I. PROVIDER NETWORK

The Plan shall establish, maintain and monitor a provider network that is reviewed and approved by NYSDOH, that is sufficient to provide adequate access to all covered services, and that meets the time, distance, and other requirements outlined in this section.

a. **Credentialing.**
The Plan shall have a uniform process for credentialing Participating Providers in accordance with managed care standards at 42 C.F.R. §§ 438.214 and 422.204 and must ensure that Providers meet the accreditation, credentialing, and re- credentialing requirements outlined in this contract.

b. **Medicare Network Rules.**
The Plan's Medicare network must meet the following requirements:

i. Network adequacy criteria are assessed at the county level and vary by specialty type.
ii. Medicare networks must meet Medicare-Medicaid Plan (MMP) specific network requirements for time, distance, and minimum number standards that are updated annually based on the dual eligible utilization. The time and distance network requirements differ by county (e.g., rural, metro, large metro) and are based on where the FIDA Plan eligible population resides as compared to all eligible Medicare beneficiaries.
iii. Plans can request exceptions to network adequacy criteria, which CMS reviews on a case-by-case basis in consultation with the state. CMS has expanded the reasons considered for exceptions under the MMP that are not permitted in Medicare Advantage. For example, for the current Contract Year 2017 annual Medicare network review, CMS will consider availability of telehealth, mobile clinics, and in-home delivery of care as exceptions.

c. **Medicaid Network Rules: Travel and Distance.**
The Plan's network must meet the following State- specific standards:
i. Travel time / distance to primary care sites shall not exceed thirty (30) minutes from the participant's residence in metropolitan and non-metropolitan areas.
ii. Travel time / distance to specialty care, hospitals, behavioral health, lab, and X-ray Providers shall not exceed thirty (30) minutes / thirty (30) miles from the participant's residence.
iii. Participants may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves.
iv. Travel time and distance will be calculated on a typical day of traffic volume
v. The Plan shall make reasonable accommodations, including access to Out- of-Network Providers, if necessary, so that no participant that is too frail to travel thirty (30) minutes or thirty (30) miles shall be required to do so to see a Participating Provider.
vi. The Plan must contract with an adequate number of Community- based LTSS Providers to allow participants a choice of at least two Participating Providers of each covered Community-based LTSS service within a 15-mile radius or 30 minutes from the participant's ZIP code of residence in the 8 county New York City, Long Island, and Westchester area and of at least two Participating Providers of each covered Community-based LTSS services within a xxxx-mile radius or xxxxx minutes from the participant's ZIP code of residence in the remainder of the state.

d. **Minimum Number of Nursing Home Providers.**

Plans must include eight (8) Nursing Facilities per county in their Network in the 8 county New York City, Long Island, and Westchester area and xxxxx (x) Nursing Facilities per county in their Network in the remainder of the state.

e. **Choice of Provider.**
The Plan shall offer each participant the choice of no fewer than three (3) Participating PCPs within distance/travel time standards as set forth herein. Participants must have a choice of at least two (2) providers within the allowable time and distance, in all provider types.

f. **Accessibility and Reasonable Accommodation.**
All Participating Providers' physical sites must be accessible to all participants if participants go to the Participating Provider's site. The Plan and its Participating Providers must comply with the ADA (28 C.F.R. § 35.130) and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its participants. The Plan shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit participants with disabilities from obtaining all covered services from the Plan.

g. **Appointment Availability Standards.**
The following minimum appointment availability standards apply to physical health and behavioral health services:

i. For emergency care: immediately upon presentation at a service delivery site.
ii. For urgent care: within twenty-four (24) hours of request.
iii. Non-urgent "sick" visit: within forty- eight (48) to seventy-two (72) hours of request, as clinically indicated.
iv. Routine non-urgent, preventive appointments: within four (4) weeks of request.
v. Specialist appointments (not urgent): within four (4) weeks of request.
vi. Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Participating Provider: within five (5) Business Days of request, or sooner if clinically indicated.
vii. Non-urgent mental health or substance abuse visits with a Participating Provider: within two (2) weeks of request.
viii. Participating Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a participant's ability to perform work within ten (10) Business Days of request.
ix. Mental Health Clinics must provide a clinical assessment within five (5) Business Days of request for participants in the following designated groups:
    (1) Participants in receipt of services from a mobile crisis team not currently receiving treatment;
    (2) Participants in domestic violence shelter programs not currently receiving treatment;
    (3) Homeless participants and those present at homeless shelters who are not currently receiving treatment;
    (4) Participants aging out of foster care who are not currently receiving treatment;
    (5) Participants who have been discharged from an inpatient psychiatric facility within the last sixty (60) calendar days who are not currently receiving treatment;
    (6) Participants referred by rape crisis centers; and
    (7) Participants referred by the State court system.
x. The Plan must establish and implement mechanisms to ensure that Participating Providers comply with the timely access requirements outlined herein, must monitor Participating Providers regularly to determine compliance, and must take corrective action if there is a failure to comply.

h. **24/7/365 Access.**
Each Plan must provide access to medical services and coverage to participants through their PCPs and obstetrics/gynecologists (OB/GYNs,) on a twenty-four (24) hour a day, seven (7) day a week basis. The Plan must instruct participants on what to do to obtain services after business hours and on weekends.

i. **Family Caregivers.**
Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.28(b)(5).

j. **Second Opinions.**
The Plan must provide for a second opinion for diagnosis of a condition, treatment, or surgical procedure by a qualified Physician or appropriate specialist, including one affiliated with a specialty care center. If the Plan determines that it does not have a Participating Provider in its Provider Network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the Plan shall authorize and pay for the participant to access services from an appropriate Non-Participating Provider.

k. **Limited English Proficiency Access.**
The Plan shall ensure that all Participating Providers understand and comply with their obligations under State and Federal law to assist participants with skilled medical interpreters and are informed of the resources that are available to assist Participating Providers to meet these obligations.

l. **Deaf and Hearing Impaired Access.**
The Plan shall ensure that Participating Providers and interpreters or translators are available for those participants who are Deaf or hearing-impaired within the Plan's Service Area.

m. **Provider Qualifications and Performance**.
The Plan must contract only with qualified or licensed Providers who continually meet Federal and State requirements, as applicable, and who meet all state established requirements and qualifications as further outlined in this contract. Additionally, the Plan must ensure that all Participating Providers are bound by contract to meet all the requirements of this contract.

n. **Value Based Payment**.
The Plan must comply with all applicable Value Based Payment requirements outlined by the state.

o. **Non-Payment and Reporting of Provider Preventable Conditions.**
The Plan shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions as required under state and federal law. The Plan agrees to take such action as is necessary in order for NYSDOH to comply with and implement all Federal and State laws, regulations, policy guidance, and State policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, including 42 U.S.C. § 1396b-1 and regulations promulgated thereunder.

p. **Participating Provider Outreach, Education and Training.**
The Plan must outreach to Participating Providers to make sure they understand the features and function of the Plan. The Plan must provide comprehensive training, to all medical, behavioral, and Community-based and Facility-based LTSS Participating Providers. This shall include Cultural Competency and disability training.

q. **Access to Non-Participating Providers.**
In some instances, participants will require specialty care not available from a Participating Provider. In these instances, the Plan will arrange that such items and services be provided by a Non-Participating Provider. In such event, the Plan will promptly negotiate an agreement ("Single Case Agreement") with a Non-Participating Provider at the applicable Medicaid or Medicare Fee-For-Service rate to treat the participant until a qualified Participating Provider is available.

r. **Continuity of Care.**
During their continuity of care period, participants shall be permitted to receive services from any Non-Participating Providers from whom they were receiving services prior to enrolling in Plan. This shall include:

i. Continued access to any Non-Participating healthcare providers for the first 90 days of enrollment for participants who are not receiving LTSS services, and for the first 90 days of enrollment or until their comprehensive assessment and care plan are completed whichever is later for Community-Based LTSS participants.
ii. Continued access to any Non-Participating Community-Based LTSS providers for the first 90 days of enrollment or until their comprehensive assessment and care plan are completed whichever is later for Community-Based LTSS participants.
iii. Continued access to any Behavioral Health Service Provider from whom a participate was receiving services at the time of enrollment for the duration of the episode of care but for not longer than two years from the date of enrollment.
iv. Continuous access to any nursing facility in which the participant was residing at the time of enrollment in the Plan.

II. PARTICIPANT PROTECTIONS

a. **Participants' Rights**

i. **Written Bill of Rights.** The Plan shall have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the ones specified herein.
ii. **Explanation of rights.** The Plan must inform a participant upon enrollment, in writing, of his or her rights and responsibilities, and all rules and regulations governing participation. The Plan must also fully explain the rights to the participant and his or her representative, if any, at the time of enrollment in a manner understood by the participant and that takes into consideration cultural considerations, functional status, and language needs. Additionally, the written participant bill of rights shall be distributed annually, posted on the Plan's website, and included in the Plan's participant handbook.
iii. **Protection of rights.** The Plan must protect and provide for the exercise of the participant's rights. The Plan must have written policies and established documented procedures to respond to and rectify a violation of a participant's rights.
iv. **Respect and nondiscrimination.** Each participant has the right to considerate, respectful care from all Plan employees and contractors at all times and under all circumstances. Each participant has the right not to be discriminated against in the delivery of required Plan services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, or source of payment.
v. **Information disclosure.** Each Plan participant has the right to receive accurate, easily

understood information and to receive assistance in making informed health care decisions.

vi. **Choice of providers.** Each participant has the right to a choice of health care providers, within the Plan's network, that is sufficient to ensure access to appropriate high-quality health care.

vii. **Access to emergency services.** Each participant has the right to access emergency health care services when and where the need arises without prior authorization by the Plan multidisciplinary team.

viii. **Participation in treatment decisions.** Each participant has the right to participate fully in all decisions related to his or her treatment. A participant who is unable to participate fully in treatment decisions has the right to designate a representative.

ix. **Confidentiality of health information.** Each participant has the right to communicate with health care providers in confidence and to have the confidentiality of his or her individually identifiable health care information protected. Each participant also has the right to review and copy his or her own medical records and request amendments to those records.

x. **Grievances and appeals.** Each participant has the right to a fair and efficient process for filing and grievances and appeals with the Plan including the requirements outlined in this Agreement.

xi. **Protection from Liability.** The Plan shall not hold a participant liable for debts of the Plan, in the event of the Plan's insolvency; services provided to the participant in the event that the Plan fails to receive payment from CMS or the NYSDOH for such services; or payments to a contracted entity or provider in excess of the amount that would be owed by the participant if the Plan had directly provided the services. Additionally, the Plan shall not charge participants coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract

xii. **Prohibition of improper/inappropriate billing:** The Plan shall prevent providers from holding a Participant liable for payment of any fees that are the obligation of the Plan or any balances unpaid by the Plan, as improper/inappropriate billing (sometimes previously referred to as balance billing).

xiii. **Specific Rights.** Each participant has the right:

(1) To receive Medically Necessary items and services as needed to meet the participant's needs, in a manner that is sensitive to the participant's language and culture, and that is provided in an appropriate care setting, including the home and community;

(2) To receive timely access to care and services;

(3) To request and receive written and oral information about the Plan, its Participating Providers, its benefits and services and the participants' rights and responsibilities in a manner the participant understands.

(4) To receive materials and/or assistance in a foreign language and in Alternative Formats, if necessary.

(5) To be provided qualified interpreters, free of charge, if a participant needs interpreters during appointments with Providers and when talking to the Plan;

(6) To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality;

(7) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

(8) Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;

(9) To not be discriminated against on the basis of and to get care without regard to sex, race, ethnicity, health status, disability, color, age, national origin, culture, language, sexual orientation, gender identity, marital status or religion;

(10) To be told where, when and how to get the services the participant needs, including how to get covered benefits from Out-of-Network Providers if they are not available in the Plan network;

(11) To complain to NYSDOH or the Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where

appropriate;

(12) To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.

(13) To appoint someone to speak for him/her about the care he/she needs.

(14) To be informed of all rights, and the right to exercise such rights, in writing prior to the Effective Date of Enrollment;

(15) To participate in his/her care planning and participate in any discussions around changes to the care plan, if/when they are warranted;

(16) To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the participant choice;

(17) To have telephone access to a nursing hotline and on-call Participating Providers 24/7 in order to obtain any needed emergency or urgent care or assistance;

(18) To access care without facing physical barriers. This includes the right to be able to get in and out of a Provider's office, including barrier-free access for participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;

(19) To receive reasonable accommodations in accessing care, in interacting with the Plan and Providers, and in receiving information about one's care and coverage;

(20) To see a specialist and request to have a specialist serve as Primary Care Provider;

(21) To talk with and receive information from Providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the participant understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.

(22) To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by Providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.

(23) To receive a written explanation if covered services were denied, without having to request a written explanation.

(24) To have privacy in care, conversations with Providers, and Medical Records such that:

- (i) Medical and other records and discussions with Providers will be kept private and confidential;
- (ii) Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law;
- (iii) Participant may request that any communication that contains Protected Health Information from the Plan be sent by alternative means or to an alternative address;
- (iv) Participant is provided a copy of the Plan's Privacy practices, without having to request the same;
- (v) Participant may request and receive a copy of his or her Medical Records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526., if the privacy rule, as set forth in 45 CFR 160 and 164, A and E, applies; and
- (vi) Participant may request information on how his/her health and other personal information has been released by the Plan;

(25) To seek and receive information and assistance from ICAN;

(26) To make decisions about Providers and coverage, which includes the right to choose and change Providers within the Plan's network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage – whether by changing to another Plan or making other changes in coverage);

(27) To be informed at the time of enrollment and at care plan update or revision meetings

of what is an Advance Directive and the right to make an Advance Directive – giving instructions about what is to be done if the participant is not able to make medical decisions for him/herself - and to have the Plan and its Participating Providers honor any Advance Directive the participant has or develops;

(28) To access information about the Plan, its network of Providers, and covered services including:

(i) information about the Plan's financial condition, its performance rating, how it compares to other plans, the number of appeals made by participants;

(ii) information about the qualifications of the Participating Providers and how they are paid; and

(iii) information about the rules and restrictions on covered services.

(29) To have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

(30) To access to an adequate network of primary and specialty Providers who are capable of meeting the participant's needs with respect to physical access, and communication and scheduling needs.

(31) To have a voice in the governance and operation of the Plan system, Provider or health plan, as detailed in this Contract.

(32) To participate in all aspects of care and to exercise all rights of appeal. Participants have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, participants must:

(i) Receive an in-person needs assessment upon enrollment in the Plan and to participate in the development and implementation of a care plan. Participants, or their designated representative, also have the right to request a reassessment by the Plan, and to be fully involved in any such reassessment.

(ii) Receive complete and accurate information on his or her health and functional status from the Plan.

(iii) Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration participant's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

a. Before Enrollment.
b. At Enrollment.
c. At the time an Eligible Individual's or participant's needs necessitate the disclosure and delivery of such information in order to allow the Eligible Individual or participant to make an informed choice.
   - Be encouraged to involve caregivers or family members in treatment discussions and decisions.

(iv) Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

(33) To free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Plan and its Providers or the State Agency or CMS provide, or arrange for the provision of, medical services to the participant.

(34) To receive timely information about Plan changes. This includes the right to request and obtain the information listed in the Marketing, Outreach, and participant

Communications materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.

(35) To be protected from liability for payment of any fees that are the obligation of the Plan.

(36) To be charged any cost sharing for Medicare Parts A and B services.

(37) To self-direct care through the CDPAS program and to be informed of this opportunity during all assessments and any time a care plan is created or updated.

(38) To continuity of care protections when transitioning into or out of Plan.

b. **Communication with Participants**

i. **Participant Call Center.** The Plan shall operate a toll-free call center to respond to participant questions that shall be operational at least 8AM-8PM daily.

ii. **Nursing Hotline.** The Plan shall operate a toll-free nursing call center which shall be available 24 hours a day, 7 days a week.

iii. **Care Management Call Handling.** To address the needs of those participants who receive LTSS services, the Plan shall provide direct access to assigned and on-call or back-up care management staff 8AM-8PM daily.

iv. **Individualized Communications Plan.** To address the needs of those participants who receive LTSS services, the participants' needs shall determine the nature and frequency of contacts from Plan care management. These individualized communications needs will be in addition to the minimum communications requirements articulated herein and will be specifically outlined in the participant's care plan.

v. **Written Integrated Coverage Decisions.** Participants must receive written notice of any approval of a service and of any reduction, suspension, denial, or termination of previously authorized services. These notices shall be integrated to incorporate Medicare and Medicaid coverage decisions.

vi. Translation and Interpretation.

(1) The Plan must make available written marketing and other informational materials (e.g., member handbooks) in prevalent languages, which is those non-English languages that meet the more stringent of Medicare's five (5) percent threshold for translation as specified in 42 CFR § 422.2264(e), or; a language that at least five percent (5%) of the Potential Participants in any county of the service area speak, who do not speak English as a first language, speak as a primary language..

(2) In addition, verbal interpretation services must be made available to Enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

(3) The Plan must inform Enrollees, Applicants and Potential Enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services, including notices about this available in the member handbook.

(4) The Plan must provide Potential Enrollees, Applicants and Enrollees with information about the availability of non-English speaking participating providers and how to access the services of a specific non-English speaking participating provider.

(5) Provider directories must identify the languages spoken by participating providers.

vii. **Communicating with the Visually, Hearing and Cognitively Impaired.** The Plan also must have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include Braille or audio tapes for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

c. **Participation in Plan Governance**

i. **Participant Advisory Committee.** The Plan must establish a participant advisory committee to provide advice to the governing body on matters of concern to participants.
   (1) The Participant Advisory Committee must be open to all participants, family, and caregiver representatives. The ICAN Ombudsman shall also be invited and permitted to attend.
   (2) The PAC must be composed primarily of participants, with at least sixty percent (60%) of those serving on the PAC being Plan participants and the composition must reflect the diversity of the Plan population;
   (3) The PAC must meet quarterly and in person, while offering the option for participants to participate remotely and it must be the participant's choice whether to participate in-person or remotely.
   (4) Participants must be provided with transportation, reasonable accommodations, and any supportive services necessary to facilitate participation and to ensure in-person access to PAC meetings.

ii. **Participant Representation on the Plan's Governing Body.** The Plan must have a governing body that meets state and federal requirements. The Plan must ensure participant representation on issues related to participant care. This shall be achieved by having participant representation on the governing body.

d. Grievances and Appeals

v. **Grievances.**
For purposes of this part, a grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.
   (1) **Process to resolve grievances.** A Plan must have a formal written process to evaluate and resolve medical and nonmedical grievances by participants, their family members, or representatives.
   (2) **Notification to participants.** Upon enrollment, and at least annually thereafter, the Plan must give a participant written information on the grievance process.
   (3) **Minimum requirements.** At a minimum, the Plan's grievance process must include written procedures for the following:
      i. How a participant files a grievance.
      ii. Documentation of a participant's grievance.
      iii. Response to, and resolution of, grievances in a timely manner.
      iv. Maintenance of confidentiality of a participant's grievance.
   (4) **Continuing care during grievance process.** The Plan must continue to furnish all required services to the participant during the grievance process.
   (5) **Explaining the grievance process.** The Plan must discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.
   (6) **Analyzing grievance information.** The Plan must maintain, aggregate, and analyze information on grievance proceedings. This information must be used in the Plan's internal quality assessment and performance improvement program.

vi. **Appeals.**
Medicare and Medicaid grievances and appeals will be processed jointly through the integrated administrative hearing process. This process will be a streamlined consolidation of Medicare and Medicaid appeals steps as required by NYSDOH and CMS.
   i. **Written appeals process.** The Plan must have a formal written appeals process, with specified timeframes for response, to address noncoverage or nonpayment of a service.

ii. **Integrated Coverage Decision.** The Plan must give the participant written notice of any adverse action. Participants will be notified of all applicable Medicare and Medicaid Appeal rights through as integrated a notice as permissible. This single notice will be specific to the item or service type in question, using a form developed by NYSDOH or NYSDOH and CMS. Notices shall be integrated reflecting Medicare and Medicaid decisions as much as legally permissible, written in plain language, and shall communicate the action, the reasons for the action, citation to the regulations supporting the action, the right to appeal, how to appeal, the steps in the appeals process, how to obtain expedited review on appeal, and, if applicable, how to have benefits continue pending the resolution of the appeal.

iii. **First Level Appeal**. Consistent with 42 CFR 438, the first level of appeal will be at the Plan level. Plan level decisions will be automatically forwarded for review by the Administrative Law Judge at the integrated administrative hearings office. Appeal Decisions shall be integrated reflecting Medicare and Medicaid decisions as much as legally permissible, written in plain language, and shall communicate the decision reached, the reasons for the decision, citation to the regulations supporting the decision, the right to appeal, how to automatic forwarding of the appeal will take place, the steps in the appeals process, how to obtain expedited review on appeal, and, if applicable, how benefits will continue pending the resolution of the appeal. The Plan shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the participant's condition or disease.

iv. **Participation in the Administrative Hearing.** The Plan must participate in the Administrative Hearing. The staff person participating must be knowledgeable in the Appeal decision reached by the Plan and the basis for the decision. The Plan shall follow all existing appeals processes and procedures that are not inconsistent with the integrated Appeal process outlined herein.

v. **Continuation of Benefits Pending Appeal.** Continuation of benefits for all prior-approved covered services that the Plan is terminating, reducing, or modifying, pending internal Plan Appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original Appeal is requested to the Plan within ten (10) calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later.

vi. **Assistance with Appeal.** The Plan shall provide the participant with reasonable assistance in filing the Appeal forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability, as well as providing the applicable forms and instructions on how the participant may appoint an Authorized Representative to represent the participant throughout the Grievance process. The Plan shall provide each participant with information about the availability of ICAN to assist the participant in filing and pursuing the Appeal.

III. QUALITY

A Plan must develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program. The program must reflect the full range of services furnished by the Plan. A Plan must take actions that result in improvements in its performance in all types of care.

a. Quality assessment and performance improvement plan.

A Plan must have a written quality assessment and performance improvement plan. The Plan governing body must review the plan annually and revise it, if necessary. At a

minimum, the plan must specify how the Plan proposes to meet the following requirements:

i. Identify areas to improve or maintain the delivery of services and patient care.
ii. Develop and implement plans of action to improve or maintain quality of care.
iii. Document and disseminate to Plan staff and contractors the results from the quality assessment and performance improvement activities.

b. **Minimum requirements for quality assessment and performance improvement.**
A Plan's quality assessment and performance improvement program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to utilization of Plan services, such as decreased inpatient hospitalizations and emergency room visits; caregiver and participant satisfaction; outcome measures that are derived from data collected during assessments, as required by the state; and nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

c. **Quality assessment and performance improvement requirements.**
A Plan must:

i. Use a set of outcome measures outlined by the state and CMS, which includes but is not limited to HEDIS, HOS, and CAHPS, to identify areas of good or problematic performance.
ii. Take actions targeted at maintaining or improving care based on outcome measures.
iii. Incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time.
iv. Set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes.
v. Immediately correct any identified problem that directly or potentially threatens the health and safety of a Plan participant.

d. **Practice Guidelines.**
Plan shall adopt practice guidelines that meet, at a minimum, the following criteria:

i. The clinical guidelines shall rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and other relevant factors;
ii. Consider the needs of the participants are adopted in consultation with Participating Providers.
iii. Are reviewed and updated periodically, as appropriate; and
iv. Are available to all affected Participating Providers, non-Participating Providers, participants, and Eligible Individuals.

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

e. **Evidence-Based Practices.**
The Plan shall require Participating Providers to use evidence-based practices. In doing so, the Plan shall:

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

ii. Demonstrate how it will ensure that its Participating Providers are following best- evidence clinical guidelines through decision support tools and other means to inform and prompt Providers about treatment options.
iii. Identify how it will employ systems to identify and track participants in ways that provide participant-specific and population based support, reminders, data and analysis, and Participating Provider feedback.
iv. Demonstrate how it will educate its Participating Providers and clinical staff about evidence-based best practices and how it will support its Participating Providers and clinical staff (through training or consultations) in following evidence-based practices.
v. Require its Participating Providers and their practices to provide services in accordance with established evidence-based clinical practice guidelines appropriate for the participants they serve.
vi. Demonstrate how it will monitor and oversee that its Participating Providers are providing services in accordance with evidence-based practices specific to their practice areas or services.

f. **No Incentives for Limiting Utilization.**
The Plan shall not compensate individuals that conduct utilization review activities in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue covered services that are Medically Necessary for any participant.

g. **Critical Incidents Required Reporting.**
The Plan shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within the Plan and, when required or otherwise appropriate, to the investigating authority.
i. The Plan shall have systems in place to report, monitor, track, and resolve critical incidents and reports of Abuse, Neglect, or Financial Exploitation for participants receiving Community-based or Facility-based LTSS and concerning restraints and restrictive interventions. The Plan shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The Plan shall require that events involving the use of restraint or seclusion are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or Financial Exploitation. The Plan shall make reasonable efforts to detect unauthorized use of restrictive interventions. The Plan shall require that events involving the use of restrictive interventions are reported to the Plan as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect, or Financial Exploitation.

h. **Quality of Care**.
The Plan shall provide quality care that enables participants to stay healthy, get better, manage chronic conditions and/or disabilities, and maintain/improve their quality of life. The Plan shall apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Plan's service delivery system through ongoing analysis, evaluation, and systematic enhancements.

i. **Quality Improvement Program**.
The Plan shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Plan's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. Plan's QI organizational and program structure shall comply with all applicable

provisions of 42 C.F.R. § 438 Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422 (subpart D), Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements. The Plan shall have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Plan's QI initiatives. Additionally, the Plan shall:

(1) The Plan shall evaluate the results of QI initiatives at least annually and per state evaluation requirements, and submit the results of the evaluation to NYSDOH and CMS.
(2) The Plan's QI Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and participant care outcomes per NYSDOH specifications for QI Programs.
(3) In the aggregate, without reference to individual Physicians or participant identifying information, all QI findings, conclusions, recommendations, actions taken, results or other documentation relative to QI shall be reported to CMS and NYSDOH on a quarterly basis or as requested by CMS and NYSDOH.

j. **Quality Improvement Activities**.
The Plan shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non- clinical care processes, outcomes and participant experience. The Plan's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. § 438.242(a) and (b), and 42 C.F.R. § 422.516(a) and § 423.514 for Parts C and D, respectively.

k. **Quality Improvement Project Requirements**.
The Plan shall implement Quality Improvement Projects in accordance with all state and federal regulations and requirements.

l. **Chronic Care Improvement Plan**.
In accordance with 42 C.F.R. § 422.152(c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the CCIP.

m. **Performance Measurement**.
The Plan shall engage in performance measurement and QI Projects, designed to achieve, through ongoing measurement and intervention, stability or improvements, sustained over time, in a clinical care and non-clinical care processes, outcomes and participant experience. Plan shall perform and report the quality and utilization measures identified by CMS and NYSDOH.

n. **Required Measures**.
Plans are required to report annually on Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Health Outcome Survey (HOS) consistent with Medicare Advantage plans, Medicare Part C and D reporting requirements. Plans are required to assess participants in accordance with the timelines outlined in Section --- on Comprehensive Assessment. Plans must complete these timely and must timely enter their required assessment information into the UAS system.

o. **Participant Experience Surveys**.
The Plan shall conduct participant experience survey activities, as directed by NYSDOH and/or CMS, disclose the survey results to NYSDOH and CMS, disclose the identified

CAHPS measurement set and the survey results to participants upon request, and provide NYSDOH with access to the de-identified CAHPS response set upon request, as specified by NYSDOH.

p. **External Quality Review (EQR) Activities**.
The Plan shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by NYSDOH and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include those outlined by the state.

IV. MARKETING

a. **Medicare Requirements.**
The Plan agrees to follow the Medicare Marketing Guidelines, and the most current Medicare-Medicaid Marketing Guidance for Plans, as well as all applicable statutes and regulations including and without limitation § 1851 (h) of the Social Security Act and 42 CFR 422.80, 422.111, and 423.50 when marketing to individuals entitled to enroll in Medicare Advantage.

b. **Medicaid Requirements Generally.**
The Plan shall conduct marketing activities for potential participants consistent with 42 CFR 438.104, applicable State Law and its implementing regulations and shall comply with the requirements outlined in this contract and any related Medicare-Medicaid Marketing Guidance NYSDOH and CMS issue for integrated programs.

c. **Integrated Marketing Materials.**
Each contract year, CMS and NYSDOH would make available model templates in English and Spanish, which would include:

- Summary of Benefits: A brief summary of the plan Medicare and Medicaid benefits and cost-sharing required to be posted on plan websites by September 30 of each year.
- Annual Notice of Change / Evidence of Coverage (ANOC /EOC). EOC is also known as the Participant Handbook. In the ANOCs, FIDA Plans summarize any changes to plans for the upcoming contract year and send them to current enrollees for receipt by September 30. The EOC or Participant Handbook contains detailed plan Medicare and Medicaid and benefits information and must be provided by December 31.
- Provider and Pharmacy Directory: This document summarizes available Medicare and Medicaid network and provider and pharmacy information and must be made available to beneficiaries and the time of enrollment and posted on the plan website by September 30.
- Formulary: This document provides integrated Medicare Part D and Medicaid-covered prescription drugs and over-the-counter drug/product information and must be made available to beneficiaries at the time of enrollment and posted on the plan website by September 30.
- ID Card: The single ID card would allow integrated care plan enrollees to access all plan services through a single participant ID card.

d. **Accessibility of Marketing Materials.**
Marketing materials must be made available in Alternative Formats, upon request and as needed, to assure effective communication for blind and vision-impaired Participants. They must be provided in a manner, format, and language that may be easily understood by persons with limited English proficiency, or for Individuals with Intellectual Disabilities or cognitive impairments.

e. **Reading Level of Marketing Materials.**
The Plan marketing materials must be written in prose that is understood at a fourth-grade to sixth-grade reading level except when the Plan is using language required by CMS, and must be printed in at least fourteen (14) point font.

f. **Translation of Marketing Materials.**
The Plan must make available written marketing and other informational materials (e.g., member handbooks) in a language that is a Prevalent Language. Prevalent Languages are those non-English languages that meet the more stringent of Medicare's five (5) percent threshold for translation as specified in 42 CFR § 422.2264(e), or A language that is the primary language of at least 5% of the FIDA Plan's enrolled population or 50 participants, whichever is less.

g. **Prior Approval of Marketing Materials.**
The CMS and NYSDOH will jointly review and approve Plan marketing videos, materials for broadcast (radio, television, or electronic), billboards, mass transit (bus, subway or other livery) and statewide/regional print advertising materials in accordance with CMS timeframes for review of marketing materials. These materials must be submitted to the CMS Regional Office for review. CMS will coordinate NYSDOH input in the review process. Approved marketing materials shall be kept on file in the offices of the Plan, NYSDOH, and CMS.

h. **Time for approval.** NYSDOH and CMS timeframes for review and approval vary depending on the nature of the material.

i. **Deemed approval.** No Marketing materials shall be deemed to be approved.

j. **Marketing Activities.**
The Plan must follow the State and Federal rules related to marketing activities.

k. **Marketing Plan.**
The Plan must establish, implement, and maintain a documentedmarketing plan with measurable enrollment objectives and a system for tracking its effectiveness. The Plan must submit its plan of Marketing activities that meet the CMS and NYSDOH requirements to CMS and the NYSDOH for review and approval. Approved Marketing plans will set forth the proposed Marketing activities of Plan staff during the contract period. The following must be included: description of materials and formats to be used, distribution methods; primary types of marketing locations and a listing of the kinds of community service events the Plan anticipates sponsoring and/or participating in during which it will provide information and/or distribute Plan marketing materials.

l. **Prohibited marketing practices.** A Plan must ensure that its employees or its agents donot use prohibited marketing practices which includes the following:
   1. Discrimination of any kind, except that marketing may be directed to individuals eligible for Plan because of the program eligibility criteria.
   2. Activities that could mislead or confuse potential participants, or misrepresent the Plan, CMS, or the State administering agency.
   3. The Plan may not offer financial or other incentives other than nominal gifts and promotional items as defined in the Medicare Marketing Guidance and the Medicare-Medicaid marketing guidance, including private insurance to induce potential participants to enroll with the Plan or to refer a friend, neighbor, or other person to enroll with the Plan.
   4. The Plan may not make unsolicited door-to-door contacts with participants or potential participants.
   5. The Plan may not make unsolicited marketing contacts with Potential Participants on a one-on-one basis, including telephone, or other unsolicited contacts.

6. Contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.

m. **Marketing Infractions.**

Marketing Infractions may result in compliance actions being taken by the NYSDOH or CMS to protect the interests of the program and its clients. These actions may include but are not limited to:

1. If the Plan or its representative commits a first-time infraction of marketing guidelines and the NYSDOH and CMS deem the infraction to be minor or unintentional in nature, the NYSDOH and CMS may issue a warning letter to the Plan.
2. If the Plan engages in Marketing activities that the NYSDOH and CMS determine, in its sole discretion, to be an intentional or serious breach of the applicable marketing guidelines or the Plan's approved Marketing Plan, or a pattern of minor breaches, NYSDOH and CMS may require the Plan to, and the Plan shall prepare and implement a corrective action plan acceptable to NYSDOH and CMS within a specified timeframe. In addition, or alternatively, NYSDOH and CMS may impose sanctions, including monetary penalties, as permitted by law.
3. If the Plan commits further infractions, fails to pay monetary penalties within the specified timeframe, fails to implement a corrective action plan in a timely manner or commits an egregious first-time infraction, the NYSDOH and CMS may in addition to any other legal remedy available to the NYSDOH and CMS in law or equity:
    a) direct the Plan to suspend its Marketing activities for a period up to the end of the Agreement period;
    b) suspend new Enrollments, for a period up to the remainder of the Agreement period; or
    c) terminate this contract pursuant to termination procedures outlined herein.