Provider Manual

Fully Integrated Duals Advantage (FIDA) Plan
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INTRODUCTION

AgeWell New York welcomes you as part of the Fully Integrated Duals Advantage (FIDA) provider network. Our network of physicians and community providers promote health and well-being through the provision of high quality, cost effective health care in the home and the community. It is our responsibility to collectively coordinate and provide necessary health care services for our participants.

You have joined a rapidly expanding network committed to caring for the frail elderly chronically ill population. AgeWell New York has been serving this population since our inception in 2012 as a Managed Long Term Care Plan (MLTC). AgeWell New York’s FIDA Program is designed to meet the needs of the dually eligible population (Medicare and Medicaid) residing in the boroughs of Queens, Brooklyn, New York (Manhattan), Bronx and the counties of Nassau, Suffolk and Westchester.

Our goal and guiding principles include:

- Offering plan benefits that improve access to appropriate care, including assistance with navigating an increasingly complex health care system
- Shifting the focus of care from the institution to the home and community
- Targeting and customizing interventions based on the needs of the participant
- Making care management the cornerstone of care and services to participants by assigning a Care Manager and Interdisciplinary Team to each and every member

AgeWell New York’s FIDA Program provides Medicare and Medicaid benefits to its members, including Part D covered items. Through its network providers, AgeWell New York has access to an adequate network of medical and supportive services. All care, either provided directly by the plan or coordinated through network providers, is coordinated by a Care Manager and the member’s Interdisciplinary Team. The Care Manager, as the leader of the Interdisciplinary Team (IDT), interacts directly with participants and providers to ensure that appropriate services are provided at the appropriate time.

As a network provider, you play a crucial role in assisting participants meet their goals by providing efficient, high quality care and services. We value your purpose and encourage that each interaction you may have with our participants be filled with compassion and dedication to excellence in service delivery.

At AgeWell New York, you are a valued partner in caring for our participants/your patients. This manual was designed to assist you and your office staff to understand the requirements of AgeWell New York, in addition to serving as a resource for any questions you have about our plan. It serves as a supplemental guide to the Provider Agreement. Since changes in Medicare and Medicaid policies and AgeWell New York operations are inevitable over time, remember changes to policies herein are subject to updates and modifications. If AgeWell New York updates any of the information in this manual, we will provide bulletins, as necessary, and post the changes on our website –www.agewellnewyork.com. You can also find a copy of this manual on the For Providers section of our website.
AgeWell New York is proud of the relationship with our participating providers and is committed to working with you to provide the support and assistance necessary to meet the needs of your patients. We look forward to a beneficial working relationship.

Thank you for joining our dedicated team of providers, should have any questions, please call Provider Relations at 866-586-8044.
**KEY CONTACTS AND RESOURCES**

I. Dedicated Staff to Assist Our Participating Providers

**Provider Relations**

Our Provider Relations Department is responsible for oversight functions related to maintaining provider network, ensuring adequacy of number of providers and access; training providers; credentialing activities and continuous monitoring of provider network performance.

The AgeWell New York Provider Relations Department is the primary connection between you and our plan. They are responsible for recruiting providers and managing the plan’s provider relationships that make up the health care delivery system, including individual practitioners, groups, hospitals, skilled nursing facilities, medical equipment suppliers and other providers. The main focus of the Provider Relations Department is to assist you with all aspects of your plan participation.

Your Provider Relations Manager will assist you by:

- Serving as a point of contact with the plan
- Orienting you and your staff on the AgeWell New York policies and procedures
- Providing ongoing education concerning changes in operational procedures
- Responding in a timely manner to any of your questions or concerns
- Establishing provider connection to the AgeWell New York systems
- Administering the credentialing process

**Provider Claims**

AgeWell New York’s Provider Claims Department provides claims processing and claims payment using certain services of RelayHealth to ensure appropriate requirements are being met efficiently and effectively, and in compliance with state and federal regulations. The Provider Claims Department is responsible for paying claims as defined in the terms of your contract with AgeWell New York.

**Utilization Management**

Our Utilization Management (UM) Department is the contact point for utilization management (UM) and related functions to include prior authorization, inpatient concurrent review, clinical training, and related compliance programs, as examples. We support the utilization management function with leading practice UM applications, monitoring and reporting tools and techniques, and professional development of staff.

**Quality Management**

The Quality Management Department oversees the following aspects of our participants’ Healthcare and service provision:
• Quality of care for our members
• Member satisfaction, including the evaluation of grievances and appeals
• Access and availability standards

Quality Management is also responsible for managing and training the appeals and grievances team and complying with state and federal requirements related to processing appeals and grievances.

**Member Services**

Member Services oversees and directs the operations of Member Services, or the Participant Call Center and ensures the adequacy and appropriate training of call center representatives. Providing excellence in customer service and responsiveness to calls from prospective or current members, it is our utmost concern.

The Member Services staff is responsible for:

- Providing telephone access through the member call center
- Providing members with information about their health benefits
- Assisting members to select or change a PCP or help them find a network provider
- Fielding and responding to member questions and complaints
- Clarifying information in the member handbook
- Responding to communications received from members and providers

**Medical Management**

Medical Management is responsible for overseeing the management of medical and clinical care to members. This includes, ensuring quality care, guiding Care Management teams, developing clinical initiatives to support improved health outcomes and use of preventive health strategies, developing and implementing effective utilization management practices, and providing overall medical expertise and direction for clinical policies, procedures and programs.

Specific activities performed include:

a. assisting providers in determining and coordinating the most appropriate setting for care;
b. assisting in the provision of timely access to health care services based on member need, available resources and community standards of care;
c. assisting in the assurance of continuity of patient care that provides early intervention and prompt initiation of discharge planning;
d. assisting in the implementation of related policies and procedures,
e. educating members on prevention and obtaining disease specific intervention,
f. coordinating and providing Medicare and Medicaid services for the member and
g. ensuring psychosocial care management is provided by contracted and credentialed behavioral health vendors, community-based organizations, within the plan’s network.
Care Management

Care Management provides the leadership, strategy, planning and related oversight to the AgeWell New York comprehensive care management program. This includes developing, maintaining and monitoring the effectiveness and performance of Care Management. Oversight is provided to ensure optimal resources, training of staff and delivery of care management services to AgeWell New York members with considerations of integrated care management, interdisciplinary care team, individualized plans of care, leading practice Health Risk Assessments and related functions to improve the health and wellbeing of members.

Upon enrollment, our members work closely with a Care Manager whose responsibility is to understand all of their health care needs and coordinate the necessary services. Our members help to develop their plan of care and, of course, agree to it. As their health care needs change, a member and his/her Care Manager, along with the interdisciplinary team (IDT), may decide to change the plan of care. The Care Manager works with the IDT to make sure that the overall plan of care meets the health care needs of the member.

Pharmacy Benefits Operations and Management

AgeWell New York contracts with EnvisionRx, a Pharmacy Benefits Management (PBM)/Part D organization that manages the pharmacy benefit, including pricing, paying pharmacies and determining levels of coverage for certain drugs. EnvisionRx is responsible for ensuring compliance with state and federal requirements, maintaining systems for seamless integration of member information into Care Management, Utilization Management, Quality Assurance and other critical functions to support the care management of members and improvement of health outcomes.

Enrollment

Oversees and manages the activities of the clinical assessment functions of the plan, including meeting the initial assessment requirements. Enrollment also works to ensure accurate member rosters and fulfillment of member materials.

II. Directory of Important Phone Numbers and Addresses

Hours of Operations

For general inquiries relating to benefits, providers and services Monday through Friday, from 8:00 am to 8:00 pm EST. Calls placed after normal business hours will be forwarded to our answering service.
Important Phone Numbers and Addresses

CLAIM SUBMISSIONS
Paper claims: AgeWell New York | P.O. Box 21536 | Eagan, MN 55121
Electronic claims: Change Healthcare (Emdeon) Payer ID: AWNY6
Provider claims call center: 866-237-2140

Claims and Billing Inquiries 866-237-2140

PROVIDER RELATIONS
718-484-5000
providers@agewellnewyork.com
1991 Marcus Avenue | Suite M201 | Lake Success, NY 11042

Claims Appeals AgeWell New York | 1991 Marcus Avenue | Suite M201 | Lake Success, NY 11042 |
Attn: Claims & Appeals

Member Grievance & Appeals AgeWell New York | 1991 Marcus Avenue | Suite M201 | Lake Success, NY 11042 |
Tel: 866-586-8044 Fax: 855-895-0778 | Attn: Grievance and Appeals

Member Services, Enrollment & Eligibility Verification 866-586-8044 (after option 3, press 1)

Medical Management Including Prior Authorization 866-586-8044 (after option 3, press 4)
Pre-Authorization fax line 1-855-527-5515

Transportation Services (Non-Emergency) National Med Trans: 855-639-6609

Dental Services HealthPlex: Provider Services: 888-468-2183 | Member Services: 888-468-9868

Vision Services VSP– 800-877-7195

Pharmacy Services
EnvisionRx Options (Pharmacy Benefit Management) Medicare Plans/Special Needs Plans 844-782-7670 FIDA (Medicare-Medicaid Plan) 855-889-0046

Interpreter Services
For assistance in coordinating interpreter services for those members in need of support with limited English proficiency (LEP) or limited reading proficiency (LRP) - 866-586-8044, Hearing and/or visual Impairment- TTY/TDD– 1-800-662-1220
III. Website Information

Please take a look at our website www.agewellnewyork.com. On our website you can find information about:

- Supporting Forms
- List of Services that Require Prior Authorization
- Provider Search
- Online Eligibility and Claims Access
- AgeWell New York Formulary
- Provider Manual
- Mandatory Provider Education, Trainings, and Attestations
- EFT/ERA Information
- Reference Guide
- Claims Submission Information
- Provider Information Change Form
- Provider Contact Update Form
I. Verifying Member Eligibility

You may obtain information on AgeWell New York member eligibility by calling the Member Eligibility at 866-586-8044. Our hours are Monday through Friday from 8:00 am to 8:00pm EST.

In order to verify a member’s eligibility please ask to see the member’s AgeWell New York ID card at each appointment, emergency visit or inpatient stay. The presentation of an ID card does not guarantee eligibility or payment of benefits because a member’s enrollment status can change due to various reasons, including disenrollment or loss of Medicaid or Medicare eligibility.

Providers should verify member eligibility as outlined below:

- Call Member Services at 866-586-8044

- Providers with eMedNY access may check the enrollment of Medicaid members on ePACES.

AgeWell New York will reimburse providers only for services rendered to currently eligible members. It is the responsibility of the provider to verify eligibility prior to providing services.
II. Member ID Card

All AgeWell New York participants in our FIDA Program are given an identification card (sample below). Members should present their ID cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.

![Sample Member ID Card]

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**Paper Claims Submission:**
AgeWell New York
P.O Box 21535
Eagan, MN 55121

**Electronic Claims Submission:**
Payer ID: AWNY6
Claims Inquiry: 1-866-237-2140
agewellnewyork.com
VSP (Vision): 1-800-877-7195
Healthplex (Dental): 1-800-468-9868
Non Par Provider: 1-718-484-5044
Utilization Management: 1-718-696-0210

**www.agewellnewyork.com**
Member Services: 1-866-586-8044
Authorization Fax Line: 1-855-895-0776
TTY for Hearing Impaired: 1-800-662-1220
Prescription Drug Member Service:
1-844-782-7670 or TTY: 711
Prescription Drug Mail Order:
1-844-293-4761 or TTY: 711
Over the Counter (OTC): 1-866-586-8044
III. Covered Services and Eligible Participants

AgeWell New York FIDA program, offers coverage to individuals who meet all of the following criteria:

- Age at least 21 years of age;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Reside in the counties of Bronx, Kings, Nassau, New York, Queens, Suffolk, and Westchester

Individuals must also meet one of the following criteria:

- Are Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS);
- Are eligible for the Nursing Home Transition and Diversion 1915 Waiver;
- Require community-based long term care services for more than 120 days.

AgeWell New York will coordinate and provide health care needs of our members through our Care Managers and the Interdisciplinary Team. We will arrange for network providers to deliver the appropriate and authorized care and services for members as determined in the member’s Person-Centered Service Plan (PCSP).

Members are not responsible for the payment to providers of covered services; therefore, providers should not seek payments from AgeWell New York members to whom they provide healthcare/services to. Providers are paid for medically necessary services by AgeWell New York, pursuant to the Provider Agreement. Medically necessary means those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant’s capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, AgeWell New York will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

Providers are prohibited from balance billing participants under the FIDA Demonstration.
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MEMBER RIGHTS AND RESPONSIBILITIES

The health and safety of all AgeWell New York members is important to everyone who is involved in their care. AgeWell New York members have the following rights and responsibilities.

I. **Member Rights**

- Each member has the right to be treated with respect and with consideration of their dignity and privacy.
- Members’ with physical disabilities have a right to reasonable accommodations when receiving care and treatment.
- Each member has the right to be treated fairly regardless of their race, religion, gender, ethnicity, age, disability or source of payment. AgeWell New York shall not discriminate against members due to medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
- Each member has the right to have their treatment and other member information kept private and confidential. Only where permitted by law, may records be released without the member’s permission.
- Each member has the right to easily access care in a timely fashion.
- Each member has the right to a candid discussion of appropriate or medically necessary treatment, and to receive information on available treatment options and alternatives for their condition, presented in a manner appropriate to the member’s condition and ability to understand.
- Each member has the right to share in developing their plan of care.
- Each member has the right to receive interpretation services at no cost to the member, including the right to receive information in a language they can understand. Information is available in alternate formats upon request.
- Each member has the right to receive information about AgeWell New York, its practitioners, programs, services, clinical guidelines, its providers and practitioners, their rights and responsibilities as members and their role in the treatment process.
- Each member has the right to receive information about clinical guidelines used in providing and managing their care.
- Each member has the right to ask their provider about their work history and training.
- Each member has the right to give input on the AgeWell New York’s Rights and Responsibilities policy.
- Each member has the right to know about advocacy and community groups and prevention services.
- Each member has the right to request certain preferences in a provider.
- Each member has the right to have provider decisions about their care made on the basis of treatment needs.
- Each member has the right to be furnished health care services in accordance with Federal and State laws that pertain to member rights.
• Each member has the right to participate in decisions regarding his or her health care, including the right to receive a second medical opinion, and the right to refuse treatment.
• Each member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.
• Each member has the right to file a complaint/grievance about AgeWell New York, a provider or the care received.
• Each member has the right to file an appeal about an AgeWell New York action or decision.
• Each member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
• Each member has the right to exercise his or her rights, and that the exercise of those rights does not negatively affect the way AgeWell New York and its providers treat the member.
• Each member has the right to receive written information on advanced directives and their rights under State law.
• Each member has the right to decline participation or withdraw from programs and services.
• Each member has the right to know which staff members are responsible for managing their services and from whom to request a change in services.
• Each member shall be informed that they will not be balance billed by a provider for any service. AgeWell New York shall have this articulated through its policies and procedures and staff training modules.

II. **Member Responsibilities**
• Each member has the responsibility to treat those giving them care with dignity and respect.
• Each member has the responsibility to give providers and AgeWell New York information they need in order for providers to deliver quality care and for AgeWell New York to deliver appropriate service.
• Each member has the responsibility to ask their providers questions about their care. This is to help them understand their care.
• Each member has the responsibility to follow their treatment plan. The plan of care is to be agreed upon by the member and provider.
• Each member has the responsibility to follow the agreed upon medication plan.
• Each member has the responsibility to tell their providers and primary care physician about medication changes, including medications given to them by others.
• Each member has the responsibility to keep their appointments. Enrollees should call their provider(s) as soon they know they need to cancel visits.
• Each member has the responsibility to let their provider know when the treatment plan is not working for them.
• Each member has the responsibility to report abuse and fraud. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.
- Each member has the responsibility to openly report concerns about quality of care.

**Member Satisfaction**

AgeWell New York periodically surveys members to measure overall participant satisfaction as well as satisfaction with the care received from participating providers. AgeWell New York reviews satisfaction survey information and the results are shared with participating providers. AgeWell New York also reviews grievance and appeal data to identify opportunities to improve participant satisfaction.

**Services Provided in a Culturally Competent Manner**

AgeWell New York is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate with AgeWell New York in meeting this obligation. AgeWell New York makes resources available to providers to support the provision of culturally, linguistically, or disability competent care. These resources include training programs, informational materials, access to our Language Line services, and conferences with our Provider Relations or Care Management professionals as requested.

**Meeting Accessibility and ADA Requirements**

All medical, behavioral, and community-based and facility-based network providers are required to attest and meet physical accessibility in the following areas:
- Reasonable accommodations to those with hearing, vision, cognitive and psychiatric disabilities
- Utilizing waiting room and exam room furniture that meet needs of those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or provide enough parking
- Utilizing clear signage and way finding throughout facilities

AgeWell New York accommodates participant individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for those with cognitive limitations, and interpreters for those who do not speak English. AgeWell New York makes resources available, including language lines, to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Participants that require culturally-, linguistically-, or disability-competent care. Please contact Provider Services for additional information.

Providers must submit a signed ADA Accessibility Attestation form. All participating providers must notify AgeWell New York of any change to meet accessibility within ten (10) business days of the change.
III. Non-Discrimination

Participating providers will comply with Title VI of the Civil Rights Act of 1964, as amended (42U.S.C. Section 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29U.S.C. Section 794) and the regulations there under, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. seq.), Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849), the Americans With Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

Each participating provider will provide all covered services to members in the same manner as such services are provided to other patients of participating providers, except as required by AgeWell New York. FIDA participating providers will not discriminate against any member on the basis of medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or in any manner in regards to access to, and the provision of, covered services. Participating providers will not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, physical handicap, marital status, age or sex.

IV. Patient Self-Determination

AgeWell New York requires that participating providers comply with the requirements of the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990). The Patient Self-Determination Act protects an adult patient’s right to participate in health care decisions to the maximum extent of his/her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for health care. All members must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive. An Advance Directive is a member’s written instructions, recognized under State law, relating to the provision of health care when the member is not competent to make health care decisions as determined under State law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

Providers must inform a member of his or her medical condition and all available treatment options, including treatments, which may not be a covered service under the member’s AgeWell New York Evidence of Coverage or Member Handbook. In addition, members must be informed of the risks and benefits of each treatment option. The adult member’s medical record must have documentation indicating whether or not the patient has executed an Advance Directive. The Advance Directive document must be signed by the member and witnessed. Providers may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

Medicare law gives members the right to file a complaint with the state survey and certification agency if the member is dissatisfied with the organization’s handling of Advance Directives.
and/or if a provider fails to comply with Advance Directive instructions. If so, the member may write the NY State Department of Health.
PROVIDER ROLE AND RESPONSIBILITIES

Participating providers are solely responsible for the medical care and treatment of members and will maintain the physician-patient relationship with each member. Nothing contained in the participating provider’s agreement is intended to interfere with such physician-patient relationship, nor is the participating provider agreement intended to discourage or prohibit participating providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by participating providers.

Participating providers agree to provide services to all members in the same manner, in accordance with the same standards and with the same priority as their other patients. Providers may not discriminate on the basis of color, race, creed, gender, and sexual orientation, place of origin, disability, and source of payment, type of illness or condition or any other prohibited basis. AgeWell New York also requires that network providers assist its members with limited English speaking proficiency and physical disabilities.

The following describes some important responsibilities for our participating providers.

I. Requirements for all Providers

AgeWell New York participating professionals, hospitals, facilities, agencies and ancillary providers agree to the following:

Contractual Requirements: Contracted providers must adhere to all contractual, administrative, medical management, quality management, appeals & grievances, and reimbursement policies as outlined in all AgeWell New York provider contracts, this provider manual and any supplemental updates. Failure to adhere or comply with all contractual/regulatory requirements may result in termination of your contract.

Non-Discrimination: As described above in section III. Non-Discrimination.

Collection of Co-payments: The AgeWell New York FIDA program is a dual demonstration program. As such, providers cannot collect copays from FIDA participants, nor can providers balance bill this population.

Cultural Sensitivity: Provider ensures members of various racial, ethnic and religious backgrounds; as well as disabled individuals are communicated with in an understandable manner, accounting for different needs. All efforts must be made to speak with the member in their primary language. Translation services through a family member, friend, or other health care professional that speaks the same language is encouraged. It is the provider’s responsibility to ensure the member clearly understands the diagnosis and treatment options that are presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

Ethical Medical Practice: Provider agrees to provide services within the scope of the provider’s license and/or specialty. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical
Association and all other medical and specialty governing bodies. Provider agrees to report to AgeWell New York any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

Credentialing and Recredentialing

- AgeWell New York credentials providers upon acceptance of application and signed participation contract.
- AgeWell New York recredits all participating providers on a three (3) year cycle from date of initial credentialing.
- Provider must notify AgeWell New York within two business days if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification in two business days is also required when any reportable action is taken by a City, State or Federal agency.
- Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur as a result of item above, the provider must notify AgeWell New York immediately.
- Groups or IPAs must contact the Network Planning and Operations Department as soon as a new associate joins the group or IPA. AgeWell New York will provide you the necessary materials to begin the credentialing process for the new providers in the group or IPA.
- Any change, addition or deletion of office hours, associate or billing address should be sent in writing within 60 days to ensure accuracy of AgeWell New York directories and databases.

Billing Requirements

- Provider may NOT balance bill members for authorized and/or covered services.
- Provider agrees that AgeWell New York reimbursement for services constitute payment in full.
- Provider agrees to follow applicable CMS/NYSDOH and AgeWell New York billing guidelines.

Medical Records and On-site Auditing

AgeWell New York participating providers must maintain medical records in accordance with good professional medical documentation standards. The provider and office staff must provide AgeWell New York staff with member medical records upon request. AgeWell New York staff must also have access to member medical records for on-site chart reviews. The provider responsibilities are as follows:

- Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
- Maintaining medical records in a safe and secure manner that ensures Member confidentiality and medical record confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
• Making the medical record available when requested by the Plan, participants (in writing), and regulatory agencies. Providers are required to allow medical information to be accessed by AgeWell New York, the New York State Department of Health, and the Centers for Medicare and Medicaid Services.

• Keeping medical records for ten years after the death or disenrollment of a member from AgeWell New York. The record shall be kept in a place and form that is acceptable to the New York State Department of Health and in accordance with Article 44.

• New York Education Law 6530 (32) requires that all New York practicing physicians and other health care professionals maintain detailed records for each patient. Maintaining proper medical records is a professional responsibility of a New York doctor or other practitioner.

**Medical Record Documentation Criteria:**

The medical record must be written in ink or computer generated and contain at minimum:

• Each page of the medical record contains identifying information for the member.
• All entries must contain author identification and professional title.
• All entries must be dated.
• All entries must be in ink or computer generated.
• Identification of all providers participating in care and information on services furnished are found in the record.
• An up-to-date problem list, including significant illnesses and medical/psychological conditions, is present in the record.
• Each note describes presenting complaints, diagnoses and treatment plan.
• A medication list containing prescribed medications, including dosages and dates of initial or refill prescriptions are present in the record.
• Information on allergies and adverse reactions (or notation that patient has no known allergies or adverse reactions) is contained in the record.
• The record contains documentation of past medical history, physical examinations, necessary treatments and possible risk factors for the member relevant to a particular treatment.
• The record is legible to other than the writer.

**Confidentiality:** Provider and staff must maintain complete confidentiality of all medical records and patient visits/admissions. Medical record release, other than to the plan or noted government agencies, may only occur with the patient’s written consent or if required by law. As an AgeWell New York network provider you will receive a privacy notice explaining AgeWell New York’s policies and procedures for appropriate use and protection of participant Protected Health Information (PHI).

**Conflict of Interest:** No practitioner in Medical Management may review any case in which he or she is professionally involved. AgeWell New York does not reward practitioners or other individual consultants performing utilization review for issuing denials of coverage or service.
**Reporting Abuse:** If a provider suspects abuse, mistreatment or neglect of a member, the provider should immediately initiate the proper notifications to any agency or authority that are required by the law in effect at the time. Please advise AgeWell New York of your concern and action by calling Provider Relations.

**Transition of Care:** Provider agrees to provide transition of care to new members and members transitioning from a provider leaving the AgeWell New York (AWNY) network according to the guidelines below:

**Care to New Members**

1. During the initial 90 day transition period after the member’s enrollment, AWNY will advise Participants and providers if and when they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, AWNY must also contact providers not already members of its network with information on becoming credentialed as in-network providers.

2. AWNY will accept and honor established service plans provided on paper or electronically transferred from FFS or prior plans when participant transition with service plans in place. Any documents received will be scanned and uploaded to the member record for use by the IDT.

3. To ensure timely transfer of Person-Centered Service Plans to other FIDA plans or other plans when a FIDA member is disenrolling from AWNY, the PCSP will be transferred via encrypted mail or faxed to the new plan, within 5 business days of the transfer notification to AWNY.

4. AWNY allows members who reside in nursing facilities to maintain current nursing facility providers for the duration of the demonstration.

5. AWNY honors prior authorizations issued for drugs, therapies or services existing in Medicare or Medicaid at the time of enrollment for a period of 90 days.

6. AWNY will change an existing care plan prior to the expiration of the 90 days under the following circumstances:
   i. The change is consented to by the new enrollee
   ii. Only after completion of the comprehensive assessment by the plan.

7. AWNY assures that, within the first 90 days of coverage, it will provide
   a. In outpatient settings, up to ninety (90) days’ worth of temporary supply(ies) of drugs, consistent with 42 CFR § 423.120(b)(3), when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan’s formulary but require Prior Authorization or step therapy under the FIDA Plan’s Utilization Management rules) that otherwise meets the definition of a Part D drug during the first ninety (90) days following Enrollment in the FIDA Plan; and
   b. A ninety (90) day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.
8. AWNY assures that, in long term care settings, such as a nursing facility or sub-
acute care facility, temporary fills of non-formulary drugs that otherwise meet the
definition of a Part D drug contain at least a 91-day supply, unless a lesser amount
is requested by the prescriber.

9. AWNY provides written notice to enrollees, within three business days of
temporary fills, if his/her drug is not part of the formulary. The written notice
includes that the member has the ability to file an exception or consult with the
prescriber to find an alternative equivalent on formulary.

Transition When Participating Provider Leaves the Plan:

When a provider leaves the plan for reasons other than fraud, loss of license, or other
final disciplinary action impairing the ability to practice, AgeWell New York will
authorize the member to continue an ongoing course of treatment for a period of up to
90 days. The request for continuation of care will be authorized provided that the
request is agreed to or made by the member, and the provider agrees to accept AgeWell
New York’s reimbursement rates as payment in full. The provider must also agree to
adhere to AgeWell New York’s quality assurance requirements, abide by AgeWell New
York’s policies and procedures, and supply AgeWell New York with all necessary
medical information and encounter data related to the member’s care. The Medical
Management Department will assist with and coordinate the transition of care plan and
assist Participants in transitioning to another provider if and when their provider leaves
the AgeWell New York network.

Specialist Communication with PCP: Specialists must work closely with a member’s PCP
and the Interdisciplinary Team, to foster continuity of care and promptly provide consultation
and progress reports to the PCP.

II. Role of Primary Care Provider (PCP) and Selecting a Provider

All members of AgeWell New York must choose a participating Primary Care Physician (PCP).
Upon enrollment, every member selects a PCP from the AgeWell New York Provider Directory.

All AWNY members are allowed to choose a primary care provider (PCP) upon enrollment.
AWNY supports the member in making this choice or will assign a PCP for members that do not
choose. If a member does not choose a PCP within 30 days of notification of enrollment,
Member Services will assign a PCP to the member.

Members may change their designated PCP at any time by contacting Member Services at the
telephone number listed in Section 1 of this provider manual. Members will receive a new ID
card with updated PCP information.

As a Primary Care Physician (PCP), you are the manager of your patients' total healthcare needs.
PCPs provide routine and preventive medical services, participate on the member’s
Interdisciplinary Team (IDT) to authorize covered services for members, and coordinate all care
that is given by AgeWell New York specialists, AgeWell New York participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Pediatricians, Geriatricians, OB/GYNs, physicians that specialize in infectious disease, and Nurse Practitioners in Adult Medicine, Gerontology Family Medicine, Gynecology or who meet the HIV Specialist Criteria referenced below.

III. Participant Guidelines

One of the cornerstones of AgeWell New York’s healthcare philosophy is the availability and accessibility of services. All PCPs must:

1. Arrange to have coverage available to provide medical services to their members, 24 hours a day, seven days a week;
2. Treat all patients equally;
3. Not discriminate because of race, sex, marital status, sexual orientation, religion, ancestry, national origin, place of residence, disability, source of payment, utilization of medical, mental health services or supplies, health status, or status as a Medicare or Medicaid recipient, or other unlawful basis; and,
4. Agree to observe, protect, and promote the rights of AgeWell New York members as patients.

For your reference, we have included a copy of AgeWell New York’s Member Rights and Responsibilities in Section 3 of this provider manual.

In becoming an AgeWell New York PCP, you and your staff agree to follow and comply with AgeWell New York's administrative, medical management, quality assurance, and reimbursement policies and procedures.

IV. Responsibilities of Primary Care Physicians

The PCP coordinates all aspects of a member’s care covered under the plan. As an AgeWell New York PCP, you agree to the following, where applicable:

1. Participate on the Interdisciplinary Team for your patient, including the development of the Patient-Centered Service Plan.
2. All the services of a PCP or other health professional typically received in a PCP’s office. These include but are not limited to:
   a. Treatment of routine illness
   b. Health consultations and advice
   c. Injections
d. Conducting baseline and periodic physical exams, including any tests and any ancillary services required to make your appraisal

e. Diagnosing and treating conditions not requiring the services of a specialist.

f. Initiating referrals from non-primary care service as required by the specific plan in which the member is enrolled.

g. Arranging inpatient care.

h. Consulting with specialists, laboratory and radiological services when medically necessary.

i. Coordinating the findings of consultations and laboratories.

j. Interpreting such findings for the member and his/her family, subject to regulatory requirements regarding confidentiality.

k. Coordinating dental care as part of the overall health care management of.

3. Appropriate coverage for your patients who may be in a hospital or skilled nursing facility.

4. Maintenance of certain standards for your office, service, and medical records.

V. **Standards of Timely Access to Care**

**Access Requirements – Appointment Availability Standards**

All Primary Care and Specialist services provided by participating providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with:

- The generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment;
- The provisions of AgeWell New York’s Quality Improvement Program and Medical Management Program;
- The requirements of State and Federal Law; and
- The standards of accreditation organizations such as NCQA and Joint Commission.

Each participating provider is required to provide advance written notice to AgeWell New York in the event of any change in the capacity of the participating provider to continue services under the terms of the participating provider’s agreement with AgeWell New York.

Providers must agree to comply with the following appointment availability standards:

a) **Telephone Coverage After Hours**

All providers must have either an answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation. (Please be sure that if the on-call number is a beeper number, members understand how to punch in the telephone number.)
b) Telephone Access During Normal Business Hours
Providers are expected to provide an immediate response to all emergent conditions. Providers should respond to urgent conditions within 4 hours and non-urgent/routine calls within 1-2 business days.

c) Covering Provider
All Primary Care Providers on extended leave (vacation, illness, etc.) must arrange with another participating AgeWell New York provider, or a non-Age-Well New York provider who agrees to accept the contracted rate, to provide 24-hour coverage for your patients.

The covering provider must also have 24-hour telephone coverage. Telephone coverage should not routinely direct a member to call 911, except in the event of an emergency or urgent situation.

d) Appointments

Primary Care Providers must make every effort to see a member within the following timeframes:

- Emergent – Member should be directed to call 911 in the event of an emergency or go the Emergency Room for treatment. PCPs are required to have arrangements for coverage 24 hours a day, 7 days per week.
- Urgent – Within 24 hours
- Routine/Symptomatic – Within 7 days
- Wellness/Non-Symptomatic – Within 30 days of Routine conditions are usually conditions that are chronic in duration. Preventive health care services are associated with keeping the member healthy. Preventive health services include, but are not limited to: physicals, mammography, digital rectal exams and colon screenings.

Behavioral Health Providers must make every effort to see a member within the following timeframes:

- Emergent – Immediately upon presentation from service site.
- Urgent – Within 24 hours
- Non-Urgent “sick”- 48-72 hours from request.
- Routine/Symptomatic/Specialist – Within four weeks of request
- Facility discharge follow up- within five business days
- Non-urgent mental health or substance abuse visits- Within two weeks
- Mental Health/Substance Abuse Assessments- Within ten business days of request.
- Mental Health Clinic assessment- Within 5 business days of request.
e) **Office Waiting Times**
Office waiting time for visits should not exceed 30 minutes from the time of the scheduled appointment.

**VI. Referring to a Participating AgeWell New York Specialist**

Refer members only to AgeWell New York network physicians, ancillary facilities, and providers. If a required specialty is not represented in AgeWell New York’s Provider Directory call AgeWell New York’s Provider Services Department at the telephone number listed in Section 1 of this provider manual.

**VII. Provider Education**

Contracted AgeWell New York Providers are required to complete training which meet state training requirements. Instructions about how to access the FIDA specific training materials will be sent to providers separately from this provider manual. Such training materials include:

- Disability training for its medical, behavioral, and community-based and facility-based LTSS providers, including information about the following:
  - Various types of chronic conditions prevalent within the target population;
  - Awareness of personal prejudices;
  - Legal obligations to comply with the ADA requirements;
  - Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;
  - Types of barriers encountered by the target population;
  - Training on person-centered planning (i.e., Person-Centered Service Plans) and self-determination, the social model of disability, the independent living philosophy, and the recovery model;
  - Use of evidence-based practices and specific levels of quality outcomes; and
  - Working with Participants with mental health diagnoses, including crisis prevention and treatment.

- Trainings for Interdisciplinary Care Team (IDT) members on:
  - The person-centered planning processes;
  - Cultural competence;
  - Accessibility and accommodations;
  - Independent living and recovery;
  - Wellness principles; and
  - Other required training, as specified by the State, which will include ADA / Olmstead requirements.

- AgeWell New York requires IDT members to agree to participate in approved training;

- AgeWell New York documents completion of training by all IDT members, including both employed and contracted personnel; and
• AgeWell New York addresses non-completion of the training.

• Coordination with behavioral health and community-based and facility-based LTSS providers;

• Providing information about accessing behavioral health and community-based and facility-based LTSS; and

• Furnishing lists of community supports available.

• Training regarding balance billing which is prohibited under AgeWell New York.

• Trainings Specific to Primary Care Providers:
  o How to identify behavioral health needs;
  o How to assist the Participant in obtaining behavioral health services;
  o How to identify community-based and facility-based LTSS needs; and
  o How to assist the Participant in obtaining community-based and facility-based LTSS services.

VIII. Provider Performance Standards and Compliance to Standards of Care

When evaluating the performance of a participating provider, AgeWell New York will review at a minimum the following areas:

• **Quality of Care**: measured by clinical data related to the appropriateness of members’ care and outcomes

• **Efficiency of Care**: measured by clinical and financial data related to members’ health care costs

• **Member Satisfaction**: measured by members' reports and services regarding accessibility, quality of health care, member-participating provider relations, and the comfort of the practice setting,

• **Administrative Requirements**: measured by the participating provider’s methods and systems for keeping records and transmitting information, and

• **Participation in Clinical Standards**: measured by the participating provider’s compliance with quality of care standards.

IX. Provider Compliance with Standards of Care

AgeWell New York participating providers must comply with all applicable laws and licensing requirements. In addition, participating providers must furnish covered evidence-based services in a manner consistent with standards, including nationally recognized clinical protocols and
guidelines, related to medical and surgical practices that are generally accepted in the medical
and professional community at the time of treatment. Participating providers must also comply
with AgeWell New York’s standards, which include but are not limited to:

1. Guidelines established by the Federal Center for Disease Control Prevention (or any
successor entity),
2. New York State Department of AIDS Institute,
3. All federal, state, and local laws regarding the conduct of their profession,
4. Participation on committees and clinical task forces to improve the quality and cost of
care,
5. Referral Policies,
6. Preauthorization and notification requirements and timeframes,
7. Participating provider credentialing requirements,
8. Care Management Program referrals,
9. Appropriate release of inpatient and outpatient utilization and outcomes information,
10. Accessibility of member medical record information to fulfill the business and
clinical needs of AgeWell New York,
11. Cooperating with efforts to assure appropriate levels of care,
12. Maintaining a collegial and professional relationship with AgeWell New York
personnel and fellow participating providers, and
13. Providing equal access and treatment to all members

Compliance Process

The following types of non-compliance issues are key areas of concern:

1. Inappropriate, out-of-network referrals/utilization,
2. Failure to obtain pre-authorization from AgeWell New York for admissions and
other services requiring prior authorization,
3. Member complaints/Grievances which are determined against the participating
provider,
4. Underutilization, over utilization, or inappropriate referrals,
5. Inappropriate billing practices, and
6. Non-supportive actions and/or attitude.

Participating provider noncompliance is tracked on a calendar year basis. Corrective actions may
be required, if areas or patterns of noncompliance are found.

Participating providers acting within the lawful scope of practice are encouraged to advise
members of AgeWell New York about:

1. The member’s health status, medical care, or treatment options (including any
alternative treatments that may be self-administered or treatments not covered by
AgeWell New York), including the provision of sufficient information to provide
an opportunity for the member to decide among all relevant treatment options,
2. The risks, benefits, and consequences of treatment or non-treatment, and

3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decision.

Quality Assurance and Medical Management

All AgeWell New York PCPs must cooperate with and participate in peer review, including utilization review quality assurance, external audits, administrative procedures, and grievance procedures.

All services that you provide to members must be consistent with appropriate medical practice. They must also be in accordance with the AMA's rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.

You must notify AgeWell New York immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

Providers agree to comply with the policies and procedures that AgeWell New York has established in the following areas:

- Quality improvement/management
- Utilization management including precertification procedures, referral management and reporting of clinical encounter data
- Member complaints
- Medical/clinical care coordination
- Provider credentialing

Providers must make member records and encounter data available to AgeWell New York to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration and The Centers for Medicare and Medicaid Services(CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

X. Confidentiality and HIPAA

As an AgeWell New York provider, you must maintain medical and non-medical records. You and AgeWell New York agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with AgeWell New York in the process of claims, medical treatment, quality assurance functions or response to a complaint or appeal. You must also make any medical, financial, or administrative records available to AgeWell New York, as requested, either for AgeWell New York administrative purposes, quality assurance purposes, or to comply
with state and federal law. You will receive a privacy notice explaining AgeWell New York’s policies and procedures for appropriate use and protection of participant Protected Health Information (PHI).

**Americans with Disabilities Act (ADA)**

AgeWell New York providers are expected to comply with Title II of the Americans with Disabilities Acts (ADA). The goals of compliance with ADA Title II requirements are to offer a level of services that allows people with disabilities access to the program in its entirety and the ability to achieve the same health care results as any AgeWell New York member.

AgeWell New York assists participating providers, at their point of service, to identify AgeWell New York members who require audio, visual, mobility aids and other accommodations. In addition, AgeWell New York offers training for providers regarding compliance with Title II requirements, such as access requirements for door widths, wheelchair ramps, accessible diagnostic/treatment rooms and equipment; communication issues, and attitudinal barriers related to disability.

**Laws Regarding Federal Funds**

Payments that participating providers receive for furnishing services to AgeWell New York members are, in whole or part, from Federal funds. Therefore, participating providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

**Sanctions under Federal Health Programs and State Law**

Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the participating provider.

Participating providers must disclose to AgeWell New York whether the participating provider or any staff member or subcontractor has any prior violation, fine, suspension, or termination has been disbarred from or had other administrative action taken under Medicare or Medicaid laws, the rules or regulations of New York, the federal government, or any public insurer. Such individuals shall not be allowed to provide services to AgeWell New York members.

Participating providers must notify AgeWell New York immediately if any such sanction is imposed on participating provider, a staff member or subcontractor

**Informed Consent and Confidentiality**

All participating providers must provide information to members necessary to give informed consent prior to the start of any procedure or treatment. In addition, all participating providers
are subject to confidentiality requirements outlined by the New York State Department Health and the Centers for Medicare and Medicaid Services.

Providers are obligated to, among other things:

- Conduct initial and annual in-service education of staff and contractors;
- Identify staff allowed access to confidential information and the limits of that access;
- Establish procedures to limit access to confidential information to trained staff (including contractors);
- Develop protocols for secure storage of confidential information (including electronic storage);
- Develop procedures for handling requests for HIV-related information; and
- Develop protocols to protect persons with or suspected of having HIV infection from discrimination.

XI. Closing of Provider Panel

When closing a practice to new AgeWell New York members, participating providers are required to:

- Give AgeWell New York 60 days prior written notice that the practice will be closing to new members as of a specified date,
- Keep the practice open to new AgeWell New York members who were patients before the practice closed,
- Uniformly close the practice to all new patients, including private payers, commercial or government insurers, and
- Give AgeWell New York prior written notice of the re-opening of the practice, including specified effective date.

Compensation

Participating providers must look only to AgeWell New York for compensation for services rendered to AgeWell New York members. AgeWell New York providers agree not to seek compensation from members.

**BALANCE BILLING OF AGEWELL NEW YORK FIDA MEMBERS IS PROHIBITED.**
I. Network Specialist Participation Guidelines

In becoming an AgeWell New York specialist, you and your staff agree to follow and comply with AgeWell New York’s administrative, patient referral, utilization review, quality assurance, disease management, and reimbursement policies and procedures. As a Participating Specialist with AgeWell New York, you must:

1. Treat all your patients equally.
2. Not discriminate because of race, sex, religion, place of residence, health status, or status as a Medicare or Medicaid Member.
3. Observe, protect, and promote the rights of AgeWell New York members as patients.
4. Participate, when requested, on the Interdisciplinary Team for the member and in the Patient-Centered Service Plan development process.

For your reference, a copy of AgeWell New York’s Member Rights and Responsibilities is included in Section 3 of this provider manual.

A Participating Specialist may serve as the member’s PCP if the following conditions are met:

- The Participating Specialist satisfies the credentialing requirements for a PCP
- AgeWell New York approves the request
- The Participating Specialist agrees to fulfill the role

II. Responsibilities to Your Patients

- Work closely with PCPs to ensure continuity of care for AgeWell New York members.
- Advise the PCP, in writing, about ongoing treatment of the PCP’s patient.
- Confer with the member’s PCP before referring the member to another specialist, except in a serious, life-threatening emergency. Similarly, if a member under specialist care must enter the hospital, the specialist must get Prior Authorization (except in an emergency), of the admission from AgeWell New York’s Medical Management Department and must notify the member’s PCP of the admission.
- Maintain certain standards for your office, service, and medical records. See below for specific requirements.
III. Confidentiality and HIPAA

As an AgeWell New York physician, you must maintain medical and non-medical records. You and AgeWell New York agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with AgeWell New York in the processing of claims and medical treatment. You must also make any medical, financial, or administrative records available to AgeWell New York, as requested, either for AgeWell New York's administrative purposes, quality assurance purposes, or to comply with state and federal law.
CARE MANAGEMENT AND THE INTERDISCIPLINARY TEAM

AgeWell New York utilizes an Interdisciplinary approach to providing each member with an individualized, comprehensive care planning process in order to maximize and maintain every member’s functional potential and quality of life. For each member, an individually tailored IDT, led by an accountable Care Manager at AgeWell New York, will ensure the integration of the member’s medical, behavioral health, community-based or facility-based long term services and supports, and social needs.

All AgeWell New York Members will be offered an Interdisciplinary Team (IDT). As defined in the AgeWell New York Contract, the IDT is a Team of individuals that will provide person-centered care coordination and care management to Members.

IDT will be person-centered, be built on the member’s specific preferences and needs and deliver services with transparency, individualism, accessibility, linguistic and cultural competence and dignity. The IDT facilitates timely and thorough coordination between the FIDA Plan, the IDT, the primary care physician, and other providers. The Care Manager serves as the lead of the IDT and handles any disagreements between the members of the IDT.

The IDT will make coverage determinations according to the following definition of medical necessity: Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant’s capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, AWNY will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

Accordingly, the IDT’s decisions serve as service authorizations and coverage determinations, may not be modified by AWNY outside of the IDT, and are appealable by the Member (or providers, designees, and/or representatives on behalf of the Member). IDT service planning, coverage determinations, care coordination, and care management will be delineated in the Member’s Person-Centered Service Plan and will be based on the assessed needs and articulated preferences of the Member.

The IDT will consist of:

a. The Participant/Member and/or, in the case of incapacity, an authorized representative;

b. The Member’s designee(s), if desired by the Member;

c. The AWNY Care Manager;

d. The Primary Care Practitioner (PCP) or a designee with clinical experience from the PCP’s practice who has knowledge of the needs of the Member;

e. Behavioral Health Professional, if there is one, or a designee with clinical experience from the Behavioral Health Professional’s practice who has knowledge of the needs of the Member;

f. Member’s home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of the needs of the Member, if the Member is receiving home care and approves the home care aide/designee’s participation on the IDT;
g. Member’s nursing facility representative who is a clinical professional, if receiving
nursing facility care; and
h. Additional individuals including;
   a. Other providers either as requested by the Member or his/her designee or as
      recommended by the IDT members as necessary for adequate care planning and
      approved by the Member and/or his/her designee; or
   b. The RN who completed the Member’s Assessment, if approved by the Member
      and/or his/her designee

All members of the IDT will have 24 hour/day, 7 days/week access to the Centralized Member
Record, Care Compass. Members of the IDT will be able to document changes in a Member’s
condition. This single, centralized, comprehensive record includes but is not limited to
documentation of the Member’s medical, functional, and psychosocial condition and will be used
to manage communication and information flow regarding referrals, transitions, and care
delivered outside the primary care site.

Responsibilities/Functions of the IDT
As the manager of care, the IDT will:

- With the Member and the Member’s designated representative, if any, establish
  and implement a written Person-Centered Service Plan (PCSP) that includes
  treatment goals (medical, functional, behavioral and social) and measures
  progress and success in meeting those goals;

- Assist each member in accessing services called for under the PCSP.

- Ensure that communication with the Member is in a manner that accommodates
  individual needs including using the Language Line or providing interpreters for
  those who do not speak English, alternative communication devices (TTY) for
  those who are deaf or hard of hearing, and accommodations for those with
  cognitive limitations.

- When a member is determined to be likely to require a level of care provided in a
  nursing facility (i.e. nursing home level of care), the care manager and/or IDT
  informs the member and/or his/her representative of any feasible alternatives and
  offers the choice of either institutional or home and community based services.

- On an ongoing basis, consult with and advise outpatient, acute, specialty, long
  term care, and behavioral health Providers about care plans and clinically
  appropriate interventions;

- Arrange, deliver and monitor long term care services and supports on an ongoing
  basis;

- Conduct Ongoing Assessments appropriately, including face-to-face meetings,
  adjust PCSPs as necessary, and communicate the information to the Member’s
  Providers in a timely manner;

- Conduct conference calls among AWNY, providers and members as required to
  enable clear timely communication between the members of the care team;
• Promote independent functioning of the Member and provide services in the most appropriate, least restrictive environment;
• Document and comply with Advance Directives about the Member's wishes for future treatment and health care decisions;
• Assist in the designation of a health care proxy, if the Member wants one;
• Maintain the Centralized Member Record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Member;
• Communicate with the Member, and the Member’s family members and significant caregivers, if any, about the Member's medical, social, and psychological needs;
• Maintain a mechanism for member complaints and grievances; and
• Use secure e-mail, fax and written correspondence to communicate.

II. Emergency Care

AgeWell New York maintains an Emergency Health Services policy that defines the process for the provision of emergency care. Emergency Services are defined as treatment of a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any bodily organ or part.

AgeWell New York also covers Emergency Room Services. Plan notification is not required for payment of Emergency room services for an emergency medical condition. The member is instructed to contact his/her Primary Care Physician and/or Care Manager after receiving emergent or urgent care services in any setting. The intent of this procedure is to allow the IDT to coordinate any needed follow up care.

AgeWell New York requires notification from facilities/service providers for inpatient and surgical day care (SDC) admissions, and outpatient functional therapies (i.e., physical, occupational and speech/language therapies).

The servicing provider (usually the hospital/facility) is responsible for notifying AgeWell New York:

• When a member is admitted to the hospital on an emergency basis, including inpatient admission from the emergency room or an observation stay.
• Prior to an elective inpatient admission.
• When a facility receives a post-emergency room transfer
• When surgical day care results in an inpatient admission.
• When outpatient functional therapy treatment is initiated (after an initial evaluation).
• When any change (e.g., diagnosis, procedure, date of service, etc.) related to a previous notification is made.

III. Notification Timeliness

Requirements for timely notification:

<table>
<thead>
<tr>
<th>Service</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent Admission</td>
<td>Two business days following admission</td>
</tr>
<tr>
<td>Elective Inpatient Admission</td>
<td>At least one week prior to the date of service</td>
</tr>
<tr>
<td>Outpatient Therapy Treatment</td>
<td>(following initial examination) Up to the date of service or no later than the next business day</td>
</tr>
</tbody>
</table>

Notification does not guarantee payment by AgeWell New York. Only claims for services that are covered under eligible members’ benefit plans are reimbursed. Refer to the Authorization Policy for specific information about services, drugs, devices, and equipment that require prior authorization, and are subject to clinical review (to determine medical necessity).

Elective Admissions
Hospitals must notify AgeWell New York when a member is scheduled for an inpatient elective service. In addition, some elective admissions require prior authorization. (Refer to the Prior Authorization Policy for specific information.)

Action Required
Notification by the servicing provider (i.e., the hospital) is required at least one week before the admission or date of service. (Consideration will be given when operating room time becomes available with less than one week’s notice. Re-notification will be required if notification has already occurred.)

• The hospital, the member’s PCP or specialist can submit notification of an elective admission.
• The appropriate surgical CPT code(s), consistent with the surgical service, must be included. Communicate elective admission through one of the following channels.

Information Required
The following information is required for notification of an elective admission:

• Member’s name and identification number
• Provider’s name and National Provider Identifier (NPI)
• Admitting provider’s name and National Provider Identifier (NPI)
• Hospital’s name, location and National Provider Identifier (NPI)
• Diagnosis and clinical information
• Service requested (i.e., admission, procedure, etc.)
• DRG and CPT code(s) appropriate to the type of admission (medical or surgical)
• Admission date

All requests for services must be submitted with a valid NPI for the requesting and servicing providers.

Notification Changes
AgeWell New York must be notified when any change to the original notification occurs, such as a change in the date of service or a change in the type of service (e.g., inpatient admission following observation or surgical day care).

AgeWell New York covers emergency services that are medically necessary to screen and stabilize members in a medical or behavioral health emergency. Members who believe they are having a medical or behavioral health emergency are encouraged to seek care at the nearest emergency facility. Neither a referral from the PCP, nor authorization from AgeWell New York is required.

Admitting hospitals are responsible for notifying AgeWell New York when a member requires emergent/urgent inpatient admission to an acute hospital or behavioral health facility from an Emergency Room/Department. Behavioral health services are managed through (pending)

Action Required
The hospital is responsible for notifying AgeWell New York within two business days following a member’s emergent/urgent admission.

Information Required
The following information is required for notification of an emergent/urgent admission.

• Member’s name and AgeWell New York identification number
• Admitting provider’s name and National Provider Identifier number (NPI)
• Hospital’s name, location and National Provider Identifier (NPI)
• Diagnosis
• Service requested (i.e., admission, procedure, etc.)
• Admission date (must be the actual date the member was admitted to inpatient status)
• All requests for services must be submitted with a valid NPI for the requesting and servicing providers.
IV. Medical Review Process

Medical Review Criteria

AgeWell New York utilizes standardized review criteria that are evidence based and supported by documented references and internally developed medical criteria for making decisions concerning medical necessity and appropriateness for services. Criteria are available and practitioners are informed of the use of criteria and how to obtain them through a provider update, provider alert, and newsletters and through the AgeWell New York website and Provider Portal. The review process is designed to ensure that medically necessary services are provided in a uniform and timely manner it members.

The primary review criteria utilized by AgeWell New York in the authorization/ review process are the Healthcare Management Guidelines (HMG) (develop by Milliman). These evidence-based, nationally recognized and accepted guidelines, are the primary criteria that AgeWell New York staff, including the Interdisciplinary Team uses when determining the appropriateness of an admission or inpatient length of stay or the medical necessity of a requested service. The HMG’s by Milliman are the primary criteria for reviewing the appropriateness of behavioral health services. During the review process, Care Management staff may additionally consult and apply a variety of peer reviewed criteria, guidelines and reference tools to assist in the medical appropriateness determination. Care managers apply criteria to individuals on a case-by–case basis and consider the individual’s age, co-morbidities, complications, progress of treatment, psychological situation, home environment, and any other individuals needs when applicable, as well as the capabilities of the local health care delivery system.

Additionally developed authorization/review criteria may be developed from various references to supplement the primary HMGs in the case where a procedure/service is not addressed in the primary criteria. These reference tools include, but are not limited to:

- Peer review medical appropriateness criteria
- Standard quality indicators (National Committee for Quality Assurance (NCQA), Health Effectiveness Data and information Set (HEDIS);
- American Medical Association (AMA) specialty guidelines.
- Governmental agencies such as Center for Disease Control, Food and Drug Administration, Agency for Health Care Policy and Research, National Institute of Health
- Non- for Profit Health Care Organizations (e.g. American Heart Association, American Diabetes Association, American Lung Association)
- Peer review periodicals and journals;
- Consultation with actively practicing physicians who are appointed to teach faculties, research, foundations and/or members of recognized specialty societies; and
- Standards of Practice for Case Management of The Case Management Society of America (CMSA)

Ongoing Review. As the outside reference materials described above are modified, the changes/updates are presented, as appropriated, to the Utilization Management Committee to
ensure that criteria are updated as needed to incorporate current developments in clinical practice.

The Utilization Management Committee reviews the new or revised guidelines and determines whether or not to adopt the changes. If adopted, the existing criteria will be modified to incorporate the recommendation of the Committee. The Director of Utilization Management then follows the same procedure as for newly developed criteria.

Annually Review. Periodically, but at least annually, the Utilization Management Committee reviews the Authorization/review criteria. The Committee makes appropriate change recommendations to the Quality Improvement Committee. Changes are communicated to the providers’ practitioners through the provider update Newsletter, web site news, and email. AgeWell New York providers’ alerts and individual mailers to each contracted Primary Care Physician and/or contracted applicable specialties as required.

Urgent/Emergent Review. For criteria requiring immediate or urgent review, The Medical Director may call an ad hoc meeting of the Utilization Management Committee. The process for developing or modifying the Authorization/Review criteria remains the same as mention above.

Distribution of Criteria. Medical review criteria are available upon requested to practitioners. Practitioners may receive a copy of individual criteria, review the entire set of criteria on site at AgeWell New York, or may have sections read or faxed upon request.

V. Review of Request for Health Care Services

AgeWell New York, through the Care Manager, and in conjunction with the IDT, will review the request for health care items and services. Before the initial Patient-Centered Service Plan is developed by the IDT, service authorizations will be made through the plan’s utilization management process. Utilization reviewers obtain relevant clinical information and consults with the treating physician when making a determination of coverage based on medical necessity. All information relevant to a member’s case is considered when making a decision.

Request for services are reviewed to determine whether adequate supportive medical documentation has been submitted by the requesting practitioner to make a decision. Information required will be limited to which is reasonably necessary to make a determination.

After the PCSP is developed by the IDT, care decisions included therein, act as service authorizations. These service authorizations may not be modified by AgeWell New York, except in cases where the member (or provider, designee on behalf of the member) appeals the IDT service authorization. The member may appeal and IDT decision, regardless of whether the member agreed to the decision. During the meeting, the IDT authorizes both ongoing service plan care and services that must be adhered to by the plan. Between IDT meetings, the plan may authorize services in addition to those included in the PCSP, as needed.
VI. GRIEVANCES AND APPEALS

Members are entitled to file Grievances and Appeals which may be filed verbally or in written form. AWNY will assist the member with the filing process and also provides information with regards to the Participant Ombudsman. All Grievances and Appeals are investigated, resolved and filed consistently in timely manner, in accordance with the guidelines outlined in Section 42 of The Code of Federal Regulations, §422.564, (Grievance Procedures), Medicaid regulation and NY State FIDA guidelines. An expedited process will be implemented whenever a grievance has been determined to be of an urgent clinical nature.

Upon receiving a request for review, AWNY must correctly distinguish between a grievance and appeal and request for coverage, as indicated in the NY State FIDA Guidelines and contract.

GRIEVANCES

1. Filing. All AWNY employees are required to know the Grievances and Appeals process, and provide assistance filing Grievances and Appeals. Training is provided to all new employees and is reinforced at least once a year. The Grievance and Appeals process is also explained to the member at the enrollment assessment time and every time that a reassessment is conducted. If any member, representative of the member is calling to initiate a grievance AWNY will help the member by making sure that:
   a. Member is offered with Translation Services when appropriate
   b. Member understands the Grievance and Appeal process
   c. Member is able to report the grievance in verbal or written form
   d. Members are informed about the availability of the Participant Ombudsman and how to access the PO calling at Participant Call Center and 1-800-Medicare.

2. Grievance Filing Deadline. All grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident). Expedited grievance must be filed within 60 calendar days of the date of the coverage decision and must include physician certificate of need.

3. Acknowledgement of Grievance. AWNY will send written acknowledgement of the grievance to the Participant within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, AWNY will not send the written acknowledgement.

4. Timeframe for Plan Decision and Notification on Grievance. AWNY must respond to a Participant’s grievance as fast as the Participant’s condition requires, but no later than:
   a. Expedited: Paper review – decision and notification within 24 hours (in certain circumstances). For all other circumstances where a standard decision would significantly increase the risk to a Participant’s health, decision and notification are made within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance. Certain circumstances requiring a response within 24 hours are defined as:
      i. The complaint involves an AWNY’s decision to invoke an extension relating to an organizational determination.
ii. The complaint involves an AWNY’s refusal to grant a Participant’s request for an expedited organizational determination under 42 CFR Part 422.570.

b. Standard: Notification of decision within 30 calendar days of AWNY receiving the written or oral grievance.

5. **Extension.** AWNY may extend the 30 calendar day timeframe by up to 14 calendar days if the Participant or provider on the Participant’s behalf (written or verbal) requests the extension or if AWNY justifies a need for additional information and documents how the delay is in the interest of the Participant. When the AWNY extends the deadline, it must immediately notify the Participant in writing of the reasons for the delay.

6. **Notification of Grievance Decision.** AWNY must notify the Participant of the decision by phone for expedited grievances and provide written notice of the decision within 3 business days of decision (expedited and standard). This letter includes Medicare and Medicare Appeals rights specific to the service or item in question.

7. **External Grievance.** A Participant may file an external grievance through contacting the Participant Ombudsman or by calling 1-800–Medicare.

**APPEALS**

1. **Appeal Filing Deadline.** Participants, their providers, and their representatives will have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. This first level of appeal is an internal appeal, to be decided by AWNY. The appeal must be requested within 60 calendar days of postmark date of notice of Action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 calendar days of the notice’s postmark date or by the intended effective date of the Action, whichever is later.

2. **Acknowledgement of Appeal.** AWNY requires that a written acknowledgement of appeal is sent to the Participant within 15 calendar days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement. The acknowledgement letter also states:
   i. Whether the appeal was receive within the time frame required to continuing benefits; and
   ii. That benefits will continue pending an appeal up to and including the Medicare Appeals Council

3. **Timeframe for Plan Decision on Appeal:** The FIDA Plan shall be required to decide the appeal and notify the Participant (and provider, as appropriate) of its decision as fast as the participant’s condition requires, but:
   a. Expedited: Paper review unless a Participant requests in person review - as fast as the Participant’s condition requires, but no later than within 72 hours of the receipt of the appeal.
b. Standard: Paper review unless a Participant requests in person review - as fast as the Participant’s condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal.

Benefits will continue pending an appeal in accordance with the FIDA MOU Appeals section.

4. Extension. Up to 14-calendar day extension. An extension may be requested by a Participant or provider on a Participant’s behalf (written or oral). AWNY may also initiate an extension if it can justify need for additional information and if the extension is in the Participant’s interest.

In all cases, the extension reason must be well-documented, and when AWNY requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited grievance if he or she disagrees with the AWNY’s decision to grant an extension.

5. Notification of Appeal Decision. AWNY will make a reasonable effort to provide prompt oral notice to the Participant for expedited appeals and must document those efforts. AWNY will send written notice within 2 calendar days of providing oral notice of its decision for standard and expedited appeals. Benefits will continue pending an appeal up to and including the Medicare Appeals Council.

ADMINISTRATIVE HEARING.

1. Automatic Administrative Hearing. Any adverse decision made by the AWNY is automatically forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA) within two business days of the decision being reached - with a copy to NYSDOH Office of Health Insurance Program Department of Long Term Care staff. This step occurs electronically to the secure mailbox established by OTDA and it occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed for matters before OTDA). AWNY has a process to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record. When AWNY sends Participants a Notification of the Appeal Decision, we also state that the adverse decision will be auto forwarded to the Integrated Administrative Hearing Office at the FIDA Administrative Hearing Unit at the OTDA and that no action is needed by the Participant. This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed). Benefits will continue pending an appeal in accordance with section IX.a.ii.12. This corresponds to the second level appeal.

2. Notices of Automatic Administrative Hearing. AWNY is required to send an acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record. The Integrated
Administrative Hearing Officer shall provide the Participant with a Notice of Administrative Hearing at least 10 calendar days in advance of the hearing date.

3. **Administrative Record for Administrative Hearing.** The Integrated Administrative Hearing Officer will create the administrative record at the second level of appeal and allow for requesting and receiving copies of the administrative record in accordance with 42 CFR Part 405.1042.

4. **Timeframe for Decision on Administrative Hearing.**
   a. Standard Timeframe: The Integrated Administrative Hearing Officer conducts a phone or in-person hearing and render a decision as expeditiously as the Participant’s condition requires, but always within 7 calendar days for Medicaid prescription drug coverage matters and for all other matters within 90 calendar days of request for the first year of the Demonstration and 30 calendar days of request for the 2nd and 3rd year of the Demonstration.
   b. Expedited Timeframe: The Integrated Administrative Hearing Officer conducts a phone or in-person hearing notify the Participant (and the provider, as appropriate) of the decision within 72 hours of the forwarding of the FIDA Plan’s appeal decision.
   c. Decision: The Integrated Administrative Hearing Officer shall issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other information required by applicable Federal and State requirements.

**MEDICARE APPEALS COUNCIL.**

If a Participant disagrees with the Integrated Administrative Hearing Officer’s decision, the Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the Integrated Administrative Hearing Officer’s decision. An adverse Administrative Hearing decision may be appealed to the Medicare Appeals Council within 60 calendar days. This serves as the third level of appeal. These appeals must be filed with the FIDA Administrative Hearing Unit, which will forward the request for appeal and administrative record to the Medicare Appeals Council. The Medicare Appeals Council will complete a paper review and will issue a decision within 90 calendar days. Benefits will continue pending an appeal in accordance with section IX.a.ii.12.

**Federal District Court.**

An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which serves as the fourth level of appeal.

**Continuation of Benefits Pending Appeal.** Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original appeal is requested to the FIDA Plan within 10 calendar days of the notice’s Postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later.
VII. Review of the Utilization Management Program

The UM Program is evaluated and the program description is updated annually based on regulatory and accreditation requirements as well as input from members and practitioners. It is approved by UM Committee, and Ultimately, the Board of Directors.

AgeWell New York reviews the claims data through monthly and quarterly reports including data on primary care and specialist, ancillary, inpatient, outpatient, emergency room, laboratory, pharmacy encounters, and selected procedures for unwarranted variation in care. If unwarranted variations in care process and deliver are discovered, AgeWell New York Utilization Management Committee discusses and reviews the appropriate changes to the Utilization Management Program. AgeWell New York maintains up to date clinical guidelines and incorporate new treatment or services at least in annual basis. The final responsible for the review and adaptation is the Medical director. He presents to the UM Committee the suggested modification for review and approval

1. Determinations –

AgeWell New York follows federal, state and NCQA decision and notification timeframes for all utilization management determinations. Where regulatory and accreditation bodies differ, AgeWell New York will use the strictest/shortest timeframe to assure compliance with all requirements. The following is a summary of AgeWell New York’s decision and notification timeframes:

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Decision standard</th>
<th>Verbal/e-notification</th>
<th>Written notification to practitioner &amp; member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-Service</td>
<td>Within 2 working days from receipt of request</td>
<td>Within 3 working days of making the decision</td>
<td>Within 3 working days of making the decision.</td>
</tr>
<tr>
<td>Urgent Pre-Service</td>
<td>Within 1 calendar day</td>
<td>Same day as decision</td>
<td>Within 2 calendar days of making the decision</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 25 calendar days of receipt of request</td>
<td>None required</td>
<td>Within 5 calendar days of making the decision</td>
</tr>
<tr>
<td>Drug requests covered under medical or pharmacy benefit</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request (denials only)</td>
</tr>
</tbody>
</table>
VIII. Quality Assurance and Medical Management

All AgeWell New York PCPs must cooperate with and participate in peer review, including utilization review (see Section 13), quality assurance, external audits, administrative procedures, and grievance procedures (see Section 12).

All services that you provide to members must be consistent with appropriate medical practice. They must also be in accordance with the AMA’s rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.

You must notify AgeWell New York immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

All AgeWell New York providers must provide HEDIS information and medical records upon request.

Providers agree to comply with the policies and procedures that AgeWell New York has established in the following areas:

- Quality improvement/management
- Utilization management including precertification procedures, referral management and reporting of clinical encounter data
- Member complaints
- Medical/clinical care coordination
- Provider credentialing
IX. AgeWell New York Model of Care

The AgeWell New York Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve and sustain member health outcomes across the care continuum in accordance with the requirements of the Medicaid and Medicare programs. Under the FIDA Demonstration, AgeWell New York will cover primary, specialty and acute medical services and Medicaid-covered long term care services as applicable to member needs. We will coordinate these services to address acute medical needs and manage chronic conditions while supporting members to remain safely in their own homes.

To achieve the above goals, the framework of the Model of Care includes the following key components with a focus on the target population:

Integrated Care Management
AgeWell New York assigns a professionally-trained Care Manager to every member to assess care needs, designs an individualized Person Centered Services Plan (PCSP), and coordinate with appropriate providers and specialized care team. Care management is documented, reported, updated and monitored for quality and performance using an advanced health information software application called Care Compass*, specifically designed for care management functions.

Interdisciplinary Care Team (IDT)
AgeWell New York assembles an interdisciplinary team (IDT) for every member according to his/her health and mental health needs. This team includes the member and family, and the Care Manager, the primary care physician, pharmacist, social worker and others as needed included physician specialists, nutritionists and health educators.

Chronic Care Improvement
AgeWell New York has designed programs focused on the improvement of clinical outcomes for those with chronic conditions. These programs seek to empower members to manage their conditions, prevent the recurrence of admissions and improve quality of life. The intent is to anticipate and provide for the scope of services required by members to achieve wellness goals and improve quality of life. These programs use both in-home and provider-based services to support the member’s needs, while also encouraging the self-management of conditions and healthy choices. Our highly trained team of nurses communicates with members and their primary care physicians to address and enforce compliance, educate members about managing their conditions, coordinate care, select services and educate/inform about treatment options.

Integration with Primary Care Physicians (PCPs)
Upon AgeWell New York enrollment, plan staff ascertains the member’s Primary Care Physician (PCP) information. The PCP is contacted about the member’s enrollment and is sent an initial PCSP for the PCP’s review and input. For ongoing care and adjustments to the PCSP, AgeWell New York coordinates closely with the PCP on a routine basis and via the Interdisciplinary Team. The PCP is included on that member’s Interdisciplinary Team and participates in care management and monitoring and improving clinical outcomes.
I. Provider Credentialing

The Credentialing/Recredentialing processes are components of the organization’s Quality Improvement Program. These processes were designed to protect members and provide continued assurance that potential and/or current participating providers meet the requirements necessary for the provision of quality care and service.

The objectives of the AgeWell New York Credentialing Program are to ensure that:

- Members who join AgeWell New York will have their care rendered by appropriately qualified providers
- Each provider applicant has equal opportunity to participate
- Adequate information pertaining to education, training, relevant experience and other credentialing criteria is reviewed by the appropriate individuals prior to approval or denial by the Credentialing Subcommittee.

Credentialing is required for all physicians who provide services to AgeWell New York members and all other health professionals and facilities who are permitted to practice independently under State law and who provide services to AgeWell New York members, with the exception of hospital based health care professionals. Hospitals and freestanding facilities are required by law to credential providers exclusively operating within their setting. As such, AgeWell New York does not credential providers that practice exclusively within the inpatient hospital or a freestanding facility setting but instead relies on the hospital’s credentialing program/appointment process for these providers. Providers in this category include, but are not limited to, providers employed by or contracted with the hospital who do not practice outside of the hospital.

Hospitals and other facilities must be licensed by and demonstrate good standing with state and federal regulatory agencies.

AgeWell New York does not discriminate in terms of participation or reimbursement against any physician or health care professional that is acting within the scope of his or her license.

Providers are obligated to submit their credentialing applications (and supporting documents) for initial and recredentialing in a timely manner.

Delegation of Credentialing

AgeWell New York may choose to delegate provider credentialing and recredentialing in accordance with established policies. However, AgeWell New York is ultimately responsible for credentialing and recredentialing of providers and maintains the responsibility for ensuring that the delegated functions are being performed according to AgeWell New York standards.
II. Application Process

AgeWell New York completes credentialing activities and notifies providers within 90 days of receipt of a completed application. The notification to the provider includes whether they are credentialed, whether additional time is needed for review or that AgeWell New York is not in need of additional providers. If additional information is required, AgeWell New York will notify the provider within 90 days of receipt of the application.

III. Initial Credentialing

The applicant is responsible for supplying all requested documentation.

A signed AgeWell New York Provider Application or CAQH Credentialing Application is required in addition to applicable credentialing documents and certifications. Examples of requested information include:

- New York State License and Registration
- Valid and Current DEA certification (physicians only)
- Board Certification
- Insurance Coverage (Participating providers are required to carry malpractice coverage amounts as specified in their contract. Non-medical providers must carry general business liability coverage as specified in their contracts.)
- Malpractice History
- Federal and/State Sanctions or Exclusions
- Medicaid Participation Status
- Curriculum Vitae (CV) and work history
- Hospital Privileges
- HIV Specialist PCP Addendum

The Credentialing Subcommittee will consider all information gathered on the Provider Application and evaluate it in light of the criteria. For more information on Credentialing Criteria please call Provider Services at the telephone number listed in Section 1 of this provider manual. The Credentialing Subcommittee will then make a determination to recommend either approval or disapproval of the provider’s application.

AgeWell New York will provide written notice to a provider whom AgeWell New York declines to include in the network, setting forth the reason for its decision.

IV. Recredentialing

Participating Providers must be recredentialed every 3 years. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance.
Confidentiality

At all times, information relating to a provider obtained in the credentialing/re-credentialing process is considered confidential.

V. Off-Cycle Credentialing

In the event information obtained by the AgeWell New York Credentialing Unit may indicate a need for further inquiry, the Credentialing Subcommittee may decide to conduct an off-cycle review of a provider’s credentialing status. Information obtained during an off-cycle review includes, but is not limited to, changes in: licensure, DEA certification, malpractice coverage, New York State OPMC actions, and Medicare and Medicaid sanctions.

Notwithstanding the above, providers who have had their licenses revoked or suspended, or who have been excluded from participation or who have opted out of the Medicare/Medicaid programs will be terminated immediately.

VI. Provider Termination and Disciplinary Action

Discipline of Providers

The Credentialing Subcommittee has responsibility for recommending suspension or termination of a participating provider for substandard performance or failure to comply with the requirements outlined in the AgeWell New York Provider Agreement.

In the event that the Credentialing Subcommittee recommends suspension or termination of participating provider, written notification is sent to the provider. The provider may then request a hearing in accordance with applicable law and regulations.

Examples of disciplinary action include, but are not limited to the following:

- Require the provider to submit and adhere to a corrective active plan
- Monitor the provider for a specified period of time, followed by a Peer Review or Credentialing Subcommittee determination as to whether substandard performance or noncompliance is continuing
- Require the provider to use medical or surgical consultation for specific types of care
- Require the provider to obtain training in specific types of care
- Cease enrolling new AgeWell New York members under the care of the provider
- Temporarily suspend the provider’s participation status
- Terminate the provider’s participation status with AgeWell New York

The Medical Director of AgeWell New York may determine at his/her sole discretion that the health of any AgeWell New York member is in imminent danger because of the actions or inactions of a participating provider, or that the provider is committing fraud or has received a final disciplinary action by a state licensing or governmental agency that impairs the provider’s ability to practice (“Immediate Action Events”) and in such case the Medical Director may
immediately suspend or restrict the provider’s participation status, during which time the Credentialing Subcommittee will investigate to determine if further action is required.

**Provider Sanctions**

All providers must comply with all laws and the rules, regulations and requirements of all federal, state and municipal governments.

Any provider who has been sanctioned, debarred, excluded or terminated by Medicare or Medicaid and has been prohibited from serving Medicare or Medicaid recipients or receiving payment from the Medicare or Medicaid program is excluded from participating in the AgeWell New York provider network.

AgeWell New York’s initial and ongoing credentialing process consists of a review of all federal and state sanctions including medical license or practice privilege probation, revocation, restriction, sanction or reprimands. AgeWell New York’s review of sanctions also includes Medicare and Medicaid reprimands, censure, disqualification, suspension or fines, as well as conviction of or indictment for a felony. Additionally, AgeWell New York reviews the General Service Administration’s Excluded Parties List System (GSA EPLS) for parties which are excluded from receiving Federal contracts and subcontracts, and certain Federal financial and nonfinancial assistance and benefits.

On confirmation of suspension, encumbrance or revocation by a duly authorized government agency, AgeWell New York immediately imposes the same suspension, encumbrance or revocation on the provider’s participation in AgeWell New York.

**VII. Appeal of Disciplinary Action**

The provider may appeal any formal disciplinary action. Requests for appeal must be submitted in writing and sent by certified mail, return receipt requested to the Credentialing Subcommittee within 30 days after the provider receives notice from the Subcommittee of its proposed action.

**VIII. Procedure for Provider Termination**

The Credentialing Subcommittee may recommend termination of the participation of a provider. Consideration of termination may be initiated by any information the Credentialing Subcommittee deems appropriate including, but not limited to the following:

- The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in the AgeWell New York Credentialing program;
- The provider rendered(s) care to a member in a harmful, potentially harmful, personally offensive, or unnecessary or inefficient manner; or fails to provide access to care to an extent that continuity of care is provided to enrolled patients is adequate;
- The provider engaged(s) in abusive or fraudulent billing practices, including but not limited to submitting claims for payment that were false, incorrect or duplicated;
• The provider fails to comply with AgeWell New York’s policies and procedures, including those for utilization management, quality management or billing;
• The provider’s privileges at a network institution, or any other institution, are lost or restricted for any reason;
• The provider’s license or DEA certification are limited, suspended or revoked by any agency authorized to discipline providers;
• The provider is censured, suspended, debarred, excluded or terminated as a Medicaid or Medicare provider;
• The provider is indicted or convicted of a felony;
• The provider fails to comply with the application, selection or recredentialing process or submits false, incomplete or misleading information with respect to credentials or fails to comply with any provision of the Program Agreement;
• The provider renders professional services outside the scope of his/her license or beyond the bounds of appropriate authorization;
• The provider fails to maintain malpractice insurance that meets approved guidelines; or
• The provider experiences physical or mental impairment, including chemical dependency, which affects his/her ability to provide care to patients or fails to meet the criteria of the plan’s Provider Impairment Policy or the relevant policies of network institutions.

A provider cannot be prohibited for the following actions and AgeWell New York may not terminate or refuse to renew a contract solely for provider performance of the following actions:

• Advocacy on behalf of a member
• Filing a complaint against AgeWell New York
• Appealing a determination made by AgeWell New York
• Providing information or filing a report with an appropriate government body regarding prohibitions of plans
• Requesting a hearing or review

If the Credentialing Subcommittee receives information which it believes suggests that the discipline or termination of a provider may be warranted for reasons relating to the provider’s professional competence or conduct, it will request the Medical Director to investigate the matter.

If the Credentialing Subcommittee believes that further information is needed, it may obtain it from the provider or other sources. The Subcommittee may request or permit the provider to appear before the Credentialing Subcommittee to discuss any issue relevant to the investigation.

In the event that the Subcommittee’s recommendation is to impose any disciplinary action, including, but not limited to, termination of the provider, the Subcommittee shall provide to the provider a written explanation of the reasons therefore and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action unless the reasons therefore involve in harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice, in which cases
Credentialing Subcommittee may immediately suspend or restrict the provider’s participation in the AgeWell New York provider network.

Subject to the provider’s rights to appeal, the Credentialing Subcommittee’s recommendations will be forwarded to the Board of AgeWell New York for final approval.

IX. Review Procedure

The procedure for termination or denial of recredentialing will apply to providers who are terminated or denied recredentialing in one or more specific specialties or subspecialties, as well as those who are terminated or denied recredentialing in terms of their total participation in the plan.

Upon reaching a recommendation that adverse action be taken against a provider, the Credentialing Subcommittee shall notify the provider that he or she has a right to request a hearing or review, at the provider’s discretion, of said recommendation.

AgeWell New York shall include in the termination notice:

- The reason for the proposed action;
- Notice that the provider has the right to request a hearing or review, at his or her discretion, before a panel appointed by the Medical Director;
- The provider has 30 days within which the provider may submit to the Medical Director a written request for a hearing and/or review; and
- A time limit for a hearing date, which must be held within 30 days after the date of the Credentialing Subcommittee receipt of a request for a hearing.

The provider termination shall not be effective earlier than 60 days from the provider’s receipt of the notice of termination.

Upon receipt of a request for hearing or review, the Medical Director shall inform the Credentialing Subcommittee members and shall select a review panel consisting of three (3) persons (the “Review Panel”), at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Subcommittee. The Medical Director may appoint more than three (3) persons to the Review Panel; provided that for appeals by providers in the AgeWell New York Medicare Advantage plan, the majority of the Review Panel must be clinical peers of the provider under review. The Board shall appoint one of the Review Panel members as chairperson ("Review Panel Chairperson").

Within fourteen (14) days of receipt of a provider’s written request for hearing, the Medical Director will notify the provider of the time and place of the hearing, which shall be no more than thirty (30) days after receipt by the Medical Director of the request for hearing, unless the parties mutually agree upon a later date. In addition, said notice shall include the witnesses, if any, to be called by the Credentialing Subcommittee in support of its recommendation, and a list of the members of the Review Panel.
X. The Hearing

The Credentialing Subcommittee will be represented by its Chairman or his or her designee during the appeal process. The Credentialing Subcommittee will be responsible for documentation and minutes of the hearing. The Review Panel Chairperson will facilitate the hearing and ensure the following procedure is followed:

- **Chairman's Statement of the Procedure**: Before evidence or testimony is presented the Chairman of the Review Panel will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of Evidence by Credentialing Subcommittee**: The Credentialing Subcommittee may present any oral testimony or written evidence it wants the Review Panel to consider. The provider or the provider's representative will have the opportunity to cross-examine any witness testifying on the Credentialing Subcommittee's behalf.
- **Presentation of Evidence by Provider**: After the Credentialing Subcommittee submits evidence, the provider may present oral testimony or written evidence to rebut or explain the situation or events described by the Credentialing Subcommittee. The Credentialing Subcommittee will have the opportunity to cross-examine any witnesses testifying on the provider's behalf.
- **Credentialing Subcommittee Rebuttal**: The Credentialing Subcommittee may present additional written evidence to rebut the provider's evidence. The provider will have the opportunity to cross-examine any additional witnesses testifying on the Credentialing Subcommittee's behalf.
- **Summary Statements**: After the parties have submitted their evidence, first the Credentialing Subcommittee and then the provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the Review Panel. The Review Panel will establish a reasonable time frame for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- **Examination by Review Panel**: Throughout the hearing, the Review Panel may question any witness who testifies.

XI. Vendor Oversight

AgeWell New York ensures that contract negotiation and implementation is handled in an effective, ethical manner, identifies and respects the needs of the impacted functional areas, ensures the most beneficial financial and business terms for the organization and monitors the performance of the vendor throughout the term of the contract.

AgeWell New York identifies the activities to be delegated, performs pre-delegation assessment, establishes performance standards consistent with those described in the contract between AgeWell New York and CMS/NYSDOH and specifies the reporting requirements necessary to monitor the vendor/provider on an ongoing basis. All written agreements, including Letter of Agreement (LOA), Memorandum of Agreement (MOA) and Contracts, that specify delegation of functions contained in the agreement between AgeWell New York and CMS/NYSDOH are developed, executed and monitored in accordance with CMS and NYSDOH requirements to
ensure appropriate quality and compliance. In an effort to avoid vendor/provider performing outside upon the standards AgeWell New York performs ongoing oversight of delegated activities.
I. Electronic and Paper Claims Submission

CMS 1500 PROFESSIONAL CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

Claim completion requirements apply to providers under fee for service and capitated arrangements. To ensure timely claims adjudication, the following information must be included on the claim form:

- Member name
- Payer specific Member ID number. The number will be a total of 11 digits.
- Date of Birth
- Provider Name, Tax ID number and NPI number
- Date of Service that falls within the effective and expiration date printed on the authorization
- Valid Place of Service code
- Service Code such as HCPCS/CPT
- Number of Units
- Co-insurance claims must include a copy of the primary insurer EOP.
- Valid Diagnosis Code
- Valid Place of Service

UB04 INSTITUTIONAL CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

Facilities and other institutional providers such as ambulatory surgical centers must submit on UB04s. Submit reporting data on the UB-04 form using the standard CMS data requirements. In addition to the member, provider and procedure information, please ensure the Revenue Codes are accurate. DRG assignments should also be noted where applicable.

- Member name
- Payer specific Member ID number. The number will be a total of 11 digits.
- Date of Birth
- Provider Name, Tax ID Number and NPI number
- Date of Service that falls within the effective and expiration date printed on the authorization.
- Service Code such as HCPCS/CPT
- Number of Units
- Co-insurance claims must include a copy of the primary insurer EOP.
- Valid Bill Type
- Valid Diagnosis Code
- Valid Revenue Code
Valid Value Code(s) and Occurrence Code(s)
Applicable Admit Dates

Submit Paper Claims to:
AgeWell New York
P.O. Box 21536
Eagan, MN 55121
1-866-237-2140

This is to be used only for claims submission. All other correspondence should be mailed to:
AgeWell New York
1991 Marcus Avenue
Suite M201
Lake Success, NY 11042

Submit EDI Claims to:
Change Healthcare/Emdeon, Payer ID: AWNY6
http://www.changehealthcare.com

II. Claims Payment

The provider is paid based on prompt payment regulations and guidelines and will be informed as to which procedures are being paid via a statement called an "Explanation of Payment" or "EOP". The EOP will be incorporated into the stub of the remittance check.

Providers may register for Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) with PaySpan 877-331-7154 www.payspanhealth.com

III. Corrected Claims Resubmission

Submission of corrected claim; (invalid/missing codes, such as CPT, place of service, missing units, etc.) should contain the original claim number for reference, applicable Bill Type for corrected claims, and indicate “Corrected Claim” visibly on the form resubmitted. Corrected Claims must be submitted within 180 days of the date of service.

IV. Claims Payment Reconsideration

Denied Claims may be disputed in writing for payment reconsideration within 60 days of the notice of denial. Provider disputes must contain the following information:
- Provider name;
- National Provider Identifier (NPI);
- Provider contact information;
- Description of the item in dispute, including the Member ID, dates of service, service code billed, units billed, amount billed and reason for contesting the determination and the justification as to why the service should be paid or approved;
- Copies of relevant information and supporting documentation required for review of the determination;
The provider must submit the information required for claim determination review to:

AgeWell New York, LLC.
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042
Attn: Claims and Appeals

**Appeal Response**
Written determination of dispute resolution will be issued within 30 days of AgeWell New York’s receipt of the dispute.

**Second Level Appeal**
A second appeal may be submitted in instances where AgeWell New York upholds the original claim denial and the provider has additional information to substantiate a second review. This request must be received within 29 days from the date of the original denial.

**V. Claims Status**

Providers may call 1-866-237-2140 to obtain information regarding the status of their claims. Please have provider National Provider Identification (NPI) number, the DOS, member name and ID number available when making a claims status inquiry. Claim status can also be reviewed on the provider portal at www.agewellnewyork.com

**VI. Billing Requirements**

- Provider agrees to follow applicable CMS/NYSDOH and AgeWell New York billing guidelines.
- For services not covered by AgeWell New York a provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member

**VII. Provider Preventable Conditions**

AgeWell New York will not pay a claim for a Provider Preventable Conditions including a Health Care Acquired Condition. These conditions include those that could have been prevented by utilizing best practices. AgeWell New York will identify and report on Provider Preventable Conditions. Providers shall not restrict access to care for members relating to treatment for a Provider Preventable Condition.