITY HABILITATION	Y	
CONSOLIDATED SUPPORTS AND SERVICES (as of 10/1/14 self-direction re-design)	Y	
DAY HABILITATION	Y	
ENVIRONMENTAL MODIFICATIONS	Y	
FAMILY EDUCATION AND TRAINING	Y	
INTENSIVE BEHAVIORAL SERVICES	Y	
PLAN OF CARE SUPPORTS	Y	
PRE-VOCATIONAL SERVICES	Y	

RESIDENTIAL HABILITATION	Y	
RESPIRE	Y	
SUPPORTED EMPLOYMENT	Y	

<sup>1</sup> Based on BENE\_PKG field

F = Only available following enrollment (i.e. Future Coverage),

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**APPENDIX H Schedule of  
Capitation Rates**

**Effective Date:** \_\_\_\_\_

<b>Age Group</b>	<b>Monthly Capitation Amount (PMPM)</b>
18 - 64	\$
65+	\$

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## APPENDIX I

### Quality Plan Guidelines for DISCOs

The following are additional standards for the DISCO's written Quality Assurance and Performance Improvement Plan:

#### **ROLES AND RESPONSIBILITIES:**

##### ***Board Governance and Quality Assurance and Improvement:***

The DISCO Board is accountable for the overall oversight of program activities and the review of the QA/PI program. The Board ensures enrollee (and advocate, family member, and others of importance to enrollees) and network provider involvement in quality assurance and performance improvement activities and evaluation of satisfaction with services.

The Board ensures annual review and approval of the program. The Board ensures the establishment of review committees and periodic feedback to the board on the review process by oversight committees.

The Board establishes a quality assurance review committee(s) to:

- (i) evaluate data collected pertaining to quality indicators, performance standards, and individual satisfaction and make recommendations for improvements based on ongoing data analysis;
- (ii) make recommendations to the board regarding the process and outcomes of the quality assurance and performance improvement program, and

Policies and procedures of the review committee:

- (i) define qualifications of individuals participating on the committee(s);
- (ii) include a method for identifying, selecting and reviewing data and information to be used in the quality assurance and performance improvement program;
- (iii) integrate the findings of the grievance and appeals process;
- (iv) define a process for recommending appropriate action to resolve problems identified as part of quality assurance and improvement activities, including providing feedback to appropriate staff and subcontractors; for monitoring effectiveness of corrective actions taken; and for reporting QA/PI findings to the board and OPWDD on at least an annual basis; and
- (v) incorporate review of the care delivery process to include appropriate clinical professionals and paraprofessionals as well as non-clinical staff, as appropriate.

##### ***Medical Director and other DISCO Key Management Staff Responsible for Oversight, Quality Assurance, and Improvement:***

The written Quality Plan includes a description of the medical director's roles and responsibilities which demonstrates ongoing quality oversight and accountability.

The written Quality Plan includes a description of the lines of accountability for the quality assurance and improvement program including the role of the governing board, the DISCO's leadership, and the roles and responsibilities of other key management staff including those responsible for the Care Coordination function.

### **CONTENTS OF THE QUALITY ASSURANCE AND IMPROVEMENT PLAN:**

#### ***General:***

The DISCOs written Quality Plan includes goals and objectives that provide a framework for quality assurance and improvement activities and discovery and corrective/remediation action both on an individual level as well as systemically across the DISCO's network. These goals and objectives are reviewed at least annually by the DISCO's senior leadership, the Board and its Quality Assurance Review Committee and revised periodically as necessary based upon this discovery, evaluation, and review.

This discovery, evaluation and review is supported by data collection activities including a focus on individualized outcome measures (including clinical, functional, and personal outcomes); encounter and utilization data; the measurement of required HCBS waiver assurances; individual satisfaction data; and may also include other appropriate and actionable quality indicators such as HEDIS measures and/or the Council on Quality and Leadership's Basic Assurance Indicators and National Core Indicators.

Quality indicators that are objective, measurable and related to the range of services provided through the DISCO and which focus on potential clinical problem areas (high volume service, high risk diagnoses or adverse outcomes) should be incorporated in the QI Plan. The methodology should assure that all services and care settings (e.g. residential, day settings, and in-home settings) are included in the scope of the quality assurance and performance improvement program.

The DISCOs Written Quality Assurance and Quality Improvement Plan describes how the DISCO will:

- Provide person-centered planning for all individuals that focuses on individual progress and outcomes in the 21 POM areas identified in the Care Coordination section of the contract (i.e., personal outcome measures) and also promote OPWDD's four outcome areas for individuals to:
  - ✓ Live and receive services in the most integrated settings;
  - ✓ have meaningful and productive community participation, including paid employment;
  - ✓ develop meaningful relationships with friends, family, and others in their lives; and
  - ✓ experience personal health, safety and growth
- Ensure that each individual who chooses to do so can self-direct his or her services including the option for budget and employer authority;
- Maintain a well trained workforce that minimally meets all OPWDD requirements and is culturally competent to meet the needs of the individuals seeking or receiving supports and services.

- Ensure adherence to applicable CMS HCBS Regulations and HCBS Waiver Assurances for enrollees who are also enrolled in the 1915 (c) waiver. The assurances are:
  - ✓ Level of Care - Persons enrolled in the waiver have needs consistent with an institutional level of care
  - ✓ Service Plan - Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan
  - ✓ Qualified Providers - network providers are qualified to deliver services/supports
  - ✓ Health and Welfare - Participants' health and welfare are safeguarded and monitored
  - ✓ Financial Accountability - Claims for waiver services are paid according to approved payment methodologies in accordance with contracts.
- Describes methods for identification and review of problems (i.e., “discovery”), the development of timely and appropriate recommendations, and the follow-up on implementation of recommendations for the resolution of problems.
- Describes methods to be used for individual case record review/audits including sampling techniques.
- Procedures used to identify and review incidents involving members and the potential quality of care implications from review of these incidents. This review should focus on ensuring that the individual is immediately safeguarded as well as any systemic improvements needed as a result of the review and trending of all incidents involving the DISCO's members.
- Assurances that the DISCO and affiliated providers will cooperate with the OPWDD in Mortality Reviews necessary for a DISCO enrollee.
- Description of credentialing/re-credentialing procedures and other processes to ensure that network providers and staff are qualified to deliver services and supports in accordance with all federal and state law/regulations and any OPWDD guidance.

This includes a description of how the DISCO will ensure that all HCBS Waiver providers meet the qualifications and standards to deliver HCBS waiver services (delegated waiver operational/administrative function to DISCO contractor) and a description of how the DISCO will assess whether direct support professionals and direct support professional supervisors and other applicable staff of network providers meet the OPWDD Core Competencies developed by the Talent Development Consortium in accordance with OPWDD specified requirements and timeframes.

- A description of how member concerns will be identified, considering sources including but not limited to grievances and complaints and satisfaction surveys and how individual concerns will be integrated into the overall QA/ plan and QI activities; and
- A process to review the effectiveness of the Care Coordination and person centered planning function including the ability to assess enrollee's care needs, sustain the enrollee's informal supports, identify the enrollee's treatment goals and individual outcomes, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization including social and environmental supports, evaluate that services and supports are provided in the most integrated settings; and amend care delivery processes and the support plan as necessary to effectuate outcome achievement and progress toward established individualized goals

## **Required Methodology for Review of Personal Outcome Measures:**

### ***Council on Quality and Leadership (CQL) Certified Interviewers:***

- The DISCO is required to use CQL certified interviewers to conduct CQL interviews using the CQL interview methodology based upon the 21 CQL outcome measures on a representative sample of DISCO members annually.
- The DISCO may contract with other entities approved by OPWDD to obtain CQL certified interviewers or may obtain certification for its own staff or network provider staff. In the latter case, the DISCO must ensure that certification is retained and that there is an adequate number of certified interviewers to conduct the required certified interviews at least annually.
- The DISCO will adhere to OPWDD CQL Practice Guidelines for DISCOs to be published on OPWDD's website including the sampling parameters.

### ***Reporting and Use of Annual CQL Interview Outcome Data:***

- Using the CQL methodology, DISCOs would assess the degree to which individual outcomes are present and the degree to which supports/services provided are supporting individual outcomes. This data would be compiled and aggregated by the DISCO for the representative sample of individuals interviewed.
- DISCOs will utilize the results of the CQL interviews for each individual interviewed in the planning and care coordination process.
- DISCOs will analyze and utilize the aggregated results of the CQL interviews for continuous quality improvement purposes in the DISCO's quality assurance and improvement program and across the DISCO's network.
- DISCOs will provide the results of the CQL interviews to OPWDD annually in the form and format specified by OPWDD and such results may be published by OPWDD or used in any manner deemed appropriate by OPWDD.

## **OPWDD Review of DISCO's CQL Interviews and Data Collection and Use for Quality Improvement:**

- OPWDD and/or the EQRO will review that the DISCO is utilizing CQL certified interviewers and conducting CQL interviews annually using the CQL methodology; that the DISCO is aggregating the data obtained from the interviews, and making use of the data for improvements to individual plans of care; and for continuous quality improvement.

## **National Core Indicator Benchmarks:**

OPWDD (or its contractors) will annually collect a representative sample of NCI interviews from each DISCO's enrollees. Particular interest lies in results for the following NCI domains/topical areas: individuals' exercise of choice and self-direction (managing both daily activities and longer term life goals), degree of community inclusion, and basic satisfaction of care coordination plus supports and services in the areas of home, employment, health, and relationships. OPWDD will share the summary data on these measures, along with NCI benchmarks collected from the regional fee for service population: DISCOs will then utilize NCI in their Quality Plans by tracking year to year trends and ongoing comparison with fee for service performance in their region. In the second year of managed care implementation, OPWDD will risk adjust each DISCO's NCI benchmarks according to relevant characteristics of their enrollee pools, e.g., large concentrations of medically frail people may limit aggregate growth in NCI community inclusion scores. As the risk adjustment framework is implemented OPWDD will use this data to help assess DISCO to DISCO performance.

The DISCO will incorporate appropriate OPWDD specified performance measures in its Quality Assurance and Improvement Program and written Quality Plan. OPWDD will maintain information on its website that specifies the measures that DISCOs will be required to include as well as measures that OPWDD may use in its Statewide Quality improvement activities.

## APPENDIX J

### DEFINITIONS

Terms used in this Contract, which are not otherwise defined, shall have the meanings set forth below.

Definitions of covered services are intended to provide general information about the level of care available through the Medical Assistance Program. The full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual. Managed care organizations may not define covered services more restrictively than the Medicaid Program. Contractors are expected to provide services for individual Enrollees as described in each Enrollee's plan of care. Services may be provided either directly or through a sub-contract.

**Abusive**, as it relates to cause for involuntary disenrollment, means subjecting program staff to physical abuse or criminal activity which exposes staff to imminent danger or verbal threats which create in staff a reasonable concern for physical safety.

**Action** is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

**Alcohol and substance abuse services** includes both inpatient and outpatient care. Inpatient services include but are not limited to: assessment, management of detoxification and withdrawal conditions, group, individual or family counseling, alcohol and substance abuse education, treatment planning, preventive counseling, discharge planning, and services to significant others provided in-home, office or the community. The following care is also provided: outpatient alcoholism rehabilitation services through programs certified by the Office of Alcohol and Substance Abuse Services (OASAS) under 14 NYCRR Part 380.3 or 380.8; medically supervised ambulatory substance abuse treatment in 1035 facilities certified by OASAS under 14 NYCRR Part 1035; and Methadone Maintenance Treatment Program (MMTP) through facilities which provide MMTP as their principle mission and are certified by OASAS under 14 NYCRR Part 1040.

**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.

**Appeal:** a request for a review of an action taken by the Contractor.

**Applicant:** An applicant is an individual who has expressed a desire to pursue enrollment in a DISCO.

**Audiology/hearing aids:** Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, earmolds, batteries, special fittings and replacement parts.

**Auto-assignment** means a process by which a DISCO Mandatory Person, who is mandated to enroll in OPWDD MANAGED CARE, but who has not selected and enrolled in a DISCO within sixty (60) days of receipt of the mandatory notice sent by the Enrollment Broker, is assigned to a DISCO offering a DISCO product in the Mandatory Person's county of fiscal responsibility.

**Benefit package** means those medical and health-related services identified in Appendix G which Enrollees are entitled to receive pursuant to Article V. A. They are also known as the Benefit Package services or Covered Services.

**CMS** means the U.S. Centers for Medicare and Medicaid Services, formerly known as HCFA.

**Care management** is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

**Chronic renal dialysis** includes services provided by a renal dialysis center.

**Contract period** is the term of the contract plus any extensions.

**Covered services** shall mean those medical and health-related services identified in Appendix G which Enrollees are entitled to receive pursuant to Article V. A. They are also known as the Benefit Package or Benefit Package services.

**Culture** refers to the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, ways of interacting, roles and relationships, customs and expected behaviors, beliefs, values, practices, customs and institutions of racial, ethnic, religious, or social groups. Culture defines: how rights and protections are exercised; how health care information is received; how health problems are defined; how symptoms and concerns about problems are expressed; how disability is defined; how appropriate service providers are determined; and, how types of treatment, services and solutions are determined and provided

**Cultural Competence** implies having the capacity and ability to have impact by functioning effectively and efficiently as an individual and an organization to respect and affirm cultural

differences within the context of the cultural beliefs, behaviors, and needs presented by the diversity of consumers and their communities.

**DHHS:** The Department of Health and Human Services of the United States.

**Dentistry** includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required alleviating a serious health condition including one which affects employability.

**Durable Medical Equipment (DME)**, includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

- can withstand repeated use for a protracted period of time,
  - are primarily and customarily used for medical purposes,
  - are generally not useful in the absence of an illness or injury; and
  - are not usually fitted, designed or fashioned for a particular individual's use.
- Where equipment is intended for use by only one patient, it may be either custom-made or customized.

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.

Prosthetic appliances and devices are appliances and devices, which replace any missing part of the body.

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.

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. Medicaid covered prescription footwear is limited to treatment of diabetics, or when the shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21.

Medicaid covered compression and support stockings are limited to coverage only for pregnancy or treatment for venous stasis ulcers.

Medicaid coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube; 2) individuals with rare inborn metabolic disorders; and 3) Children up to age 21 who require liquid oral enteral

nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein.

**Emergency condition** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

**Emergency transportation** is transportation by ambulance as a result of an emergency condition.

**Enrollee** means a person enrolled in the plan who is entitled to covered services in accordance with the provisions of this Agreement from the effective date of his/her enrollment until the effective date of his/her disenrollment.

**Enrollee agreement** shall mean the written agreement provided to Enrollees, which agreement is to be signed by Enrollees and by the Contractor.

**Grievance** – An expression of dissatisfaction by the member or provider on member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

**HCFA** shall mean the Health Care Financing Administration of Department of Health and Human Services (DHHS), now known as the Centers for Medicare and Medicaid Services.

**Home care** includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

**Home health aide** means a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home. Qualifications of home health aides are defined in 10 NYCRR 700.2(b)(9)..

**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) month or less. Hospice programs provide patients and families with

palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations that must be certified under PHL Article 40. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangement to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care that reflects the changing needs of the patient/family.

**HCS** shall mean the Health Commerce System, an internet based communications infrastructure of the New York State Department of Health designed to allow the secure and efficient exchange of reporting, surveillance, statistical, and general information with its public health and health provider partners.

**Inpatient hospital services** are those items and services, provided under the direction of a physician, physician's assistant, nurse practitioner, or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Inpatient hospital services include care, treatment, maintenance and nursing services as may be required on an inpatient hospital basis. Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.

**LDSS** means Local Department of Social Services or the Human Resources Administration of the City of New York. For individuals who are state charge and fiscal district code is District 98/OPWDD, the RSFO (Revenue Support Field Office) is deemed the LDSS.

**Laboratory services** include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services. Physicians providing laboratory testing may perform specific laboratory testing procedures identified in the Physician's eMedNY Provider Manual.

**Life Plan**, also known as the Individualized Service Plan (ISP), is a plan resulting from a person centered planning process directed by the individual served, with assistance as needed by a representative(s) identified and chosen by the individual and in collaboration with the care coordination team. This is an understandable personal plan written in plain language and is a accessible and usable personal plan for implementing decisions made during personal planning. It summarizes what a person wants and needs, reflects a person's strengths and preferences, and his/her unique network of paid and unpaid supports and services which may be self-directed or provider directed. The ISP does not serve as a clinical assessment; but rather is a summary of assessments. It is not a repository of all information about the person; additional information is found in other sources such as the Coordinated Assessment System (CAS), historical summaries, clinical assessments, etc.

**Meals:** Home-delivered and congregate meals provided in accordance with each individual Enrollee's plan of care.

**Medically necessary** shall mean necessary to prevent, diagnose, correct or cure conditions in the Enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Enrollee's capacity for normal activity, or threaten some significant handicap.

**Medical social services** means assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care. These services must be provided by a qualified social worker as defined in 10 NYCRR 700.2(b) (24).

**Mental health services** include both inpatient and outpatient care. Inpatient services include medically necessary voluntary and involuntary admission to State psychiatric centers, Article 31 inpatient psychiatric hospitals and Article 28 hospitals. Outpatient service include but are not limited to: assessment (stabilization), treatment planning, discharge planning, verbal therapies, medication therapy and education, symptom management, case management services, crisis intervention (and outreach services), chlozapine monitoring and collateral services as certified by OMH, rehabilitation services in OMH licensed community residences and family based treatment programs certified under 14 NYCRR 586.3. Mental health service include: intensive psychiatric rehabilitation treatment programs under 14 NYCRR Part 587; day treatment services certified by OMH under 14 NYCRR Part 587; continuing day treatment services certified by OMH under 14 NYCRR Part 587; intensive case management for seriously and persistently mentally ill individuals; and partial hospitalization services certified by OMH under 14 NYCRR Part 587. Fee-for-service Medicaid does not cover inpatient mental health services in an Institution for Mental Disease (IMD) for individuals age 21 through 64.

**NAMI** shall mean the amount of net available monthly income determined by the Department that a nursing home resident must pay monthly to the nursing home (or to the Contractor if stipulated in the Subcontract agreement) in accordance with the requirements of the medical assistance program.

**Nurse practitioner services** mean services provided under a practice agreement and practice protocol with a collaborating physician (agreement and protocol available to the Department during Medicaid audits) which meet the definitions for nurse practitioner services in the eMedNY Provider Manual, generally services considered to be primary care.

**Nursing services** include intermittent, part-time and continuous nursing services provided in accordance with an ordering physician's treatment plan as outlined in the physician's recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to the individual and instructions to his family or caretaker in the procedures necessary for the patient's treatment or maintenance.

**Nursing home care** is care provided to Enrollees by a licensed facility as specified in Chapter V, 10 NYCRR.

**Nutrition** means 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 patient'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 a specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist as defined in 10 NYCRR 700.2(b)(5).

**Occupational therapy:** Rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of occupational therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A DISCO plan may authorize additional visits.

**OPWDD (Office for People with Developmental Disabilities) 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 Diagnosis & Treatment Centers explicitly certified by the Department as serving primarily persons with developmental disabilities; day treatment services provided in an ICF 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 the developmentally disabled.

**Optometry** includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the Enrollee's condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary.

If the Contractor 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 Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee 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 Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

**An ophthalmic dispenser** fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of qualified practitioner. Coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses should duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts should duplicate the original prescription and frames.

Repairs to and replacement of frames and/or lenses must be rendered as needed. Eyeglasses do not require changing more frequently than every two years unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.

If the Contractor 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 Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee 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 Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

**Outpatient hospital services** are services which are provided by a hospital division or department primarily engaged in providing services for ambulatory patients, by or under the supervision of a physician, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition.

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

**Party** shall mean either the Department or the Contractor.

**Personal care** means some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a qualified person as defined in 10 NYCRR 700.2(b)(14), in accordance with a plan of care.

**Person Centered Service Plan (or plan of care)** is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems. Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.

**Personal Emergency Response System (PERS):** PERS is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling

devices. Such systems are usually connected to a patient's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.

**Physical therapy:** Rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of physical therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A DISCO plan may authorize additional visits.

**Physician services** include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under New York State Law. Physician services include the services of physician extenders, e.g., physician's assistants, social workers. Physician services may be provided in the office, home and facilities including but not limited to hospitals and diagnostic treatment centers.

**Podiatry:** Podiatry means services by a podiatrist which must include routine foot care when the Enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.

**Potential Enrollee** means a Medicaid recipient who is eligible to voluntarily elect to enroll in a DISCO plan, but is not yet an Enrollee of DISCO plan.

**Prescription and non-prescription drugs:** Include drugs on the "New York State List of Medicaid Reimbursable Drugs: Non-Prescription Drugs and Prescription Drugs" (inclusive of those agents such as blood products) as well as supplies which appear on the list of "Allowable Medical and Surgical Supplies" which are ordered by a qualified practitioner.

**Private duty nursing services** are continuous and skilled nursing care provided in an Enrollee's home by properly licensed registered professional or licensed practical nurses.

**Provider Contract:** shall mean a written contract with the Contractor pursuant to which a person or entity provides certain services or items the Contractor deems necessary or advisable to the operation of the plan.

**Provider:** shall mean a person or entity with whom the Contractor has entered into a written Provider Contract.

**Radiology** and radioisotope services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services are performed upon the order of a qualified practitioner.

**Respiratory therapy** means the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. These services must be provided by a qualified respiratory therapist as defined in 10 NYCRR 700.2(b) (33).

**Rural health clinic services** are services provided by a clinic certified as a “rural health center” under 42 CFR 491.

**Same Day Grievance** means a grievance that is resolved by the Plan to the satisfaction of Enrollee the same day the grievance is lodged. A Same Day Grievance does not require written acknowledgement from the plan; however information about the Same Day Grievance must be documented by the plan in its records.

**Service area** shall mean the geographic area for which the Contractor has been approved by the DOH to provide services.

**Social services** are information, referral, and assistance with obtaining or maintaining benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social services also involve providing supports and addressing problems in an Enrollee’s living environment and daily activities to assist the Enrollee to remain in the community.

**Speech-language pathology:** A licensed and registered speech-language pathologist provides rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of speech therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A DISCO plan may authorize additional visits.

**Surplus amounts:** shall mean the amount of medical expenses the Department determines a “medically needy” individual must incur in any period in order to be eligible for medical assistance (as currently described in 18 NYCRR 360-4.8). Surplus amounts are also referred to as spenddown.

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

- a. accident-only coverage or disability income insurance;
- b. coverage issued as a supplement to liability insurance;
- c. liability insurance, including auto insurance;
- d. Workers Compensation or similar insurance;
- e. automobile medical payment insurance;
- f. credit-only insurance;
- g. coverage for on-site medical clinics;
- h. dental-only, vision-only, or long term care insurance;
- i. specified disease coverage;

- j. hospital indemnity or other fixed dollar indemnity coverage; or
- k. prescription-only coverage.

**Transportation:** shall mean transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. The Contractor is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to Enrollees.

**Urgent care** shall mean medically necessary services required in order to prevent a serious deterioration of an Enrollee's health that results from an unforeseen illness or injury.

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## **APPENDIX K**

### **GRIEVANCE SYSTEM, MEMBER HANDBOOK LANGUAGE AND SERVICE AUTHORIZATION REQUIREMENTS**

#### **1. GRIEVANCE SYSTEM REQUIREMENTS**

The Grievance System regulations in Subpart F of 42 CFR Part 438 apply to both “expressions of dissatisfaction” by enrollees (grievances) and to requests for a review of an “action” (as defined in section 438.400) by a managed long-term care plan (an appeal). For managed long-term care plans, the Grievance System processes identified in Subpart F have been combined with the grievance requirements in New York State Public Health Law (PHL) § 4408-a and the utilization review and appeal requirements in Article 49 of the PHL.

##### **A. Grievances**

Grievance – An expression of dissatisfaction by the member or provider on member’s behalf about care and treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

Grievances that can be immediately (same day) decided to the member’s satisfaction do not need to be responded to in writing. Plans are required to document the grievance and decision, and log and track the grievance and decision for quality improvement purposes. If the grievance cannot be decided immediately (same day), the plan must decide if grievance is expedited or standard.

Expedited Grievance – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function. A member may also request an expedited review of a grievance.

##### **Expedited and Standard Grievances**

1. Plan must send written acknowledgement of grievance within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with the notice of decision (one notice).
2. Must be decided as fast as member’s condition requires, but no more than:
  - a. Expedited: 48 hours from receipt of all necessary information, but no more than 7 calendar days from the receipt of the grievance.
  - b. Standard: 45 calendar days from receipt of all necessary information, but no more than 60 calendar days from receipt of the grievance.

3. Up to 14 calendar day extension. Extension may be requested by member or provider on member's behalf (written or verbal). Plan may also initiate extension if it can justify need for additional information and if extension is in member's interest. In all cases, extensions must be well documented.
4. Plan must notify the member of decision by phone for expedited grievances and provide written notice of decision within 3 business days of decision (expedited and standard).

Grievance Appeal - Member has 60 business days after receipt of notice of grievance decision to file a written appeal. Appeal may be submitted by letter or on a form supplied by the plan. Upon receipt of a written appeal, the plan must decide if the appeal is expedited or standard appeal. A member or provider may also request an expedited review of a grievance appeal. The determination of a grievance appeal on a non-clinical matter must be made by qualified personnel at a higher level than the personnel who made the grievance determination. Grievance appeal determinations with a clinical basis must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer.

#### **Grievance Appeal – Expedited and Standard**

1. Plan must send written acknowledgement of grievance appeal within 15 business days of receipt of request. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with notice of decision (one notice).
2. Must be decided as fast as member's condition requires, but no more than:
  - a. Expedited: 2 business days of receipt of all necessary information.
  - b. Standard: 30 business days receipt of necessary information.
3. Plan must provide written notice of decision. Notice must include reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.
4. No further appeal.

### Necessary Written Notices for Grievances and Grievance Appeals

Notices	Grievance	Grievance Appeal
<p>Written acknowledgement</p> <ul style="list-style-type: none"> <li>• Name, address and telephone number of the individual or department designated by the plan to respond to the grievance or grievance appeal.</li> <li>• If a member has requested an expedited grievance or grievance appeal, and the plan has decided not to expedite the grievance or grievance appeal, the acknowledgement must indicate that the grievance or grievance appeal will be handled on a standard basis.</li> <li>• Must identify any additional information required by the plan from any source to make a decision</li> </ul>	<p>X</p> <p>X</p>	<p>X</p> <p>X</p> <p>X</p>
<p>Notice of plan-initiated extension, if applicable. (May be combined with acknowledgement)</p> <ul style="list-style-type: none"> <li>• Reason for extension</li> <li>• Explain how the delay is in the best interest of the member and identify any additional information that the plan requires from any source to make its determination</li> </ul>	<p>X</p> <p>X</p>	
<p>Plan Decision</p> <ul style="list-style-type: none"> <li>• Date of grievance, summary of grievance</li> <li>• Reason for determination and description of any actions that have been or will be taken by the plan; in cases where the determination has a clinical basis, the clinical rationale for the determination</li> <li>• Notification of availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance</li> </ul>	<p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p>
<ul style="list-style-type: none"> <li>• Procedure for filing a grievance appeal including a form for the filing of such an appeal.</li> </ul>	<p>X</p>	
<ul style="list-style-type: none"> <li>• Letter indicating plan will not make a determination on the grievance appeal because the request was not submitted within 60 business days of the receipt by the member of original grievance decision</li> </ul>		<p>X</p>

### Required Plan Documentation on Grievances and Grievance Appeals

The plan must maintain a file on each grievance and associated appeal, if any, that must include (at a minimum):

- the date the grievance/grievance appeal was filed and a copy of the grievance/grievance appeal;
- the date of receipt of and a copy of the enrollee's acknowledgement letter, if any, of the grievance/grievance appeal;
- all member/provider requests for expedited grievances/grievance appeals and plan decision about the request;
- necessary documentation to support any extensions, and
- the determination made by the plan, including the date of the determination, titles, and in the case of a clinical determination, the credentials of the plan's personnel who reviewed the grievance/grievance appeal.

## **B. APPEALS**

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member’s disagreement with plan’s decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.

Note: New York has elected to require that a member exhaust the plan’s internal appeal process before an enrollee may request a State Fair Hearing.

### **Appeal – Expedited and Standard**

1. Appeal must be requested within 45 days of postmark date of notice of action if there is no request for aid to continue or within 10 days of the notice’s postmark date or by the intended date of the action if aid to continue is requested and appeal involves the termination, suspension or reduction of a previously authorized service.
2. If aid to continue requested, services will continue until the sooner of: a) appeal is withdrawn, b) the original authorization period has expired, or c) until 10 days after appeal decision is mailed, if the decision is not in the member’s favor, unless a NYS Fair Hearing has been requested.
3. Plan must send written acknowledgement of appeal within 15 days of receipt. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with the notice of decision (one notice).
4. Must be decided as fast as member’s condition requires, but:
  - a. Expedited: within 2 business days of receipt of necessary information, but no later than 3 business days of receipt of appeal request.
  - b. Standard: no later than 30 calendar days of receipt of appeal request.

5. Up to 14 calendar day extension. Extension may be requested by member or provider on member's behalf (written or verbal). Plan may also initiate extension if it can justify need for additional information and if extension is in the member's interest. In all cases, extension reason must be well-documented
6. Plan must make a reasonable effort to give oral notice for expedited appeals and must send written notice within 2 business days of decision for all appeals. If dissatisfied, members may file both State Fair Hearing and External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

### **Necessary Templates for Written Notices for Appeals – Expedited and Standard**

1. Letter indicating the plan will not make a determination on the appeal because the appeal request was not submitted by the member within 45 days of the notice of action.
2. Written acknowledgement
  - Name, address and telephone number of the individual or department designated by the plan to respond to the appeal.
  - If a member has requested an expedited appeal and the plan has decided not to expedite the appeal, the acknowledgement must indicate that the appeal will be handled on a standard basis, and inform the member of his/her right to file a grievance and how to do so.
  - The acknowledgement must identify any additional information required by the plan from any source to make the appeal decision.
3. Notice of plan-initiated extension, if applicable (may be combined with acknowledgement)
  - Reason for extension
  - How the delay is in the best interest of the member
  - Any additional information that the plan requires from any source to make its determination
4. Plan Decision
  - Date and summary of appeal
  - Date appeal process completed by plan
  - Reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination
  - If decision not in favor of member, State Fair Hearing notice and description of process for filing Fair Hearing request (and process and timeframes for requesting aid continuing if member is entitled to make such a request as a result of termination, reduction or suspension of services), and how member may obtain assistance from the plan with filing of Fair Hearing request
  - If denial of appeal was due to issues of medical necessity or because the service was experimental or investigational, must include a clear statement that the notice

constitutes the final adverse determination and procedures for filing an External Appeal and how member may obtain assistance from plan in filing External Appeal

- If the Action Appeal was expedited, a statement that the Enrollee may choose to file a Standard Action Appeal with the Contractor or file an External Appeal

(Plans must notify members of the availability of assistance (for language, hearing, speech issues) if a member wants to file Fair Hearing request and/or an External Appeal and how to access that assistance.)

### **Required Plan Documentation for Appeals**

The plan must maintain a file on each action and associated appeal (both expedited and standard), if any, that includes (at a minimum):

- a copy of the notice of action;
- the date the appeal was filed;
- a copy of the appeal;
- member/provider requests for expedited appeals and the plan's decision;
- the date of receipt of and a copy of the enrollee's acknowledgment letter of the appeal (if any);
- necessary documentation to support any extensions, and
- the determination made by the plan, including the date of the determination, the titles and, in the case of clinical determinations, the credentials, of the plan's personnel who reviewed the appeal.

## **2. MODEL MEMBER HANDBOOK GRIEVANCE AND APPEAL LANGUAGE**

The following language relating to the managed long-term care demonstration grievance and appeal process must appear in the Contractor's Member Handbook.

                     (*plan name*) will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by (insert plan name) staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please call: xxxxxxxx or write to: xxxxxxxx. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

***What is a Grievance?***

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

### ***The Grievance Process***

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information
2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

### ***How do I Appeal a Grievance Decision?***

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

### ***What is an Action?***

When (insert plan name) denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit;

reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

### ***Timing of Notice of Action***

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

### ***Contents of the Notice of Action***

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

### ***How do I File an Appeal of an Action?***

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

### ***How do I Contact my Plan to file an Appeal?***

We can be reached by calling XXX-XXX-XXXX or writing to (*address*). The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

### ***For Some Actions You May Request to Continue Service During the Appeal Process***

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than 10 days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

### ***How Long Will it Take the Plan to Decide My Appeal of an Action?***

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

### ***Expedited Appeal Process***

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

### ***If the Plan Denies My Appeal, What Can I Do?***

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

### ***State Fair Hearings***

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

### ***State External Appeals***

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within 45 days from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

### **3. SERVICE AUTHORIZATIONS**

A Prior Authorization is a request by the Enrollee or provider on Enrollee’s behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period.

A Concurrent Review is a request by an Enrollee or provider on Enrollee's behalf for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited - the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from the concurrent review must be handled as expedited.

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900 (2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental/investigational services, must be made by a licensed, certified or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit (where coverage is dependent on an assessment of the Enrollee's health status) and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals and out-of-network services.

#### Prior Authorization and Concurrent Reviews – Expedited and Standard

1. Plan must decide and notify Enrollee of decision by phone and in writing as fast as the Enrollee's condition requires but no more than:
  - a. Prior authorization
    - i Expedited - 3 business days from request for service.
    - ii Standard – within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services.
  - b. Concurrent review
    - i Expedited – within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services.
    - ii Standard – within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.
    - iii In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services.
2. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an

extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

3. Enrollee or provider may appeal decision – see Appeal Procedures.
4. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

### **Necessary Written Notices for Service Authorizations – Prior Authorizations and Concurrent Reviews – Expedited and Standard**

1. Notice to the Enrollee that the plan will not address request as expedited and that request will be handled as standard request (if applicable) if Enrollee has made a request for an expedited review.
2. Notice of plan-initiated extension (if applicable)
  - a. Reason for extension
  - b. How the delay is in the best interest of the Enrollee
  - c. Any additional information that the plan requires from any source to make its determination
3. Notice
  - a. Date of service request; summary of service request
  - b. Reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination
  - c. Procedure for filing an internal appeal and an explanation that an expedited appeal can be requested if longer time frame would be injurious to Enrollee health
  - d. Description of what additional information, if any, must be obtained by the plan from any source for the plan to make an appeal decision if an internal appeal will be requested
  - e. Reference to the option of filing a Fair Hearing request after internal appeal process is exhausted, as well as an external appeal if the service denial is related to issues of medical necessity or experimental or investigational nature of service
  - f. Must notify Enrollee of opportunity to present evidence and examine her/his case file during appeal
  - g. Inform Enrollee of the availability of the clinical review criteria relied upon in making the decision, if the action involved medical necessity or if treatment or service was experimental or investigational
  - h. For Actions based on a determination that a requested out-of-network service is not materially different from an alternate service available from a Participating Provider, the notice of Action shall also include:
    - i. notice of the required information for submission when filing an appeal from the plan's determination as provided for in PHL 4904(1-a);
    - ii. a statement that the Enrollee may be eligible for an External Appeal;

- iii. a statement that if the denial is upheld on Action appeal, the Enrollee will have 45 days from the receipt of the final adverse determination to request an External Appeal;
  - iv. a statement that if the denial is upheld on an Expedited Action Appeal, the Enrollee may request an External Appeal or request a Standard Appeal; and
  - v. a statement that the Enrollee and the Contractor may agree to waive the internal appeal process, and the Enrollee will have 45 days to request an External Appeal from receipt of written notice of that agreement.
- i. For Actions based on issues of Medical Necessity or an experimental or investigational treatment, the notice of Action shall also include:
- i. a clear statement that the notice constitutes the initial adverse determination and specific use of the terms “medical necessity” or “experimental/investigational”;
  - ii. a statement that the specific clinical review criteria relied upon in making the determination is available upon request;
  - iii. a statement that the Enrollee may be eligible for an External Appeal;
  - iv. a statement that if the denial is upheld on Action Appeal, the Enrollee will have 45 days from receipt of the final adverse determination to request an External Appeal;
  - v. a statement that if the denial is upheld on an expedited Action Appeal, the Enrollee may request an External Appeal or request a standard Action Appeal; and
  - vi. a statement that the Enrollee and the Contractor may agree to waive the internal appeal process, and the Enrollee will have 45 days to request an External Appeal from receipt of written notice of that agreement.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

## APPENDIX L

### DISCO ENROLLEE RIGHTS

The following identifies, at a minimum, managed long-term care demonstration Enrollee rights, and the language that must be used when communicating these rights to Potential Enrollees, Applicants and Enrollees in written material.

- f* You have the Right to receive supports and services without which you would require ICF/DD level of care,
- f* You have the Right to timely access to care and services.
- f* You have the Right to privacy about your service record and when you get supports and services.
- f* You have the Right to get information on available supports and service options and alternatives presented in a manner and language you understand, including the use of sign language and communication devices as needed.
- f* You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- f* You have the Right to get information necessary to give informed consent before the start of supports and services.
- f* You have the Right to be treated with respect and dignity.
- f* You have the Right to get a copy of your service records and ask that the records be amended or corrected.
- f* You have the Right to lead decision making about your supports and services, including the right to refuse supports and services.
- f* You have the Right to development of a person-centered service plan that meets all areas of your assessed need and updates of that plan as your needs change.
- f* You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- f* You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- f* You have the Right to be told where, when and how to get the services you need from your DISCO, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- f* You have the Right to be informed of the financial impact to you of receiving out-of-network supports and services.
- f* You have the Right to complain to the New York State Department of Health; OPWDD, the New York State Justice Center and an independent advocate, and the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- f* You have the Right to appoint someone to speak for you about your supports and services.
- f* You have the Right to request an advocate to assist with understanding information necessary to provide informed consent and with decision making.
- f* You have the Right to request to receive personal care services from a same gender staff person.

## APPENDIX M

### DISCO INFORMATION REQUIREMENTS

#### Information and Language Requirements Pursuant to 42 CFR 438.10

##### Written Materials

###### **Federal Requirement**

*42 CFR 438.10(b) (1-3) state as follows:*

###### *(b) Basic rules.*

- (1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- (2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.
- (3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

###### **State Implementation**

- For Statewide materials, DOH has defined prevalent language of potential enrollees for written material as primary language of 5% or more of the target population (based on population in NYS from 2010 census) for potential enrollees. For statewide materials, in addition to English, this would include Spanish.
- All plans are required to translate all written materials into Spanish, and additional languages if 5% or more of the population in a county which it serves speaks Spanish as a primary language (according to 2010 U.S. Census data).
- Additionally, all plans are required to translate all written materials into prevalent languages.
- DOH defines a prevalent language as a language spoken by at least 5% of the plan's enrolled population or 50 members, whichever is less. Census data are used as the basis for defining prevalent languages.

##### Interpretation

###### **Federal Requirement**

*42 CFR 438.10(b)(4) states that the state must:*

Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

###### **State Implementation**

- Oral interpretation services (via the State's contracted Language Line, staff capabilities, etc.) are available through every LDSS/RSFO/DDRO.
- All plans must have the capability for interpretation services, through staff, telephone translation, electronic translation device, etc.

## **Notifying Potential and Actual Enrollees About Translation Services**

### **Federal Requirement**

*42 CFR 438.10(c)(5) states that the state must:*

Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—

- (i) That oral interpretation is available for any language and written information is available in prevalent languages; and
- (ii) How to access those services.

### **State Implementation**

- There must be statements about interpretation service availability and the right to free language assistance services in the plan member handbooks.
- DOH/OPWDD require that plans meet necessary requirements for notification of availability of interpretation services.

## **Alternative Formats**

### **Federal Requirements**

*42 CFR 438.10(d)(1-2) states that for written materials:*

- (1) Written material must—
  - (i) Use easily understood language and format; and
  - (ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- (2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

### **State Implementation**

- Plans must select the alternative format(s) to be used (e.g., audiotapes, reading content of written materials to prospective applicants/enrollees) and obtain DOH/OPWDD approval of the selection.
- Plans will ensure that their member services staff screen calls for those individuals who might need materials in alternative formats.
- Plan guidelines require written material in easily understood and readable formats.

## **Information for Potential Enrollees**

### **Federal Requirements**

*42 CFR 438.10(e)(1) and (2)(D) states:*

(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:

- (i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
- (ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs.

(2) *The information for potential enrollees must include the following:* Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients.

**State Implementation**

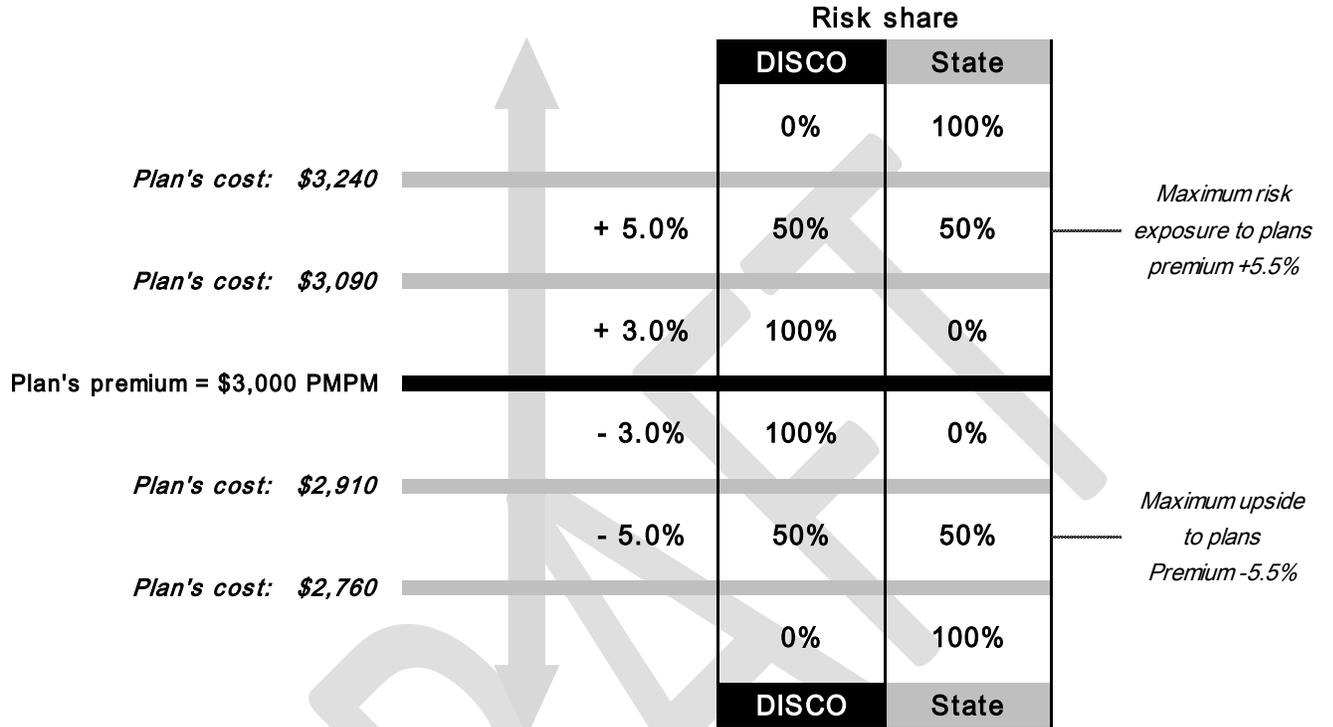
- DOH and OPWDD define potential enrollee as an individual who makes inquiry of the plan.
- Plan provider directories are required to identify the languages spoken by providers as well as known expertise in working with the deaf or hard of hearing community.
- Plan handbooks also must include a statement (prevalent languages as appropriate) that directs potential enrollees to call the plan to obtain the most current information about languages spoken by participating providers.
- Plans must meet necessary requirements for notifying potential enrollees and enrollees about the availability of non-English speaking providers.

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# APPENDIX N

FOR ILLUSTRATION PURPOSES ONLY

## DISCO Risk Corridor



## APPENDIX O

### DISCO REQUIREMENTS FOR CULTURAL COMPETANCE PLAN

#### Suggested Guidance to develop Cultural Competence Plan

##### *Effective Communication*

- What internal policies/procedures need to be developed for serving people who have a communication barrier?
- Has an assessment of communication barriers for individuals and families seeking services been conducted? Take into consideration:
  - Any document intended to provide information or education to the individual
  - Forms
  - Department signage
- Is the preferred language (including American Sign Language) for receipt of information recorded in a person's clinical record?
- Are individuals informed of their right to a qualified interpreter/translation service at no charge?
- Does the organization/agency have the appropriate equipment to use telephonic interpreting services?
- Has bilingual staff at the facility been identified?
- Does the organization/agency have TTY and assistive-listening devices available?

##### *Integration of Culturally Competent Services*

- Do these policies and procedures identify the data and information to be gathered during IQ, psychosocial, emotional, health and behavioral assessments? Such screening should include:
  - Religion, spiritual beliefs, values and preferences
  - Ethnic and cultural factors
  - Social factors
  - Communication skills
  - Family circumstances
- Is the assessment information reflected in the clinical record and used to determine available treatment and services?
- Has a process been developed by which the person and/or family members are informed of their rights while receiving care, including:
  - The right to have a language interpreter
  - The right to receive an accommodation for a disability
  - The right to be free from discrimination when receiving care
  - The right to designate a surrogate decision-maker
- Is the physical environment welcoming to a diverse population?
- Have appropriate steps been taken to ensure each individual's dignity, autonomy, positive self-regard, civil rights, and right to the involvement in his or her care throughout the course of assessment and service provision? This includes:
  - Carefully planning and providing care, treatment, and services with regard to the person's personal values, beliefs, and preferences, which reflect the person's cultural, ethnic and religious heritage;
  - Supporting rights through quality interactions with individuals by involving them in decisions about their care, treatment, and services;
  - Ensuring that health information is understood by infusing health literacy strategies into discussions and materials;
  - Basing education and training for staff on each person's need and abilities;

- Accommodating a person's cultural, religious, or ethnic food and nutritional preferences, unless contraindicated;
- To the extent possible, providing care and services that accommodate the person and their family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs; and ,
- Accommodating the person's right to religious and other spiritual services.
- Do plans for services reflect the roles and participation of the person's designated

### ***Data Collection and Outcomes***

- Is data collected on race, ethnicity, language, religion, spirituality, sexual orientation, age, gender, and other specific information for the purposes of quality improvement?
- For planning purposes, and to allow for assessment of success in providing culturally and linguistically competent care, is data obtained on the demographic composition of the community served, and has a cultural profile of the population served been developed?
- Is there a process for gathering feedback from persons, families and representatives of the community served, using existing vehicles such as satisfaction surveys, complaint resolution structures, the Board of Visitors, and any new methods that arise out of an agency or community database?

### **Outreach and Engagement**

- Is information about agency services, programs, and initiatives responsive to cultural and linguistic needs, including availability of the family?
- Does the agency/organization attempt to establish relationships with religious leaders for facilitating the process of an individual's right to practice his or her faith?
- Does the agency/organization collaborate with community organizations, peer groups, and other vested stakeholders in the creation of services and programs available to the community?
- Is there a deliberate process to engage various stakeholders across the organization/agency to collaborate on cultural and linguistic initiatives?
  - Committees may consist of:
    - Staff (at all levels of the organization)
    - Individuals and families served
    - Community leaders
    - Religious leaders

### **Training**

Agency/organization training directors should consider the following strategies when planning cultural and linguistic competence training:

- Provide all new staff with a course on cultural and linguistic competence that is two hours long, at minimum.
- Provide on-going opportunities for staff to learn about culturally competent care, cultural awareness, and issues with specific limited-English proficient communities in their catchment area.

