Medicaid Managed Long Term Care
Partial Capitation Model Contract 2017-2021
Compliance Aid*

Article	Section Reference	Description of Change	Documents Required for Submission to DOH
I	G-8	**Adds language:** 8. Enrollees will be provided with education on all available plan options. Contractor must accept the transfer of all Enrollees affected by the termination of another MLTCP that select or are auto-assigned to Contractor. These transferring Enrollees are presumed to meet the eligibility requirements for MLTC. Contractor must accept enrollment of these Enrollees, and is not required to conduct an assessment prior to enrollment.	**Enrollment Policy**
IV	E 2—3	**Adds section:** **E. Conflict Free Evaluation and Enrollment Center (CFEEC)** 2. The CFEEC shall establish the minimum baseline eligibility for each applicant according to Article IV, Section B.6 of this Agreement. 3. If the Contractor does not agree with the initial eligibility determination established by the CFEEC, the Contractor should seek clarification of the discrepancy with CFEEC. If the dispute cannot be resolved satisfactorily, the Contractor shall refer the matter to the Department for resolution.	**Eligibility Policy**
V	B-1-c-ii	**Adds language:** ii. The Contractor's initial assessment for MLTC eligibility must be conducted within thirty (30) days of first contact by an individual requesting enrollment or of receiving a referral from the Enrollment Broker or other source. This assessment must be performed by a Registered Nurse (RN) in the individual's home. A Person Centered Service plan must be developed based on the findings of this assessment.	**Enrollment Policy**
V	B-1-d-iii.—iv.	**Adds language:** iii. The Contractor must provide the Applicant with written notice of the proposed Person Centered Service Plan resulting from the assessment prior to enrollment. iv. The Contractor must provide a monthly report to the Department or entity designated by the Department listing all individuals for whom an assessment was completed in a format determined by the Department. The report must include the name of the individual; the date of initial contact to the plan for individuals that were not referred by the LDSS or entity designated by the Department; and the date the MLTCP conducted its assessment for program eligibility. The report must be submitted within ten (10) business days of the close of each month.	**iii. Enrollment Policy** **iv. Please note: required report**

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V	B-2-b—c	**Adds language:** b. The initial assessment for MLTC eligibility must be conducted within thirty (30) days of first contact by an individual requesting enrollment or of receiving a referral from the Enrollment Broker or other source. This assessment must be performed by an RN in the individual's home. A Person Centered Service Plan must be developed based on the findings of this assessment. c. The Contractor must provide the Applicant with written notice of the proposed Person Centered Service Plan resulting from the assessment prior to enrollment.	**Enrollment Policy**
V	C-9	**Adds language:** 9. If an enrollee is being disenrolled from another MLTC Plan to the Contractor's MLTC Plan due to an approved service area reduction, closure, acquisition, merger, or other approved arrangement, the Contractor must continue to provide services under the Enrollee's existing Person Centered Service Plan for a continuous period of 120 days after enrollment or until the Contractor has conducted an assessment and the Enrollee has agreed to the new Person Centered Service Plan.	**Enrollment Policy** **Handbook**
V	D-1-a	**Adds language:** a. The Contractor shall comply with disenrollment policies and procedures developed by the Contractor as approved by the Department. Such written policies and procedures shall address all aspects of disenrollment processing and shall contain the disenrollment forms and materials used by the Contractor. The Contractor must submit any proposed material revisions to the policies and procedures for Department approval prior to implementation of the revised procedures. The Contractor agrees to conduct disenrollment of an Enrollee in accordance with the Agreement and guidance for Disenrollment as issued by the Department.	**Disenrollment Policy**
V	D-1-b	**Replaces language:** b. The effective date of disenrollment shall be the first day of the month following the month in which the ~~disenrollment is processed through eMedNY~~ event occurred that resulted in the Enrollee being ineligible for enrollment.	**Disenrollment Policy** **Handbook**
V	D-2-a	**Adds language:** a. An Enrollee may initiate voluntary disenrollment at any time for any reason upon oral or written notification to the Contractor. The Contractor must provide written confirmation to the Enrollee of receipt of an oral request and maintain a copy in the Enrollee's record. The confirmation must include the Enrollee's CIN, name, the date of the request and the effective date of the voluntary disenrollment.	**Disenrollment Policy**
V	D-4-f	**Adds language:** e. an Enrollee is not eligible for MLTC because he/she is assessed as no longer demonstrating a functional or clinical need for the authorization and delivery of any community-based long term care services on a monthly basis or, for non-dual eligible Enrollees, in addition no longer meets the nursing home level of care as determined using the assessment tool prescribed by the Department. An Enrollee whose sole service is identified as Social Day Care must be disenrolled from the MLTC plan. An Enrollee who no longer requires and receives at least one CBLTCS in each	**Disenrollment Policy** **Handbook**

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		calendar month must be disenrolled. The Contractor shall provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such determination;	
V	D-4-h	**Replaces language:** h. ~~an Enrollee has not received services for more than 30 consecutive days, regardless of the reason therefore.~~ an Enrollee provides the Contractor with false information, otherwise deceives the Contractor, or engages in fraudulent conduct with respect to any substantive aspect of his/her plan membership.	**Disenrollment Policy** **Handbook**
V	D-5-c—d	**Deletes language:** c. ~~an Enrollee knowingly fails to complete and submit any necessary consent or release.~~ d. ~~An Enrollee provides the Contractor with false information, otherwise deceives the Contractor, or engages in fraudulent conduct with respect to any substantive aspect of his/her plan membership.~~	**Disenrollment Policy** **Handbook**
V	E-4-a	**Adds language:** a. The Contractor shall retain in each Enrollee's record documentation that the Enrollee received the information and notifications required by Appendix L of this Agreement.	**Enrollment Policy** **Handbook (should include Appendix L)**
V	E-7 E-8 E-9	**Adds language:** 7. The Contractor must provide written notification of the effective date of any Contractor-initiated, or Department-approved Benefit Package change to Enrollees. Notification to Enrollees must be provided at least thirty (30) days in advance of the effective date of such change. 8. Upon approval by CMS of an applicable amendment to New York State's 1115 waiver Standard Terms and Conditions, Enrollees may disenroll without cause when the Department has determined that Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the SSA or 42 CFR 438. 9. If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 CFR 438, the Department will notify affected enrollees of their right to terminate enrollment without cause.	**Appropriate Policies and Procedures**
V	F-3	**Adds section:** 3. Upon approval by the Department, the Contractor may offer its Enrollees incentives for completing a health goal such as finishing all prenatal visits, participating in a smoking cessation session, and timely completion of immunization or other health related programs. Additionally, the Contractor may offer its Enrollees incentives to promote the delivery of preventive care services, as defined in 42 CFR 1003.101 the Department will determine if the incentive meets the requirements at 42 CFR 1003.101 and outlined in DHHS OIG Special Advisory Bulletin "Offering Gifts and Other Inducements to Beneficiaries." a.) Enrollee incentives described in this section of this Agreement may not be cash or instruments convertible to cash (e.g., checks, money orders, or debit cards) and must be related to the delivery of preventive care services to the Enrollee or the Enrollee achieving a health goal. The value of such incentives may not be disproportionally large in relationship to the value of the preventive care service or health goal completed by the Enrollee.	**Quality Plan/Policy**

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		i. The Contractor should consider SSI earned income thresholds that may apply to SSI Enrollees when developing incentive programs. ii. Under no circumstances shall the Contractor establish incentive programs that result in Enrollees that have achieved the same health goal or received the same preventive care service receiving an incentive of differing value. iii. The Contractor shall maintain contemporaneous records identifying the Enrollee, CIN, date, amount paid and the nature of the health goal for which the incentive is being paid. b.) The Contractor may not make reference to Enrollee incentives in its pre-enrollment marketing materials or discussions. c.) The Contractor shall not offer an incentive program to Enrollees that has not been approved by the Department. i. The Contractor shall submit all incentive program related materials to the Department for review and approval at least 60 days prior to the commencement of the incentive program and include documentation that supports that the value of the incentive complies with subsection (a) above.	
V	G-3-b	**Adds and replaces language:** b. The Contractor shall comply with disenrollment policies and procedures developed by the Contractor as approved by the Department. Such written policies and procedures shall address all aspects of disenrollment processing and shall contain the disenrollment forms and materials used by the Contractor. The Contractor must submit any proposed material revisions to the policies and procedures for Department approval prior to implementation of the revised procedures. a listing and copies of the specific marketing formats to be used (e.g., radio ~~announcements~~, television, billboards, newspapers, leaflets, brochures, ~~letters, posters, brochures, handbooks~~, websites, social media, yellow pages advertisements, letters, posters, and verbal presentations) and the forums for distribution or presentation (e.g., health fairs, provider offices, community events);	**Marketing Plan/Policy**
V	G-3-h	**Adds language:** h. a discussion as to if or how the Contractor plans to provide nominal gifts of no more than $5 in fair market value for the target population, addressing application of such gifts to ensure they are not construed as an offer of financial gain or service incentive to induce either enrollment or transfer;	**Marketing Plan/Policy**
V	G-4-a	**Replaces language:** a. The Contractor may use radio, television, billboards, newspapers, leaflets, brochures, ~~the Internet~~ websites, social media, yellow page advertisements, letters, posters and verbal presentations by marketing representatives at health fairs and other appropriate events to market its product.	**Marketing Plan/Policy**
V	G-4-n	**Adds language:** n. The Contractor shall comply with any and all marketing guidance issued by the Department.	**Marketing Plan**
V	G-5-a—b	**Adds language:** a. Routine postings on social media sites such as basic reminders of the availability of smoking cessation programs and flu vaccinations, and items such as healthier living related tips do not require prior approval by the Department.	**Marketing Plan**

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		b. All electronic means of interaction with Potential Enrollees of public health insurance programs, while not directly approved by the Department, will be routinely monitored for compliance with this Section.	
V	G-7 - 9	**Adds language:** 7. The Contractor shall not list any contact information pertaining to the Contractor's eligibility assessment staff, agents, subcontractors, and any entities that perform eligibility assessments on behalf of the Contractor, in any MLTC plan marketing materials and member handbooks. 8. The Contractor must provide the contact information for the Conflict-Free Evaluator on all MLTC plan materials that can reasonably be interpreted as intended to market to Potential Enrollees. 9. Department-approved English language versions of outreach/advertising materials and other informational materials (e.g. Member handbooks) that are then translated into other languages in accordance with Appendix M of this Agreement, do not need to be resubmitted to the Department for approval. The Contractor, however, is required to keep a copy of the Certificate of Accuracy on file and submit to the Department upon request.	**Marketing Plan/Policy** **Marketing Materials**
V	H-4-b	**Adds language:** b. the methods the Contractor will use to provide information to Applicants and Enrollees who speak other than English as a primary language including provision of oral interpretation service for any language;	**Handbook** **Marketing Materials**
V	H-5	**Adds and replaces language:** 5. The Contractor shall obtain and retain a signature on the Enrollment Agreement/Attestation signed by the Applicant an the Contractor shall maintain a copy of the agreement/attestation in the Applicant/Enrollee's record. ~~which~~ It will certify ~~provide evidence~~ that each Applicant/Enrollee has:	**Enrollment Policy**
V	H-6-c—d	**Adds language:** c. ~~and Medical~~ Language interpreter services must be provided during ~~a medical visit~~ scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible. d. The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request at no charge to the Enrollee.	**For c)** **Provider Manual** **For d)** **Handbook**
V	H-8	**Adds language:** 8. The Contractor must submit any proposed service change in the handbook to the Department for approval prior to use.	**Marketing Plan/Policy**

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V	H-10	**Adds language:** 10. Upon the direction of the Department, the Contractor shall submit the format and content of all written notifications regarding disease management, medication adherence, health literacy, preventive health and Department-identified public health initiatives for review and prior approval by the Department. Such materials shall be submitted by the Contractor to the Department at least 30 days prior to issuance of the notification.	**Care Management Policy**
V	J-4	**Adds section:** 4. The Contractor may subcontract with another entity for the provision of Care Management Services to the Contractor's Enrollees by entering into a Care Management Administrative Services (CMAS) agreement with such entity utilizing the guidelines issued by the Department. a. If Care Management responsibilities are subcontracted, Care Management Protocols must be provided to the subcontractor's administrator, and b. The Contractor shall provide timely notification to the subcontractor's administrator of new enrollments and disenrollment's, and such notices shall promptly follow the Contractor's notification of this information by the Department and/or the Enrollment broker.	**Care Management Policy**
V	J-6-a	**Adds language:** a. Provide a minimum of one successful Care Management telephone communication per month with each Enrollee. If successful communication with an Enrollee does not occur, the reason thereof must be documented in the Care Management record;	**Care Management Policy**
V	J-6-d—e	**Adds language:** d. Consideration should include, but is not limited to, evidence of multiple co-morbidities, lack of informal supports, housing circumstances, and ability to self-direct. The ratio of care managers to Enrollees must be lower for those Enrollees with greater Care Management needs. If Care Management is provided in a "team approach," then the Care Management Protocols must address how the team operates to maintain the identified ratio; e. documentation of the methods used to educate and inform the Enrollee must be maintained in the Care Management record.	**Care Management Policy**
V	J-6-i—j	**Adds language:** i. Ensure that Enrollees have access to Care Management services 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary. j. Enrollees who are determined to be permanently placed in a Nursing Home are exempt from all Care Management requirements.	**For i)** **Care Management Policy** **Handbook** **Marketing Materials** **For j)** **Care Management Policy**
V	J-7	**Adds language:**	**Care Management Policy**

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		7. A comprehensive reassessment of the Enrollee and a Person Centered Service Plan update shall be performed as warranted by the Enrollee's condition but in any event at least once every six (6) months; such reassessment shall be completed by a Registered Nurse prior to the expiration of the six (6) month period.	
V	J-9-c-ii.—iii.	**Adds language:** ii. All Enrollees and Potential Enrollees shall receive a Person Centered Service Plan after initial assessment, or reassessment where applicable, which must be completed within fifteen (15) days of enrollment/reassessment, or must document reason for any delay in the Enrollee's record. The completed PCSP must be signed by the Enrollee and a copy must be provided to the Enrollee, and a signed copy must be retained by the Contractor. An attempt to obtain the Enrollee's signature is required. If Enrollee refuses, the refusal must be documented in the Enrollee's record. iii. The Person Centered Service Plan must be developed with the assistance of the Enrollee and those individuals selected by the Enrollee to participate in service planning and delivery, including service providers and the Enrollee's chosen informal supports.	**Enrollment Policy** **Care Management Policy** **Handbook**
V	J-9-c-xii	**Adds language:** xii. The Contractor must adhere to the Person Centered Service Plan of each Enrollee. The Contractor must document and maintain a timely and accurate log within the Care Management system of Enrollee services and document any situations in which the Enrollee's authorized CBLTCS have not been provided. In the event that the Enrollee is leaving the service area temporarily, the dates of the Enrollee's expected departure and expected return, if available, shall be documented in the Enrollee's record.	**Care Management Policy**
V	J-9-d-vii. and viii.	**Adds language:** vii. permit the Enrollee to appoint someone to speak on their behalf about that care that is needed: viii. assure that the Enrollee or their designated representative plays a central and active role in the development and execution of the Enrollee's approved Person Centered Service Plan.	**Care Management Policy**
V	K-2-a	**Changes language:** 2. The Contractor must ensure that all ~~prospective and current~~ eligible Enrollees are: a. notified on initial assessment and at reassessment that CDPAS is an available voluntary benefit;	**CDPAS Policy** **Handbook**
V	K-3	**Adds language:** 3. The Contractor must document in each Enrollee's record that the notifications required under Article V.K.2 of this Agreement have taken place.	**Care Management Policy** **CDPAS Policy**
V	K-4	**Changes language:**	**CDPAS Policy** **Handbook**

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		4. ~~The Enrollee may designate a legal or non-legal representative to assist with or assume employer responsibilities.~~ In the event the Enrollee is not self-directing, a designated representative will be identified to assume Enrollee responsibilities for CDPAS. Such representative may not act as the Enrollee's personal assistant.	
V	K-8	**Deletes language:** ~~8. The Contractor shall inform FIs of its claims procedures. The Contractor shall process all claims and pay clean claims in a timely manner, as determined by the agreement with the FI, and notify FIs in writing as to the reason(s) claims are fully or partially denied. The Department may require a plan of correction, impose sanctions or take other regulatory action should it determine the Contractor consistently delays payments to FIs without due cause.~~	**Provider Manual**
V	M	**Adds language:** **M. Advance Directives** The Contractor shall, in compliance with the requirements of 42 CFR § 438.3(j)(l) and 42 CFR Part 489 Subpart I, maintain written policies and procedures regarding Advance Directives and inform each Enrollee in writing at the time of enrollment of an individual's rights under State law to formulate Advance Directives and of the Contractor's policies regarding the implementation of such rights. The Contractor shall include in such written notice to the Enrollee materials relating to Advance Directives and health care proxies as specified in 10 NYCRR §§ 98-1.14(f), 400.21 ~~Part 98~~. The written information must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.	**Enrollment Policy** **Handbook**
V	P-6	**Adds language:** 6. The Contractor shall maintain a record of health education provided to Enrollees.	**Care Management Policy**
V	T-1-a - c	**Adds section:** **T. Elections Based on Moral or Religious Grounds** 1. In accordance with 42 CFR § 438.102(b), the Contractor may elect not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, if it furnishes or has furnished information about the services it does not cover: a. to its Enrollees at least 30 days before the effective day of the policy; and either b. to the Department concurrently with its application for qualification for a Managed Long Term Care Partial Capitation Plan; or c. to the Department whenever it adopts the policy during the term of the contract.	**Develop a new policy or add to an existing policy.**
V	U-1—5	**Adds section:** **U. Emergency Preparedness** 1. The Contractor shall provide its emergency contact information (staff names, telephone numbers and email addresses) to the Department and shall notify the Department immediately upon any subsequent updates of that information.	**Emergency Preparedness Policy**

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		2. The Contractor shall develop and adhere to an Emergency Preparedness Plan (EPP) to support the health, safety and welfare of Enrollees during emergencies. Such plans shall include, but are not limited to, the following elements: a. Description of anticipated types of emergencies and disasters covered by the EPP, and any specific actions to be taken dependent on the nature of the emergency; b. Identification of staff roles and responsibilities during implementation of the EPP; c. Procedure to classify Enrollees by risk according to their characteristics and needs, which specifies how risk categories/levels are assigned; d. Process to identify Enrollees receiving community based long term support services, designate those Enrollees at highest risk during an emergency, and ensure that, at a minimum, all highest risk Enrollees are contacted and assisted according to their needs; e. Procedure for communicating during an emergency with all Enrollees, subcontractors, the LDSS, local emergency management agencies, and the Contractor's employees; f. Description of alternate communication procedures to be used in case of telecommunication and/or internet systems outages; g. Plan to implement Helplines for Enrollees and subcontracted providers to contact the Contractor, with 24 hours/day, 7days/week availability; h. Plan for accessing Enrollee health and contact information during an emergency, with alternate procedures for off-site access or in event of systems failures; i. Procedures for evacuation and subsequent tracking of Enrollees and subcontractors' employees; j. Procedure for suspension of prior authorization requirements in medically urgent situations during emergency; k. Procedure to allow use of out-of-network providers, as needed, and to pay providers accordingly; l. Criteria for initiation of EPP: for anticipated emergencies, the EPP will specify how many days before the onset of the emergency the Contractor will prepare a report of all Enrollees categorized as high risk; and m. Plan for holding post-emergency debriefing and evaluation of Emergency Preparedness Plan implementation, and to provide a summary report of findings to the Department within ten (10) business days. 3. Contractors shall notify the Department when the EPP is initiated, and at what location(s), and provide periodic updates to the Department until the emergency is resolved. 4. The Contractor will review details of the EPP with employees annually.	

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		5. The Contractor shall ensure annually that all subcontractors have adequate emergency preparedness protocols in place.	
V	V-1—2	**Adds section:** **V. Discharge Planning** 1. The Contractor will make all reasonable efforts to work with hospitals, Article 31 facilities, mental health facilities, Article 32 OASAS programs, RHCFs and outpatient and community-based providers in developing discharge plans for their Enrollees when a change in the Enrollee's level of care is proposed. As part of discharge planning, the Contractor shall arrange for and authorize covered services as medically necessary for the Enrollee's care. For the purposes of this Section, "reasonable efforts" include, but are not limited to, as applicable and appropriate to the Enrollee's circumstances: participation in discharge planning meetings; face-to-face meetings with the Enrollee to assess needs and preferences for care; identification of medical, environmental or social obstacles to safe discharge; referral to the Contractor's care management program; collaboration with a Health Home, if applicable; enrollment and care management efforts; referral to Medicaid waiver programs; and/or referral to state and local government agencies. Consistent with this Agreement, where the Enrollee has intensive medical or behavioral health needs, the Contractor will ensure sufficient time is provided to fully implement the discharge plan and PCSP, including assurance of informal and formal supports at the lower level of care. 2. Where safe discharge from a Residential Health Care Facility cannot be arranged solely due to the Enrollee's lack of housing, the Contractor shall continue coverage of the stay, as applicable, and work collaboratively with the facility to explore all options and referrals available considering the Enrollee's specific circumstances, including coordination with housing providers, homeless services, and Health Home care management agencies, as applicable.	**Care Management Policy**
V	W	**Adds section:** **V. Cost-Effective Alternative Services** The Contractor may provide cost-effective services or settings that are an alternative to those services and settings covered under the Benefit Package, as permitted by 42 C.F.R. 438.3(e) and approved by the State.	**Service Authorization Criteria/ Service Auth Policy**
V	W	**Adds section:** **W. Requirements for the "Money Follows the Person" (MFP) Demonstration** In order to comply with MFP requirements, MLTC plans must: a) Include the "MFP Attestation for Enrollment Agreement" in the plan's Enrollment Agreement; and; b) Include the following language describing MFP in the plan's Member Handbook: **Money Follows the Person (MFP)/Open Doors**	**Handbook** **Enrollment Agreement**

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		This section will explain the services and supports that are available through *Money Follows the Person (MFP)/Open Doors*. *MFP/Open Doors* is a program that can help Enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they: • Have lived in a nursing home for three months or longer • Have health needs that can be met through services in their community *MFP/Open Doors* has people, called Transition Specialists and Peers, who can meet with enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help Enrollees by: • Giving them information about services and supports in the community • Finding services offered in the community to help Enrollees be independent • Visiting or calling Enrollees after they move to make sure that they have what they need at home For more information about *MFP/Open Doors,* or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit *MFP/Open Doors* on the web at www.health.ny.gov/mfp or www.ilny.org.	
V	Y 1 through 10	**Adds section:** 1. Rights and Responsibilities a. The Contractor, or subcontractor to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, must comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR Part 455 and 42 CFR Part 438 Subpart H. b. Pursuant to 42 CFR 438.608(a), the Contractor, or subcontractor to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment under this Agreement, shall implement and maintain arrangements or procedures to detect and prevent fraud, waste and abuse. The arrangements or procedures must meet all of the requirements of this Section. c. Nothing in this Section shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or Department to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party. 2. Compliance Program a. In accordance with 42 CFR 438.608(a)(1) and 18 NYCRR Part 521, the Contractor must have a compliance program which includes all of the following:	**Compliance Policy** **Fraud Waste Abuse Policy** **SIU**

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		i. written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable Federal and State requirements; ii. the designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the chief executive officer and the board of directors; iii. the establishment of a regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Agreement; iv. a system for training and education for the compliance officer, the Contractor's senior management, and the Contractor's employees for the Federal and State standards and requirements under this Agreement; v. effective lines of communication between the compliance officer and the Contractor's employees; vi. enforcement of standards through well-publicized disciplinary guidelines; and vii. establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. 3. Contractor Obligation to Return Overpayments Pursuant to 42 CFR 438.608(c)(3), the Contractor shall return, and shall require its subcontractors to return, to the Department any capitation payments or other payments in excess of amounts specified in this Agreement, as reported to the Department pursuant to Section F(3)(u) of Article VIII of this Agreement, within sixty (60) days of identification, or receipt of notice, of such payments. 4. Prevention Plans and Special Investigation Units a. If the Contractor has an enrolled population of 10,000 or more persons in the aggregate in any given year, the Contractor must comply with 10 NYCRR Part 98-1.21. This includes development and submission to the commissioner of a fraud and abuse prevention plan as well as designation of an officer or director who has responsibility and authority for carrying out provisions of the plan, and who reports directly to senior management. The Contractor shall also develop a special investigation unit (SIU) for the detection, investigation and prevention of fraudulent activities.	

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		i. In accordance with the provision for internal monitoring and auditing, the SIU must conduct audits and/or investigations specific to the Medicaid line of business. These audits and/or investigations must involve five percent (5%) or more of Medicaid claims each calendar year. The SIU may collaborate with other program integrity areas of the MCO to accomplish this. The SIU will be responsible for tracking the information related to the Medicaid specific audits and investigations conducted each year and shall make that report available to the Department and OMIG upon request and as part of the Provider Investigative Report as referenced in section F of Article VIII of this Agreement. b. If the Contractor has fewer than 10,000 Enrollees or is otherwise not subject to 10 NYCRR § 98-1.21(a), the Contractor shall submit annually to the Department and OMIG, in a form and format to be determined by the Department or OMIG, a report of overpayments recovered. 5. Service Verification Process Pursuant to 42 CFR 438.608(a)(5), the Contractor will implement a service verification process that accurately evaluates the delivery of billed services to the recipient population by using statistically valid sample sizes and timeframes that determine whether Enrollees received services billed by Providers. 6. Withholding of Payments. a. Pursuant to 42 CFR 438.608(a)(8) and consistent with 42 USC § 1396(b)(i)(2)(C), the Contractor must, if directed by OMIG or the Department, withhold payments to Participating or Non-Participating Providers, in whole or in part, when OMIG or the Department has determined that a Participating or Non-Participating Provider is the subject of a pending investigation of a credible allegation of fraud in accordance with 42 CFR § 455.23 and 18 NYCRR § 518.7. The Contractor shall begin withholding payments to Participating or Non-Participating Providers not later than five (5) business days from the date of notification from OMIG or the Department. b. OMIG or the Department will provide notice to the Participating or Non-Participating Provider of the withhold in accordance with 18 NYCRR § 518.7(b) and (c). 7. Shared Recovery Based on Referral In instances where the Contractor refers a potential case of fraud or abuse to OMIG, in accordance with Article V(X)(2)(h) of this Agreement, the Contractor may be eligible to share in the portion of the non-federal share of the recovery made by OMIG. OMIG shall determine whether the Contractor is eligible to share in the recovery, depending upon the extent to which the Contractor substantially contributed to the investigation and recovery, at a percentage to be solely determined by OMIG. Where OMIG determines that the Contractor substantially contributed to the investigation and recovery, the percentage shall be not less than one percent (1%) and not greater than ten percent (10%) of the non-federal share of the amount of Medicaid payments recovered which were received by the Provider from the Contractor. The Contractor must report its portion of the shared recovery as part of the Medicaid Managed Care Operating Report (MMCOR) reporting process. In no event shall the Contractor share in any recovery that results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. §455.23 and other pertinent authority.	

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Article	Section Reference	Description of Change	Documents Required for Submission to DOH
		8. Liquidated Damages for Failure to Report Recoveries a. If the Contractor breaches this Agreement by failing to report or inaccurately reporting monies recovered on its Quarterly Provider Investigative Report, in accordance with Article VIII(F)(3)(r) of this Agreement, or on its MMCOR, the Department or OMIG will be entitled to monetary damages in the form of liquidated damages. In the event the Department or OMIG determines that they will impose liquidated damages in accordance with this Section, the Department or OMIG shall notify the Contractor in writing, in a Notice of Damages. The Department or OMIG may assess liquidated damages against the Contractor regardless of whether the breach is the fault of the Contractor (including the Contractor's subcontractors, Participating Providers, agents and/or consultants), provided the Department or OMIG has not materially caused or contributed to the breach. b. The liquidated damages prescribed in this section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's and OMIG's projected financial loss and/or damage to the program resulting from the Contractor's nonperformance, including financial loss as a result of audit, investigation or review delays. Accordingly, in the event the Contractor fails to perform in accordance with this Agreement, the Department or OMIG may assess liquidated damages as provided in this Section. c. If the Contractor fails to report or inaccurately reports monies it recovers during the reporting period in accordance with Article VIII(F)(3)(r) of this Agreement or on its MMCOR submission, the Department or OMIG may assess liquidated damages in an amount equal to twice the amount not reported or inaccurately reported. Any liquidated damages assessed by the Department or OMIG shall take into consideration the amount involved, frequency, and nature of the breach and shall be due and payable to the Department or OMIG within thirty (30) days after the Contractor's receipt of the Notice of Damages, regardless of any dispute in the amount or interpretation which led to the notice. d. Dispute Resolution i. The Contractor may, within thirty (30) days of the date of the Notice of Damages submit written arguments and documentation on whether: (A) the determination was based upon a mistake of fact; or (B) the Department and/or OMIG were materially responsible for the breach. ii. Written arguments and documentation shall be submitted to the address specified in the Notice of Damages. iii. The Contractor waives any arguments it fails to raise in writing within thirty (30) days of the date of said Notice of Damages, and waives the right to use any materials, data, and/or information not contained in or accompanying the Contractor's submission within thirty (30) days of the date of the Notice of Damages in any subsequent legal, equitable, or administrative proceeding.	

Article	Section Reference	Description of Change	Documents Required for Submission to DOH
		iv. Within sixty (60) days of receiving written arguments or documentation in response to the Notice of Damages, OMIG will review the determination and notify the Contractor of the results of that review. After the review, the determination to assess liquidated damages may be affirmed, reversed or modified, in whole or in part. 9. State and Federal False Claims, Written Policies Pursuant to 42 CFR 438.608(a)(6), the Contractor, if it makes or receives annual payments under this Agreement of at least $5,000,000, must have written policies for all employees of the entity, and of any subcontractor, contractor or agent, that provide detailed information about the Federal False Claims Act, and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about the rights of employees to be protected as whistleblowers. 10. Fraud, Waste or Abuse Referrals Pursuant to 42 CFR 438.608(a)(7), the Contractor shall refer all cases of potential fraud, waste, or abuse to both SDOH and OMIG, and may also refer cases of potential fraud to the New York State Office of the Attorney General, within five (5) business days of identification. The Contractor shall include such referrals in reports submitted in accordance with the requirements of Section F(3)(d) of Article VIII of this Agreement.	

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V	Z-1-4	**Adds section:** **Z. Compliance with State Medicaid Plan, Applicable Laws and Regulations** 1. The Contractor shall ensure that any cost sharing imposed on an Enrollee is in accordance with the State Medicaid Plan and with requirements at 42 CFR 447.50 through 42 CFR 447.60. a. The Contractor shall exempt from MMC premiums any Native American Enrollee who is eligible to receive or has received a covered item or service furnished by an Indian Health Care Provider or through referral made by an Indian Health Care Provider. b. The Contractor shall exempt from all cost sharing requirements any Native American Enrollee who is eligible to receive or has received a covered item or service furnished by an Indian Health Care Provider or through referral made by an Indian Health Care Provider. 2. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: a. furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act (Act); b. furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); c. furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments; 3. The Contactor shall not expend any funds provided through this Agreement for a purpose under or in violation of the Assisted Suicide Funding Restriction Act (ASFRA) of 1997; or 4. The Contractor shall not expend any funds provided through this Agreement for roads, bridges, stadiums, or any item or service not described in the State Medicaid Plan, except when such expenditures are for an item or service: a) otherwise permissible under this Agreement; b) allowable under 42 CFR 438.3; or c) that the Contractor has been directed by SDOH to provide pursuant to Section 4.3 of this Agreement	**Compliance Policy** **Fraud Waste Abuse Policy**
VI	F-6	**Adds language:** 6. In all cases of retroactive Disenrollment, including Disenrollments effective the first day of the current month, the entity designated by the state or LDSS is responsible for sending notice to the Contractor at the time of Disenrollment, of the	**Disenrollment Policy**

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Article	Section Reference	Description of Change	Documents Required for Submission to DOH
		Contractor's responsibility to submit to the Department's Fiscal Agent voided premium claims within thirty (30) business days of notification from the entity designated by the state or LDSS for any full months of retroactive Disenrollment.	
VI	L-2	**Adds language:** 1. The Contractor agrees to notify the LDSS or entity designated by the Department in writing within five (5) business days of such information becoming known to the Contractor of admission of an Enrollee to a nursing facility, either for Permanent Placement or for a rehabilitation services stay that exceeds 29 days…	**Spendown Policy**
VI	Q-1 through 5	**Adds language:** Q. Conditions on Incentive Arrangements Pursuant to 42 CFR § 438.6, any incentive arrangements between SDOH and Contractor may not result in a gross payment to Contractor in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. All incentive arrangements between SDOH and Contractor shall: 1. be for a fixed period of time, and performance will be measured during the rating period under the contract in which the incentive is applied; 2. not be renewed automatically; 3. be made available to both public and private contractors under the same terms of performance; and 4. not condition be conditioned on the Contractor entering into or adhering to any intergovernmental transfer agreement. be necessary for the specified activities and targets, performance measure, or quality-based outcomes that support program initiatives specified in the VBP Roadmap.	**VBP Policy, if applicable**
VII	A-4-b	**Adds and deletes language:** b. Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment broker for education on all plan options. Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type. ~~taking into consideration ONLY the managed care options that best meet the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one MLTCP over another.~~	**Provider Manual**
VII	A-4-c	**Adds and deletes language:** Participating Providers are prohibited from displaying ~~may display~~ the Contractor's outreach materials ~~provided that appropriate material is conspicuously posted for all other MCOs with whom the Participating Provider has a contract.~~	**Provider Manual**
VII	C-1	**Adds language:**	**Compliance Policy**

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		This shall include, but not be limited to, requesting and reviewing any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last time the Contractor credentialed the Participating Provider.	**Provider Manual**
VII	C-10-i	**Revises language:** i. A provision specifying how the provider will insure…for inspection, evaluation, and audit through ten (10) years from the final date of the Provider Contract… Change from "six (6)"	**Provider Manual**
VII	C-10-j, l, m, n	**Adds section:** j. A provision specifying how the subcontractor will ensure that pertinent contracts, books, documents, papers and records of their operations are available to the Department, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later. l. Any Value Based payment arrangements, as applicable to the subcontract or Provider Contract. m. A provision that the New York State Office of the Attorney General (OAG), the Department, OMIG and the State Comptroller (OSC) have the right to audit, investigate, or review the provider and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et. Seq. or 31 U.S.C. § 3729 et seq and to bring criminal prosecutions. n. A provision that the provider shall provide the New York State Office of the Attorney General, the Department, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider's, or the provider's subcontractor's, premises, physical fatalities, equipment, books, records, contracts, computer or other electronic systems relating to Contractor performance under this Agreement for the purposes of audit, inspection, evaluation and copying. The provider shall give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider. o. A provision requiring that the provider promptly report to the Contractor after it identifies any overpayment related to performance under this agreement.	**Provider Manual** **VBP Policy, if applicable**
VII	C-13	**Adds and deletes language:** ~~The Contractor must enter into alternate payment arrangements with providers. The arrangements must be an alternative to fee for service such as shared savings, capitation, pay-for-performance, etc.~~ Each year, the Contractor must meet the percentage of total provider payment targets that are detailed in the NYS Value Based Payment Roadmap.	**VBP Policy, if applicable**

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VII	C-14 through C-15	**Adds language:** 14. The Contractor shall, upon contracting with a Participating Provider or subcontractor, provide the following information about the grievance and appeal system to Participating Providers and subcontractors: a. the right of the enrollee, or, with the enrollee's written consent, a provider or an authorized representative, to file grievances and appeals; b. the requirements and timeframes for filing a grievance or appeal; c. the availability of assistance in the filing process; d. the right to request a State fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee; and e. the fact that, when requested by the enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee. 15. The Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's service authorization request, appeal, or grievance.	**Provider Manual**
VII	D-4	**Adds section:** 4. The Contractor shall not include in its network from any provider a. Who has been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the SSA; or b. Who has had his/her license suspended by the New York State Education Department or the NYSDOH Office of Professional Medical Conduct.	**Compliance Policy**
VII	D-6	**Adds language:** 6. The Contractor will conduct a county specific (or service area if appropriate) review of appointment availability and access surveys annually. The Contractor shall take appropriate corrective action with providers who fail to meet reasonable standards. Results of such surveys must be kept on file and be readily available for review by the Department upon request.	**Compliance Policy**
VII	F-3—7	**Adds language:** 3. The parties agree that where the Contractor has previously recovered overpayments, by whatever mechanism utilized by the Contractor, from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by the agencies listed in Section 22.7bF(8) of Article VII of this Agreement.	**Compliance Policy** **Provider Manual**

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		4. The parties agree that where the Contractor has recovered overpayments from a Participating Provider, the Contractor shall retain said recoveries, except where such recoveries are made on behalf of OMIG or the Department as provided in Section F(6) of Article VII, or pursuant to a combined audit as provided in Section F(7) of Article VII of this Agreement. 5. The Contractor shall require and have a mechanism in place for its Participating or Non-Participating Providers to report to the Contractor when the Participating or Non-Participating Provider has received an overpayment, to return the overpayment within 60 days of the date of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment. 6. OMIG or the Department shall have the right to request that the Contractor recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its Participating Provider consistent with the requirements of Insurance Law § 3224-b. In such cases OMIG or the Department may charge the Participating Provider a collection fee as set forth in State Finance Law, in an amount to be determined by OMIG or the Department in its sole discretion. The Contractor shall remit, on a monthly basis, to the Department all amounts collected from the Participating Provider. Upon collection of the full amount owed to the Medicaid program, the Contractor may retain the collection fee to account for the Contractor's reasonable costs incurred to collect the debt. The Contractor shall report the amounts recovered in its Quarterly Provider Investigative Report in accordance with Section F(3)(t) of Article VIII of this Agreement. OMIG will only request that the Contractor recover an overpayment, payment or other damage where there has been a final determination. For purposes of this section, a final determination is defined as: i.) a Notice of Agency Action issues by OMIG pursuant to 18 NYCRR Part 515; ii.) a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516; iii.) a Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517; iv.) a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or v.) an Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519: however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision. 7. Consistent with 18 NYCRR § 517.6(g) OMIG may enter into an agreement with the Contractor to conduct a combined audit or investigation of the Contractor's Participating Provider, Non-Participating Provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between the Contractor and OMIG as provided for in the combined audit or investigation agreement. In no event shall the Contractor share in any recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.	
VII	I-2	**Adds language:**	**Compliance Policy**

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		The Contractor shall comply with all of the requirements of 42 CFR § 438.610(a). (b). and (c) regarding prohibited affiliations.	
VII	M	**Adds language:** The Contractor shall comply with all applicable provisions of State Labor Law § 652.1(a) and (b), minimum wage law. The Contractor shall develop protocols for compliance, and such protocals shall include adequate record keeping methodologies and identify rate reimbursement as appropriate.	**Compliance Policy**
VII	N	**Adds language:** 1. The Contractor shall inform FI's of its claims procedures. The Contractor shall adjudicate all appropriately submitted claims in a timely manner, as determined by the agreement with the FI, and notify FIs in writing as to the reason(s) claims are fully or partially denied. The Department may require a plan of correction, impose sanctions or take other regulatory action should it determine the Contractor consistently delays payments to FIs without due cause. 2. Pursuant to SSL 365-f, and in accordance with guidance issued by the Department, the Contractor will be required to solely contract with FIs that have either initiated or received Department approval of Fiscal Intermediary authorization.	**Compliance Policy** **Notices**
VII	O	O. Value Based Payment (VBP) Arrangements 1. For the purposes of this Section, "On Menu VBP Arrangements" means Value-Based Payments arrangement types that are specifically identified in the NYS VBP Roadmap and the Clinical Advisory Groups (CAG) Playbooks, which are available on the Department's website. "Off Menu VBP Arrangements" means Value-Based Payments arrangements that are not specifically identified in the NYS VBP Roadmap or the CAG Playbooks, but are aligned with the principles of VBP. 2. Pursuant to Article VII (C)(10)(k) of this Agreement, the Contractor shall include VBP arrangements in subcontracts with Participating Providers. VBP arrangement types include: a. On-Menu VBP Arrangements The Contractor may utilize On-Menu VBP Arrangement types, as set forth in the NYS VBP Roadmap and the CAG Playbooks. These Playbooks contain the definitions of these VBP arrangements as well as the performance measures that the Participating Providers have to report to the MCO and the State. On-Menu VBP Arrangement types include: i. Total care for general population; ii. Integrated primary care; iii. Selected care bundles; and/or iv. Special needs subpopulations. b. Off-Menu VBP Arrangements In addition to utilizing On-Menu VBP arrangement options, the Contractor may also develop Off-Menu VBP arrangements with Participating Providers that are aligned with the principles of VBP. All Off-Menu VBP arrangements included in subcontracts are required to meet the criteria that is described in the NYS VBP Roadmap.	**VBP Policy, if applicable**

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		3. The contractor shall ensure that the Level of the arrangement (1, 2 or 3) is consistent with the Level definitions as outlined in the NYS VBP Roadmap. 4. The Department shall classify subcontracts containing VBP arrangements pursuant to the NYS VBP Roadmap, and the Department-issued "Provider Contracting Guidelines." The Department shall review such subcontracts according to the degree of provider risk included in the subcontract. 5. The VBP Innovator Program The Department shall notify the Contractor of designated qualified providers for participation in the VBP Innovator Program. Upon notification by the Department of qualified providers for participation in the VBP Innovator Program, the Contractor shall modify subcontracts with such designated providers to include the parameters of the VBP Innovator Program, as set forth in the NYS VBP Roadmap.	
VIII	F-3-d i-iii	**Replaces language:** d. Fraud, Waste or Abuse Reporting Requirements i. Pursuant to 42 CFR 438.608(a)(7), the Contractor, and its subcontractors to the extent the Contractor has delegated to the subcontractor responsibility for coverage of services and payment of claims under this Agreement, shall report all cases of potential fraud, waste and abuse to OMIG. (A) Reporting of potential fraud, waste and abuse under this section includes all potential fraud, waste or abuse committed by, including but not limited to, the Contractor, Participating or Non-Participating Providers, subcontractors, vendors, Enrollees, rendering professionals, ordering or referring professionals, the Contractor's or subcontractor's employees, management or any third party. (B) The Contractor and its delegated subcontractors shall submit to both the Department and OMIG the following information for each case of potential fraud, waste or abuse it identifies through complaints, organizational monitoring, contractors, providers, beneficiaries, Enrollees, or any other source: (1) The name of the individual or entity that committed, or is suspected of committing the fraud, waste or abuse; (2) The source that identified the potential fraud, waste or abuse; (3) The type of provider, entity or organization that committed, or is suspected of committing the fraud, waste or abuse; (4) A description of the potential fraud, waste or abuse; (5) The approximate dollar amount of the potential fraud, waste or abuse; (6) The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred. No disposition of any case by the	**Fraud/Waste/Abuse Policy**

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		Contractor shall limit the authority of the New York State Office of the Attorney General, the Department, OMIG, or the Office of the State Comptroller (OSC) to investigate, audit or obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party; and (7) Other data/information as prescribed by OMIG. (C) Such reports shall be submitted within five (5) business days of the Contractor, or subcontractor, identifying the potential fraud, waste or abuse, and shall be reviewed and signed by an executive officer of the Contractor or of the subcontractor. (D) For all cases of potential fraud, waste or abuse, after reporting the case to OMIG, the Contractor, or subcontractor, may, unless otherwise directed by OMIG, continue to investigate, but shall not unless prior written approval is obtained from OMIG, take any of the following actions: (1) Inform the subject of the referral of the existence of the referral or investigation by the State; (2) Enter into or attempt to negotiate any settlement or agreement regarding the case of potential fraud, waste or abuse; or (3) Impose or accept any credit, debit, or offset in connection with the case of potential fraud, waste or abuse. ii. In addition to the Contractor's obligation to refer all cases of potential fraud to OMIG, and to comply with all of the requirements of Section F(3)(d)(i) of Article VIII of this Agreement, the Contractor or subcontractor may also refer cases of potential fraud to the OAG. With respect to any case of potential fraud referred to the OAG, the Contractor or subcontractor may, unless otherwise directed by the OAG, continue to investigate, but shall not, unless prior written approval is obtained from both the OAG and OMIG, take any of the following actions: (A) Inform the subject of the referral of the existence of the referral or investigation by the State; (B) Enter into or attempt to negotiate any settlement or agreement regarding the case of potential fraud; or (C) impose or accept any credit, debit, or offset in connection with the case of potential fraud. iii. For the purposes of this Section, potential fraud, waste or abuse includes, but is not limited to, submitting claims for services not rendered, providing unnecessary services, or possessing forged documents including prescriptions.	
VIII	F-3-g	**Adds language and re-letters section:** ~~f~~g. Participating Provider Network	**Report**

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Article	Section Reference	Description of Change	Documents Required for Submission to DOH
		i. The Contractor shall submit electronically to the Department, through the Provider Network Data System Portal, an updated provider network report on a quarterly basis, or more frequently if network changes occur, as outlined in the Provider Network Data Dictionary. The contractor shall adhere to the data layout an submission frequency as described in the latest version of the Dictionary. The Contractor shall submit an annual notarized attestation that the providers listed in each submission have executed an agreement with the Contractor to serve Contractor's Enrollees. The report submission must comply with the latest version of the Provider Network Data Dictionary or any other manner acceptable to the Department.	
VIII	Q-1 through 3	**Adds section:** 1. The Contractor shall notify OMIG of its intention to initiate an audit of a Participating Provider or Non-Participating Provider. The following shall constitute the notification process. For purposes of this Section, an audit refers to activity which will or may result in a post payment recovery and/or referral to OMIG in accordance with Article V, Section X(2)(g) of this Agreement. a. The notification to audit shall be communicated by the Contractor to OMIG in a form and format to be determined by the Department and OMIG. The notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed. b. Upon receipt of the Contractor's notification to audit, OMIG shall within ten (10) business days: ii. Acknowledge receipt of the notification; and iii. Acknowledge that there is no conflict with the Contractor conducting the audit; or iv. Alert the Contractor to stop the audit or any further activity if a conflict exists. c. If the Contractor does not receive a response from OMIG in ten (10) business days, the Contractor may proceed with its audit. d. Notwithstanding the above, OMIG may initiate an audit of the Contractor's provider at any time. 2. OMIG shall notify the Contractor of its intention to initiate an audit of a Participating Provider in the Contractor's network or Non-Participating Provider. The following shall constitute the notification process. a. OMIG shall email the notification to audit to the Contractor's designee. The notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed. b. Upon receipt of OMIG's notification to initiate an audit, the Contractor's designee shall respond within ten (10) business days as follows: i. Acknowledge receipt of the notification by email; and/or ii. Alert OMIG of a conflict; d. If OMIG does not receive a response from the Contractor within ten (10) business days, OMIG may proceed with its audit.	**Appropriate Policy**

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Article	Section Reference	Description of Change	Documents Required for Submission to DOH
		e. Upon receipt of OMIG's notification to initiate an audit, the Contractor shall provide to OMIG, in a form and format required by OMIG, all records required by OMIG to complete its audit, investigation or review of the Contractor's Participating or Non-Participating Provider, or subcontractor. The Contractor shall provide such records to OMIG within ten (10) business days of OMIG's notification to initiate an audit. 3. Once notified of OMIG's intent to audit a Participating Provider or Non-Provider, the Contractor shall not take any of the following actions as they specifically relate to Medicaid claims, and the audit scope and time period identified in OMIG's notification of intent to audit: a. Initiate an audit of the same provider: b. Enter into or attempt to negotiate any settlement agreement with the provider; or c. Accept any monetary or other thing of valuable consideration offered by the provider.	
X	E	2. The Contractor shall not unlawfully discriminate in access to enrollment or provision of services on the basis of age, sex, race, ~~color,~~ gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services place of origin, or with regard to the Capitation Rate the Contractor will receive.	**Enrollment Policy** **Handbook**
X	RR-1 through 2	**Adds language:** **RR. Cultural and Linguistic Competence** 1. The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse faith communities. For the purposes of this Agreement, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor's organization. 2. In order to comply with this section, the Contractor shall: b. Maintain an inclusive, culturally competent provider network; c. Adopt policies and procedures that incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities; d. Maintain a Cultural Competence component of the Contractor's Internal Quality Assurance program referenced in Article V.(F) of this Agreement; e. Develop and execute a comprehensive cultural competence plan based on Culturally Linguistically Appropriate Services (CLAS) national standards of the US Department of Health and Human Services. Office of Minority Health and managed through the Contractor's Internal Quality Assurance Program; f. Perform internal cultural competence activities including, but not limited to conducting: i. Organization-wide cultural competence self-assessment; ii. Community needs assessments to identify threshold populations in each Service Area in which the Contractor operates; and	**Care Management Policy** **Handbook** **Marketing Materials** **For e) iii - Quality Plan/Policy**

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		iii. Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards. g. Facilitate annual training in cultural competence for all the Contractor's staff members. All elements of the curriculum shall be consistent with and/or reflect CLAS national standards. The Contractor's cultural competence training materials are subject to the review and approval by the State. The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.	
X	SS	**Adds language:** SS. Native Americans Access to Services From Tribal or Urban Indian Health Facility The Contractor shall not prohibit, restrict or discourage enrolled Native Americans from receiving care from or accessing Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center**.**	**Appropriate Policy**
Appendix G	Chart	**Adds language:** PT, OT, SP or other therapies provided in a setting other than a home. Limited to ~~20~~ 40 visits of ~~each~~ physical therapy and 20 visits each for OT, SP and other therapies ~~therapy type~~ per calendar year, except for children under 21 and the developmentally disabled.[5] MLTC plan may authorize additional visits.	**Marketing Materials** **Service Criteria** **Handbook**
Appendix J		**Adds language:** **Back-up Care Plan** means a plan that is in place to ensure that needed assistance will be provided when the regular services and supports in the Enrollee's Person Centered Service Plan are temporarily unavailable. The Back-up Care Plan may include other individuals, services, or settings and must be included in the PCSP. Individuals available to provide temporary assistance include informal caregivers such as the Enrollee's family member, friend or other responsible adult.	**Care Management Policy**
Appendix J		**Adds language:** **Community First Choice Option (CFCO) Services** are community based, person centered, and designed to maximize an Enrollee's independence in the community. All services in this category must directly relate to an assessed need and must be authorized in the Enrollee's Person Centered Service Plan. Some CFCO Services are available to all Enrollees. Other CFCO Services are only available to those who qualify for CFCO and will be designated as "(CFCO Only)" here and in Appendix G. To qualify for CFCO, Enrollees must be determined to need Nursing Home Level of Care. Full eligibility criteria are detailed in Departmental guidance entitled *Guidelines for the Provision of Services Under the Community First Choice Option (CFCO) Benefit Within Managed Long Term Care*, CFCO services include: • *Assistive technology beyond the scope of Durable Medical Equipment* (CFCO Only) – items, pieces of equipment, product systems, or instruments of technology, whether acquired commercially, modified, or customized, that increase an Enrollee's independence or substitutes for human assistance that would otherwise be authorized, e.g., personal care services.	**Service Criteria Policy** **Handbook** **Other policies as appropriate; please rely on final CFCO guidance from NYSDOH, which will supersede these contract sections.**

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		• *Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's) skill acquisition, maintenance, and enhancement* (CFCO Only) – services intended to maximize the Enrollee's independence and/or promote integration in to the community by addressing the skills needed for the Enrollee to perform ADL's and IADL's. This service may include assessment, training, supervision, cueing, or hands-on assistance to help an Enrollee perform specific tasks. • *Community Transitional Services* (CFCO Only) – assistance to an Enrollee who is transitioning from an institutional setting to a home in the community. This service includes tasks related to setting up a household. • *Moving Assistance* (CFCO Only) – assistance to physically move an Enrollee's furnishings and other belongings to the community-based setting where the Enrollee will reside. • *Environmental Modifications (e-mods)* (CFCO Only) – internal and external adaptations to an Enrollee's residence when the adaptations are beyond the scope of what is currently covered under the social and environmental supports benefit. • *Vehicle Modifications* (CFCO Only) – modifications to a vehicle that is the primary means of transportation for the Enrollee and when the modifications are necessary to increase the Enrollee's independence and inclusion in the community. • *Personal Care Services* (CFCO Only) – medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Includes medically necessary assistance with Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADL's) and health-related tasks through hands-on assistance, supervision, and/or cueing. • *Home Health Aide Services* – health care tasks, personal hygiene services, housekeeping tasks and other related supportive services essential to the patient's health. • *Personal Emergency Response Services (PERS)* – Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency. • *Home Delivered and/or Congregate Meals* – Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or to have them prepared.	
Appendix J		**Adds language:** **Conflict Free Evaluation and Enrollment Center (CFEEC)** is the entity that contracts with the Department to provide initial evaluations to determine if an Applicant is eligible for Community Based Long Term Care (CBLTC) for a continuous period of more than 120 days. The CFEEC will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for Applicants in need of care. CFEEC evaluations are conducted in the Applicant's home (includes hospital or nursing home) by a Registered Nurse.	**Enrollment Policy Handbook**
Appendix J		**Adds language:**	**CDPAP Policy**

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		Consumer Directed Personal Assistance Services means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of an Enrollee or the Enrollee's designated representative. Personal assistants are hired, trained and if necessary, fired by the Enrollee or their designated representatives. Personal assistants are paid through a Fiscal Intermediary, which is an entity that has a subcontract with the Contractor to provide wage and benefit processing and other fiscal intermediary responsibilities specified in subdivision (i) of Section 505.28 of Title 18 of the NYCRR.	**Handbook**
Appendix J		**Adds language:** **Emergency Preparedness Plan** is a plan that is in place to continue care during man-made and natural emergencies and disasters. It includes mechanisms to appropriately respond to the Enrollee's needs and to support the health and safety of Enrollees during emergency situations. This plan shall include procedures for evacuations, plans to shelter-in-place, transition of Enrollees and Enrollee information, telecommunication network failures, and preparedness training of the Contractor's and subcontractors' staff.	**Emergency Preparedness Policy**
Appendix J		**Adds language:** **Informal Caregivers** are individuals who provide care to an Enrollee on an informal basis. Such persons may include members of the Enrollee's family, a friend, or other responsible adult.	**Care Management Policy**
Appendix J		**Adds language:** **Long Term Services and Supports or (LTSS)** means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services, and institutional services including Long Term Placement in Residential Health Care Facilities.	**Handbook**
Appendix J		**Adds language:** **Money Follows the Person (MFP)** means a demonstration that is part of Federal and State initiatives designed to rebalance long term care services, and promote consumer choice. As New York State continues to shift the focus of its long term care systems away from institutional care and towards integrated home and community-based care, support from the MFP program becomes valuable to all Managed Care Organizations (MCO's). MFP is designed to streamline the process of deinstitutionalization for vulnerable populations. Under the name *Open Doors*, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home (with a maximum of four unrelated people).	**Handbook**
Appendix J		**Adds language:** **Non-Emergency Medical Transportation** shall mean transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. The Contractor is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to Enrollees.	**Service Criteria Policy** **Handbook**

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Appendix J		**Adds language:** **Telehealth** means the use of electronic information and communication technologies by telehealth providers to deliver healthcare services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring.	**Service Criteria Policy** **Care Management Policy** **Handbook**
Appendix J		**Adds language:** **Value Based Payment (VBP)** means a strategy that is used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to both quality and cost outcomes.	**If applicable, VBP Policy**
Appendix J		**Adds language:** **VBP Innovator Program** means a program that is for qualifying providers that are supporting their total cost of care for both VBP subpopulations and the general population of their attributed members under an advanced VBP Level 2 or a VBP Level 3 arrangement. The Department is responsible for identifying providers that qualify to participate in this program.	**If applicable, VBP Policy**
Appendix K	1-B	**Adds language:** B . Appeals The Plan must consider the Enrollee, his/her representative, or the legal representative of a deceased Enrollee's estate as parties to an appeal.	**Appeal Policy**

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