AMIDA CARE

HEALTH.
ADVOCACY.
CARE.

Provider Manual

January 2025

Section **Page**

Introduction to Amida Care

1.1 How to Use this Manual

Thank you for joining the Amida Care Team that goes above and beyond for its members! Enclosed in this manual is a quick reference of all the materials you will need to care for Amida Care members.

The manual is available in paper or electronic form. All forms and reference materials are available in electronic form on the Amida Care Website, http://www.amidacareny.org. If you do not have access to our website, we will be happy to send you a copy; please call us at Provider Services, 800-556-0674.

This manual is an extension of your Provider Agreement and is amended as our operational policies change. We regularly communicate these updates and other important information through available communication channels, including:

- Targeted mailings to directly impacted providers;
- New Policy & Alerts, Claims, and Clinical postings to our Provider Services

This manual will be amended when the Plan's operational policies changes.
webpage: http://www.amidacareny.org/providers-services.htm

Disclaimer: Please note that if there is a conflict with what is described in this manual and an executed provider contract, the executed provider contract term takes precedence. If the executed contract has any conflict with the State of New York Standard Clauses, these Standard Clauses will take precedence.

1.2 Amida Care Quick Reference Guide

Includes brief summaries of helpful information for AmidaCare Providers. The Quick Reference Guide can be found on the Amida Care Website, https://www.amidacareny.org/provider-services/provider-resources/ or contact Provider Services Department at 1-800-556-0674 and/or via email: providerservices@amidacareny.org.

1.3 Who is Amida Care, INC Above and Beyond for You

Amida Care, Inc. is a private not-for-profit Health Plan with a licensed by the State of New York as a Medicaid Special Needs Plan. Amida Care operates in the five boroughs (Bronx, Brooklyn, Manhattan, Queens, and Staten Island) of New York City, NY. The Plan specializes in providing comprehensive health coverage and coordinated care to Medicaid members with chronic conditions, including HIV/AIDS and behavioral health disorders and Transgender/Non-Binary (TGNB) individuals.

Amida Care is recognized in the health care industry as a high-quality health plan that provides comprehensive medical, behavioral, and psychosocial support services to members with multiple chronic conditions.

Amida Care was founded in 2003 by seven community-based organizations that offered primary care, licensed adult day health care, skilled nursing facilities, COBRA case management, housing, and other community services. These sponsors are Acacia Network, Community Health Network, Harlem United, Housing Works, St. Mary's Center, Sun River Health, and Village Care.

Today, Amida Care delivers benefits through an expanding specialized integrated network of over 200 HIV primary care providers over 5,600 primary care providers, 17,000 specialists, close to 400 facilities, 48 Federally Qualified Community Health Centers, and 37 hospitals.

More information about Amida Care is found at: https://www.amidacareny.org/about-us/

1.4 Our Mission

"Amida Care's mission is to provide access to comprehensive care and coordinated services that facilitate positive health outcomes and the general well-being of our members".

1.5 Amida Care's Model of Care

Amida Care's Model of Care (MOC) is designed to promote member health and well-being. The foundations of the Model of Care are care coordination and member support. Interdisciplinary Care Teams (ICTs) are at the heart of the Model of Care. Every member is assigned to an ICT. ICTs conduct care planning activities, including the mitigation of barriers to care, to ensure the provision of patient-centered medical, behavioral, and other specialty care services.

Each ICT is comprised of a team of Amida Care staff that work in collaboration with the member to ensure their unique needs are met. The core of the ICT is a Care Coordinator and staff who are experts in behavioral health, pharmacy, treatment adherence, housing, community-based outreach, and long-term care. Amida Care encourages members to participate in their own care planning and welcomes members to ask their family members and support systems to participate as well.

Providers are uniquely positioned to support the member's progress towards reaching their treatment plan goals. Providers are integral to the care planning process and invited to collaborate with the ICT. Providers often have a combination of knowledge and experience of the member which can best contribute to the care planning process.

This collaborative team of Care Coordinators, content experts, the member and their Provider promotes health, hope and empowerment while assisting each member to get the right care, at the right time, and in the right way to promote optimal health.

There is an Individualized Care Plan (ICP) for each member. The ICP is created by the ICT using information from a variety of sources including the member's intake assessment or reassessment

as well as the member's and Provider's input, when offered. The purpose of the ICP is to coordinate the care and services deemed necessary to achieve the member's goals. The ICP also identifies barriers to health and cultivates solutions. It is important to note the ICP exists alongside, and in support of, the care plan developed by each member's PCP.

Amida Care Provider Rights and Responsibilities

2.1 Joining the Amida Care Network – Provider Enrollment

Amida Amida Care is always open to new participating providers that provide quality, affordable health care with dignity and respect, to our members.

The Plan is accepting requests to join our Provider Network from Primary Care Providers including HIV Primary Care Providers, specialists, and health care facilities.

If you are interested in joining our Plan please review our application requirements at https://www.amidacareny.org/provider-services/become-an-amida-care-provider.

If you are a HIV Primary Care Provider, please be sure to review the Primary Care Provider Criteria before completing the Application.

Amida Care participates in the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD). The UPD is an online service that allows practitioners to complete one standardized information set to meet the credentialing needs of all participating health care organizations. Participating practitioners may update their application information at any time via the CAQH website.

Please call the Provider Services Department at 1-800-556-0674 if you have any questions.

2.2 Provider Rights and Responsibilities

Amida Care is committed to working with its participating providers to ensure that high- quality services are provided in an atmosphere of collaboration and mutual respect. This commitment encompasses the health care services provided to Amida Care members as well as the support services and operational efficiencies that Amida Care offers its provider network as part of its mission to manage a successful health plan.

Amida Care provides copies of the Member Rights and Responsibilities in the Member Welcome Kit. Providers are responsible for making sure each member's rights are observed.

Provider Rights and Responsibilities

What Providers Can Expect from Amida Care

- Open, respectful and receptive communication
- Knowledgeable and helpful staff
- Timely response to questions and concerns
- Timely communication of policy changes
- Comprehensive orientation, training and educational programs
- Timely processing of provider applications
- Timely payment for covered services rendered
- Responsive to grievance and appeals processes
- Feedback on performance and utilization

What Amida Care Expects from Participating Providers

- Professional, respectful and responsible healthcare for Provider
- Timely response to inquiries
- Assistance with problem-solving and other issues
- Maintenance of all contractual credentialing standards and obligations
- Adherence to accessibility and availability standards
- Compliance with utilization management, and quality management and improvement protocols
- Timely and accurate claims submission
- Cooperative office and administrative staff
- Adhere to recovery-oriented principles and including provision of person centered services
- Culturally sensitive care for our Transgender/Non-Binary (TGNB) members
- Amida Care will not discriminate against any health care professional acting within the scope of his or her license or certification under NY state law regarding participation in the network, reimbursement or indemnification, solely on the basis of the practitioner's license or certification. The following circumstances are exceptions to this policy:
  Amida Care may refuse to grant participation status to health care professionals in excess of the number necessary to meet the needs of Amida care members;
  a. Amida Care may use different reimbursement methodologies for different provider and/or facility types; and/or
  b. Amida Care may implement measures designed to maintain quality and control costs consistent with its responsibilities.
  c. For monitoring HCBS utilization for eligible members, see section 9.
- As Amida Care's operational policies change, the Provider Manual will be amended to reflect these changes; Amida Care providers will be given written notice of these changes at least 30 days before the changes are implemented.
- Amida Care will not prohibit, restrict, or otherwise obstruct health care professionals, acting within the lawful scope of his/her practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled in any Amida Care plan. Amida Care will allow healthcare professionals to give unimpeded advice to patients regarding the following:

- The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
    - The risks, benefits, and consequences of treatment or non-treatment; or
    - The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
- Adhere to Amida Care standards and guidelines as indicated in Sections 2.3 and care coordination and treatment as indicated in Section 2.7 through 2.9 and prior authorization requirements in Section 9.
- Provide information regarding services, both clinical and non-clinical, in a culturally- competent manner. Providers will ensure that information and access is available to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, and/or those with diverse cultural and ethnic backgrounds. Health Care professionals will ensure they have effective communications with participants throughout the health system when making decisions regarding treatment options, including the option of no treatment.
- Ensure the use of communication strategies to meet the needs of members with physical and/or mental disabilities (which include provision of translator services, interpreter services, teletypewriters, or TTY connections) so they can make decisions regarding treatment.
- Uphold all terms within the Amida Care provider agreement including compliance, the requirements of Center for Medicare and Medicaid Services, Article 44 of the NY State Public Health Law, and requirements for individuals and organizations receiving Federal Funds.
- Participate in Amida Care's continuous quality improvement program. See Section 10 for provider monitoring, improvement plans and reports.
- Complete all Department of Health Disease Reporting Requirements.
- Providers are responsible for adhering to Amida Care policies and procedures including observing member's rights and responsibilities. A copy of these rights and responsibilities are in the next section.
- Child/Teen Health Plan Services (C/THP) Screening for children and adolescents.
- Behavioral Health screening by a PCP for all members, including children as appropriate.
- Have a procedure for monitoring HCBS utilization for eligible members, see section 12.

2.3 Amida Care Provider Standards

Amida Care standards for timely access to care and member services are designed to provide excellence in care delivery. We use these standards to measure our effectiveness and in our reporting to our regulatory agencies. Amida Care's Quality Management Department is responsible for the measurement and reporting of these standards. Review Quality Management, Section 10, for information on how providers are measured.

Providers are requested to have policies and procedures to assure appropriate access to appointments for members who present at the site for unscheduled non-urgent care.

Appointment Availability Standards Quick Reference Guide Medical Services for Adults	
Emergency care	Immediately upon presentation at a service delivery site
Urgent medical or behavioral problems	Within 24 hours of request
Non-urgent “sick visits”	Within 48 to 72 hours of request, as clinically indicated
Adult baseline and routine physicals	4 weeks from date of request (adults older than 21)
Specialist appointments, non-urgent	Within 4 to 6 weeks of request
In-plan mental health or substance use follow-up visits (pursuant to an emergency or hospital discharge)	Within 5 days of request, or as clinically indicated; In-plan, non-urgent mental health or substance use visits within 2 weeks of request; Substance use follow-up visits (pursuant to an emergency or hospital discharge) within 24 hours, or as clinically indicated
Provider visits to make health, mental health and substance use assessments for the purpose of making recommendations regarding a member’s ability to perform work, when requested by the local department of social services	Within 10 days of request
Appointments for ongoing treatment needs	Within 7 days of request, if medically necessary
Women, Children and Additional Standards	
Initial prenatal visit	Within 3 weeks during first trimester and 2 weeks during the second trimester and 1 week thereafter
Initial visit for newborns	Within 48 hours of hospital discharge, or the following Monday if the discharge occurs on a Friday
Initial family planning visit	Within 2 weeks
Walk-in patients with non-urgent needs	Within 2 hours or scheduled for an appointment, consistent with the Provider’s written schedule procedures
Walk-in patients with urgent needs	Within 1 hour

- **Waiting Time Standard:** Member Complaints about appointment wait times longer than this standard should call member services at 800-556-0689.
- **Pregnant Members**: All pregnant members will have access to HIV pre-test counseling with clinical recommendation of testing for all pregnant members. The parents and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.

In-Office Waiting Times Standard	
Any provider office, any scheduled appointment	A scheduled appointment wait time must not exceed 1 hour (60 minutes) without explanation or opportunity to reschedule the appointment
Walk-in patients with non-urgent needs	Seen within 2 hours or scheduled for an appointment, consistent with the Provider's written scheduling procedures
Walk-in patients with urgent needs	Seen within 1 hour

PCP Access to Care Requirements: The role of the PCP is to assure the delivery of primary care services and to supervise and coordinate medically necessary health care of the member including 24/7 coverage. PCPs shall adhere to the following access to care standards:

- Practice at least two (2) days per week, 16 hours per week at each location.
- Provide 24 hour-a-day coverage and a "live voice" answering service, 7 days a week, either directly or through shared coverage arrangements with other Amida Care providers. If the provider uses an answering machine, the message must direct the member to a live voice.
- The Plan may request a waiver from the New York State Department of Health AIDS Institute for those HIV PCPs who have less than 16 hours a week per site; if approved, the waivered HIV PCPs will be allowed to have a panel of Amida Care members.

OB/GYN Access to Care Requirements – Members must have access to live voice answering services for after-hours and for emergency consultation and care. If the provider uses answering machine, the message must direct the member to a live voice.

Behavioral Health Appointment Standards: Behavioral Health Providers are required to assure the following appointment availability standards are met. Amida Care's Quality Management Department is responsible for the measurement and reporting of these standards in conjunction with Amida Care Behavioral Health Vendor – Carelon Behavioral Health. Appointment Standards are found in section 12.1.

Clinical Standards of Care

Providers are expected to use the following guidelines that are accepted national standards as a decision support tools to standardize practices. These standards of care are reflective of professional and generally accepted standards of medical practice.

2.4 PCP and Physician of Choice Panel Capacity and Roster:

Primary Care Providers

A full-time provider practicing forty-hours per week may have a panel of no more than 350 Amida Care members. If a full-time provider is practicing in combination with a Physician Assistant or Nurse Practitioner, the panel can be no larger than 500 members. The Plan will prorate panel size for participating providers who represent less than one FTE.

HIV Primary Care Provider

HIV Primary Care Provider meets all the Primary Care Provider requirement. The Provider will also need to meet one of the following recognized bodies criteria:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider:
- HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM) or
- Advanced AIDS Credited Registered Nurse Credential given by the HIVAIDS Nursing Certification Boar
- HIV PCPs must complete a minimum of 15 HIV related CME every year unless Specialist is certified by HIVMA in which case it is 45 CME/3 years (yearly reviews). Amida Care will accept annually a maximum of 7 CME from "Up to Date" with Course Title and a maximum 2 CME from this source without Course Title.

The HIV PCP receives a monthly panel report (roster) indicating the Amida Care members enrolled in the PCP's panel for that month. Amida Care provides assistance with PCP selection and changes. PCP changes are effective on the day of the request. Urgent changes may be permitted in special circumstances. PCPs are instructed to refer to their rosters and to verify eligibility.

2.5 Confidentiality

All participating Amida Care providers must adhere to the Health Insurance Portability and Accountability Act (HIPAA). Providers must have general HIPAA and HIV confidentiality policies and procedures in place to maintain the confidentiality of member information, including, but not limited to, electronic and paper protected health information or medical records, conversations, images, photographs, inadvertent disclosures, etc. These policies must include initial and annual in-service education of staff and contractors. HIV confidentiality policies must limit the access to information to trained staff and contractors, provide protocols for storage of information and requests for HIV-related information, and include steps to protect members with, or suspected of having, HIV from discrimination.

Providers are required to adhere to all Mental Health and Substance Use and HIV-related confidentiality laws as well including policies and procedures that assure confidentiality that addresses the following:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for BH/SU information
- Protocols to protect persons with behavioral health and/or substance use disorder from discrimination

At Amida Care, to help employees, understand their duty regarding confidential information, each new employee signs an attestation regarding general and HIV confidentiality policies and procedures, and will be required to attend an initial employment and annual confidentiality training. For care coordination, billing and other administrative purposes, providers may share member information with the Plan without a member's signed release of information. Members sign a release of information at the time of enrollment approving communication amongst network providers and the Plan.

Breach of Confidentiality: Any breach of a member's confidentiality must be reported to the Amida Care HIPAA Helpline at 866-857-4040. Contact Provider Services and they will transfer you to the Compliance Department.

2.6 Advance Directives Policy

Amida Care providers will adhere to the Advance Directives decisions of its members, including the right to execute Advance Directives and to make decisions regarding his/her health care including behavioral health services when accepting or refusing medical or surgical treatment.

The member's Primary Care Provider or Physician of Choice, including Behavioral Health Providers, is responsible for having a copy of his or her patient's signed Advance Directives as part of the patient's medical record, and to communicate this, as needed, to an admitting facility if the patient condition changes.

Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. **This included New York Department of Health Medical Orders for Life Sustaining Treatment (MOLST)**

The New York Health Care Proxy form and instructions to assist your patients are available as an Adobe Acrobat PDF (portable document format) in the following languages at the links below. This form is also available on the Amida Care website in the provider section under forms. https://www.amidacareny.org/provider-services/provider-resources/

English https://www.health.ny.gov/publications/1430.pdf
Spanish **https://health.ny.gov/publications/1431.pdf**
Chinese https://www.health.ny.gov/publications/1401.pdf
Russian https://www.health.ny.gov/publications/1402.pdf

If any contracted provider has an objection, they must raise their individual concerns. If a provider does have an objection, that provider must advise the member of both the

- New York State legal authority permitting such objection; and the range of medical conditions and/or procedures affected by the conscience objection.

2.7 Continuity and Integrated Care

Amida Care follows a model of care that is most effective for its members. The Department of Integrated Care will assist and support providers in rendering care as described in Section 6. All providers are expected to support continuity of services and care coordination within the Amida Care model of care for the member's selected health plan, using the following processes to support continuity of care.

Direct Access (Self-Referral Services): An Amida Care member may self-refer for the following services to participating providers when covered benefits:

- Preventive OB/GYN care: Members may obtain comprehensive family planning and reproductive health services from either a participating Primary Care Provider, family

planning provider or from any appropriate non-participating Plan Medicaid health care provider of the member's choice.
- Prenatal Care, two routine visits per year and any follow-up care, and acute gynecological care
- Family Planning and Reproductive Health Services - member may self -refer" to any Amida Care Provider or the Member can use their Medicaid Card to access non-participating providers who accept Medicaid.
- Hearing Testing
- Immunizations
- Smoking Cessation Counseling (SCC)
- Vision care with participating provider- ophthalmologist and optometrist
- HIV pre-test counseling for all pregnant women
- Diagnosis and treatment of TB by public health agencies
- Outpatient Mental Health or Substance Use services. Amida Care members may have access to services on an unlimited basis

Primary Care and Specialist Coordination
Appointments with in-network (par) specialists do not require a referral. Members can schedule consultations, either intake or follow-up, without advance notification of Amida Care. A specialist may request pre-visit documentation as part of their standard office procedure, as they deem appropriate for their practice. If the Primary Care Provider (PCP) is either initiating, or made aware by the member, of the consult visit, they are encouraged to indicate to the specialist the purpose of the referral along with any relevant medical information.

The Specialist is encouraged to follow up with the PCP in writing or other means to apprise them of consultation results, diagnostic testing results, and treatment plans. This is especially important if the Specialist is not part of the same EMR/EHR system as the PCP.

Specialist as PCP: A Specialist can serve as the member's PCP to a member diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period. The Specialist The PCP/ Specialist and Amida Care Medical Director is required to agree to a treatment plan.

When a provider is designated as both a PCP and a specialist, he/she must meet the credentialing requirements for each role and be dual designated by Amida Care.

Physicians with this designation must assume the roles necessary for continuity of care within the network and submit CPT/HCPCS codes with the modifier AF when performing services as a specialist.

Standing Referrals: A PCP may refer a member with chronic, disabling, or degenerative conditions disease to a specialist for a set number of visits within a specified time period.

Specialty Care Centers: A member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a referral to a specialty care center. Such referral will require prior

approval by the managing entity's medical director. A treatment plan must be agreed upon among the PCP, Amida Care Medical Director, and the provider.

Out of Network Care: The Primary Care Provider (PCP) determines the need for his or her members to receive a referral to an out of network provider. The PCP reviews the Amida Care Provider Directory to determine if there is an appropriate specialist in the Amida Care network. Provider Relations may also be contacted to determine if an appropriate specialist was recently added to the network.

If a specialist with appropriate training and experience cannot be found within the network or medically necessary services are not available through network providers, the PCP or a designee will contact Utilization Management to request authorization for out-of-network services.

The out-of-network request will be approved and made pursuant to an approved treatment plan. The PCP, the provider requesting authorization if other than the PCP, the member and the out-of- network provider are all notified by phone and in writing of the approval, in accordance with all regulatory guidelines. The member may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment.

If network services are available within the Amida Care network, Utilization Management will contact the requesting provider to discuss the network options. If the provider continues to request an out- of-network referral after indicating that the services the member requires cannot be provided by an in-network provider, the PCP is asked to submit supportive documentation, and the case is reviewed with the Vice President of Clinical Services and Programs.

If the supporting information provided does not meet clinical criteria, the case will be referred to Amida Care's Medical Officer or his/her designee. Amida Care may contact the provider to discuss the treatment plan and to make a determination regarding approval of the out of network referral.

If Amida Care determines that there are providers available within its network that can provide the care, Amida Care will issue an adverse organization determination via the written notice. The member and/or the member's designee can initiate an appeal if he or she believes that the out-of-network services are materially different from those recommended by an in- network provider. If an out-of-network request is denied for a lack of medical necessity, Amida care will issue a written notice.

If the member, the member's representative, or the provider acting on behalf of the member disagrees with the denial determination, they have the right to an appeal. See Section 8 for information on Pre-Service Appeals.

Transitions of Care: Amida Care makes every effort to assist new members whose current providers are not participating in the Amida Care network to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the Effective Date of Enrollment if the member requests to continue an ongoing course of treatment with the member's current provider when:

- The member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days.

- The member has entered the second trimester of pregnancy at the effective date of enrollment. The transitional period shall include provision of post-partum care related to the delivery.

  Amida Care's Integrated Care Department will work closely with the member's PCP to manage transitions of care between facilities and to the home. Copies of discharge plans will be sent to the PCP's office by the discharging facility and confirmed by Amida Care. PCPs are responsible for monitoring and following through on discharge plans for members, including:
- If applicable, post-acute care follow-up, including a face-to-face visit at and/or with a doctor, within 48 hours of discharge or within 1-2 business days in the event of a Friday discharge.
- Providing an appointment within the first 5-10 days after an acute care episode.

Children Transitions of Care is found in Section 8.2 and 8.3

2.8 Coordination with Behavioral Health Providers – Mental Health/Substance use Dependency Providers

Amida Care partners with Carelon Behavioral Health to provide a network of physicians and other licensed professionals, community agencies, and inpatient and outpatient facilities to provide a full spectrum of behavioral health care, including mental health and substance use dependency services. These providers include individual licensed practitioners and New York State Office of Mental Health (OMH) and Office of Alcohol and Substance Use Services (OFFICE OF ADDICTION SERVICES AND SUPPORTS) licensed programs and facilities. Individual mental health and substance use providers include psychiatrists, psychologists, psychiatric nurse practitioners, psychiatric clinical nurse specialists and licensed clinical social workers. Mental health and/or alcoholism/substance use providers must be certified pursuant to Article 23 or 31 of Mental Hygiene Law. OFFICE OF ADDICTION SERVICES AND SUPPORTS programs include Certified Drug and Alcohol Counselors employed only by OFFICE OF ADDICTION SERVICES AND SUPPORTS licensed programs.

An initial mental health and substance use dependence assessment is performed for each Amida Care member as a component of the new member assessment process for our Plan. The member's PCP conducts a reassessment of mental health and substance use dependence status annually. The (Amida Care) Care Team ensures that inpatient and outpatient behavioral health services are appropriate and coordinated with other necessary care. Amida Care promotes integration of behavioral health services with physical health by working to increase communication and sharing of member information between providers. Integration and coordination of physical and behavioral health is done by communication between the member's Care Coordinator and Carelon Behavioral Health staff.

Amida Care, in partnership with our Behavioral Health vendor, Carelon Behavioral Health , works to promote behavioral and physical health integration for children., This includes at-risk populations defined by the State:

- Provider access to rapid consultation from child and adolescent psychiatrists;
- Provider access to education and training; and
- Provider access to referral and linkage support for child and adolescent patients.

As of January 1, 2016, all providers will be required to have a procedure for monitoring member's utilization of Home and Community Based Services (HCBS) by eligible Amida Care members.

Carelon Behavioral Health Clinical Practice Guidelines
Please refer to Carelon Behavioral Health Policy and Procedure Manual for Providers, accessed via their web portal, for polices regardingbehavioral health clinical practice guidelines: https://www.carelonbehavioralhealth.com/providers/resources/provider-handbook

Carelon Behavioral Health incorporates the following into provider guidance:

- OMH Clinic Standards of Care: https://omh.ny.gov/omhweb/clinic_restructuring/default.html
- OFFICE OF ADDICTION SERVICES AND SUPPORTS Clinical Guidance:* https://Office of Addiction Services and Supports.ny.gov/system/files/documents/2021/10/clinical-standards-for-Office of Addiction Services and Supports-certified-programs.pdf https://Office of Addiction Services and Supports.ny.gov/system/files/documents/2020/02/822-clinical-standards.pdf
- OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2023* https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/vfca_mmc_transition_policy_paper.pdf
- OCFS Working Together: Health Services for Children/Youth in Foster Care Manual* https://ocfs.ny.gov/main/sppd/health-services/manual.php
- OHIP Principles for Medically Fragile Children – https://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-01-24_final_mfc_wrkgrp_rpt.pdf

2.9 Experimental & Investigational, Clinical Trials & Rare Disease Treatment

The Plan will review requests for experimental, investigational or rare disease treatment. The following guidelines have been provided:

- The member's PCP or Physician of Choice has certified that:
    - The member has a life-threatening or disabling condition or disease,
    - Accepted practice or standard services, procedures, and medication have proven ineffective or medically inappropriate; or,
    - a more beneficial standard health service which would be covered by Plan does not exist; and,
    - An IRB approved clinical trial exists.
- The member's referring provider must be a board-certified or board-eligible provider qualified to practice in the area of practice appropriate to treat the member's life threatening or disabling condition/disease, and must have recommended either:
    - A health service or procedure that, based on two peer reviewed documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
    - A clinical trial for which the member is eligible; and

    - The specific health service or procedure recommended by the attending provider would otherwise be covered except for Amida Care determination that the health service or procedure is experimental or investigational.
- If the provider of the experimental or investigational treatment is not a member of Amida Care provider network, the PCP or referring Specialist must make a referral for out of network services.
- A letter of medical necessity is required when requesting experimental or investigational treatment, including information on the recommended course of treatment when available.
- All requests are processed by the Utilization Management Department; reviewers will refer such cases to the Plan's Chief Medical Officer for review and determination.

Clinical Trials:
Through clinical trials, members may gain access to new treatments not yet available to the general public. The information gained through these studies will ultimately improve the health of people living with Chronic Illness such as HIV/AIDS. Amida Care encourages providers to keep abreast of available clinical trials and to make this information accessible to members. Amida Care will provide periodic updates and include information on clinical trials in the greater New York area. Amida Care will also provide links to clinical trials for all members under the age of 21, as appropriate.

As an example, the AIDS Community Research Initiative of America (ACRIA) at www.acria.org, and Cornell's Clinical Trials Unit (CCTU) https://medicine.weill.cornell.edu/divisions-programs/infectious-diseases/research/hivaids/cornell-clinical-trials-unit are two resources for providers to secure comprehensive listings of HIV and HIV-related clinical trials.

Rare Disease Treatment:
"Rare Disease" is defined as a life threatening or disabling condition or disease that is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network, or one that affects fewer than two hundred thousand United States residents per year and for which there does not exist a standard health service or procedure covered by Amida Care that is more clinically beneficial than the requested treatment. Request for rare disease treatment requires prior authorization. See Section 9 for authorization details.

2.10 Cultural Competency

Cultural competency is critical to reducing health disparities and improving access to high- quality health care by providing health care that is respectful of and responsive to the needs of diverse patients. Amida Care membership is racially diverse and consists of people from many ethnic backgrounds as well as individuals with disabilities. Providers are responsible for ensuring that members understand their diagnosis and treatment options, and that cultural and language differences or disabilities do not interfere with provider communication or member understanding.

HIV Special Needs Plans (HIV-SNPs) such as Amida Care are required to ensure cultural competence in their provider network and are required to certify annual completion of a New York State-approved cultural competence training curriculum. This includes training on the use of interpreters and is for all network providers and their staff who have regular or significant contact with our membership.

The New York State Department of Health (DOH) approved cultural competence training offered by the U.S. Department of Health and Human Services (HHS). The training, Think Cultural Health, offers several provider-specific programs and is offered online. Behavioral health providers may take New York State's previously approved Cultural Competency Training to satisfy this requirement.

Providers who completed Cultural Competency Training within the past 12 months with another managed care plan, do not need to complete the training again but must provide Amida Care with an attestation form certifying that you have completed training by visiting:

Cultural Competency Attestation Website Address
https://www.amidacareny.org/cultural-competency-training-for-amida-care-providers/

Participating providers are required to complete the cultural competence training annually thereafter.

2.11 Assisting Disabled Memebers

Amida Care requires the contracted network of providers and facilities to be in compliance with the Americans with Disabilities Act of 1990 (ADA) as well as Section 504 of the Rehabilitation Act of 1973. Both Title II and Title III of the ADA and Section 504 requires that medical care providers provide individuals with disabilities. Full and equal access to their health care services and facilities; and Reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services).

2.12 Provider Change in Status and/or Availability

Provider Changes Quick Reference Guide		
Provider Modification Form address:	**Provider Amida Care Portal:**	**Modification Form Submission:**
https://www.amidacareny.org/wp-content/uploads/provider-modification-form-updated.	https://amidacare.ppi.com/provider/sign_in	providerservices@amidacareny.org

Providers who anticipate changes in their status (name, address, telephone number, email, hours, languages, and/or site), or take a leave of absence must contact the Provider Services Department.

The provider will need to complete and submit the Amida Care Modification Form. The form can be found at https://www.amidacareny.org/provider-services/provider-resources/. Form is available on the Amida Care website in the provider section under Documents and Forms.

If you have any questions contact Provider Services Department at 800-556-0674 or send a communication through the Provider Services Portal.

2.13 Provider Disciplinary Action Process

Amida Amida Care policies, procedures, and standards of care are designed to ensure that a high-quality, cost-effective care is provided to all Amida Care members. Disciplinary action may be taken against providers who do not meet Amida Care's standards of care or comply with its policies and procedures. Problems that may indicate the need for disciplinary action include, but are not limited to:

- Quality of care concerns;
- Non-compliance with access requirements, appointment availability standards or program guidelines;
- Unsatisfactory utilization management; and
- Behavior that is not consistent with Amida Care's managed care objectives.

Depending on the nature and the severity of the situation, Amida Care may decide to reduce or suspend the provider's privileges or formally terminate the provider's participation with Amida Care.

Disciplinary actions are instituted upon the recommendation of Amida Care's Chief Medical Officer or its Quality Management Committee. Amida Care follows the reporting obligations of the National Practitioners Data Bank. Amida Care will report to the appropriate state, local and federal agencies a provider who is terminated from the Plan for reasons relating to alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare.

2.14 Provider Termination

Amida Care or its participating providers may decide to terminate or elect not to renew a provider agreement. Termination procedures are subject to the provisions of the provider agreement, modified by certain limitations as outlined in this section of the Provider Manual. If there are conflicts in language, the language in the provider agreement will prevail.

Voluntary and Involuntary Terminations without Cause and Continuity of Care:
Providers that are sanctioned by NYSDOH's Medicaid Program will be excluded from participation with Amida Care's Med SNP plan. The applicable provisions of the individual Provider Agreement or the Hospital Entity/Health Care Services Agreement govern the termination of a provider agreement with Amida Care. All providers voluntarily terminating their affiliation with Amida Care must give written notice of the termination in a timeframe consistent with their individual contract. Written notice must include a termination date. Verbal notification is not sufficient to initiate the termination process. If Amida Care elects to deny participation status in the Amida Care provider network, or to suspend or terminate a Provider Agreement, written notice will be given that includes some or all the following:

- The reason for the proposed action;
- The standards and the profiling data the organization used to evaluate the health care professional;
- The number and mix of reviewing health care professionals required by the Amida Care network;

- The affected provider's right of appeal, and the process and timeframe for requesting a hearing before a panel appointment by Amida Care.
- Time limit for a time limit of not less than 30 days within which a healthcare professional may request a hearing; and
- Time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

Subsequent to a written notice of termination being given by a provider or by Amida Care, providers are required to continue the offer of services to Amida Care members for a period consistent with the individual provider contract so that appropriate transition of care advocaat take place. In the case of providers caring for women in the second trimester of pregnancy, the continuity of care/transition period may be extended up to delivery and through post-partum visit. If the member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days.

Transition of Care when a Provider Leaves the Network: When a provider leaves the Amida Care network, a member or the provider can request approval to continue an ongoing course of treatment for a transitional period up to 90 days. The transitional period begins on the date the provider's contractual obligation to provide services to Amida Care terminates and ends no later than 90 days (or if the provider is providing obstetric care and the Member has entered her second trimester of pregnancy at the time of the provider's termination, the transitional period includes post-partum care related to the delivery). In order to request approval to continue an on-going course of treatment, call (888) 364-6061. Requests will only be approved if the provider agrees to:

- Continue to accept Amida Care reimbursement rates applicable prior to transitional care
- Adhere to our quality assurance program and provide medical information related to the Member's care; and
- Adhere to our policies and procedures, including referrals, obtaining pre-authorization, and a treatment plan approved by Amida Care.

Immediate Termination: Amida Care reserves the right to terminate a provider contract immediately, with written notice to follow, under the following circumstances:

- Final disciplinary action is taken by a governmental regulatory agency that impairs the provider's ability to practice;
- There is a determination of fraud on the part of the provider; and/or
- Continuation of the provider's participation may cause imminent harm to patients. Providers whose contracts have been terminated due to any of the above situations are not eligible for a review or a hearing.

Termination for Cause: Amida Care reserves the right to terminate a provider's contract upon prior written notice to the provider within a timeframe consistent with the individual provider contract, for reasons including:

- Repeated failure to comply with quality assurance, peer review, and utilization management procedures;
- Unprofessional conduct as determined by the appropriate state professional licensing agency;

- Conviction for a criminal offense related to the practice of medicine or any felony unrelated to such practice;
- Failure to comply with Amida Care's credentialing standards and procedures;
- Revocation, reduction, or suspension of privileges at any participating hospital or any hospital where the physician conducts practice; and/or
- Discrimination against Amida Care members as outlined in the Provider Agreement.

During the 30-day notice period, the provider may request a hearing pursuant to Public Health Law Section 4406-d.

Non-renewal of Contract: The decision not to renew a contract is not considered a termination event. Either Amida Care or a participating provider may elect not to renew a contract by giving written notice to the other party prior to the expiration date of the respective provider contract, and in a timeframe consistent with the individual provider contract but not less than 60 days. As indicated in the previous section on voluntary disaffiliation, providers must continue to offer their services until arrangements are made to transition member's care to another provider.

Providers may be expected to continue providing medical services for up to 90 days, except in situations in which the member has entered the second trimester of pregnancy at the time of contract non-renewal.

Under no circumstances will Amida Care initiate termination or non-renewal actions against a provider solely because he or she has:

- Advocated on behalf of a member;
- Filed a complaint against Amida Care with state or federal regulatory bodies;
- Appealed a decision made by Amida Care;
- Provided information or filed a report pursuant to PHL4406-c regarding prohibitions of plans; and/or
- Requested a hearing or review.

Notification to Members: When a provider elects to terminate a participation agreement with Amida Care, members will be informed by letter of the termination of participating providers from whom they are receiving a course of treatment/services within 15 days of the provider advising Amida Care of their status change, but no less than 30 days before the termination effective date. The letter advises the member that he/she may call Amida Care for assistance in selecting a new provider. If a member does not contact Amida Care, a new PCP will be selected for him/her by the Plan. Members will also be advised as to how they may be able to continue care with this provider for a defined period of time.

Reporting Terminated Provider Agreement: If Amida Care suspends or terminates a contract with a physician because of deficiencies in the quality of care, it shall give written notice of that action to licensing or disciplinary bodies, or to other appropriate authorities. Notification shall be submitted to the New York Office of Professional Medical Conduct under the following circumstances:

- Alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare;

- Voluntary or involuntary termination of contract or employment to avoid disciplinary action;
- A determination of fraud or of imminent harm to a patient's health; and
- Termination of an Independent Practice Association subject to the requirements of Public Law Section 4406-d.

Appeal Hearings: Providers who have received a termination notice from Amida Care have the right to appeal the decision by submitting a written request to Amida Care within 30 days of receipt of the notice. A hearing to reconsider the proposed action will be scheduled within the 30-day period following Amida Care's receipt of a written request from the provider for a hearing.

Amida Care will appoint a Hearing Panel. It will consist of at least three participants, at least one of whom is a clinical peer of the provider in question. A "clinical peer" is defined as a provider having the same or a substantially similar medical specialty as the provider under review. If the assembled panel has more than three members, at least one third of the panel's membership will be clinical peers.

The Hearing Panel will render a decision on the appeal in a timely manner, and the provider will be notified of the Panel's decision in writing. Decisions will include one of the following:

- Reinstatement;
- Provisional reinstatement with conditions set forth by Amida Care; or
- Termination

If the outcome of the hearing is to continue with the termination process, the date of termination received in the original termination letter will remain final.

1. A letter will be send no less than 30 days after the receipt by the health care professional of the hearing panel's decision.

A provider terminated due a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professionals' ability to practice is not eligible for a hearing or a review.

2.15 Value Based Program

Amida Care's The Value-Based Program for providers refers to a healthcare payment and delivery model that focuses on the quality and outcomes of care delivered to patients, rather than just the volume of services provided. In traditional fee-for-service models, providers are paid based on the number of tests, procedures, or services they deliver, which can create incentives for more frequent or unnecessary treatments.

The Plan Value-Based Program aims to align the financial incentives of healthcare providers with the overall health and well-being of their patients. The key principles of the Amida Care Value-Based Provider Program include:

1. Quality over Quantity: Providers are rewarded for delivering high-quality care and achieving positive patient outcomes. This could involve meeting certain performance measures or

achieving specific healthcare targets.

2. Care Coordination: Value-Based Programs often emphasize the importance of coordinated care among different healthcare providers and settings. The goal is to improve care continuity and avoid unnecessary duplications.
3. Patient-Centered Care: The focus of the program is on meeting the individual needs and preferences of patients. Providers are encouraged to engage patients in their care decisions and provide them with the necessary support to manage their health effectively.
4. Cost-Effectiveness: While quality and outcomes are prioritized, Value-Based Programs also aim to control healthcare costs. Providers may be incentivized to deliver care efficiently and reduce unnecessary medical expenses.
5. Data-Driven Decision Making: Value-Based Programs rely on robust data analytics to measure performance and outcomes accurately. Providers need to track and report relevant data to assess their performance and make improvements.
6. Shared Savings/Shared Risk: In some Value-Based Programs, providers may have the opportunity to share in the cost savings achieved if they deliver care more efficiently than expected. Conversely, they may also share in financial risk if costs exceed projected levels.

Currently, Amida Care Providers have initiate set of Value-Based Programs including: Accountable Care Organizations (ACOs), Bundled Payment Initiatives, and Pay-for-Performance programs. These initiatives are intended to improve patient care, increase care coordination, and enhance overall healthcare system efficiency.

For more information about Amida Care Value Based Program, please contact the Provider Services Department at 1-800-556-0674 and/or via email: providerservices@amidacareny.org

2.16 Amida Care Electronic Funda Transfer & Electronic Remittance Advice Process

Amida Care provides The Electronic Funds Transfer (EFT) and the /Electronic Remittance Advice (ERA) program offers for payment of Claims. These services allow direct deposit and automated documentation of claim payments. With EFT, reimbursements are wired directly into the provider's checking account, which means no lost checks, no deposit slips to prepare, and no waiting for checks to clear. ERA is a digital Explanation of Payment (EOP), an electronic statement that reduces paperwork and allows the vendor to easily reconcile reimbursements to their patient accounts.

- The Provider will need to enroll through the Amida Care Portal and register with Vesta Care. The provider can submit the enrollment requirements through PPI using the Amida Care payment ID. Providers will need to submit the following information:
    - Provider Information
    - Provider Identification Information
- Federal Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- Provider Type
    - Financial Institution Information
    - The provider will submit a copy of a voided check or a bank letter that is no older than 60 days.

- EFT/ERA forms must be completed and signed only by the provider associated with the Tax ID Number indicated on the form or by a verifiable, authorized employee/representative empowered to make bank account changes on the provider/organization's behalf.

  https://claims.vestacare.com/servlet/apps.Login?P=ACH

2.17 Amida Care Provider Portal

Provider Portal Website
https://amidacare.ppi.com/provider/signin

Amida Care Online is a secure, electronic portal developed specifically for providers in Amida Care's network. It enables you to gain immediate access to real-time data about claims, authorization status, member eligibility, and other patient information.

if you are a first-time user, please call 1-800-556-0674 to register.

If you have questions on how to register or if you are having trouble logging in, please contact the Provider Services Department at 1-800-556-0674.

Our Provider Services Team

3.1 Provider Services Team and Contract Information

The The Amida Care Provider Services team is responsible for contracting, in-servicing, and servicing network participating providers. Providers can reach the Amida Care Provider Services Department at 800-556-0674, Monday through Friday, during regular business hours.

Provider Services Quick Reference Guide		
Contact Phone#	**Contact Email**	**Fax**
1-800-556-0674	providerservices@amidacareny.org	1-646-786-1803
Mail Address		**Hours**
Att: Provider Services 14 Penn Plaza, 2nd Floor New York, NY 10122		Monday – Friday 8:00am to 5:00pm

To aid in a quick response to your needs, other Amida Care Team members, such as care management, utilization management and claims, may be able to assist you. Our standard is to respond to your request for information whenever possible within one (1) business day, and in all cases within three (3) business days (unless otherwise noted)

Providers can request the following:

- Provider Manual
- Provider Directory
- Claims and Billing (may require additional investigation)

3.2 Education and Orientation

As an Amida Care provider, we count on you to help us deliver the best care to our members, and to follow the care management models designed by our Chief Medical Officer and Care Management Department. This manual describes the care model and administrative process for the Amida Care Medicaid plan. Our Provider Services team will provide an initial provider orientation for all new providers including all benefits and populations. In-service training to providers and their staff as health plan changes occur or new programs are offered. This electronic education will include but is not limited to the following: access and availability, medical billing and coding, cultural competency Training, documentation requirements, provider profiling, transportation benefit, and Medicaid Certification Requirements.

The Plan offers training to providers and their staff on the processes for assessment for HCBS

eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and plan of care (POC) development and review. Periodically, we will send you a provider newsletter with program updates. Our Chief Medical Officer will also provide clinical guideline and care model updates as required.

Additionally, our Provider Services staff will be making office visits to assist you with any additional information and support you will need.

3.3 Chief Medical Officer Updates

The (Amida Care) Care Team includes a Chief Medical Officer who is responsible for overseeing the administration of benefits and utilization. Our Chief Medical Officer works closely with the Quality Management department to monitor quality of care, and under and over utilization of medical services. Updates to this manual as well as clinical guidelines and plan medical policies are delivered to the provider network through mailings, e-mails, and Electronic notices., which are posted at the Amida Care website.

Our Credentialing Team

Credentialing Quick Reference Guide		
Contact Email	**Fax**	**Hours**
Providerservices@amidacareny.org	1-646-786-1803	Monday – Friday 8:00am to 5:00pm

4.1 Overview

Amida Care is committed to providing health care services to its membership through a high-quality provider network that meets the standards outlined by regulatory and oversight agencies, including the Centers for Medicare and Medicaid Services (CMS), New York State Department of Health AIDS Institute, the National Committee for Quality Assurance (NCQA), and/or the Joint Commission and Accreditation of Healthcare Organizations (JCAHO). Approved Non delegated providers are initially credentialed and periodically re-credentialed every 3 years conducted by Amida Care. Approved delegation agreement's credentialing review process is conducted yearly by Amida Care. Providers are initially credentialed and periodically re-credentialed through approved delegation agreements, or through a credentialing review process conducted by Amida Care.

The Plan recruits and credentials providers for its network based on the health care service needs of its members, without regard to a provider age, race, gender, sexual orientation, national origin, nor any other unlawful discriminatory practice. Any provider who has been sanctioned by Medicare or Medicaid or has been prohibited from serving Medicaid recipients and/or receiving Medical Assistance payment is excluded from participating.

The Plan will credential and re-credential all providers who participate in the delivery of health care service outside of the inpatient care setting and re-credential at least once every three (3) years. Through its documented credentialing and re-credentialing processes, the Plan endeavors to contract with providers who meet uniform standards established to ensure the selection of appropriately trained and qualified Plan Medical Doctors (MDs), Doctor of Osteopathic Medicine (DOs), Doctor of Podiatric Medicine (DPMs), Nurse Practitioners (NPs), Certified Nurse Practitioners (CNPs), Obstetricians/ Gynecologists (OB/GYNs) and other licensed independent health care professionals to provide covered services to Plan members in accordance with the Amida Care, Inc., CMS and the New York City and State DOH Agreement.

4.2 Initial Application

Amida Care participates in the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source (UPD).

Developed by CAQH, the UPD is an online service that allows practitioners to complete one standardized information set to meet the credentialing needs of all participating health care

organizations. Participating practitioners may update their application information at any time via the CAQH Web site, at https://:UPD.caqh.org/UAS.

A fully executed provider agreement, or relevant facility contract is required to initiate the credentialing process. Certified Nurse Mid-wife (CNM) and Nurse Practitioners (CNP/FNP) must submit a copy of their Collaborative Agreement with a collaborating MD and/or DO who is also par with Amida Care.

The applicant must submit their CAQH Identifier Number and signed attestations or complete Amida Care's Credentialing application if CAQH Identifier number is not available, as well as all supporting or applicable documentation and attachments, as required by the NCQA standard guidelines.

4.3 Application – Initial/Re-Credentialing Requirements

Provider credentialing application request forms are available by request; by calling the Provider Services Department toll-free telephone number at 800-556-0674 for those that are unable to complete a CAQH application.

Applicants that do not have a CAQH application number will be required to complete Amida Care application.

The credentialing application process for each applicant will be completed by the credentialing specialist staff and submitted to the Credentialing Sub-Committee for approval within 60 days of receipt of credentialing application.

Amida Care will allow newly licensed Health Care Professionals (HCPs) and HCPs relocating from other states to apply for provisional credentialing, as long as the following criteria is met.

Applicants will be required to attach the following supporting documentation to the CAQH application (at a minimum):

1. Amida Care Application Request Form, that includes the CAQH application number
2. If a provider does not have a CAQH application number, an Amida Care Initial credentialing or Recredentialing application form must be completed
3. CV/Resume
4. Liability Insurance
5. W-9 form
6. Hospital Affiliation or Collaborative Agreement
7. Medicaid Certification Statement

HIV Primary Care Provider: If a provider is certified as an HIV Primary Care Provider to provide services for HIV/AIDS infected members, the applicant must complete an HIV Primary Care Provider Attestation Form and meet the AIDS Institute HIV Specialist Definition: "HIV Specialist PCP" means an HIV experienced Primary Care Provider who has met the criteria of one of the following recognized bodies:

1. The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider or

2. HIV Specialist status accorded by the American Academy of HIV Medicine(AAHIVM) or
3. Advanced AIDS Credited Registered Nurse Credential given by the HIVAIDS Nursing Certification Board

An HIV Primary Care and/or General Primary Care Provider or OB/GYN specialist must have evidence of 24-hour, 7-days-a-week, and 365-days-a-year access and/or appropriate coverage.

Amida Care HIV Specialist PCPs in the preceding 36 months provided care for at least 25 persons living with HIV and has completed 45 HIV related CME hours specific Continuing Medical Education (CME) credits.

Amida Care HIV Specialist PCPs are required to earn thirty (40) hours of approved HIV-specific Continuing Medical Education (CME) credits. The provider must submit 15 CMEs within a 12-month period that are consistent with NYSDOH/AI guidelines for HIV specialty care and include management of antiretroviral therapy or submit the HIV Medicine (HIVMA) certificate.

Each HIV Specialist PCP will be required to submit documentation to the Provider Services Department documenting compliance with CME requirements on an annual basis. This form is available through Provider Services. This information will be used in annual assessments of HIV Specialist status as well as to investigate and/or address any Quality Management or Continuous Quality Improvement issues.

New York State Designated Providers

New York State-designation of providers will suffice for the Plan's credentialing process. Amida Care will not - separate credential individual staff members in them. capacity as employees of this state designated program. Amida Care credentialing department will conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid, or any other way excluded from Medicaid reimbursement. The Plan shall still collect and accept program integrity related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program

Amida Care does not credential :

1. Case Managers
2. Social workers are credentialed through Carelon Options This should be excluded. LCSW and LMSW: Licensed Clinical Social Workers (LCSW) and/or Licensed Master of Social Work (LMSW) must complete Amida Care's Provider Application, as required for credentialing
3. Physician Assistants

4.4 Credentialing Process and Decision

The credentialing staff will make every effort to obtain the necessary documents to complete the process of receipt of the application within 60 days. If additional requested documentation is needed, the Plan will make every effort to notify the provider as soon as possible to obtain requested

documents, but not more than 60 days from the receipt of the application. If at the 45-day mark requested, documentation ais not received, the Provider Services team will make a final outreach to the provider to obtain the appropriate documents. If the Provider Services Representative is not able to obtain the appropriate documentation within 14 days, the providers application will be terminated. If the Plan discontinues the credentialing process, the provider will receive written notification of such, within 30 days from present date of discontinuation and/or denial of application.

Per NYS law and the NCQA credentialing requirements, the initial applications are reviewed within 60 days of receiving a fully completed application, and the provider is notified in writing within 90 days of an approved application.

4.5 Re-Credentialing Process

Amida Care requires all practitioners to undergo recredentialing every three years by the month of the initial participation.

Practitioners must maintain the same minimum qualification requirements as applicable for the initial credentialing.

Practitioners will receive an email advising that their re-credentialing is due for renewal. Providers should make any changes to their information on the CAQH UPD, update the malpractice claims history accordingly, and include updated copies of their curriculum vitae, State License, Drug Enforcement Agency certification and proof of malpractice insurance coverage with the application.

Practitioners with a complete application on file with CAQH UPD can advise Amida Care to retrieve all documentation from that source. More information on our relationship with CAQH can be found in this chapter in the section on Council for Affordable Quality Healthcare Universal Provider Database.

All Credentialing/Recredentialing Committee approved/denied applicants will receive a Welcome/Denial Letter.

4.6 Delegation of Credentialing and Re-Credentialing Related Activities

Amida Care may delegate credentialing to contracted facilities, Independent Practice Associations (IPAs), or large medical groups whose credentialing standards have passed an Amida Care pre-delegation audit. Upon successful completion of a pre-delegation audit, Amida Care will execute a delegation agreement with the facility, IPA, or large medical group.

Facilities to which provider credentialing/recredentialing are delegated by Amida Care, must be either accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or show evidence by their bylaws and/or policies and procedures that they are following JCAHO credentialing processes. All facilities with delegated credentialing and re- credentialing will submit a/an:

- Copy of the facility's current JCAHO accreditation certificate, if applicable.
- Accurate and current list of providers who are to be included for participation in the Amida

Care network of providers contracted by the facility to Amida Care.

- "Statement of Credentialing" signed by the President/CEO or an appropriate designee which verifies that the hospital has conducted credentialing in compliance with the facility's credentialing policies and procedures; and
- A copy of their credentialing policies and procedures, and/or by laws.
- The hospital will notify Amida Care of changes in provider status by submitting delegated roster. In addition, Amida Care supplies a template of the delegated roster's data elements required per the credentialing. Amida Care will monitor provider's Re-credentialing by a conducting an annual Delegated Oversight Audit per the credentialing and recredentialing standards.

4.7 Delegated Credentialing Oversight

Provider File Operations and the Designated Delegated Credentialing Auditor will monitor the overall quality and timeliness of all credentialing verifications conducted by the Delegated credentialing staff, entity, or accredited CVO. The Credentialing Sub-Committee and/or the Quality Management Committees at a minimum l receives all credentialing audit information annually.

- The Plan will maintain evidence of oversight of the delegated activity. The delegation agreement describes, without limitation:
- The responsibilities of the Plan and the delegated entity.
- The activities being delegated.
- The process by which the Plan evaluates the delegate's performance; and
- The remedies, including termination of the delegated agreement, available to the Plan if the delegated entity fails to meet its obligations. The Plan retains the right, based on quality issues, to approve new providers and sites, and to terminate or suspend individual providers.

4.8 Provider Performance Evaluation

Amida Care will periodically perform various quality reviews of its Network Providers and/or facilities. The purpose is to assess for strengths and weaknesses with respect to the quality, timeliness, and access to health care services in our benefit package and improve our organization and its associated network.

Below is a list of categories of activity that may be reviewed, but not limited to:

- validation of performance improvement projects;
- validation of performance measures;
- review of compliance with access and availability, structural and operations standards;
- review of credentialing and recredentialing data records;
- evaluation of member complaints/grievances;
- strategic reports on consumer-reported satisfaction surveys;
- strategic reports of HEDIS/QARR Analysis;
- technical assistance on member information;
- coordination of care;
- evaluation of provider-based quality strategy;

- implementation of focused studies and identification of special health care needs;
- dissemination of information to keep key stakeholders within network involved and informed:
    - External Quality Review work projects and tasks; development of reports for submittal to regulatory agencies as required;
    - Will provide providers with any information and profiling data used to evaluate the providers performance; shall make available on a periodic basis and upon the request of the healthcare professional the information, profiling data and analysis used to evaluate the provider's performance; and
    - Each provider shall be given the opportunity to discuss the unique nature of the provider's professional patient population which may have bearing on the provider's profile and to work cooperatively with the plan to improve performance.

4.9 Medical Record Documentation

Providers must adhere to Amida Care's Medical Records Review Standard and Criteria. A copy of this standard is available upon request from the Provider Services Department

These activities impact not only Amida Care and its Provider Service Network but, most importantly, the consumer that we all serve and hope to retain. It is possible that an improvement action plan will be requested if a performance measure falls below accepted, evidenced-based standards

Our Member Services Team

Verify Member Eligibility Quick Reference Guide			
Plan Type	**Department**	**Member Appeals**	**Hours**
Medicaid Amida Care Live Life • HIV • Homeless • Transgender/non-binary (TGNB)	NY Medicaid Choice: Call: 800-505-5678 Amida Care Member Services 800-556-0689	Att: Amida Care Appeal Department 1120 Pittsford-Victor Road Pittsford, NY 14534	Monday – Friday 8:00am to 6:00pm Saturday 10:00am to 6:00pm Except National Holidays

5.1 Member Services Overview

Member Services: Amida Care's Member Services Department strives to ensure that all members understand their rights and responsibilities as well as the care and service options that are available to them through enrollment in the Plan.

It is the policy of Amida Care to provide all members and providers with courteous, accurate, and timely service for their requests and needs. Amida Care receives a wide variety of calls throughout the day relating to the provision of services to our members. The Member Services Department serves as a centralized resource, providing support for member education on managed care and Amida Care's benefits and services.

In addition, the department responds to member inquiries and complaints, and facilitates access to appropriate medical and preventive health services and health education programs. Specially trained, multi-lingual staffs are available at the hours listed below. In the event that the multilingual staff cannot accommodate a language need, third party language line interpreters are available. Members and providers that need help after hours, on weekends and holidays, should call us at the same number and our live voice after-hours service will provide assistance, or take a message for the Amida Care Member Services staff. To reach member services call 1-800-556-0689.

5.2 Members Requirements

HIV Positive

HIV positive Medicaid members may be enrolled in the Plan, subject to verification of HIV infection within ninety (90) days of the effective date of enrollment. Acceptable verification of HIV infection shall include one of the following laboratory test results or other diagnostic tests approved by the AIDS Institute:

- HIV antibody screen assay;
- Viral Identification Assay (e.g., p24 antigen assay, viral culture, nucleic acid [RNA or DNA] detection assay) or
- CD4 Level Measurement of less than 200. For patients currently under treatment without diagnosis- confirming laboratory results and with undetectable viral load, a physician's statement verifying HIV status will be accepted when other verifying tests are not available.

Children of member under 21 even if the child does not have HIV or AIDs including member's child in Foster Care

Homeless
Members identified on the Human Resources Administration (HRA) homeless roster likewise qualify for the Plan and may remain enrolled in the Plan until the member has achieved an extended period of housing stability. To be verified as homeless, the member must have evidence of having accessed services in DHS shelters or drop-in centers. If the member is not connected to New York City Department of DHS, then an attestation by a certified organization providing homeless services to the member can suffice.

Transgender/non-binary (TGNB)
Members identified as transgender/non-binary (TGNB) also qualify for the plan. Acceptable verification of transgender/non-binary (TGNB) status include:

a. A signed and dated statement from a physician, nurse practitioner or physician assistant who has treated, or reviewed and evaluated the gender related medical history of the member, including language that the member has undergone appropriate clinical treatment for a person diagnosed with gender dysphoria. This can be in the form of a support letter for a gender affirming service, or a signed and dated gender marker change letter.
b. A signed and dated TGNB provider attestation, attesting to the member's status as a transgender/non-binary (TGNB) person and their involvement in the provider's care;
c. A copy of a Certified Amended Birth Certificate; or a passport; or a New York State Driver's License; or a Non-Driver ID card; or a statement from the Social Security Administration reflecting the change in gender designation.

5.3 Methods for Verifying Member Eligibility

Plan Type	Department	Hours
Amida Care Live Life • HIV • Homeless • Transgender/non-binary (TGNB)	EPACES – Eligibility Plan Code is OD	Monday – Friday 8:00am to 6:00pm

For a provider claim to be paid, a member must be eligible at the time of services. Providers are

responsible for checking a member's eligibility before any non-emergent services are provided. Member eligibility can be verified online at the Amida Care website or by calling Member Services. Medicaid eligibility can also be verified on EPACES, the state's web-based eligibility verification system.

At the time of services, members should present a member card. Verify the PCP's name on the member ID Card. If a member has recently changed from one PCP to another, the member's new PCP may not be on the card. Please call Member Services to verify eligibility. Specialist and other providers are responsible for sending reports of care to the member's PCP of record. Below is a quick reference guide to be used when checking a member's eligibility.

5.4 Member Rights and Responsibilities

Amida Care Members have the right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services you need from Amida Care.
- Be told by your PCP the current information concerning a diagnosis, treatment and prognosis in terms and language that you expect to understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use Amida Care complaint system to settle any complaints or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Member Responsibilities

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.

- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

5.5 Member Enrollment Services

All Medicaid Special Needs applicants must enroll through New York State Medicaid. If you have a patient that is interested in enrolling in an Amida Care product, please direct them to the appropriate Amida Care department. Your patient must call Amida Care directly to enroll. We will take it from there to walk them through the process, verify their eligibility and provide them the information they need to make an informed decision. If you have a Medicaid member who is HIV positive and interested in enrolling in Amida Care's Live Life Plus plan, they must contact the Enrollment Broker, New York Medicaid Choice at 1-800-505-5678. See the quick reference guide below with the phone number and hours of operation.

Disenrollment and Enrollment Lock-in Periods: Some plans have lock-in periods that may prevent a Medicaid recipient from switching plans at any time. Please check the reference guide below for the permissible

Enrollment Lock-in Quick Reference Guide
When Can Member Enroll or Change Plan?
• First 90 days of enrollment • After 90 days and before 12 months consumers may change to an HIV Special Needs Plan at any time • After 1-year consumers can change plans

Newborn Enrollment for Amida Care Live Life Plus Members: Amida Care Live Life Plus Members who give birth while covered by Amida Care automatically have health care coverage for their newborn, unless the mother specifies that she does not want the child.

Consultation with the Quality Management Committee (QMC) will advise Provider Services of any additional information that is needed.

5.6 Members Selection and Change of Primary Care Provider (PCP)

If a member has not selected a PCP during enrollment, a letter advising the member of the need to select a PCP is sent with the Amida Care Provider Directory. The Member Services Department will assign a PCP for the member within 30 days of his/her effective date based upon criteria noted above. PCP assignments made by the Plan are based upon various criteria including geographic convenience to the member, member age, special health needs and PCP panel size, and/or language capability. Upon PCP assignment, a confirmation letter is sent to the member. Upon receipt of confirmation letter, the member still has the option to select a different PCP.

Member Change of PCP: Plan members (unless part of the restricted recipient program) may change their PCP for any reason by calling Member Services or submitting a written request. The Member Services department upon request by the member processes the change. The change is effective immediately.

5.7 Member Card

Members Amida Care Identification card on the day the member enrollment is processed. The Member will received the ID within 10 calendar business days following the request.

5.8 Member Handbook and Evidence of Coverage

All Amida Care members receive a New Member Kit which includes a Member Handbook or Evidence of Coverage booklet. These booklets describe how the member can access services and the benefits of their plan. Copies of these booklets as well as other Plan materials such as benefit summaries are available to providers as a reference on the Amida Care website at www.AmidaCareNY.org.

5.9 Member Complaints, Grievances and Appeals

Amida Care seeks to serve our health plan members well. But if a member has a concern or problem, as the Member Handbook or Evidence of Coverage advises, the member or a representative on the member's behalf should:

- First talk with their Care Team or Physician or PCP; or
- Call Member Services; or
- Write to Amida Care. See the quick reference guide below for the address by plan type.

Member has the right to Member complaints/grievances are thoroughly investigated by the (Amida Care) Appeals and Grievance Team. Timelines for filing and resolution are found in the Quick Reference Guide below to understand timelines of resolutions. A member may have a designee file a complaint, complaint appeals and action appeals on their behalf.

A member may contact Member Services at 800-556-0689 for assistance to file complaints, complaints appeals and action appeals.

Member Complaints/Grievance Pre-Service Medical Quick Reference Guide	
Plan Type	**Timeline**
Medicaid Amida Care Live Life Plus – Medicaid HIV/ Homeless Special Needs/ Transgender/non-binary (TGNB) A complaint is any communication by an Amida Care Live Life Plus member to the Plan of dissatisfaction about the care and treatment a member receives from our staff or providers of covered services. Member Services: 800-556-0689	• When a member complaint is urgent (delay would involve a risk to a member's health), the complaint is investigated and resolved between 48 hours and up to 7 days from the date of receipt. • Notice of the decision will be given immediately by telephone with written follow-up mailed within 3 business days. • All other complaints will be resolved within 60 calendar days of receipt of all necessary information. • Once a determination regarding a complaint is made, a letter will be mailed to the member within the timeframes noted above. • If a member is not satisfied with the attempt to resolve the complaint, they may file an appeal. The appeal may be filed in writing or by telephone. • For Medicaid, oral appeals must be followed up by written signed appeal. **2.** Complaint appeals are submitted directly to the A&G department in writing from the date of the resolution letter. Members also have the option of contacting The NY State Dept. of Health (SDOH) (1-800-206-8125) or New York Medicaid CHOICE (1-800-505-5678).

Member Service Appeals and Fair Hearing Quick Reference Guide	
Appeals Mailing Address: Medical Amida Care Appeal Department 1120 Pittsford-Victor Road Pittsford, NY 14534	• Members can also file an Action Appeal if he/she does not agree with an action that Amida Care has taken (like denying or limiting services, or not paying for services). • This appeal request must be filed within 60 business days and no more than 90 days of the date on the notice of Action to file an Action Appeal. Appeals are to be in writing unless an expedited appeal is requested.
Fair Hearing	• A member or their designees has the right and can request a State Medicaid Fair Hearing within 120 days of receipt of a Final Adverse determination. • The Member must exhaust internal appeal process before requesting a Fair Hearing. • Amida Care will provide instruction for requesting a Fair Hearing with the NYS Office of Temporary Disability Agency including the information required with the Final Adverse Appeal determination letter. • The member or their designee can send the letter directly to The New York State Office of Temporary and Disability Assistance Fair Hearings, P.O. Box 22023, Albany, NY 12201-2023 • The member or their designee can make a telephone request for Fair Hearings can be made by calling our statewide toll-free number: 1 (800) 342-3334. • Members have the right to aid continuing and liability of member for services if the denial is upheld in the fair hearing. See Section 9.7 for aid continuing protocol. • The information will be mailed to the member with the Final Adverse Appeal determination letter. • The information will be mailed to the member with the Final Adverse Appeal determination letter.

5.10 Provider Outreach

Amida Care recognizes that the bond between the patient and provider can be strong and that patients often seek guidance from their providers with regard to insurance coverage. Amida Care works with its network providers to provide educational information on the products offered by Amida Care. This information is provided at provider orientation and available upon request.

Amida Care will make informational material available to providers to post in their offices. Amida Care

Enrollment and Retention Specialist will ensure that any provider or facility that is willing to make available and/or distribute Amida Care outreach materials understands it must be willing to distribute or make available plan materials for all plans with which the provider participates.

Providers may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll in Amida Care.

Providers shall not pay any individual, or accept in payment from Amida Care, any commission, bonus, or similar compensation that uses numbers of eligible persons enrolled in Amida Care health plans as a factor in determining compensation.

Permissible and Impermissible Outreach Activities for Providers
Providers who wish to communicate with their patients about Amida Care's options must advise patients to take into consideration ONLY the managed care organizations (MCO) that best meets the patient's health needs. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one plan over another.

Providers may:

- Display the Amida Care's Outreach materials, provided that appropriate material is conspicuously posted for all other MCOs with whom the provider has a contract
- Not conduct "cold call" solicitations
- Not provide mailing lists of their patients to managed care organizations.

Amida Care shall not require providers to distribute Plan-prepared communications to their patients. All Amida Care Enrollment and Retention Specialist shall conduct themselves in an orderly, non-disruptive manner, and shall not interfere with the privacy of potential members or the general community; and Providers shall not target individuals and families who are already enrolled in managed care plans.

Additional Guidelines:
Amida Care conducts its outreach activities in strict compliance with the New York State Department of Health Guidelines.

Amida Care's outreach policies mandate that providers:

- Are not permitted to have conversations or conduct any activities for the sole purpose of persuading persons to join Amida Care
- Must identify all Health Plans with whom they are affiliated, if they choose to provide such information (orally or written) to their patients
- Must not provide lists of potential members to Amida Care and should be aware that Amida Care will not accept lists of potential members from its network of contracted providers

HIV SNP Outreach Rules for Providers:

Requirements: The HIV SNPs in New York City are contracted with the New York State Department of Health and are subject to contractual terms and conditions including comprehensive outreach guidelines.

Outreach. Outreach is defined broadly in the Amida Care contracts and is not limited to traditional "sales pitches" by health plan Enrollment and Retention Specialist. Instead, "outreach" encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

Outreach Guidelines. The contractual outreach rules apply not only to the Amida Care and its employees, but also to any subcontractors or individuals or entities affiliated with the Amida Care. Hospitals, clinics, physicians, and other providers belonging to the provider network of a SNP are considered subcontractors and are subject to the outreach guidelines.

Summary of Rules for Providers:

Written Outreach Materials: Written materials generated by providers must be approved by DOH, Office of Health Insurance Programs. Materials should first be submitted to Amida Care for review and approval.

Written materials must contain certain specified information to ensure that potential Amida Care members receive basic information. A model letter has been approved for use by providers to communicate information about HIV SNPs to their patients; see sample letters in English and Spanish in the next section. No further review will be required if the model letter is used. However, any modifications to this letter must be approved by DOH.

Outreach Encounters

Outreach encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular Amida Care.

All Outreach encounters must communicate at least the following information:

- A statement that participation is mandatory as of September 2010, and that persons with HIV/AIDS may choose an Amida Care or join or remain in a mainstream Medicaid health plan.
- The potential member will have a choice among several plans. Upon enrollment in a Amida Care, the member will be required to use his/her HIV Experienced Providers and other plan providers exclusively for medical care, except in certain limited circumstances.
- Newborns of a mother enrolled in Amida Care will automatically be enrolled in the mother's Plan. The infant may be disenrolled at any time at the mother's request.

Providers who wish to let their patients know of their affiliation with one or more HIV SNPs and with Medicaid Managed Health Plans must list each plan with whom they hold contracts.

Outreach Conduct

- Outreach encounters are to be conducted in a manner that does not disclose nor breach the confidentiality of the potential member's HIV status.
- Providers may not give mailing lists of patients to Amida Care.
- Providers may not target mailings to HIV/AIDS patients, or patients with a significant

probability of having HIV/AIDS unless the patient has consented in writing to mail contact. This is to protect patient confidentiality.

- Some providers, such as facilities specializing in HIV/AIDS care, should consider handouts of literature rather than a mailing to avoid confidentiality problems.

Our Health Services Team

Health Services Quick Reference Guide			
Health Services	**Fax**	**Standards of Care – Clinical Practice Guidelines**	**Hours**
Phone: 888-364-6061	Fax: 888-273-8296	https://www.amidacareny.org/provider-services/provider-resources/	Monday-Friday 8:00am to 5:00pm

6.1 Clinical Standards of Care

Providers are expected to use the above guidelines that are accepted as national standards as decision support tools to standardize practices. These standards of care are reflective of professional and generally accepted standards of medical practice.

6.2 Amida Care Coordination Model - Integrated Care Team (ICT)

The Integrated Care Team (ICT) coordinates care for Amida Care members and works with members to maintain their physical and behavioral health. The ICT intervenes where appropriate to make sure those plan members with acute health care needs are monitored closely and their subsequent physical health, behavioral health and psychosocial needs are being appropriately addressed. The ICTs facilitate coordination and communication between medical providers and behavioral health providers to co-manage care in an effort to enhance care planning and services provided, which leads to improved health outcomes. From time to time when appropriate, the retention for care unit will operate as Community Liaisons.

Amida Care's model of care coordination centers on member engagement. The ICT is designed to effectively manage members with HIV and multiple co-morbidities, as well as to identify barriers to care. Such barriers include psychosocial issues, behavioral health needs, substance use issues, inadequate housing, financial needs, transportation, and/or access to new services. Once barriers are identified, the ICT works to eliminate them through referrals to appropriate internal resources including the Retention Care Unit before local community-based providers and organizations.

Each member is assigned to an ICT, which is comprised of a team of Amida Care staff that work in collaboration with the member, family/supports, health home (where applicable), the PCP and other providers to ensure that unique needs are met, and self-identified health-related goals are achieved. The core team of the ICT includes staff with knowledge in physical health, retention in care and case management. Also available to all ICT's are content experts in behavioral health, pharmacy, treatment adherence, housing, community-based outreach, and long-term care.

Various data is used by the ICT for care coordination. The data sources used include the following:

- Claims or encounter data – identify members with specific diagnoses, high-cost members,

and utilization of services

- Hospital discharge data – identify specific diagnoses, inpatient stay services and readmission patterns
- Pharmacy data
- Data collected through the UM processes – identify members through emergency room visits, hospital admission including current and prior authorization review processes.
- Review of Laboratory results and/or data

Integration of physical and behavioral health is facilitated through the multidisciplinary team collaboration and by ICT interventions such as connecting members to appropriate providers and community-based organizations. This includes management of the transition from acute care settings back to the community with ongoing monitoring of member needs to ensure community tenure. Progress of the case is tracked through case review, discussions with physical and behavioral health providers, Health Home staff when appropriate, and community-based treatment providers.

The care coordination program is structured to include the assessment of the member's medical, behavioral health, social, cultural, lifestyle and support needs. Because these members are seeing multiple providers, are taking multiple medications, and have multiple chronic conditions, the Care Coordinator works with the member and their caregivers when necessary, to identify services and care needs including possible gaps in care including medication reviews. The Care Coordinator will coordinate care with the member's PCP and providers and seek the assistance of a pharmacy technician who is part of the Care Team to identify any opportunities to improve the medication treatment or compliance issues. In addition, the Care Coordinator will support the member and their caregivers to help them understand their conditions, early symptoms, and how to manage those and the multiple medications.

Core team members are listed below. Ad Hoc Specialists from Amida Care and external services are called upon as needed and are listed in the third column of the quick reference guide.

Care Team Quick Reference Guide			
Plan Type	**Core Care Team**	**AD HOC Care Specialists**	**Care Model**
Medicaid *Amida Care Live Life Plus –* *Medicaid HIV/ Homeless Special Needs* *Care Coordination: 888-364-6061*	• Member • Care Giver • PCP • Care Coordinator • Case Manager Coordinator • Health Services Specialists • Health Navigator • Community Health Outreach Worker (CHOW)	• Amida Care Housing Coordinator • Amida Care Pharmacy Tech • Amida Care Member Service Representative • Amida Care Long Term Care Coordinator • External Case Manager • Representative from BH Vendor including Clinical and Case Manager • Representative from Health Home • ADHC Representative • PCA or Home care agency staff including nutritional support • Rehabilitation specialists such as Occupational, Physical, or speech therapists from a contracted provider • Pastoral Care specialists from a contracted hospice or hospital • End of Life specialists from a local hospice • Other medical specialties from the contracted provider network	Intake Assessment within 30 days by Member Services if not completed by enrollment broker ↓ Initial Comprehensive Assessment 60 days by External Case Mgr. if member accept case management Reassessment every 180 days ↓ Care Coordination with PCP, Providers and Care Team

Integrated Care Team Members Role Descriptions

Care Coordinator (CC) is a qualified clinical professional such as a registered or license practical nurse, who functions as the ICT Team Lead, and assists with coordination of services based on the specific need(s) of the member. The Care Coordinator facilitates communication between the member and members of the Care Team. The CC monitors service delivery and oversees the physical health utilization management process. In addition, s/he is responsible for oversight of services provided by contracted providers through review of assessments, service plans and routine interaction with the providers and agency staff. The CC tracks member's utilization of services and adherence to treatment through review of claims. They document the request for services in the member's file and circulate the request to the other members of the Care Team for review and incorporation into the Care Plan. If the request is urgent, the Care Coordinator works with the Case Manager for immediate review.

The Care Coordinator is also an advocate for the member, ensuring the provision of member education, works closely with the Member Services Department in providing information to members, clarifying benefits, and answering general questions and assisting members in getting an appointment or filing a complaint. The Care Coordinator works with the Provider Services Department to assist with provider training regarding utilization management, supportive case management, and policies and procedures of care coordination.

Case Coordination/Management Claims Submission visits thresholds have been established based on the benefit package, which is defined as supportive case management. Providers may bill up to:

- If a provider submits claims for case management visits grater than the threshold for a specific member, the claim will be denied for the units above the threshold. The provider can appeal this claim by following the Plan's appeal process and submitting supportive documentation with the appeal.

G9012	CMS Sessions (s), 15 minutes. Indicated # of units (excludes travel time); Note CM session should not be billed when providing escort services; see acceptable Escort codes below.
CPLAN	CM Assessment submissions- to ensure payment Assessments must be submitted to Care Coordination at **888-364-6061**
ESCRT	Escort, Roundtrip
G9007	Care Team Conference, 15 minutes. Indicate number of units utilized when the provider/CM staff conferences Amida Care's Care Coordination regarding a member's case and/or services in an effort to establish and implement a plan of action for members who require additional Amida Care support.
TVGP	Therapeutic Group (s)/Per Member

Primary Care Provider (PCP) is an internal medicine, family practice, pediatrician or general practice physician who manages the medical care of the member including all specialty services. The PCP is responsible for an initial physical, routine medical care and the coordination of the member's overall care. In this role, the PCP provides referrals for specialty care and ancillary services and ensures that continuity of care is maintained as well as completes a treatment plan for each member.

Member's Primary Care Physician is responsible for assisting the care teams in any new needs identified medically as well as psychosocial needs.

The PCP works with the member to address issues related to adherence, primary and secondary prevention, public health issues (such as TB/DOT), and treatment planning. The PCP provides oversight of the member's behavioral health services, including the completion of the mental health and behavioral health annual screening. The PCP works in close collaboration with the other Care Team members.

Every member must select a PCP. Guidelines for a PCP include the following:

- Adult members enrolled in the HIV SNP Medicaid Special Needs programs must have a PCP who is an HIV Specialist.
- If a member is using behavioral health clinic that also provides primary care services, member may select lead provider to be PCP as long as it meets the HIV Specialist requirements.
- A Homeless HIV diagnosed Amida Care member may designate a shelter physician, who may not be HIV experienced, as his or her PCP while in the shelter system.
- If a newly enrolled homeless HIV infected person is engaged in care with a PCP who is not HIV experienced, Amida Care may designate that PCP until such time as the member can be transitioned to an HIV experienced PCP.
- In both cases, Amida Care will employ a co-management model in which an HIV Specialist assists the non-HIV experienced PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the non-HIV experienced PCP. Amida Care will provide the AIDS Institute with evidence of this ongoing co-management on request.

Case Manager Coordinator (CMC) The CMC works with external case management entities to ensure that psychosocial assessments are completed at intervals that meet the needs of the member and comply with regulatory requirements. For those members not connected to external case management agencies, the CMC completes the psychosocial assessment within regulatory timeframes. The CMC also provides psychosocial support to members as well as referrals to providers and organizations that can assist with meeting member psychosocial needs.

Health Services Specialists are responsible for supporting the Health Services operations by providing administrative support, conducting member and provider outreach to obtain information and to educate on Amida Care policies, care coordination activities, community resources and how to access plan benefits; and completing routine data entry and reporting.

Medical Director provides oversight of the medical management program. The Amida Care Medical Director is a board-certified medical doctor who is responsible for ensuring that providers adhere to the use of clinical practice guidelines. The Medical Director is an integral team member working with the Plan's PCPs, specialists, and the beneficiary.

Outreach and Retention in Care Resources

Amida Care's Integrated Care Team includes resources to prevent members from falling out of care

and to re-engage members who have done so. It has been well documented that psychosocial factors such as homelessness, mental illness, substance use, and lack of financial resources, among others, can be a significant barrier in establishing and maintaining regular medical care. In addition, ancillary services such as case management, mental health treatment, substance use treatment, housing services, transportation, translation, and legal services play a substantial role in keeping patients connected to medical care. These resources address barriers to accessing regular medical care with a PCP or HIV specialist, and link Amida Care members with community service providers who will afford them ongoing management of their bio-psychosocial needs. These resources include:

- Community Outreach Specialist
- CHOWS

Community Outreach Specialist work with members who have fallen out of care, as defined by not having a primary care appointment with an PCP in six months or more, or members who have been identified as being at risk for falling out of care by their PCP, Care Coordinator, or other community based provider. Community Outreach Specialist work with members anywhere from 60 days to 6 months, depending on need.

Community Outreach Specialists provide the following functions:

- Conduct needs assessments to determine what services members need to be connected to
- Develop individualized member goals and objectives
- Refer and connect members to appropriate services/service providers
- Schedule intake/initial appointments at indicated facilities
- Escort members to initial appointments and if needed ongoing appointments
- Escort members to PCP appointments
- Provide transportation to members when appropriate
- Follow up with service providers
- Follow up with members
- Provide health education and promotion
- Treatment adherence education

Community Outreach Specialists are professional staff, all of whom have a background in HIV Case Management and/or Community Outreach NYS Mandated Reporters and trained in motivational interviewing techniques. Community Outreach Specialists provide:

- Health Education
- Health Promotion
- Treatment Adherence Education

Community Health Outreach Workers (CHOW). Amida Care's Retention in Care Unit uses specially trained, professional peer Community Health Outreach Workers (CHOWs) to assist a select group of members and serve as a bridge between the members, the healthcare and social systems, and the health plan. CHOWs provide their assigned members with information and specialized services so that they will engage in their healthcare. CHOW's work with members on a short term basis and generally have one to two contacts with them.

CHOWs provide the following functions:

- Escort - assist to and from appointments;
- Community Canvasser - outreach to members who have failed to attend their initial appointments;
- Translator- clarify benefits and access to services; and
- Buddy - check on assigned caseload regularly to assess progress in adherence to care plan and assist with any emerging needs; and
- New Member Orientation – conduct face-to-face orientation when member services is unable to connect with member over the phone.

To refer a member for retention in care services, please contact the member's care coordinator or Manger of Amida Care Outreach Programs.

6.3 Health Home – Care Coordination/Management

Health Homes is a Medicaid reimbursable care management service model where all of an individual's caregivers communicate with one another so that patient's needs are addressed in a comprehensive manner. A Health Home provider is the central point for directing patient-centered care. The Health Home is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; and providing timely post discharge follow-up. The goal is to improve patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Adult Amida Care members can be offered Health Home Care Management services if:

- They have two (2) or more chronic conditions
- They are identified as having a Serious Mental Illness (SMI)
- They are HIV Positive
- They are qualified for a Health and Recovery Plan (HARP)

Amida Care receives and reviews the Health Home Assignment File and the Health Home Enrollment File from New York State. Amida Care coordinates member's enrollment into the Health Home. Every effort is made to assign a member to a Health Home in his/her community or with a known provider. Amida Care can also refer members for Health Homes who have been determined to meet Health Home eligibility requirements by Plan staff or providers. Providers can refer members who they believe meet Health Home requirements to the Integrated Care Team (ICT). The Integrated Care team will review the member's service utilization and make the necessary referrals when appropriate. The ICT will evaluate member's eligibility for Health Home during case reviews especially when the following triggers are identified:

- Rapid inpatient readmissions or ER utilization
- Member has not been adherent to medications
- Member is lost to care including primary and behavioral health

Amida Care monitors the member status with the health home and supports member engagement when necessary. Members have the opportunity to opt out of the Health Home benefit at any time if they so choose.

Amida Care's Health Home Unit is reached through Amida Care's main phone line or HealthHomeUnit@amidacareny.org

6.4 Primary Care Provider – Care Coordination/Management

Primary Care Provider (PCP) is an internal medicine, family practice, pediatrician or general practice physician who manages the medical care of the member including all specialty services. The PCP is responsible for an initial physical, routine medical care and the coordination of the member's overall care. In this role, the PCP provides referrals for specialty care and ancillary services and ensures that continuity of care is maintained as well as completes a treatment plan for each member. Member's Primary Care Physician is responsible for assisting the care teams in any new needs identified medically as well as psychosocial needs.

The PCP works with the member to address issues related to adherence, primary and secondary prevention, public health issues (such as TB/DOT), and treatment planning. The PCP provides oversight of the member's behavioral health services, including the completion of the mental health and behavioral health annual screening. The PCP works in close collaboration with the other Care Team members.

Every member must select a PCP. Guidelines for a PCP include the following:

- Adult members enrolled in the HIV SNP Medicaid Special Needs programs must have a PCP who is an HIV Specialist:
    - select lead provider to be PCP as long as it meets the HIV Specialist requirements
- A Homeless HIV diagnosed Amida Care member may designate a shelter physician, who may not be HIV experienced, as his or her PCP while in the shelter system.
    - If a newly enrolled homeless HIV infected person is engaged in care with a PCP who is not HIV experienced, Amida Care may designate that PCP until such time as the member can be transitioned to an HIV experienced PCP.
    - In both cases, Amida Care will employ a co-management model in which an HIV Specialist assists the non-HIV experienced PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the non-HIV experienced PCP. Amida Care will provide the AIDS Institute with evidence of this ongoing co-management on request.

6.5 Obstetrician/Gynecologist – Care Coordination/Management

Members have access to Obstetrician/Gynecologist (Ob/Gyn) care from any in-network provider without referral from their assigned PCP.

An OB/GYN is responsible for providing and managing medical care for obstetrical and gynecological conditions. This includes but not limited cervical cancer screening, mammography screening services, and annual chlamydia testing for women of child-bearing age, and three doses of HPV vaccine between the ages of nine (9) and thirteen (13). Additionally, providers should treat any

gynecological-related clinical condition.

- Members may choose to receive Family Planning and Reproductive Health services from a nonparticipating provider who accepts Medicaid for these services (also known as “Free Access Policy”). Family Planning and Reproductive Health services mean the offering, arranging, and furnishing of those health services that enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. This does not include obstetrical care for pregnancy.
- OB/GYN providers and nurse midwives shall deliver prenatal care to pregnant members according to American College of Obstetricians and Gynecologists (ACOG) standards and New York State's Prenatal Care Standards for Managed Care Plans.

6.6 Specialty Care – Care Coordination/Management

Specialists’ provider work in partnership with Primary Care Providers (PCPs) to provide appropriate, quality medical care to Amida Care members. PCPs refer members to specialists for specific services based on evaluation, diagnosis, and direction of care. Specialists play a critical role by providing efficient care within their area of expertise and within the scope of the provider license.

6.7 Social Care Networks

Effective January 1, 2025, the New York Health Equity Reform (NYHER) 1115 Waiver Demonstration established regional Social Care Networks to help ensure that Social Care needs are met for individuals and families who are Medicaid Members. The role of Social Care Networks (SCNs) is to identify Member’s unmet social needs, connect Members to HRSN services, and sustainably reimburse organizations screening Members, navigating Members to services, and providing HRSN services. SCNs include a range of HRSN service providers, including community-based organizations (CBOs) and other partners (e.g., regional non-profits), alongside health care providers)

Who are our Social Care Network Providers?

SCNs	By Borough	Website
Public Health Solutions	Manhattan, Queens, Brooklyn	https://www.healthsolutions.org/
Staten Island Performing Providers System (SIPPS)	Richmond	https://statenislandpps.org/
Somos Healthcare Providers, Inc.	Bronx	http://www.somoscommunitycare.org/

What Can You Expect from the Social Care Network(s)?

- **Seamless Collaboration:** Connect with other providers, social services, and community organizations to deliver holistic care to patients.
- **Comprehensive Resources:** Access educational materials, tools, and training programs designed to improve social care practices.
- **Streamlined Referrals:** Simplified processes for referring patients to needed social services and ensuring timely follow-up.

- **Impactful Outcomes:** Contribute to the creation of stronger, healthier communities by addressing the broader factors affecting patient health.

What types of Services?

New York State Medicaid is expanding coverage of certain services that address Health Related Social Needs (HRSN), as evidence indicates that these benefits are critical drivers of patients access to health services that keep them well and will improve health outcomes. There are four categories of enhanced HRSN services reimbursable under New York's 1115 Waiver Demonstration, such as: Nutrition, Housing, Transportation, and Social Care management. For more information, please use the link below:

https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/intro_hcp_guide.pdf

Why partner with Social Care Network(s)?

We believe in building partnerships that help our members lead healthier, more fulfilling lives. By joining the Social Care Network(s), you'll be equipped with the knowledge and support to meet the growing demand for social care, reducing health disparities and improving health outcomes.
HRSN service providers are primarily CBOs but may include larger non-profits, health care, or in some cases private sector entities. Service providers should reflect the diversity and unique needs of each region. HRSN service providers may be but are not limited to:

- Community-based organizations (e.g., food banks and pantries, supportive housing organizations, voluntary foster care agencies) and regional non-profits
- Health care providers (e.g., hospitals with food prescription offerings in partnership with CBOs or directly)
- In some cases, for-profit service providers (e.g., private transportation companies, nurse-family partnerships, grocery stores) may also participate.

There is no minimum or maximum number of participating HRSN service providers in each regional SCN. If they are active in multiple regions, they may contract with multiple SCN Lead Entities.

What services are reimbursable?

SCN Lead Entities can reimburse service providers within their regional SCN for the provision of screening, navigation, and enhanced HRSN services to qualifying Members, based on a regional fee schedule.

How can health care providers be reimbursed?

To receive reimbursement, health care providers must:

- Contract with a regional SCN
- Do at least one of: screen Members for HRSNs using the AHC tool in the SCN IT Platform, provide social care navigation to help Members access to services, or provide enhanced HRSN service(s)
- Remain in Medicaid Good Standing by meeting state licensure requirements

- Follow agreed upon terms as outlined in contract with SCN Lead Entity
- Complete training and onboarding to the SCN IT platform include meeting data and reporting requirements

Amida Care Contact Information

Provider Services	Member Services	Utilization Management	Claims Department
646-757-7000 mproviderservices@amidacareny.org	800-556-0689	888-364-6061	800-556-0674

Our Benefits Covered Services Overview

Providers can reference a complete summary of member benefits including supplemental benefits in the Amida Care Benefit Guide. The below link is a summary of key benefits and services.

Benefits Covered Services Quick Reference Guide	
Plan Type	**Benefits Care Coverage Guide**
Medicaid - Amida Care Live Life • HIV • Homeless • Transgender/non-binary (TGNB)	https://www.amidacareny.org/provider-services/utilization-management/

7.1 Informing Member of Non-Covered Servces

If services are not covered by the Plan, the provider must advise the member, prior to initiating service, that the service is uncovered and disclose the cost of the service, which may be covered by other funding sources. The provider must inform members that they will be personally responsible for all fees related to services that are not covered by the Plan or/and Medicaid, and obtain an executed acknowledgement of financial responsibility from the member or the member's legal representative. Only if these steps have been taken shall the provider be entitled to bill the member directly and collect for such services. Provider may not bill the member for services covered by the Amida Care, except for applicable co-pays, co-insurance or permitted deductibles.

7.2 Case Management

Assessment Mail Address:	Document Fax:
Att: Case Management Coordination 14th Pen Plaza , 2nd Floor New York, NY 10122	1-646-786-1802

Part of the new member orientation process is to ascertain if a member is receiving Case Management services. If a member has a relationship with a Case Manager, whether that case manager is at an ADHC, Health Home, PCP site or Community Based Organization, the goal of Amida Care is to ensure that the member's services are not disrupted. Case manager selections are communicated to the case management agencies on regular rosters and/or member data records. Rosters identify members that will require outreach, orientation and an initial or follow up Case Management Psychosocial Assessment. All assessments are submitted to the Integrated Care Department. Documents should be mailed or faxed to 646-786-1802, Attention: Case Management Coordination. If a member declines case management services, the Amida Care case manager coordinator will reoffer case management services

every 180 days when they attempt to conduct a reassessment.

Documentation and Time Frames. Amida Care staff will attempt to perform an initial Case Management assessment within 30 days of a member's enrollment. If the member accepts Case Management, the external/psycho-social Case Manager or Amida Care Case Manager Coordinator will complete an Initial Comprehensive Assessment and a Service Plan within 60 days. The external/psycho-social Case Manager or Case Management Coordinator will also perform and submit reassessments every 180 days. Additionally, they will submit copies of member assessment; reassessments, service plans and service plan updates to the Amida Care Case Management Team. All other documentation, including case contact dates and summaries, shall be maintained in the member's Amida Care Data Base, and made available for scheduled audits as requested by Amida Care, and/or as a component of regulatory audits conducted by the *New York State Department of Health* or by an agency on behalf of the *New York State Department of Health*.

Assessments

During new member orientation (NMO) member services conducts a mini-screen of a member's psycho-social needs within their first 30 days of enrollment. At that time a Health Risk Assessment (HRA) is also conducted if not previously done by Maximus and communicated to the plan via the e-file. Needs identified through the NMO auto-generate services for the ICT team to review. If a member accepts case management services their needs are communicated from the team to their case manager. The case manager is responsible for ensuring a comprehensive assessment is conducted within 60 days of enrollment into the plan.

7.3 Emergency Services

The term "emergency medical 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:

- placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or
- Serious impairment to such person's bodily functions; or
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency services include health care services and procedures, including psychiatric stabilization and medical detoxification from drugs or alcohol, furnished in the emergency department of a hospital or a specialized psychiatric emergency room.

In the event of an emergency medical condition, the member is encouraged to go to the closest emergency room or the nearest hospital, or to call 911 for assistance. Members are requested to contact Amida Care and/or their physician or PCP of choice within 48 hours of the emergency, or as soon as reasonably possible as instructed on their membership identification card, Member Handbook and or

Evidence of Coverage.

Emergency services, including CPEP, are not subject to prior approval. Behavioral Health Crisis Intervention and OMH/ OFFICE OF ADDICTION SERVICES AND SUPPORTS specific non-urgent ambulatory services are not subject to prior approval.

If a member who is having a behavioral health crisis or emergency contacts the Amida Care member services 800-556-0689 number, the member services representative will transfer the call to Carelon Behavioral Health while remaining on the call until Carelon's representative is on the line. The member services representative may also transfer the call directly to a clinician at Carelon Behavioral Health and remain on the call until the clinician is on the call. Amida Care Member Services documents calls transferred to Carelon Behavioral Health and a report of members transferred are submitted to the Plan for follow up with the member and the member's providers on the next business day. Carelon Behavioral Health also provides a report of all emergency and crisis calls on the next business day to Amida Care.

The provider is required to contact the Plan withing 48 hours of admission.

7.4 National Diabetes Prevention Program (NDPP)

The National Diabetes Prevention Program (NDPP) is an evidence-based educational and support program, taught by trained Lifestyle Coaches, that is designed to prevent or delay the onset of type 2 diabetes. This benefit will cover 22 NDPP group training sessions over the course of a calendar year and is taught using a trained lifestyle coach.

Eligibility

Members may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

Also, they must meet *one* of the following criteria:

- They have had a blood test result in the prediabetes range within the past year, or
- They have been previously diagnosed with gestational diabetes, or
- They score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test: https://www.cdc.gov/prediabetes/takethetest/

7.5 Gender-Affirming Surgery (GAS)

Amida Care covers certain gender-affirming surgery (GAS)). We feel this is a significant aspect of medical care for transgender/non-binary (TGNB) and gender-diverse individuals and that it is essential for healthcare providers to have accurate and comprehensive information about these procedures to offer appropriate and respectful care to their members. Amida Care members seeking GAS must have a

diagnosis of Gender Dysphoria and require specific support letters and clinical documentation to be submitted for review upon request for GAS.

GAS Services Quick Reference Guide	
Gender-Affirming Department Contact	**Inquiries Contact Email:**
646-757-7982	GIST@amidacareny.org

NYS Medicaid covers the following GAS procedures:

1. Chest/Breast Surgery (Top Surgery
2. Genital Reconstruction (Bottom Surgery):
3. Pre-op electrolysis

Amida Care is committed to providing medically necessary GAS to help alleviate Gender Dysphoria. The following:

GAS procedures are reviewed for medical necessity: (note: this is not an all-inclusive list)

1. Facial Feminization and Masculinization Surgery (FFS/FMS):
2. Voice feminization therapy and surgery
3. Body Contouring
4. Facial and Body electrolysis

A. Indications of Coverage

GAS is reasonable and necessary when the member demonstrates:

1. Persistent, well-documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Member is eighteen (18) years of age or older;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
5. For genital surgeries: 12 continuous months of hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual.
6. For breast/chest surgeries*:* Hormone therapy is not a prerequisite for FTM members. For MTF patients, it is required that members undergo feminizing hormone therapy for a minimum 24 months prior to breast augmentation surgery, unless clinically contraindicated.
   These criteria do not apply to members who are having these procedures for medical indications other than Gender Dysphoria.

B. Documentation Requirements

Gender affirming procedures shall be covered for a member who is eighteen (18) years of age or older and has letters from two qualified New York State licensed health professionals who have independently assessed the individual and are recommending the individual for the surgery and/or procedure. Certain GAS require clinical documentation that demonstrates the medical necessity of the procedure to help alleviate the member's gender dysphoria.

Letters Of Support For Diagnosis Of Gender Dysphoria:

- Two letters of support are required for any service or surgery for the treatment of gender dysphoria.
- One of these letters must be from a psychiatrist, psychologist, nurse practitioner, psychiatric nurse practitioner, or licensed clinical social worker with whom the member has an established and ongoing relationship.
- The other letter may be from a psychiatrist, psychologist, nurse practitioner, physician, psychiatric nurse practitioner, or licensed clinical social worker acting within the scope of his or her practice, who has only had an evaluative role with the member.
    - It is recommended that one letter come from the member's primary care provider.
- The *totality* of the referral letters together must establish the following and must be written within 12 months at the time of surgery request:
    - Member has persistent and well-documented gender dysphoria;
    - Has received hormone therapy appropriate to the member's gender goals, which shall be for a minimum of twelve (12) months in the case of a member seeking genital surgery or twenty-four (24) months that resulted in negligible breast growth in the case of a member seeking MTF breast augmentation surgery, unless such therapy is medically contraindicated, or the member is otherwise unable to take hormones;
- Hormone therapy is necessary if it is appropriate to the member's gender goals recommended by the member's treating provider, clinically appropriate for the type of surgery requested, not medically contraindicated, and the member is otherwise able to take hormones.
- Has lived for twelve (12) months in a gender role congruent with the member's gender identity, and has received mental health counseling, as deemed medically necessary, during that time; there is no requirement that mental health counseling be provided continuously for twelve (12) months prior to surgery.
- Has no other significant medical or mental health conditions that would be a contraindication to gender affirmation surgery, or if so, that those are reasonably well-controlled prior to surgery;
- Has the capacity to make a fully informed decision and to consent to the treatment

For more information, please visit our website: https://www.amidacareny.org/wp-content/uploads/Amida-Care-GD-Clinical-Guidelines-Approved-8-29.pdf

C. Providers of Gender Affirming Surgery

Physicians who provide surgical treatments for Gender Dysphoria should have appropriate credentials and training for the procedures they provide. Commonly these surgeons are board certified gynecologists, general surgeons, plastic surgeons, otorhinolaryngologists, and urologists. Surgeons who perform genital surgeries should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon.

D. Common CPT Codes

Contact the Amida Care Provider Services for the list of common CPT codes associated with Gender Affirming Surgeries.

7.6 Third-Party Service Providers

A. Pharmacy

Beginning in April 1, 2023, all Medicaid members enrolled in Amida Care will receive their prescription drugs through NYRx, the Medicaid Pharmacy Program.

Pharmacy Quick Reference Guide		
Amida Care Prior Authorizations (J codes)	**Pharmacy Appeals and Inquiries (J Codes)**	**NYRX or Magellan – Authorizations and drugs list**
1-646-757-7979	1-646-757-7979	1-877-309-9493 https://newyork.fhsc.com/providers/pdp_about.asp

Providers can find Information about the transition of the pharmacy benefit from Amida Care to NYRx, the Medicaid Pharmacy Program can be found here:
https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_transition/index.htm

Member can receive a 72-hour supply in situations where medically necessary and pursuant to New York State SSL §364-j (25) and (25-a) and Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health.

For medications to be administered by a healthcare professional (J-codes), vaccines, and COVID-19 related drugs, please refer to the " Amida Care's Vaccine Coverage Guidelines. These coverage guidelines detail vaccine coverage for adults and children as well as which location you can receive the vaccine and which vaccines require prior authorization. You can also find updated retail pharmacy instructions for vaccine billing. The link is below:

Vaccine Coverage Guidelines

Pharmacy Vaccine Billing Process

J-Codes

In most instances, NDC numbers are assigned a CPT or HCPCS code. Most injectable medications begin with a "J." It is important that claims be submitted with the most accurate information when billing for injectable medications that are administered in the office during a patient's visit. Please see the attached list of J-Codes that require an authorization through Amida Care. Prior to administering any of the JCODES on the list below complete the prior authorization form for approval for payment.

1. J-Codes List
2. J-Codes Form

Key Contacts for NYRX for Providers and members

- Prior Authorization Line for Providers Only and is available 24 hours and 7 days a week: 877-309-9493
- NYRx Education and Outreach: 833-967-7130
- Pharmacy Help Desk: 800-343-9000 option 1
- Medicaid Consumer Line: 855-648-1909

B. Dental Services

Dental Services Quick Reference Guide		
Healthplex– Dental Services	**Provider Portal**	**Members Contact Info.**
1-877-282-7012	UHCdental.com	yourdentalplan.com/Healthplex **or call at 866-795-6493**

UHC Dental/ Health Plex is the network provider of preventive and dental services for covered benefits under Amida Care Plans. Members seeking care for covered benefits need no referral. Participating dental providers are in the Amida Care Provider Directory.

C. Vision Services

Vision Services Quick Reference Guide		
Versant - Vision Services Phone	**Email Address**	**Website address**
1-800-773-2847	providerhelp@versanthealth.com	https://versanthealth.com/

Members may access these services from any participating Versant - Vision provider without a referral. The Member Benefit:

- Routine eye examinations and eyeglasses every year, and replacement frames or lenses as necessary.

D. Transportation Services

Transportation Services Quick Reference Guide	
Contact Info. – Providers	**Member Transportation Appeals**
Provider Inquires: (MAS) at 1-844-666-6270	**1-**800-556-0689

AmidaCare members are eligible for emergency and non- emergency transportation benefits. When there is an emergency condition, the member should call 911 for emergency transportation to the nearest

emergency facility. Non-emergency transportation (NEMT) services are available to members who require assistance traveling to and from medical or behavioral care.

In the event a member has been informed that a transportation benefit has been denied, the member can appeal the denial through contacting Member Services at 800-556-0689.

NEMT services are available to members who require assistance traveling to and from medical or behavioral care. NEMT is a fee-for-service Medicaid benefit and is administered by Medical Answering Service (MAS). The standard benefit is for public transportation (subways and buses).

Members with disabling conditions may be eligible for ambulance, ambulette and/or livery taxi service.

The member's physician must complete a Patient Transportation Restriction form (PTR) and submit it to Medical Answering Services (MAS)for a approval., New York City's contracted vendor. There are two PTR forms to choose from:

1. A 2015 Form (request for transportation inside the common medical marketing area)
2. A 2020 Form (request for transportation outside the common medical marketing area)

MAS will approve or deny the form within 30 days. Once approved the form is valid for 12 months.

The form can be found on the Medical Answering Service website at https://www.medanswering.com/login.taf (a login in must be created).

MAS manages this benefit. Appointments for transportation can be made by contacting MAS 844-666-6270. For your convenience, transportation services can also be requested online.

Public Transportation Reimbursement for mass transit for New York City Medicaid Managed Care members is handled by New York State Department of Health effective November 1, 2013, through the Public Transit Automated Reimbursement (PTAR) program.

Medical Answering Service no longer administers the PTAR Metro Card distribution program.

Members can only get Metro Cards from healthcare providers who participate with PTAR. Metro Cards are available when the distance to the providers' office is ten blocks or more from the member's home.

Members who live within ten blocks or less are not eligible for a Metro Card. If you are registered as a participating Public Transit Automated Reimbursement (PTAR) provider, your electronic submitted invoice will be reimbursed by the New York State Department of Health's. We encourage non-participating PTAR clinics and programs to enroll into PTAR. To join the PTAR program, the provider needs to send a request to the state by email to MedTrans@health.state.ny.us.

7.7 Harm Reduction

Effective July 1, 2018, Harm Reduction Services provided by NYSDOH-authorized and waivered Syringe Exchange Programs. Amida Care Harm Reduction services benefit will be covered when recommended in writing by a physician or other licensed practitioner. The Plan will specifically cover and reimbursement for the following services:

- Development of a Plan of Care
- Individual and Group Supportive Counseling
- Medication Management and Treatment Adherence Counseling.
- Psychoeducation – Support Groups

For more information, contact Provider Services or Member Service

7.8 Home Care Services

A. Personal Care Services (PCS)

(PCS) provide assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the member's health and safety in his or her own home.

As of May 16, 2023, NYS Medicaid implemented a new process for Medicaid recipients to request/obtain new Personal Care Service:

- For new requests, members can call the New York Independent Assessor (NYIA) Helpline and speak to a NYIA call center representative at 855-222-8350. New requests require an assessment and clinical appointment to be completed by NYIA.
- For member's receiving service PCS prior to May 16, 2023, the process below still applies:
  - The service must be ordered by a physician or nurse practitioner, and there must be a medical need for the service. Licensed home care services agencies, as opposed to certified home health agencies, are the primary Providers of PCS.

Personal Care Services (PCS) can be provided two ways;

- Member can be assigned to a participating Licensed Certified Home Care Agency
- Consumer Directed Personal Aide Program (CDPAP)- CDPAP offers the member the independence of being cared for by a close friend, neighbor, or family member.

Once the Personal Care Services (PCS) assessment is completed the member is contacted to discuss Personal Care Services (PCS) delivery, Personal Emergency Response Service (PERS), offer Consumer-Directed Personal Assistance Services (CDPAS) and Medically Tailored Meals (MTM) if service criteria is met.

Members may request CDPAS at any time by contacting their Care Coordinator. The member's Care Coordinator is responsible for reviewing the request and preparing the plan for review by the Care Team.

CDPAP Member Eligibility Requirements: To participate in consumer-directed care, a member must meet the following eligibility requirements:

a. Be eligible for long-term care services provided by a certified home health agency, long-term home health care program, or private duty nursing services.
b. Have a stable medical condition.

c. Be self-directing or, if non-self-directing, has a designated representative.
d. Participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes.
e. Is under the guidance and direction of the primary care physician (PCP).

Amida Care Approval: All CDPAS plans are presented to the Care Team for review and approval, and are under the guidance and direction of the PCP. CDPASs are evaluated on at least an annual basis, and it is at Amida Care's discretion as to whether they will continue with a member's individual care plan

B. Personal Emergency Response System (PERS)

PERS is electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency. PERS must be in conjunction with Personal Care Services or Home Care Services.

C. Medically Tailored Meals

To be eligible to receive Medically Tailored Meals the member's provider must provide a referral and the member must:

- Receive or are eligible to receive 20 hours/week or more of Personal Care Assistant (PCA) care with time assigned for meal preparation.
- have been admitted to the hospital more than once within a year due to cancer, diabetes, heart failure, and/or HIV/AIDS diagnoses;
- have visited the Emergency Room five times within a year due to cancer, diabetes, heart failure and/or HIV/AIDS; or
- have been admitted to the hospital once and visited the Emergency Room four times within a year due to cancer, diabetes, heart failure and/or HIV/AIDS

  **This service will be in the place of PCA meal preparation, which will result in a reduction in the amount PCA hours received each week, for a 6-month period.

Medically-Tailored Meals are provided for members who meet certain criteria, please contact Amida Care for more information at MTM@amidacareny.org.

7.9 Durable Medical Equipment (DME), Orthotics and Prosthetics and Enteral Formula/Supplies (Separate Sections

Durable Medical Equipment (DME) are to aid in the treatment of illness or injury or to improve bodily function. The provider must document in the member's medical record that these items are medically necessary.

DME may be obtained through a participating DME provider with a provider's written order and the appropriate authorization from Amida Care.

- Progress in adherence to care plan and assist with any emerging needs; and
- New Member Orientation – conduct face-to-face orientation when member services is unable to connect with member over the phone.

Our Children Services

8.1 Medically Fragile Children

The Plan contracts with providers who have expertise in caring for medically fragile children to ensure that medically fragile children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers including Primary Care Providers will refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the plan for out-of-network providers when participating providers cannot meet the child's needs.

8.2 Children Transition of Care

As of January 2019, some services for children under 21 transitioned to plan management and out of Fee for Services.

For continuity of care purposes Amida Care will allow children to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This requirement will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.

To preserve continuity of care, children members will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. The Plan will be required to pay on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan.

Carelon Health Options will continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the member or the provider refuses to work with the plan) for no less than 180 days, during which time, a new plan of care is to be developed.

During the initial 180 days of the transition, Amida Care will authorize any children's specialty services newly carved into managed care that are added to the plan of care under a person-centered process without conducting utilization review.

The Plan shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan shall monitor the use of SCAs to identify high-volume, nonparticipating providers for contracting opportunities and to identify network gaps and development needs. The Plan must pay at least the FFS fee schedule for 24 months for all SCAs.

For the 24 months from the date of transition of the children's specialty services carve-in, for fee-for-service children in receipt of HCBS at the time of enrollment, the Plan must continue to authorize covered HCBS and Long Term Support Services (LTSS) in accordance with the most recent plan of care for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity,

and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the member or the provider refuses to work with the plan) for no less than 180 days, during which time, a new plan of care is to be developed. While alternative payment arrangements, in lieu of the fee-for-service rates, may be allowed they require prior approval from OMH and OFFICE OF ADDICTION SERVICES AND SUPPORTS.

The Plan must pay at least the Medicaid fee-for-service fee schedule for 24 months or as long as NYS mandates (whichever is longer) for the following services/providers:

i. New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
ii. OFFICE OF ADDICTION SERVICES AND SUPPORTS clinics (Article 32 certified programs)
iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)
iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified

- Children Requiring Environmental Modifications (EMOD), Vehicle Modifications (VMOD) and Adaptive and Assistive Technology (AT) the following process is to be used to access these services
- For Children receiving care management from a health home, the health home will assit in access these services
- For Children receiving care management the Children and Youth Evaluation Service (C-YES), Amida Care will work with (C-Yes) provider to access these services

8.3 Transition of Children's HCBS to Managed Care

Services previously delivered under agency-specific 1915(c) waivers be aligned and moved under authority of NYS's 1115 MRT, MRT Waiver. All reimbursement for children's HCBS covered in the managed care benefit package will be non-risk for 24 months from the date of inclusion in the MMCO benefit package. The Plan capitation payment will not include children's HCBS. These will be paid on a non-risk basis. The benefits are listed below (additional detail can be found in the current HCBS Manual:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf):

a. Health Home (if not otherwise eligible under the State Plan)
b. Accessibility Modifications
c. Adaptive and Assistive Equipment
d. Caregiver/Family Supports and Services
e. Community Self-Advocacy Training and Support
f. Habilitation
g. Non-Medical Transportation[1]
h. Palliative Care
i. Prevocational Services

[1] Non-Medical Transportation will be paid Fee-for-Service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care, to leverage the existing Medicaid Fee-for-Service transportation infrastructure.

j. Respite
k. Supported Employment
l. Financial Management services for the Customized Goods and Services (phased in as a pilot)
m. Customized Goods and Services (phased in as a pilot)

All HCBS under the 1115 MRT Waiver are available to any child/youth determined eligible. Eligibility is based on Target Criteria, Risk Factors, and Functional Limitations. Individuals must meet institutional and functional eligibility criteria for LOC under the Demonstration using either: 1) the Child and Adolescent Needs and Strengths New York (CANS-NY) tool; or 2) the Office for People with Developmental Disabilities (OPWDD) Level of Care/Medical Care Screen eligibility tool for children with developmental disabilities who may be medically frail or in foster care. Health Homes will provide Care Management to children/youth eligible for HCBS.

8.4 Members in Foster Care

As of July 1, 2021, Amida Care's provider network will include Voluntary Foster Care Agencies that can complete initial diagnostic assessments for members upon intake into foster care and any additional assessments mandated by OCFS/LDSS/VFCA. This assessment will be provided to members within the timeframes specified in the table below including the development of a Plan of Care (POC). Following these assessments, the Plan shall facilitate access to providers and coordinate care for recommended treatment.

Foster Care Initial Health Services and On-going Assessment and Treatment

Time Frame	Activity	Mandated Activity**	Mandated Time Frame**	Who Performs
24 Hours	Initial screening/screening for abuse/neglect	X	X	Health Practitioner (preferred or child welfare caseworker
5 Days	For children under the age of 13, conduct HIV Risk assessment*	X	X	Child Welfare Caseworker or Designated Staff
10 Days	Request consent for release of medical record & treatment	X	X	Child Welfare Caseworker or Health Staff
30 Days	Initial medical assessment	X	X	Health Practitioner
30 Days	Initial dental assessment	X	X	Health Practitioner
30 Days	Initial mental health assessment	X	R	Health Practitioner
30 Days	Family Planning Education and Counseling and follow-up health care for youth 12 and older (or younger as appropriate	X	X	Health Practitioner
30 Days	Initial development assessment	X	R	Health Practitioner
30 Days	Initial substance use assessment	X	X	Health Practitioner
60 days	Follow-up health evaluation	R	X	Health Practitioner

**OCFS Regulations regarding HIV Counseling and Testing of children and youth in foster care have been revised to reflect the May 2017 updates to Public Health Law. VFCA/LDSS are required to conduct an HIV risk assessment on children under the age of 13 within 5 days of entering foster care placement and annually thereafter. All patients aged 13 or older receiving primary care services must be offered HIV testing at least once as a routine part of health care.*

***An "X" in the Mandated Activity and/or Mandated Timeframe column indicates that the activity is required within the indicated time frame. An "R" in the Mandated Activity and/or Mandated Timeframe column indicates that the activity is required by OCFS.*

Amida Care is responsible for reimbursing Voluntary Foster Care Agencies (VFCA) for all medically necessary services for which the VFCA is licensed to provide that are provided to our members. This includes reimbursement for any services paid through a State determined Preventive Residential Supports and Services rate (currently in development).

1. If our members are placed in a VFCA located outside of the Plan's service area Amida Care is responsible for the reimbursement of medically necessary services provided to Plan members by the VFCA.
2. In the event a Plan member is placed in a VFCA outside of the Plan's services area and requires health care services for which the VFCA is not licensed to provide, the Plan must permit such members to access medically necessary services from non- participating providers with expertise treating children involved in foster care located within 30 minutes/30 miles of the member's placement (or next closest provider if no providers of the service are located within 30 minutes/30 miles).

When an Amida Care member who is in foster care is placed in another county, and Amida Care operates in the new county, the child will be able to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.

When an Amida Care member who is in foster care is placed outside of the plan's service area, Amida Care permits the member to access providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.

The Plan will execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan will pay at least the Medicaid fee-for-service fee schedule for 24 months for all SCAs.

Transition of Populations into Medicaid Managed Care

As of July 1, 2018, statewide, the State removed the exemptions from Medicaid Managed Care enrollment for children in the following HCBS waivers with a physical, emotional, or developmental disabilities diagnosis:

- OMH Serious Emotional Disturbance (SED) 1915(c) waiver (NY.0296)
- Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
- Bridges to Health (B2H) Medically Fragile 1915(c) waiver (NY.0471)

- Bridges to Health (B2H) DD 1915(c) waiver (NY.0470)
- DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
- Office for People with Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176

After January 1, 2019, the following occurred:

- The State removed the exclusion from Medicaid Managed Care enrollment for children in Voluntary Foster Care Agencies
- Medicaid-eligible children, who meet at-risk LON criteria are able to receive HCBS.
- Medicaid eligibility was expanded to children who meet at-risk LON criteria and are determined Medicaid eligible through Family of One and receive HCBS.

Children/youth who continue to be excluded from enrollment in a managed care plan or who are exempt and choose not to enroll will continue to receive benefits via the fee-for-service (FFS) delivery system.

Transition of State Plan and Demonstration Services into Medicaid Managed Care

Existing NYS Medicaid State Plan services and HCBS covered under FFS was included in the managed care benefit package to more fully integrate children and youth's access to PH and BH care. Under the proposed 1115 Waiver Amendment, beginning July 1, 2018, statewide, Plans administer most children's BH services, including six new Medicaid State Plan services and the full array of children's HCBS as well as the four BH Demonstration services. These services are administered in conjunction with the Community First Choice Option (CFCO) services, which were added to the Medicaid managed care plan benefit package on April 1, 2018.

The four BH Demonstration services are already included under the 1115 demonstration in managed care:

- Outpatient addiction services,
- Residential addiction services,
- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

NYS's Medicaid State Plan was expanded to include the following new State Plan services: (see the current State Plan services manual for a complete description of these services.

1. Other Licensed Practitioner (OLP)
2. Crisis Intervention
3. Community Psychiatric Support and Treatment (CPST)
4. Psychosocial Rehabilitation Services (PSR)
5. Family Peer Support Services
6. Youth Peer Support and Training

These services were concurrently transitioned into the Medicaid managed care benefit package and therefore are available to any Medicaid member under 21 years of age who meets Medical Necessity Criteria (MNC).

Table 1 lists the Medicaid State Plan and Demonstration benefits that are currently in Medicaid managed care and/or targeted for transition into managed care. Costs for all State Plan services will be included in the capitated rates. A description of the new State Plan benefits may be found in the current State Plan services manual.

Table 1: Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21 Included in the Children's System Transformation

Services	Current Delivery System	MMCO BENEFIT PACKAGE
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult oriented service)	FFS	7/1/18
CFCO State Plan Services for children meeting eligibility criteria	FFS	Current MMC Benefit as of 4/1/18
Children's Crisis Intervention	FFS/1915(c) Children's Waiver service	7/1/18 (as New SPA service for Children)
Children's Day Treatment	FFS	TBD
Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed	Current MMC Benefit for individuals age 21 and over	7/1/18
Continuing day treatment (minimum age is 18 for medical necessity for this adult oriented service)	FFS	7/1/18
CPST	N/A (New SPA service)	7/1/18
Crisis Intervention Demonstration Service	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
Family Peer Support Services	FFS/1915(c) Children's waiver service	7/1/18 (as New SPA service for Children)
Health Home Care Management	FFS	7/1/18
Inpatient psychiatric services	Current Medicaid Managed Care Benefit	Current Benefit
Intensive Psychiatric Rehabilitation Treatment (IPRT)	FFS	7/1/18
Licensed Behavioral Health Practitioner (NP-LBHP) Service	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
Licensed outpatient clinic services	Current MMC Benefit	Current Benefit
Medically Managed detoxification (hospital based)	Current Medicaid Managed Care Benefit	Current Benefit

Services	Current Delivery System	MMCO BENEFIT PACKAGE
Medically supervised inpatient detoxification	Current Medicaid Managed Care Benefit	Current Benefit
Medically supervised outpatient withdrawal	Current Medicaid Managed Care Benefit	Current Benefit
OFFICE OF ADDICTION SERVICES AND SUPPORTS Inpatient Rehabilitation Services	Current Medicaid Managed Care Benefit	Current Benefit
OFFICE OF ADDICTION SERVICES AND SUPPORTS opioid treatment program (OTP) services	FFS	7/1/18
OFFICE OF ADDICTION SERVICES AND SUPPORTS Outpatient and Residential Addiction services	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
OFFICE OF ADDICTION SERVICES AND SUPPORTS Outpatient Rehabilitation Programs	FFS	7/1/18
OFFICE OF ADDICTION SERVICES AND SUPPORTS Outpatient Services	FFS	7/1/18
OMH State Operated Inpatient	FFS	TBD
Other Licensed Practitioner (OLP)	N/A (New SPA service)	7/1/18
Partial hospitalization	FFS	7/1/18
Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)	FFS	7/1/18
Psychosocial Rehabilitation (PSR)	N/A (New SPA service)	7/1/18
Rehabilitation Services for residents of community residences	FFS	TBD
Residential Rehabilitation Services for Youth (RRSY)	FFS	TBD
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	OCFS Foster Care	1/1/19
Residential Treatment Facility (RTF)	FFS	TBD
Teaching Family Home	FFS	TBD
Youth Peer Support and Training	FFS/1915(c) Children’s Waiver service	7/1/18 (as new SPA service)

Children Requiring Environmental Modifications (EMOD), Vehicle Modifications (VMOD) and Adaptive and Assistive Technology (AT) the following process is to be used to access these services.

- For Children receiving care management from a health home, the health home will assist in access these services.
- For Children receiving care management the Children and Youth Evaluation Service (C-YES), Amida Care will work with (C-Yes) provider to access these services

Our Authorization and Utilization Management

9.1 Utilization Management

Personnel trained in the principles and procedures of the Amida Care Utilization Management (UM) Department conduct utilization reviews. Administrative personnel only perform intake screening, data collection and non-clinical review functions and are supervised by appropriate licensed personnel. Licensed certified or registered health care professionals render determinations for medical necessity, experimental/investigation, clinical trials or rare disease treatment. Licensed certified or registered healthcare professionals are able to review and make determinations based on nationally recognized guidelines/criteria and assessment of the health status of members to determine level of care, quantity or delivery method of care. Only Amida Care's Chief Medical Officer and other clinical peer reviewers with similar licensure selected by the Plan may render adverse determinations. All UM personnel are trained in the appropriate principles and procedures.

Amida Care's UM Department addresses the health care needs of our Members by performing the following services:

- Out-Patient Prior Authorization
- Emergency Visit Utilization Review
- Pre-Admission and Concurrent Review of Elective Admissions;
- Initial and Concurrent Review of Emergent Admissions;
- Early Initiation of Discharge Planning;
- Identification of Potential Quality Of Care Issues; and,
- Coordination of Services.

The UM department works closely with your Patient's Care Team. Please note the contact information for each plan type and the hours of operation.

Authorization and Utilization Management Quick Reference Guide			
Medical Utilization Management	**Carelon Behavioral Health**	**Dental UHC Dental/ Health Plex**	**Vision Versant**
Phone: 888-364-6061 Fax: 888-273-8296 After Hours: Answering service including nights, weekends and holidays. Inquiries: AmidaCareCOsupport@monroeplan.com	Phone: 866-664-7142 For Members and Providers, During Business and After Hours	For Providers 877-282-7012 UHCDental.com For Members: 866-795-6493	For Providers 800-773-2837 umfax@versanthealth.com

Amida Care uses these specific written criteria and practice guidelines in carrying out a determination of medical necessity:

- InterQual Criteria;
- In the absence of an InterQual Criteria
- Clinical and Practice Guidelines approved by the quality Management Committee;
- AIDS Institute Clinical Guidelines for the care of individual's and family living with HIV/AIDS; and,
- Nationally recognized guidelines and standards.

Criteria used in decision-making are available upon request. Our vendors, to whom utilization review responsibilities have been delegated, follow these same standards, and they may be reached at the toll-free numbers included on the Quick Reference Guide.

9.2 Carelon Behavioral Health Options Level of Care Criteria

Carelon Behavioral Health Quick Reference Guide		
Provider Utilization Services	**Inpatient/Outpatient Mental and Detox/Rehab Utilization:**	**BH Claims and Appeals**
1-866-664-7142	1-866-664-7142	Carelon Behavioral Health Options, Amida Care Health Plan Claims Department: P.O. Box 1856 Hicksville, NY 11802-1856

Carelon's Level of Care (LOC) criteria were developed from the comparison of national, scientific and evidence based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance use and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). For substance use treatment services Carelon utilizes the Level of Care for Alcohol and Drug Treatment Referral (LOCATDR) as it's criteria as mandated by the Office of Alcoholism and Substance use Services (OFFICE OF ADDICTION SERVICES AND SUPPORTS). Carelon's LOC criteria, are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice.

Members must meet medical necessity criteria for a particular LOC of care. Medically necessary services are those which are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance use care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less

resource intensive treatment is available.

- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Carelon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Carelon's LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

Carelon Behavioral Health decisions for all denials, grievances, and appeals are made based on peer-to-peer review. Specifically, a physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.

In addition to meeting Level of Care Criteria; services must be included in the member's benefit to be considered for coverage.

Carelon Behavioral Health New York Level of Care Criteria, can be accessed via their web portal: https://www.Carelonhealthoptions.com/providers/clinical-information/

9.3 Evaluation of New Medical Technology

Timely review of requests for the use of new/experimental/investigational technologies is conducted by Amida Care in accordance with statutory timeframes and necessary regulatory guidelines. Experimental and investigational procedures, items, and medications are not covered. FDA Category B Devices are only covered when the Plan's coverage requirements are met.

Amida Care will cover certain Investigational Devices. Only certain FDA designated Category B devices (see Definitions) are covered under the investigational device exemption (IDE). To be covered, all of the following criteria must be met:

1. The device must be used within the context of an FDA-approved clinical trial.
2. The device must be used according to the clinical trial's approved protocols.
3. The device must fall under a covered benefit category and must not be excluded by law, regulation or current Medicaid coverage guidelines.
4. The device is medically necessary for the member, and the amount, duration and frequency of use or application of the service is medically appropriate.
5. The device is furnished in a setting appropriate to the member's medical needs and condition.
    a. Payment may not exceed the amount that would have been paid for an FDA- approved device that is currently used for the same medical purpose.
    b. Medical devices that have not been approved for marketing by the FDA are considered investigational and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part.

Amida Care does not provide coverage for any devices that would otherwise not be covered by Medicaid; e.g., statutorily excluded devices or items and services excluded from coverage through regulation or current manual instructions.

Providers and members may submit a request for a New Technology Review to the attention of the Amida Care Medical Director. Reviews will be conducted as expeditiously as the member's health care requires, but no later than 14 calendar days for a standard decision or 72 hours for an expedited decision from the date of receipt.

9.4 Services Requiring Authorization

A Pre-Authorization request means a service Authorization Request by the Member, or a provider on the Member's behalf, for coverage of a service, before such service is provided to the Member shall require review for medical necessity. In the below link please find services requiring prior authorization.

Call the Utilization Management Department if you have any difficulty locating it or if you have a question at 1-888-364-6061.

Plan Type	Services Requiring Authorization
Medicaid Amida Care Live Life • HIV • Homeless • Transgender/non-binary (TGNB)	https://www.amidacareny.org/wp-content/uploads/ac-benefit-guide-05-10-2022_2022510161728.pdf

Amida Care authorizes services in accordance with established timeframes as required by the following

- New York State Medicaid Managed Care Model Contract;
- Office Health Insurance Programs (OHIP) - Principles for Medically Fragile Children: and
- Early Periodic Screening Diagnosis and Treatment, Home and Community Based Services (HCBS), and Community First Choice Option (CFCO) rules; and with consideration for extended discharge planning.

Emergency services, including CPEP, are not subject to prior approval. Behavioral Health Crisis Intervention and OMH/ OFFICE OF ADDICTION SERVICES AND SUPPORTS specific non-urgent ambulatory services are not subject to prior approval.

Medical Necessity: Amida Care uses the following definition of medical necessity:
"Medical Necessity" means healthcare and services that are necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are ameliorate or palliate the effects of a

physical, mental, behavioral, genetic, or congenital condition, injury or disability.

Confidentiality: The Utilization Management activities at Amida Care remain confidential pursuant to State Law. Amida Care hereby affirms that all individually identifiable information relating to Medicaid members is keptconfidential pursuant to Article 27 (f) of the State Public Health Law, Section 3313 of the State Mental Hygiene Law and Section 2780-2787 concerning confidential disclosure of HIV-related information in this state, the provisions of Section 369 of the State Social Services Law, 42 USC Section 1396 (a) (7) of the Federal Social Security Act, 42 CFR Part 2 and other regulations promulgated there under. This information is used by Amida Care or its providers only for a purpose directly connected with performance of Amida Care's obligations under the Medicaid program. This affirmation will remain in effect as long as Amida Care maintains any individually identifiable information relating to Medicaid beneficiaries.

All minutes, records, reports, worksheets, study documents, and any other materials collected as part of Utilization Management activities are considered strictly confidential and handled in a manner designed to ensure confidentiality. All records will be maintained for a minimum of seven years (7) as required by law.

9.5 Types of Service Authorization Request Determinations and Timeframes

Services Authorization Request List and Timeframes
https://www.amidacareny.org/wp-content/uploads/ac-benefit-guide-05-10-2022_2022510161728.pdf

Pre- Authorization : Amida Care will make a decision and notify the Member and the provider by phone and in writing, within three (3) business days of receipt of necessary information or as quickly as the Member's condition requires and (1) within 72 hours of receipt of an expedited authorization request or in all other cases, within 3 business days of receipt of necessary information.

Concurrent Review: Concurrent review procedures allow for continued or extended health care services for the purpose of validating the appropriateness of disposition and/or level of care, medical necessity of treatment and/or procedures, quality of care rendered and information provided during any previous review. Concurrent review determinations will be made as fast as the member's condition requires and within one (1) business day of receipt of necessary information.

Determination notices are provided in writing and by telephone to the member and the provider of service.

Amida Care will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level of care is approved for such care.

Retrospective Reviews

1. Retrospective Reviews consist of a review of member medical records and other clinical documentation to validate the quality of care, medical necessity, clinical coding, appropriateness of place of service, and length of stay associated with care.
2. Retrospective Reviews will be accepted for review within 120 days of the DOS.
3. When completing a Retrospective Review, Amida Care will review cases within 30 days of receipt of the necessary information. Clinical information will be reviewed to determine Medical Necessity and evaluate appropriate level of care. This review will also assist to identify potential quality issues including possible premature discharge.
4. A complete medical record may be requested for Retrospective Review.
5. Timeframes for Prospective or Concurrent Review determinations for standard, expedited and retrospective requests may be extended for up to 14 days if:
    a. The member, the member's designee or the provider requests an extension orally or in writing; or
    b. Amida Care demonstrates or substantiates that there is a need for additional information and that the extension is in the member's best interest. Amida Care will ensure that there is supportive documentation to demonstrate justification for the extension, and ensure that documentation is made available upon New York State Department of Health (DOH) request.
6. Business days or no later than the date the extension expires using whatever information has already been received. If request is denied, written notification must be sent on the date of payment denial.
7. Emergency services are not subject to prior authorization nor shall reimbursement be denied on Retrospective Review provided that such services are Medically Necessary to stabilize or treat an emergency condition.
8. Amida Care may reverse a pre-authorized treatment, service or procedure on Retrospective Review in accordance with section 4905(5) of the Public Health Law only when:
    a. The relevant medical information presented to Amida Care upon Retrospective Review is materially different from the information that was presented during the pre-authorization review; and
    b. The information existed at the time of the pre- authorization review but was withhel or not made available: and
    c. Amida Care was not aware of the existence of the information at the time of the pre-authorization review
    d. Had Amida Care been aware of the information, the treatment, service or procedure being requested would not have been authorized. This determination is to be made using the same specific standards, criteria or procedures as used during the pre-authorized review

Reversals: Amida Care reserves the right to reverse/deny a pre-authorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to us or any utilization review agent upon retrospective review is materially different from the information that was presented during the pre- authorization review
- The information existed at the time of the pre-authorization review, but was withheld or not made

available

- Amida Care or the Plan's agent was not aware of the existence of the information at the time of the pre- authorization review: and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Additional Information Needed to Make a Determination

Expedited and standard review timeframes for pre-authorization and concurrent review may be extended by an additional fourteen (14) days if:

- The Member, designee or provider requests an extension
- Utilization Management staff demonstrates there is a need for more information, and the extension is in the Member's interest. Notice of extension to Member will be made

Expedited review will be conducted when Amida Care or a provider indicates delay would seriously jeopardize the Member's life or health, or ability to attain, maintain, or regain maximum functions. Members have the right to request expedited review, but such requests may be denied, and the review will be processed under standard timeframes.

A clinical peer reviewer will make all adverse determinations. A written notice of an adverse determination (initial adverse determination) will be sent to the Member and provider and will include:

- The reasons for the determination, including the clinical rationale, if any
- Instructions on how to initiate internal appeals (standard and expedited) and eligibility for external appeals
- Notice of the availability, upon request of the Member, or the Member's designee, of the clinical review criteria relied upon to make such determination.

Adverse Determinations:

Adverse determinations may be appealed by the member or the provider and if upheld considered a final adverse determination. Amida Care will send a written notice of the initial adverse determination on the date of the denial when a service authorization for a health care service, treatment or procedure is given.

The written notice of initial adverse determination shall be transmitted (oral or written) to the member and provider The notice will also include:

- The reason for the determination including the clinical rational, if any;
- Instructions on how to initiate internal appeals (standards and expedited appeals) and eligibility for external appeals. And
- Notice of the availability upon request of the members, or the member's designee, of the clinical review criteria relied upon to make such adverse determination.
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, the Plan in order to render a decision the appeal.

For members the notice will include:

- A description of Action to be taken

- A statement that Amida Care will not retaliate or take discriminatory action if an appeal is filed by member or a provider.
- The process and timeframe for filing/reviewing appeal with Amida Care. The member will be mailed information to explain the member right to file an expedited review.
- The member's right to contact DOH, at 1-800-400-8882 regarding their complaint.
- A Fair Hearing Notice including aid to continue rights. The protocol for aid continuing is found in section 9.7
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

When an adverse determination is rendered without provider input, the provider has the right to a reconsideration. The reconsideration shall occur within (1) business day of receipt of the request and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination.

Failure of Amida Care to make an UR determination within the applicable time frames is deemed to be an adverse determination subject to appeal . Amida Care must send a notice of action on the date the review timeframe expires.

For actions based on issues of medical necessity or an experimental or investigational treatment the written notice will also include specific language defining the adverse determination as one of the following: medical necessity, experimental/investigational, rare disease, and or clinical trial. Members wishing to dispute an action may do so or designate a person to do so on their behalf. To appoint a designee; the member may also have the provider file the complaint on their behalf.

Fair Hearing:
A member/representative can request a State Medicaid Fair Hearing only after internal appeal process has been exhausted and member has received a final adverse determination. The member/representative make the request within 120 days of the final adverse determination. Amida Care will provide instruction for requesting a Fair Hearing with the NYS Office of Temporary Disability Agency (reference OTDA website). The information will be mailed to the member with the Final Adverse Appeal determination letter.

9.6 Types and Timeframes for Appeal of Utilization Reviews

The following presents the address and phone number to file an appeal:

Appeal of Utilization Review Quick Reference Guide		
Toll-Free Number	**Facsimile Number**	**Address**
1-888-364-6061	1-888-273-8296	Amida Care Appeal Department 1120 Pittsford-Victor Road Pittsford, NY 14534

Expedited Appeals

A Member, the Member's designee and, in connection with retrospective adverse determinations, a provider, may appeal an adverse determination on an expedited or standard appeal basis. A Member or the Member's designee may also appeal certain out-of-network denials. Appeals can be filed in writing or by telephone. Oral appeals must be followed up by written signed appeal.

An expedited appeal may be filed:

- For continued or extended health care services, procedures or treatments.
- For additional services for member undergoing a course of continued treatment.
- When the health care provider believes an immediate appeal is warranted.
- A member/representative may request an Expedited Appeal when the health status of the member is at risk for or member may suffer temporary and permanent impairment. This process will provide a determination within 72 hours.
- Member asking for home care services after hospital discharge
- Additonal inpatient substance use treatment or mental health at least 24 hours before discharge or before a court appearance.

Process for Filing an Expedited Appeal Review:

- Expedited appeals should be accompanied by a copy of the action, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The review timeframe begins with the first receipt of the appeal by Amida Care, whether filed orally or in writing.
- If the plan denies the request for an expedited timeframe, Amida Care will immediately provide oral notice by phone , followed by written notice in two (2) days, and the review will take place according to standard time frames.
- A member may request an expedited external appeal at the same time of the request for an internal appeal. A fair hearing may only be requested after receiving notice that the managed care entitiy is upholding the adverse determination .
- If Amida Care requires information necessary to conduct an expedited appeal, Amida Care will immediately notify the member and the provider by written notice to request the necessary information.
- A decision will be made as expeditiously as the member's health condition requires, but no later than the date the extension expires.

Amida Care will make the decision as fast as the member's condition required or 2 business days after receipt of all necessary information but no more than 72 hours of receipt of the appeal. The time may be extended for up to 14 days upon member or provider request; or if Amida Care demonstrate more information is needed and delay is in best interest of the member and so notices the member.

The appeal review will be conducted by a physician, clinical peer reviewer, who was not involved in the prior determination or initial actions.

Written notice of final adverse determination concerning an expedited appeal shall be transmitted to

member within 24 hours of rendering the decision. Amida Care will make reasonable efforts to provide oral notice to the member and provider at the time the determination is made. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed through the external appeal process

Standard Appeal:

A Standard Appeal may be filed by the member or the member's designee. Appeals are filed in writing or by telephone/oral. A provider may file a UR Standard Appeal for a retrospective denial.

The member and/or provider have 60 calendar days from the date of the adverse determination notice to file an appeal. Amida Care will acknowledge receipt of the Appeal within 15 days in writing. If additional information is needed to conduct the appeal, the Plan will notify the member and the member's health care provider, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. If only a portion of the necessary information is received, Amida Care will request the the missing information within five(5) business days of receipt of the partial information.

The appeal review will be conducted by a physician, clinical peer reviewer, who was not involved in the prior determination or initial actions.

For members, before and during the appeal review period, the member, or his/her designee may see the case file and may present evidence to support their appeal in person or in writing.

Amida Care will make a standard appeal determination as fast as the member condition requires and no later than within 30 days from receipt of the appeal. This time may be extended for up to 14 days upon the member or provider request or if the Plan demonstrates more information is needed and delay is in the best of interest of the member and notifies the member. Amida Care will notify the member, the member's designee and provider wtihin 2 business days of the resolution.

Each notice of final adverse determination will be in writing, dated, and will include:

- The basis and clinical rationale for the determination
- The words "final adverse determination";
- Amida Care contact person and phone number;
- Member coverage type;
- Name and address of agent, contact person and phone number;
- Health service that was denied, including facility/provider and developer/manufacturer of available;
- Statement that the Member may be eligible for external appeal and timeframes for appeal; and
- Standard description of external appeals process.

In addition, the notice will also include:

- Summary of appeal and date filed;

- Date appeal process was completed;
- Description of the Member's fair hearing rights if not included with initial denial;
- Right of the Member to complain to the Department of Health at any time with 1-800-505-5678; and
- A statement that notice is available in other languages and formats for special needs and how to access these formats.

Failure of Amida Care to make a determination with the applicable time periods for expedited and standard appeal, shall be deemed to be a reversal of the utilization review agent's adverse determination

Amida Care and the member may jointly agree to waive the internal appeal process; if this occurs, Amida Care must provide a written letter with information regarding filing an external appeal to member within 24 hours of the agreement to waive the plan's internal appeal process.

External Appeal:
A member has a right to an external appeal of a final adverse determination. The request must be made within 4 months from when you receive the adverse determination notice. regardless of whether or not a second level appeal is requested. Informs the member's provider that the member or member 's designee in connection with retrospective adveerse determination, a member's healthcare provider has the right to request and external appeal

An external appeal may be filed:

- When the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care services is not medically necessary and;
- The health care plan has rendered the final adverse determination with respect to such health care service or;
- Both Amida Care and the member have jointly agreed to waive any internal appeal.
- The member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health plan or (c) for which there exists a clinical trial and;
- The member's attending physician, who must be a licensed board eligible physician qualified to practice in the area of practice appropriate to treat the member's life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on the two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation

and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

9.7 Aid Continuing Protocol

Members may receive continuation of benefits, known as Aid Continuing, when Amida Care makes a determination to:

- Terminate, suspend, or reduce any previously authorized service during the period for which the service was approved
- Partially approve, terminate, suspend, or reduce level or quantity of long term services and support or nursing home services (short or long term) for a subsequent authorization period of such services

Members will receive notice of their right to Aid Continuing when Amida Care makes the determination. A member may request Aid Continuing 10 days from the date of the Final Adverse Determination, or the effective date of the decision, whichever is later. The NYS Office of Administrative Hearings (OAH) may also grant a continuation of services once a Fair Hearing is filed.

Amida Care must continue the member's services provided under Aid Continuing until one of the following occurs:

- The member withdraws the request for aid continuing, the appeal or the fair hearing
- OAH determines that the member is not entitled to aid continuing
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the member
- The provider order has expired, except in the case of the home bound member

If the Fair Hearing is decided against the member or member withdraws prior request for Aid Continuing, the member may be liable for the cost of any continued benefits. .

Decision to reverse Initial Adverse Determination with Aid Continuing

- Authorize services according to the Utilization Management Determinations Policy and Procedure.

Decision to uphold Initial Adverse Determination with Aid Continuing

- Escalate to Amida Care Health Services Department senior management to review the case with the delegated UM Vendor(s) and the Finance Department. They will establish the best course of action for the specific member with regards to communicating the termination of services and the potential recoupment of costs for the continued benefit.

Our Quality Management and Continuous Improvement Program

Quality Management Quick Reference Guide			
Email address:	**Fax:**	**QM mail address**	**Hours**
quality@amidacareny.org	1-646-786-1836	Att: Quality Management Dpt. 14 Penn Plaza, 2rd Floor New York, NY 10122	Monday – Friday 8:00am to 5:00pm

10.1 Overview of Quality Management and Continuous Improvement Program

The Amida Care Quality Management Program (QMP), in partnership with its providers, has established as its mission, the provision of access to comprehensive medical and social services to its members in order to improve their quality of life. The Amida Care Board of Directors is ultimately responsible for the quality of care and services provided to Amida Care members. The Board delegates to the Amida Care Quality Management Committee, co- chaired by the Amida Care Chief Medical Officer and a member of the Board of Directors, the responsibility for the development and implementation of the Amida Care QMP. The overall goal of the QMP is to ensure the quality of all aspects of the delivery of care and services to Amida Care members. Participating providers support and involvement is essential to the success of the Amida Care QMP.

10.2 Quality Program Mission and Goals

The quality statement is an articulation of the goals of Amida Care's quality program toward which all activities are directed. The Quality Management Committee (QMC) developed a vision and mission statement that reflects local priorities as well as national goals.

To achieve its vision, Amida Care's Quality Management program works to ensure access to comprehensive, high-quality care, and supportive health care services for its members by:

- Ensuring adherence to clinical guidelines and standards of care;
- Maximizing collaboration and coordination of care with providers to enhance access;
- Promoting partnerships of members and providers that are respectful and promote client self-management;
- Providing services that are culturally appropriate and focused on individual client needs; and
- Maximizing the efficient use of resources to provide cost-effective services.

10.3 Quality Program Structure and Activities

The Quality Department informs decisions for improving quality, providing expertise in quality improvement initiatives, improving patient safety, and leveraging our clinical informatics team to support local teams through the development of high quality and timely analyses and reports. The Medical Director is responsible for the development, execution, and oversight of Amida Care's quality management plan.

A copy of the Amida Care QMP and the Quality Management Policies and Procedures is provided to all members of the Amida Care Board of Directors and Amida Care Senior Staff. Amida Care members are advised of their ability to obtain a copy of the QMP in the Member Handbook distributed to all members.

Key Areas of Focus

Performance improvement initiatives are focused on monitoring and improving health care delivery and health outcomes. This includes tracking and addressing metrics as highlighted in the HEDIS specifications, as well as the important health care metrics evaluated in the annual HIV Quality of Care report. Every year a subset of metrics are chosen for closer monitoring, in conjunction with performance improvement initiatives, and regularly tracked during the monthly Quality meetings.

- HEDIS/QARR: Amida Care regularly collects and analyzes data to monitor its performance in health care delivery and delineate areas in need of improvement. Metrics from each domain, as specified in HEDIS, are selected annually. Benchmarks established by DOH are used, as well as the monitoring of trends amongst Amida Care providers.
- HIVQUAL: The SNPs are evaluated annually on how well providers adhere to primary care guidelines in persons living with HIV. This includes preventive care services and viral load suppression rates.
- Performance Improvement Projects (PIP): The 2022-2023 PIP is focused on improving the Adult Preventative Dental Access rate. Lack of Preventative dental care puts members at risk for unaddressed tooth decay and/or gum disease that can lead to infections and other conditions that can put the body at risk for health issues.
- CAHPS: The annual CAHPS survey conducted by the DOH is reviewed annually by the Quality team and Member Services, in order to ascertain areas in need of improvement. These findings will subsequently inform the modified CAHPS survey conducted by a vendor for Amida Care on an annual basis.

Identifying Member Needs

Data Cleansing and Analysis: Data collection, that is complete and accurate, is extremely important for the monitoring and oversight of health care service delivery. The Data Warehouse in development, co-sponsored by the Medical Director and VP of Information and Technology, will allow for a single centralized database retrieved from all sources, including heath care facilities, vendors, data exchange, laboratory sites, and SHIN-NY. The Information Oversight Committee meets regularly to ensure that the data warehouse will adequately provide quality data that is accessible, reliable, and readily available for analyses needed to evaluate metrics important for each department.

Data Quality: The volume, source and quality of the data received by Amida Care will be reviewed and monitored on a regular basis and formally in monthly meetings by IT, MI, and the Data Warehouse co-chairs. Concerns about data quality are tracked and addressed.

We use various sources of data to measure quality of care and health outcomes, which allows us to delineate potential barriers to appropriate care. Data sources include:

- Appeals
- CAHPS
- Case Management Services
- Claims Data
- Encounter Data
- Enrollment Data
- Epidemiological data
- HEDIS (Healthcare Effectiveness Data and Information Set)
- HIV Quality of Care
- Laboratory Data
- Medical Records
- Peer Review (e.g. Appropriateness of Care Reviews)
- Pharmacy data
- PIPs and other clinical studies
- Utilization Review data
- RHIO / HIE Data

Other sources of data include HEDIS/QARR data, demographic, and census data about the New York population, and practitioner, provider, and member surveys. Software includes, but is not limited to, claims systems, NCQA approved HEDIS software, credentialing and recredentialing software, Microsoft products.

HEDIS SOURCES DATA
https://www.ncqa.org/hedis/measures/

Quality Improvement Initiatives

- Collaboration with internal and external shareholders: As mentioned the Pharmacy and Therapeutics and the BHQM subcommittees will collaborate with the Quality team to improve outcomes for the key HEDIS goals in their respective domains. Similarly, there will be partnership in improving health care outcomes with vendors by enhancing data available, and defining strategies to improve access and quality of services received.
- Member and Provider Education – Member education is conducted through care coordination, pharmacy outreach, mailings (newsletters, targeted letters), events, and customer services. Provider education is conducted through gaps in care reports to health homes and primary care providers. Select PCPs will also receive reports focused on viral load suppression status, with attention to members who may be non-adherent to therapy.
- A Value Based Program is established with specific sites to improve engagement, performance, collaborations, and enhance data exchange.
- Healthy Rewards is a member engagement program and is reviewed annually and modified as needed to ensure that it adequately addresses important health care goals.
- Enhanced Data Exchange through partnerships will be leveraged to improve routine and consistent data exchange with all vendors, sites selected for VBP, the RHIOs, and all contracted sites throughout the year.

Use of Data, Reports and Analyses

Data will be used to regularly monitor epidemiological data, enrollment composition, utilization of health care services (including medical, behavioral, and pharmacologic data), care management, clinical studies, and health care outcomes. All performance improvement plans, and outcomes will be communicated to relevant staff, members, groups and agencies via reports, and meetings as deemed appropriate. Reports developed for regulatory bodies to evaluate quality of care distributed across membership will also be evaluated internally and summarized for the QMC, and subsequently the Board of Directors. Performance improvement projects mandated by the Department of Health will be similarly presented, at the outset and following completion, to the QMC and Board of Directors.

Patient Safety

Amida Care is committed to ensuring our facilities provide safe quality health care to our membership. This includes partnering with patients and health care providers to meet preventive health care goals, engage in regular primary care, and avoid preventable complications during hospitalizations.

If patient safety or quality of care is of concern this will be addressed by the Medical Director or CMO. Depending on the nature of the concern a clinical review may need to be completed. Sources to help identify potential compromise to patient safety include member complaints, surveys, referred cases from our vendors (e.g. Carelon, ESI), and during peer review activities. Following case review actions taken will depend on the concerns identified.

Confidentiality of Health Information

The Plan's Quality Management Program adheres to maintaining the confidentiality of members and providers as required by federal and state law. Electronic and paper reports, minutes, medical records, or any other information generated are excluded from release or discoverability except as required by federal or state laws, or licensing authorities. All information is protected in accordance with current peer review privacy and confidentiality, and access to member information is granted on a need-to-know basis. All Amida Care employees must read and sign a Confidentiality Agreement and Code of Conduct at the start of their employment and annually, as well as participate in required trainings, including Confidentiality and Privacy training.

Quality Program Implementation, Monitoring and Evaluation

- Annual QMP document and work plan – the QMP document is available to all Amida Care staff and an abbreviated version will be made available to providers and members. The work plan is for internal purposes only and details the activities circumscribed by the QMP.
- Continuous monitoring and reporting of the quality program, overseen by the Medical Director, occurs regularly through the activities of the subcommittees, and the performance improvement activities, which are each formally reviewed during the QMC quarterly meetings,.
- Annual program evaluation – during the first quarter of each year the Quality Management Program is reviewed and analyzed in detail by the Quality team.
- Program Review and Approval – Following annual evaluation of the QMP, feedback is solicited from the subcommittee chairs regarding any concerns and needed modifications. All agreed upon

modifications are incorporated and then reviewed during the QMC meeting, and subsequently submitted to the Board of Directors for approval.

10.4 Quality Management Program Monitoring Framework and Committee and Sub-Committees Structure

The Amida Care Board of Directors is responsible for oversight of care and services delivered to its members. During its regular meetings, this leadership group approves the QMP and receives and reviews reports on status of quality improvement activities, credentialing decisions, policy and procedure revisions, external and internal audit results, member complaints and grievances, customer experience summary and medical and behavioral health care utilization data. Quality Management functions include:

- QMP document approval, monitoring, and evaluation
- QMP work plan approval and monitoring
- Review of subcommittee activities (includes pharmacy program, clinical services, behavioral health, credentialing activities, member experience)
- Evaluation and review of UM (clinical and behavioral health services)

Committee Structure

In accordance with the regulatory requirements and prevailing standards, Amida Care has a Quality Management Committee and six subcommittees, to monitor various plan activities to ensure appropriate and high-quality care to our members. The Medical Director is a co-chair for each subcommittee and the remaining membership includes representatives from various functional areas, practitioners, providers, and member representatives, if needed. Each committee's proceedings are recorded in detailed minutes and include topics discussed, decisions made, and actions and follow up actions. Status of actions and follow up items are included in future meetings for closing out those items and/or to ensure outstanding questions/issues are resolved. All subcommittees must provide a separate report for each meeting to the QMC. The QMC meets at minimum quarterly, and its sub-committee met at minimum semi-annually.

10.5 Medical Record Standards, Clinical Peer Reviews and Quality of Care Reviews

All providers rendering health care services to Amida Care members must maintain a member health record in accordance with standards adopted by Amida Care and in compliance with NCQA Guidelines for Medical Record Review. A copy of these separate standards is available from the Provider Services Department. Providers maintain these documentation standards and ensure adherence to all confidentiality regulations when sharing medical record information with other providers. The medical record verifies that the PCP is responsible and coordinate the care of the member.

Amida Care, in its continuing effort to provide high-quality health care to its members, requests medical records and conducts reviews to evaluate practice patterns, identify opportunities for improvement, and to ensure compliance with quality standards. A summary of Amida Care's Medical Review program is as follows:

- Oversight of pregnant member for third trimester patient care management review reports;

- Quality of clinical care investigations;
- Appropriateness of Care Reviews at sites providing primary care to persons living with HIV
- Quality of care review to persons living with chronic conditions, such as diabetes or hypertension
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations and review billing issues;
- HEDIS and QARR
- HIVQUAL annual review
- Coordination of Care annual IPRO Review

Plan providers are required to meet the following medical record standards:

- Separate medical record for each member;
- The record verifies that PCP coordinates and manages care;
- Medical record retention period of six years after date of service rendered to members and for a minor, three years after majority or six years after the date of the service, whichever is later; and
- (Prenatal care only): centralized medical record for the provision of prenatal care and all other services

All Amida Care medical record reviews are conducted by clinical professionals; all information contained in the records is kept strictly confidential. Providers must make medical records available upon request by Amida Care, the NYSDOH, CMS, LDSS, or the IPA, for utilization review and quality assurance. Member authorization to allow the health plan to review records is obtained at the time of the member's enrollment. Specifically, Amida Care reviews medical records as part of the following activities:

HEDIS/QARR Medical Record Review and Clinical Data Collection: Amida Care's Quality Management (QM) Department performs annual medical record data collections for HEDIS® (Healthcare Effectiveness Data and Information Set) and QARR (New York State Department of Health Quality Assurance Reporting Requirements) that are overseen by the National Committee on Quality Assurance (NCQA).

HEDIS and QARR measure the performance of health plans and their participating practitioners on important aspects of preventive, acute and chronic health care. HEDIS and QARR data are used by regulatory and accreditation agencies as well as consumers to assess the effectiveness of care.

As an Amida Care network provider, providers may be contacted to supply medical records for HEDIS/QARR reporting. If contacted, please take the time to find the requested member records and provide them to the QM department for our review. Please note that HEDIS and QARR scoring methodology consider a missing record to be non-compliant, and we will not receive credit for the service.

New York State Law requires that Amida Care and its network physicians comply with HEDIS and QARR initiatives, and that we report the results to the NYSDOH. Supplying the requested records to us for HEDIS/QARR reporting does not violate the HIPAA Privacy Rule, 45 CFR 164.

506 (c) (4).

Providers cooperation in completing any requested medical record reviews will help the Plan communicate to the medical and consumer community that we, as a team, are committed to meeting the standards of care

For QARR/HEDIS guidelines and chart documentation protocols, providers can access the QARR/HEDIS Quick Reference Guides from www.amidacareny.org

10.6 Incident Reportion, Care Concerns, and Investigations

Amida Care staff and all of its delegated entities are responsible for identifying, investigating, documenting, and tracking any potential quality issues. When a potential quality issue is identified, the appropriate staff member collects relevant information and presents it to their supervisor/manager who determines whether a quality issue exists.

If determined that a quality issue exists, the incident is documented on the quality referral form, and emailed with any supporting documents to Quality Management for review. The Medical Informatics Auditor and Director of Quality Management review the issues with the Amida Care Chief Medical Officer and/or Director of Medical Management, as indicated. When indicated by risk of potential or further patient harm, the quality issue is immediately reported to the appropriate agencies.

When a quality concern/issue/complaint is identified, the Quality Management Department in conjunction with the Plan's Chief Medical Officer will send a letter to the provider/facility requesting a response and/or Plan of correction. The Amida Care Chief Medical Officer reports quarterly to the Amida Care Quality Management Committee a summary of the potential quality issues identified, findings of review and further actions planned and/or taken. This information is reported to the appropriate government agencies.

10.7 Communicable Diseases and Public Health Reporting

Clinicians are required by Article 11 of the New York City Health Code (24 RCNY 11.03-11.07) to report certain disease conditions and events to the DOH. Providers required to report include physicians, dentists, doctors of osteopathy, physician's assistance, nurse practitioners and persons in charge of hospitals and clinics or their designees.

Conditions that must be reported by clinicians or their designees are specified in the

New York City Health code and posted at http://www.nyc.gov/html/hra/html/home/home.shtml Health care providers per Section 11.03 of the NY City Health Code, must immediately report by telephone any suspected outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestations of disease in any individual.

Our Claims Submission and Payment

This section outlines the requirements for claims processing, capitation payments, and reimbursement for services provided. All participating Amida Care providers are required to submit claims for services reimbursed according to fee-for-service rates. All claims' data must be complete, accurate and submitted in a timely manner. Providers must never bill Amida Care members for covered services except for applicable co-pays, co-insurance or permitted deductibles.

Payment for services rendered is subject to verification that the member was enrolled in Amida Care on the date of service and to the provider's compliance with Amida Care's Medical Management policies at the time of service. Providers MUST verify member status on the date of service to ensure that the member is enrolled in Amida Care. Failure to do so may affect claims payment. Note: members, may lose their eligibility with Amida Care after the date of service. Thus, verification of eligibility is not a guarantee of payment by the Plan.

11.1 General Requirements for Claims Submission and Inquiry

Claims submitted electronically will be paid within 30 days and paper or facsimile claim submissions will be paid within 45 days. All claims are adjudicated according to the provider's contracted reimbursement method and rates. Use this quick reference guide to determine where claims should be submitted.

To inquire about the status of a claim or to receive a copy of an Explanation of Payment (EOP) for a processed claim, check the quick reference guide below for the appropriate claims department. Whenever possible, an explanation regarding the claim payment will be provided immediately over the telephone; otherwise, the inquiry will be researched, and an answer or status update will be provided. Adjustments will be reflected on subsequent payments and will be included on the Explanation of Payment (EOP)

Claims Services Quick Reference Guide				
Medical Claims Address	**Medical Claim Electronic Submitter ID**	**Medical Claim Status Phone Number/Web**	**Behavioral Claims Payor ID#, Claims Status Phone Number, and claims address**	**Amida Care Claims Appeals:**
Amida Care - Claims PO Box 21455 Eagan, MN 55121	Amida Care ID# 79966	1-800-556-0674 https://www.amidacareny.org//provider-services	**Amida Care Claims,** Amida Care ID# 029 Claims Status: 1-800-556-0674 Carelon Behavioral Health claims address: PO BOX 1866 Hicksville, NY 11802-1866* Carelon Payor ID is: BHOVO or BEACON963116116 www.carelonbehavioralhealth.com	**Att: Claims Appeals** **14 Penn Plaza** **2nd Floor** **New York, NY 10122**

Claims submitted electronically, by mail or facsimile on CMS 1500 or UB-04 forms must be complete and legible.

The following information must be included with the claim to ensure timely claims payment.

- Member's name, ID number, and date of birth;
- Provider's name, Tax ID number, and address;
- Provider National Provider Identifier (NPI) should reside in:
    - 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI);
    - 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI).

Prior to being adjudicated, all claims are reviewed within the Amida Care Claims department for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the Amida Care utilization systems. If the following information is missing from the claim, the claim is not "clean" and will be rejected:

Data Element	CMS-1500	UB-04
Member Name	X	X
Member Date of Birth	X	X
Member Sex	X	X
Member Name and Address	X	X
Amida Care Member ID Number	X	X
Other Insurance Information/Coordination of Benefit	X	X
Dates of Service	X	X
ICD-10 Diagnosis Code(s), including 4th, 5th, 6th, and 7th Digit when Required	X	X
CPT/HCPCS Codes and/or Revenue Codes (UB-04 only)	X	X
HCBS Codes	X	X
Service Code Modifiers	X	X
National Drug Code (NDC) Number**/Quantity/Unit Type**	X	X
Place of Service Code (CMS-1500) or Bill Type (Institutional)	X	X
Charges per Service and Total Charges	X	X
Provider Name (Rendering and Billing)	X	X
Provider Address/Phone Number (Rendering and Billing)	X	X
National Provider Number (NPI)	X	X
Tax ID Number	X	X
Hospital/Facility Name and Address	X	X
Value Codes and Value Code Amounts		X
Taxonomy Code(s)		X

Incomplete Claims: If required information is missing from a Medicaid member claim, Amida Care will reject the claim. Providers may resubmit the claim with the missing information added. Providers may resubmit a rejected claim for missing information within 45 business days. (See Section11.3 for Submission of Corrected Claims

Claims Review Software: All Medicaid claims submitted to Amida Care are reviewed using claims adjudication based on the Center for Medicare and Medicaid Services, (CMS) and industry-based standards.

No CPT Code on Fee Schedule – If the contracted fee schedule does not include a specific CPT code, then Amida Care will reimburse that service using Usual and Customary fees.

11.2 Coordination of Benefits

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of health care services. Amida Care follows all standard guidelines for COB. The birthday rule is applied when determining the primary payer for Amida Care members. Members are asked to provide information about other insurance plans under which they are covered.

Amida Care is always the secondary payer in the following circumstances:

- Workers Compensation;
- Automobile Medical; and
- No-Fault or Liability Auto Insurance.

Amida Care does not pay for services provided under the following circumstances when there is coordination of benefits:

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services); and
- When VA-authorized services are provided at a non-VA hospital or by a non-VA physician.

Member Non-Liability

Contracted providers are prohibited from billing, charging, collecting a deposit from, seeking compensation, remuneration or reimbursement from or have any recourse against a member of Amida Care for services covered under the Amida Care Plans for the period the member is enrolled.

11.3 Timely Filing of Claims

Providers must initially submit claims within the contractually required time frame but no later than 120 calendar days after the date of service, unless otherwise specified by the provider's contract or a different timeframe is required by law. If the agreement between the provider and Amida Care has a claim submission timeframe that is different from 120 days, the agreement will prevail, but the time frame cannot be less than 90 days; the statute does not supersede contracts in existence on 1/1/2010 except for timeframes with less than 90 days for claims submission. All authorization requirements must be met.

Corrected Claims Submissions

If a provider disagrees with the payment determination, a corrected claim must be submitted within sixty

(60) days of the remittance advice for that claim. If the Plan does not receive a request for a corrected claim within sixty (60) days of the remittance advice for that claim, the provider shall be deemed to have waived all rights to assert that the claim is incorrect.

A ***Corrected Claim*** is a claim that has any changes made to an original claim previously submitted that includes, but not limited to a change of the following:

- Place of Service
- Date of Service
- Procedure Codes - including adding or removing modifiers
- Diagnosis Billed
- Units per service
- Dollar amounts
- Provider status changed
- Provider specialty change
- Provider tax id number change

When submitting a Corrected" Professional and/or Institutional claim, the Providers should submit based on the following type of claim:

- HCFA 1500 - Providers will need to populate box 22 on the claim form with "7" and also provider original claim number being corrected.
- UB04 – Claim Bill Type XX7 -

Notes; Corrected Claims submission must follow timely filing guidelines for new claims (Refer to Timely Filing Section for timely filing rules

Reconsideration of Claims Denied Exclusively for Untimely Submission

Where the provider has submitted an untimely claim and can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submission, Amida Care will consider reimbursement of the claim. The criteria for determining what constitutes an unusual occurrence are defined as:

- EOB from Medicaid FFS or any other insurance carrier stating that member is not eligible for coverage with them. The denial EOB must be dated within 90 days of claim submitted to Amida Care.
- Certified receipt from post office showing delivery date of claim to be within 90 days of date of service
- NEIC report/printout from EDI submitter
- Documentation showing extenuating circumstances that the member could not inform insurance carrier

The Provider will need to submit the reconsideration within 60 days of receipt of the denial EOB.

11.4 Explanation of Payment (EOP)

The Explanation of Payment (EOP) describes how claims for services rendered to Amida Care members have been processed. It details the adjudication of claims, indicates the determination made on each claim and describes the amounts paid or denied. There are separate EOPs for inpatient facility services and for outpatient services. The outpatient services EOP includes outpatient facility services, physician services and ancillary services such as durable medical equipment. The EOP shall include the following elements

- Name and Address of Payor
- Toll-free Number of Payor
- Member's Name
- Member's Identification (ID) Number
- Provider's Name
- Provider Tax Identification Number (TIN)
- Claim Date of Service
- Type of Service
- Total Billed Charges
- Allowed Amount
- Discount Amount
- Excluded Charges
- Explanation of Excluded Charges (Denial Codes)

The EOP is arranged numerically by member account number. Inpatient facility claims are sorted separately from all other claims. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- Paid Claim Lines: If the Paid Amount field reads greater than zero (0), the claim was paid in the amount indicated.
- Denied Claim Lines: If the Not Covered field is greater than zero (0) and equal to the allowed amount, the service was denied.
- End of Claim: Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Please note that if you wish to request a review and reconsideration of a claim, a copy of the claim along with a copy of the EOP should be submitted to the address in the claims quick reference guide. All claim review requests must be submitted within 60 days of the date of the EOP. Failure to submit a request within 60 days will result in denial of the request.

11.5 Overpayment, Under Payments and Duplicate Payments

Medical Appeals Address
Amida Care -Claims PO Box 21455 Eagan, MN 55121

Amida Care will give providers an opportunity to challenge an overpayment recovery, including the sharing of claims information. Providers have 30 days from the date of the written notice to challenge the recovery of the overpayment. The provider's challenge must include the specific grounds on which the challenge is based.

If the provider does not respond within 30 days from the date of the written notice, Amida Care will act to recover the funds. The Plan's recovery process may include but is not limited to offsetting the outstanding amount against future claims payment and other collection methods deemed appropriate until the full amount is recouped. The Plan reserves the right to pursue recovery when a written response is not received from the provider thirty (30) days from the date of the notice; during the overpayment challenge process; and/or prior to final determination made.

Amida Care will not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by the provider. However, no such time limit will apply to overpayment recovery efforts that are:

- Based on a reasonable belief of fraud or other intentional misconduct, or abusive billing;
- Required by, or initiated at the request of, a self-insured plan; or
- Required or authorized by a state or federal government program or coverage that is provided by this state to its residents.

11.6 Administrative Claim Appeal and Reconsideration Process

An Appeal Reconsideration is a request by a provider on his/her own behalf to reverse a claims determination, including, but not limited to:

- Payment amount
- Denials in whole or in part due to scope of benefit coverage
- Member eligibility
- Lack of authorization/referral:
- Payor appropriateness: and
- Late claim submission.

Requests by providers on behalf of a Member and requests to reverse determinations governed by Article 49 of New York Public Health Law (i.e., clinical/utilization review determinations) are excluded from this definition.

Participating providers have sixty (60) days from receipt of an Explanation of Payments ("EOP") to submit a Review and Reconsideration related to a claim contained therein. A separate Request must be

submitted for each claim. To be accepted for consideration, the Administrative Appeal must (in addition to being timely): Include the following information

- Provider's identification number.
- Member's name and Amida Care identification number.
- Copy of the EOP
- Date(s) of service.
- Amida Care claim number.
- If applicable evidence of Timely Filing
- If applicable, evidence of Member Eligibility
- Include a copy of the EOP

If an Appeal fails to include all required elements or is not received at the following address by the submission deadline, The Plan's payment of the claim will not be revisited.

The Amida Care Claims Department may deny claims for the following administrative reasons:

- Timely Filing Limit Exceeded (claim receipt date and DOS exceeds 120 calendar days);
- Invalid procedure/diagnosis code;
- Member ineligible on dates of service;
- Duplicate submission of claims;
- No Authorization;
- Lack of Clinical Information;
- Member is SSI Eligible;
- Services requiring pre-authorization;
- Late Notification; an
- Inappropriate Procedure and ICD-9 codes submitted.

The Plan will make a decision on Reconsiderations within sixty (60) days of receipt, although this timeframe may be extended for any particular appeal in The Plan's sole discretion (e.g., to account for complexity, additional documentation, etc.). The provider written notice of our decision will be either an updated EOP or a letter upholding the initial determination/original claim decision. Such notice constitutes our final internal decision related to the claim and no further internal review is available. Should a participating provider wish to challenge our Administrative Appeal decision, further appeal rights, if any, are as dictated by the provider's participation agreement (e.g., dispute resolution process, arbitration, etc.).

Pursuant to Section 3224-a(h)(1) of New York Insurance Law, should we receive an Reconsideration from a participating provider regarding a claim that was denied exclusively because it was submitted untimely, the denial will be reversed, subject to a potential twenty-five (25%) reduction, if the provider is able to demonstrate that: a) his/her non-compliance with the applicable claim submission timeframe was the result of an unusual occurrence; and b) he/she has a pattern/practice of timely submitting claims. The foregoing will apply only if the claim had been submitted within one (1) year of the date of service.

11.7 Serious Adverse Events (SAE) / Other Provider-Preventable Conditions (OPPCs) and Hospital-Acquired Conditions (HACs) / Health Care-Acquired Conditions (HCACs)

Effective November 01, 2012, Amida Care providers are required to forego payment, in whole or in part pursuant to the provisions below, from the Health Plan and hold the member harmless for costs, charges, and expenses directly associated with the occurrence of any Provider Preventable Condition (PPC)/Serious Adverse Event (SAE)/Other Provider Preventable Condition (OPPC) or a Hospital-Acquired Condition (HAC)/Health Care-Acquired Condition(HCAC). Hospitals are required to populate the Present on Admission (POA) indicator on all claims for it to pay.

The Centers for Medicaid and Medicare (CMS) and NYSDOH prohibits the Plan to render payments for the additional cost of services that result from certain preventable healthcare acquired illnesses or injuries, generally referred to as Provider Preventable Conditions (PPCs), Serious Adverse Events (SAE) or “never” events. There are two distinct categories of PPCs: Health Care-Acquired Conditions (HCACs), which apply to inpatient hospital settings, and Other Provider Preventable Conditions (OPPCs), which apply broadly to both inpatient and outpatient health care settings where such events may occur. To implement this rule, payment will not be made by Amida Care for services provided on or after November 01,2012, that include the modifiers PC (wrong surgical or invasive procedure performed on a

patient), PA (surgical or other invasive procedure performed on the wrong body part), or PB (surgical or other invasive procedure performed on a patient).

As Health Care-Acquired Conditions (HCACs), and formerly referred to as Hospital-Acquired

Conditions (HACs), NYSDOH recognizes the following ten HACs for which there will be no payment when the diagnosis is not present on admission (POA):

1. A foreign object retained within a patient´s body after surgery.
2. The development of an air embolism within a patient´s body.
3. A patient blood transfusion with incompatible blood.
4. A patient´s development of stage III or stage IV pressure ulcers.
5. Patient injuries resulting from accidental falls and other trauma, including, but not limited to:
    a. Fractures
    b. Dislocations
    c. Intracranial injuries
    d. Crushing injuries
    e. Burn
    f. Electronic shock
6. A patient´s manifestations of poor glycemic control, including, but not limited to:
    a. Diabetic ketoacidosis
    b. Nonketotic hyperosmolar coma
    c. Hypoglycemic coma
    d. Secondary diabetes with ketoacidosis
    e. Secondary diabetes with hyperosmolarity.
7. A patient´s development of a catheter-associated urinary tract infection.
8. A patient´s development of a vascular catheter-associated infection.
9. A patient´s development of a surgical site infection following:

a. a coronary artery bypass graft – mediastinitis
b. bariatric surgery, including, but not limited to, laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery
c. orthopedic procedures, including, but not limited to, such procedures performed on the spine, neck, shoulder, and elbow.

10. A patient´s development of deep vein thrombosis or a pulmonary embolism in connection with a total knee replacement or a hip replacement, excluding pediatric patients, defined as patients under eighteen years of age, and also excluding obstetric patients, defined as patients with at least one primary or secondary diagnosis code that includes an indication of pregnancy.

In addition, the NYSDOH recognizes the following three CMS National Coverage Determinations, for which Amida Care also will make no payment when they occur in either an inpatient or an ambulatory setting, including a physician's office:

1. Surgery on the wrong patient.
2. Wrong surgery on a patient.
3. Surgery performed on the wrong site.

Other Provider Preventable Conditions that will disallow reimbursement:

1. Patient disability associated with a medication error.
2. Patient disability associated with use of contaminated drugs, devices, biologics provided by healthcare facility.
3. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
4. Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
5. Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended

11.8 Claims Requiring Manufacturer's Invoice

Claims that require a manufacturer's invoice for payment consideration (*e.g. "By Report" (BR) procedure*) must be submitted with all of the following required information in order to be validated as an acceptable invoice:

- Manufacturer's Name
- Provider Name
- Item with Description
- Acquisition Cost on the invoice
- Invoice Date

Some examples of **unacceptable** invoices are: altered manufacturer's invoice, purchase orders, sales orders, order confirmations packing slips and delivery receipts.

Note, any claim received by Amida Care that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice, will be denied.

Our Behavioral Health

12.1 Behavioral Services Quick Reference Guide

Behavioral Health Appointment Standards: Behavioral Health Providers are required to assure the following appointment availability standards are met. Amida Care's Quality Management Department is responsible for the measurement and reporting of these standards in conjunction with Amida Care Behavioral Health Vendor – Carelon Behavioral Health.

ADULT APPOINTMENT AVAILABILTY STANDARDS

Quick Reference Guide of Appointment Availability Standards: **Behavioral Health Services for Adults (age 21 and over)** ***All acronyms in this table are explained in the legend below the grid**						
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**BH Specialist**	**Follow-up to emergency or hospital discharge**	**Follow-up to jail/prison discharge**
MH Outpatient Clinic/PROS Clinic		Within 24 hours	Within 1 week		Within 5 days of request	Within 5 days of request
ACT		Within 24 hours for AOT		n/a	Within 5 days of request	
PROS		Timeframe to be determined	Within 2 weeks		Within 5 days of request	Timeframe to be determined
Continuing Day Treatment				2-4 weeks		Timeframe to be determined
IPRT				2-4 weeks		
PHP					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Adults (age 21 and over) *All acronyms in this table are explained in the legend below the grid						
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**BH Specialist**	**Follow-up to emergency or hospital discharge**	**Follow-up to jail/prison discharge**
OFFICE OF ADDICTION SERVICES AND SUPPORTS Outpatient Clinic		Within 24 hours	Within 1 week of request		Within 5 days of request	Timeframe to be determined
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hours				
OTP		Within 24 hours			Within 5 days of request	
Rehabilitation services for Residential SUD treatment supports				2-4 weeks	Within 5 days of request	
1915(i)-like Home and Community Based Services (HCBS)						
Rehabilitation and Habilitation	n/a	n/a	Within 2 weeks of request		Within 5 days	
Crisis Intervention/Respite	Immediately	Within 24 hours for short term respite	n/a		Immediate	
Educational and Employment Support Services	n/a	n/a	Within 2 weeks of request		n/a	

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Adults (age 21 and over) *All acronyms in this table are explained in the legend below the grid						
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**BH Specialist**	**Follow-up to emergency or hospital discharge**	**Follow-up to jail/prison discharge**
Peer Supports	n/a	Within 24 hours for symptom management	Within 1 week of request		Within 5 days	

LEGEND: Behavioral Health Services for Adults (age 21 and over)

ACT – Assertive Community Treatment BH – Behavioral Health CPEP – Comprehensive Psychiatric Emergency Program IPRT – Intensive Psychiatric Rehabilitation Treatment MH – Mental Health	OFFICE OF ADDICTION SERVICES AND SUPPORTS – Office of Alcoholism and Substance use Services OTP – Opioid Treatment Program PHP – Partial Hospitalization Program PROS – Personalized Recovery Oriented Services (PROS) SUD – Substance Use Disorder

CHILDREN APPOINTMENT AVAILABILTY STANDARDS

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Children — Under Age 21 *All acronyms in this table are explained in the legend below the grid					
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**Follow-up to emergency or hospital discharge**	**Follow-up to residential services, detention discharge, or discharge from justice system placement**
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2–4 weeks	Within 24 hours	

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Children — Under Age 21 *All acronyms in this table are explained in the legend below the grid					
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**Follow-up to emergency or hospital discharge**	**Follow-up to residential services, detention discharge, or discharge from justice system placement**
PHP				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OFFICE OF ADDICTION SERVICES AND SUPPORTS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Children — Under Age 21 *All acronyms in this table are explained in the legend below the grid					
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**Follow-up to emergency or hospital discharge**	**Follow-up to residential services, detention discharge, or discharge from justice system placement**
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 business days of request		Within 2 weeks of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request

Quick Reference Guide of Appointment Availability Standards: Behavioral Health Services for Children — Under Age 21 *All acronyms in this table are explained in the legend below the grid					
Service Type	**Emergency**	**Urgent**	**Non-urgent MH/SUD**	**Follow-up to emergency or hospital discharge**	**Follow-up to residential services, detention discharge, or discharge from justice system placement**
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

LEGEND: Behavioral Health Services for Children (Under age 21)

CPEP – Comprehensive Psychiatric Emergency Program CPST – Community Psychiatric Support and Treatment IPRT – Intensive Psychiatric Rehabilitation Treatment MH – Mental Health OFFICE OF ADDICTION SERVICES AND SUPPORTS – Office of Alcoholism and Substance use Services	OLP – Other Licensed Practitioners OTP – Opioid Treatment Program PHP – Partial Hospitalization Program PSR – Psychosocial Rehabilitation SUD – Substance Use Disorder

12.2 Behavioral Health Services

Behavioral Health Quick Reference Guide		
Provider Utilization Services	**Inpatient/Outpatient Mental and Detox/Rehab Utilization:**	**BH Claims and Appeals**
1-866-664-7142	1-866-664-7142	Carelon Behavioral Health Options, Amida Care Health Plan Claims Department: P.O. Box 1856 Hicksville, NY 11802-1856

Amida Care's network provider for behavioral health services is Carelon Behavioral Health . Carelon's network includes over three thousand providers including specialties in Psychiatry (child, adult, and addiction), Licensed/Clinical Social Work, Counseling, and Psychology. The

key components of this managed Behavioral Health Services program are:

- Credentialing of all providers and facilities;
- Ensuring mental health and substance use dependency screening at least annually;
- Utilization management of outpatient and diversionary services as contractually indicated
- Utilization management of inpatient mental health services, inpatient substance use dependence services and outpatient detoxification services as contractually indicated
- Quality management of all behavioral health services to ensure that members are being served appropriately.

Initial screening and comprehensive mental health and substance use dependency assessments are performed for each Amida Care member as a component of the new member assessment process. Primary Care providers are required to conduct at least annually an assessment of mental health and substance use dependence status using a nationally recognized tool. PCP may submit claims for the assessment using the appropriate procedure codes.

An Amida Care member may receive substance use dependence counseling or mental health support services co-located at his/her PCP site or at another location.

The member's PCP is responsible for connecting members to behavioral health services as needed. The Primary Care Site ensures that inpatient and outpatient behavioral health services are appropriate and coordinated with the member's other care.

Benefits: Behavioral health benefits available to Amida Care members are listed in the summary of benefits; see the quick reference guide at the end of this section or at the following https://www.amidacareny.org/wp-content/uploads/ac-benefit-guide-05-10-2022_2022510161728.pdf

Access to Care: All Amida Care members may self-refer to behavioral health services for outpatient mental health assessments and services, outpatient substance use dependence assessments and services, for inpatient or outpatient detoxification, inpatient rehabilitation, and inpatient psychiatric hospitalization. Self-referrals for children may originate at the suggestion of a school guidance counselor or other such professional.

Utilization Management: Behavioral health services are subject to utilization management to ensure that the most appropriate treatment and level of care are being provided to Amida Care members. All behavioral health services utilization management is provided by Carelon Behavioral Health . See Section 5 in Carelon Behavioral Health Provider Manual for utilization management timeframes and phone numbers.
https://www.carelonbehavioralhealth.com/providers/forms-and-guides/ny

Buprenorphine Treatment Services: The administration of Buprenorphine is a covered benefit when an in-network provider conducts the service. The management of Buprenorphine is conducted for the maintenance or detoxification of patients with substance use dependency. Buprenorphine is administered as part of a clinic or office visit. In order for a provider to obtain reimbursement for rendering these services, the provider must be contracted for this service

and also be a certified dispenser of this medication. Amida Care will confirm that a provider is certified to render this treatment by checking that the provider's name appears on the listing generated by the Substance use & Mental Health Services Administration (SAMHSA). The provider must qualify as an authorized provider under the Drug Addiction Treatment Act of 2000 (DATA 2000).

Each certified physician may have a maximum of 30 patients on opioid replacement therapy at any one time for the first year. If the provider would like to increase the number of patients they can treat, the increase must be at least one year after the date they notified SAMHSA of their intent to render this service. After this timeframe has elapsed the provider can submit a secondary notification of the need and intent to treat up to 100 patients.

When a new certified provider is going through the credentialing process, the provider must indicate if they are in fact a certified provider. Once the provider has completed the credentialing process, the provider will be notified (1) what specialty they have been approved to render services as and (2) that they have been confirmed as a certified Buprenorphine provider.

Behavioral Health Care Provider Responsibilities:

Amida Care expects behavioral health providers to assume the following responsibilities:

- Comply with the established policies and procedures of Amida Care's Utilization (Medical) Management Plan and Quality Management and Improvement Programs.
- Adhere to the Amida Care treatment principles outlined below.
- Coordinate with Amida Care when necessary to ensure appropriate integration of services.

Details including contracting, and credentialing processes for behavioral health providers including OMH licensed and OFFICE OF ADDICTION SERVICES AND SUPPORTS certified are found in our Behavioral Health Vendor, Carelon Behavioral Health, and provider manual. The Carelon Behavioral Health provider manual also presents all the requirements including quality managements and data and claims submissions. The Carelon Behavioral Health Provider Manual can be access through their web portal at:
https://www.carelonbehavioralhealth.com/providers/forms-and-guides/ny.

The Carelon HARP Provider Manual can be access through their web portal at:https://www.carelonbehavioralhealth.com/content/dam/digital/carelon/cbh-assets/documents/ny/behavioral-health-policy-and-procedure-manual-for-providers-harp.pdf

Amida Care Behavioral Health Treatment Principles:

Amida Care follows general treatment principles and guidelines that are consistent with established clinical practice and standards for behavioral health care. Carelon Behavioral Health provide these principles for Amida Care members. See Section 4 and 5 in Carelon Behavioral Health Provider Manual.

12.3 Covered Behavioral Health Benefits

The following behavioral health services covered through Carelon Behavioral Health for Amida

Care members

- Applied Behavior Analysis (ABA)
- Inpatient – Substance Use Disorder and Mental Health
- Clinic – Substance Use Disorder and Mental Health
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment (ACT), Young Adult ACT & Youth ACT
- Continuing Day Treatment (CDT)
- Partial Hospitalization
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intensive Outpatient Program (IOP)
- Mental Health Outpatient Treatment and Rehabilitative Services
- Opioid Treatment Programs
- Outpatient Substance use Dependence Rehabilitation
- Rehabilitation Services for Residential SUD Treatment Support
- Rehabilitation Supports for Community Residences
- Residential Rehabilitation Services for Youth (RRSY)
- Buprenorphine Prescribers
- Ambulatory Detox
- Inpatient and Outpatient Electroconvulsive Therapy (ECT)
- Mobile Crisis Intervention
- Crisis Residence Services
- Children and Family Treatment and Support Services (CFTSS)
- Adult Behavioral Health Home and Community Based Services (Adult BH HCBS)
- Children's Home and Community Based Services (HCBS)
- Community Oriented Recovery and Empowerment Services (CORE)

HARP Eligibility Target Criteria and Risk Factors or HARP Eligibility Target Criteria

Amida Care members who are HARP eligible are identified by New York State Department of

Health using the following target criteria and risk factors.

A. **The State of New York has chosen to define HARP targeting criteria as: OFFICE OF ADDICTION SERVICES AND SUPPORTS**

i. Medicaid enrolled individuals 21 and over;
ii. Serious Mental Illness (SMI)/Substance Use Disorder (SUB) diagnoses;
iii. Eligible to be enrolled in Mainstream MCOs;
iv. Not Medicaid/Medicare enrolled ("duals");
v. Not participating or enrolled in a program with the Office for People with Developmental
vi. Disabilities (OPWDD) (i.e., participating in an OPWDD program).

B. **Risk Factors:** For individuals meeting the targeting criteria, the Risk Factor criteria include any of the following:

i. Supplemental Security Income (SSI) individuals who received an "organized" MH service in the year prior to enrollment.
ii. Non SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
iii. SSI and non SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
iv. SSI and non SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
v. SSI and non SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
vi. SSI and non SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
vii. SSI and non SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
ix. Members with two or more services in an inpatient/outpatient substance use dependence detoxification program within the year prior to enrollment.
x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis related group and a secondary diagnosis of SUD within the year prior to enrollment.
xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
xiii. Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

Members who meet these criteria and risk factors will be referred for enrollment in a Health Home. As of January 1, 2016, HARP eligible members may be able to access Home and Community Based Services (HCBS) (Services listed below). For more information on eligibility for these services including the assessment process see Health Home section 15.2

Adult Home and Community Based Services

Adult HCBS	
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST) • Crisis Intervention	**Habilitation** • Habilitation • Residential Supports in Community Settings
Peer Support	**Family Support and Training**
Respite **b.** Short-term Crisis Respite, **c.** Intensive Crisis Respite	**Employment Supports** • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment
Non-medical transportation	**Education Support Services**
Supports for self-directed care [phased in as a pilot; see details below] • Information and Assistance in Support of Participation Direction • Financial Management Services	

Children Home and Community Based Services

Children HCBS	
i.	Caregiver/Family supports and services
ii.	Community self-advocacy Training and supports
iii.	Respite (planned and crisis)
iv.	Prevocational services
v.	Supported employment.
vi.	Community Habilitation
vii.	Day Habilitation
viii.	Palliative care
ix.	Environmental modifications
x.	Vehicle modifications
xi.	Adaptive and assistive equipment

Amida Care's HCBS provider network is provided by Carelon and Amida Care for Palliative Services. For Carelon Palliative Care Services, please refer to: https://www.carelonhealth.com/palliative-care

Details on provider requirements are in the Carelon HARP Provider Manual. Included in the Carelon HARP Provider Manual are:

- Appointment and availability standards;
- Credentialing criteria;
- Utilization management criteria including service plans and member chart requirements;
- Provider Education and Training; and
- Billing and Claims submission requirements.

CARELON BEHAVIORAL HEALTH – HARP PROVIDER MANUAL
https://www.carelonbehavioralhealth.com/content/dam/digital/carelon/cbh-assets/documents/ny/behavioral-health-policy-and-procedure-manual-for-providers-harp.pdf

*An “organized” MH service is one, which is licensed by the NYS Office of Mental Health.

Definitions

CDOH shall mean the New York City Department of Health and Mental Hygiene

CMS shall mean the Centers for Medicare and Medicaid Services – Federal agency that administers Medicare program and oversees Medicare Advantage plans.

SDOI shall mean the New York State Department of Insurance.

Participating Provider shall mean a Provider who contracted with and credentialed by Amida Care to provide services to Amida Care members.

Primary Care Provider (PCP) shall mean a Participating Provider who has been credentialed as a PCP in accordance with Amida Care credentialing policies.

Provider shall mean a Health Professional, pharmacy, hospital, nursing home or other health care facility engaged in the delivery of health care services, which is licensed and/or certified as required by applicable state, and/or federal law

NYSDOH shall mean the New York State Department of Health.

HIV Specialist Primary Care Provider shall mean an HIV-experienced Primary Care Provider who has been credentialed as an HIV Specialist PCP by Amida Care.

Emergency Condition shall mean 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 afflicted 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, or (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. N.Y. ISC. LAW 4303: NY Code - Section 4303.

Medically Necessary shall mean health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.

Clean Claim shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

AMIDA CARE COMPLIANCE HOTLINE 888.394.2285

If you suspect fraud, waste, or abuse:

Do you suspect any cases of fraud, waste, or abuse?

Please call the Amida Care Compliance Hotline at 888-394-2285. We're here to help 24 hours a day, 7 days a week, 365 days a year. The call is free.

When you call the hotline, you can leave your name and number. Or you can stay anonymous. Either way, the source of the facts you share will remain anonymous.

Other options for reporting anonymously:

Compliance mailbox: compliance@amidacareny.org

Compliance address: Amida Care, Attn: Compliance, 14 Penn Plaza, 2nd Floor, NYC, NY 10122