



AMIDA CARE, INC.
PROVIDER MANUAL
03/14/2012

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1. HISTORY AND OVERVIEW

Amida Care, Inc. is a comprehensive HIV/AIDS Special Needs Plan (SNP) incorporated as a freestanding not-for-profit corporation under New York State law to provide health care to Medicaid recipients who are living with HIV/AIDS. The program was created by seven (7) community based organizations that offer primary care, licensed adult day health care, skilled nursing facilities, COBRA case management, housing and other community services. Listed below are the original organizations who founded Amida Care.

- Promesa
- Greyston
- H.E.L.P. /P.S.I.
- Harlem United Community AIDS Center, Inc.
- Housing Works
- St. Mary's Episcopal Center
- Village Care of New York

Since its founding, Amida Care has expanded its network to include a variety of primary care settings including private practices, community health centers (CHCs) and designated AIDS centers (DACs). This breadth of primary care settings gives members numerous choices in selecting the primary care setting that best fits their needs. In addition, the plan provides access to comprehensive medical services including those from specialty and ancillary providers, mental health and social services to individuals with HIV/AIDS and their families. Amida Care has fee-for-service agreements with our vast network of providers in three boroughs of New York City, Manhattan, Brooklyn and the Bronx. Amida Care is unique with its rich programmatic activities that cover not only medical services but enhanced programs for membership including the active Member Advisory Committee, *Live Your Life Program* and *bi-annual Life Celebrations*.

Mission

Amida Care is committed to ensuring that its members receive easily accessible, high-quality, comprehensive health care services that are delivered with attention to the individual needs of the member and his or her family. Providers with a goal to meet the needs of persons living with HIV/AIDS effectively, appropriately, and affordably, govern Amida Care.

Plan Benefits

Amida Care offers its members (Medicaid recipients) a full range of health services including a Primary Care Practitioner (PCP) who is an HIV Specialist and a Case Manager (CM). Members receive coordinated care with access to a network of high quality providers including inpatient hospital and specialty services. There is a focus on coordination of care with access to 24-hour medical coverage, transportation services for health care related travel, and a full Member Services Department (See Benefit Guide in Appendix F).

Our Membership

Amida Care provides services to Medicaid recipients with HIV/AIDS and their related children under age of 21 with or without HIV/AIDS. While enrollment in Managed Care has become mandatory for most Medicaid recipients LWHA, enrollment into Amida Care and other SNP's must be initiated by the consumer. Medicaid does not auto-assign consumers into SNPs. Information about the Plan is

provided by trained Amida Care Member Services Field Representatives in accordance with the provisions of the SNP contract and using materials pre-approved by the New York State Department of Health. All Enrollment applications are processed by New York City's Medicaid broker, *New York Medicaid Choice*, reachable at 1-800-505-5678.

Care Model and Care Team

Amida Care recognizes the complex psychosocial and medical needs of people living with HIV/AIDS and has created a unique care coordination model to address those needs. We believe the best way to keep our members healthy is by keeping them engaged in their own healthcare and taking advantage of the treatments available for people living with HIV/AIDS. A team of providers – called a Care Team – works with each member to ensure the delivery of comprehensive, coordinated health care and supportive services, and consists of:

Primary Care Provider (PCP): An HIV Specialist who manages the medical care of the member, including all specialty services, or a general practitioner for uninfected children. The PCP is responsible for an initial physical, routine medical care, and the coordination of the member's overall care. In this role, the PCP provides referrals for specialty care and ancillary services and ensures that continuity of care is maintained as well as completion of a treatment plan for each member. The PCP works with the member to address issues related to adherence, primary and secondary prevention, public health issues (such as TB/DOT) treatment planning. The PCP provides oversight of the member's behavioral health services including the completion of the mental health and behavioral health annual screening. The PCP works in close collaboration with the other Care Team members.

External Case Manager (CM): A case manager experienced in working with people living with HIV/AIDS. Amida Care's HIV case management services are oriented toward assisting members with the actual challenges, both clinical and practical, of *living* with HIV/AIDS.

The Case Manager facilitates the member's access to social and supportive services, such as but not limited to housing, legal assistance, peer groups, harm reduction, as well as medication adherence and other educational programs. The CM also collaborates with community agencies and reaches out to members when they drop out of care. The CM may be co-located at the PCP provider site, or based at a community-based organization. The CM completes and submits a comprehensive Assessment and Service Plan to the Amida Care Case Management Department.

Amida Care Case Management

The Amida Care Case Managers are responsible for collecting and reviewing the initial assessment and reassessment of members by their community-based Case Manager and PCP. Any new needs identified, medical needs are referred to the PCP; psycho-social needs are referred to the external Case Manager

Care Coordinator (CC): An Amida Care nurse who functions as a facilitator to assist the members of the Care Team with coordination of services based on the specific need(s) of the member. The Care Coordinator facilitates communication between the member, members of the Care Team, and within the Plan. Care Coordinators monitor and facilitate services that members receive, and oversee the utilization management process. The

CC tracks member's utilization of services and adherence to treatment through review of claims. The CC is also an advocate for the member and a resource for the Care Team. The CC ensures the provision of member education (such as disease management, STD primary and secondary prevention, TB/DOT, and health maintenance) either directly or through a qualified clinician. The CC works closely with the Member Services Department in providing information to members, clarifying benefits and answering general questions, assisting members in getting an appointment or filing a complaint. The CC works with the Provider Services Department to assist with provider training regarding Utilization Review, Supportive Case Management and policies and procedures of the Care Coordination and Utilization Management Department.

The Care Team may be expanded to meet the specific needs of the member. Additional Care Team members may include, but is not limited to, Specialists, behavioral health provider, home care providers, and other ancillary providers.

Amida Care believes that the way to improve a member's health and prevent negative clinical outcomes is to provide preventive healthcare, involve the member in health promotion and foster self-empowerment. As a health plan, Amida Care works closely with the Care Team to help keep members engaged in their own health care. Routine medical care and care coordination between the Care Team is integral to Amida Care's Care Coordination philosophy.

Oversight

The New York State Department of Health (NYSDOH) and regulate Amida Care's operations. Specifically, Amida Care contracts with the New York State Department of Health (NYSDOH) Office of Health Insurance Programs Division of Managed Care. Amida Care's premium rates are set by the NYSDOH. In addition, NYSDOH approves Amida Care's provider contracts, as well as Amida Care's member materials and policies and procedures.

2. PROVIDERS

Amida Care Providers

Amida Care contracts with health care providers through contracts with community health centers, private practices, hospital facilities and medical centers, as well as with groups of providers (e.g. IPAs) known as Participating Provider Groups. Amida Care values its providers as key representatives of effective delivery of health care services to all of Amida Care's members.

Amida Care has relationships with a network of community-based organizations for the provision of Case Management, which provides supportive services that are responsive to the changing needs of its members. Amida Care has a full roster of community-based case management providers as well as case managers co-located at some Primary Care sites to ensure that every member's language and cultural needs are met.

All network providers contractually assume responsibility for the care of Amida Care's members and also agree to adhere to all applicable regulatory standards as well as to Amida Care's policies and procedures, reporting requirements, and standards, including those relating to medical records maintenance, quality management, and utilization management.

As network providers, the Primary Care Providers (PCP), specialists, ancillary service providers and all professional service providers are responsible for compliance with Amida Care's quality management, care coordination and utilization management standards as well as appointment access standards. In the case of PCPs and Obstetricians/Gynecologists, they are required to provide members access on a 24-hour, seven-day a week basis.

Amida Care encourages providers to discuss all treatment options with the Plan member regardless of whether the treatment is a covered service. Nothing in the provider agreement is intended to interfere with the provider's relationship with an Amida Care member, or with Amida Care's ability to administer its Quality Management, Care Coordination, Utilization Management, and Credentialing programs.

Provider Roles and Responsibilities

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

Mutual expectations are as follows:

From Amida Care

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

- Feedback on performance and utilization.

From Participating Providers

- Professional, respectful, and responsible healthcare for members;
- Timely response to inquiries;
- Assistance with problem-solving and other issues;
- Maintenance of all contractual credentialing standards and licensing obligations;
- Adherence to access and availability standards;
- Compliance with utilization management and quality management and improvement protocols;
- Timely and accurate claims submission; and
- Cooperative office and administrative staff.

Provider Rights

Amida Care will not discriminate against any health care professional acting within the scope of his or her license or certification under state law regarding participation in the network, reimbursement or indemnification, solely on the basis of the practitioner's license or certification. The following circumstances are exceptions to this policy:

- Amida Care may refuse to grant participation status to health care professionals in excess of the number necessary to meet the needs of Amida Care members;
- Amida Care may use different reimbursement methodologies for different provider and/or facility types; and/or
- Amida Care may implement measures designed to maintain quality and control costs consistent with its responsibilities.

As Amida Care's operational policies change, the Provider Manual will be amended to reflect these changes and Amida Care providers will be given written notice of these changes, at least 30 days before the changes are implemented.

Amida Care will not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a Amida Care member regarding the following:

- The patient's health status, medical care or treatment options, including any alternative treatments.
 - This includes providing sufficient information to the individual so that s/he can make informed decisions about his/her health care choices;
- The risks, benefits and consequences of treatment or non-treatment; and/or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Provider Responsibilities

Amida Care maintains provider agreements that incorporate a set of provider and health plan responsibilities that are consistent with industry standards and that are in compliance with Article 44 of the New York State Public Health Law, the HIV SNP Model Contract and requirements for individuals and organizations receiving Federal Funds.

Amida Care members have the right to obtain complete current information concerning a diagnosis,

treatment and prognosis in terms the member can be expected to understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.

The following requirements are applicable to Amida Care participating providers.

Plan Provider Standards

Amida Care maintains rigorous provider access, provider availability, visit scheduling, and waiting time standards that comply with New York State regulations. Amida Care and the *New York State Department of Health* actively monitor adherence to these standards. All participating providers are expected to care for their Amida Care members within these access guidelines.

Clinical Standards of Care

Providers are expected to use the following guidelines that are accepted national standards as a decision support tools to standardize practices:

- The NYSDOH AIDS Institute's Office of the Medical Director clinical practice guidelines, developed in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines can be located at <http://www.hivguidelines.org/> and include:
 - [Post-Exposure Prophylaxis](#)
 - [Adults](#)
 - [Adolescents](#)
 - [Infants and Children](#)
 - [Women's Health](#)
 - [Perinatal Transmission](#)
 - [Transgender](#)
 - [HIV Prevention](#)
 - [HIV and Mental Health](#)
 - [HIV and Substance Use](#)
 - [HIV and Oral Health](#)
 - [HIV and Pharmacy](#)
- The U.S. Department of Health and Human Services (HHS) guidelines available at <http://www.aidsinfo.nih.gov/> that include:
 - Antiretroviral Treatment
 - [Adult and Adolescent Treatment Guidelines](#)
 - [Pediatric Treatment Guidelines](#)
 - Maternal-Child Transmission
 - [Perinatal Guidelines](#)
 - Management of HIV Complications
 - [Prevention and Treatment of Opportunistic Infections Guidelines: Adults and Adolescents](#)
 - [Prevention and Treatment of Opportunistic Infections Guidelines: Children](#)
 - [Incorporation of HIV Prevention](#)
 - Care for Disaster Displaced HIV-Infected Patients
 - [Guidance for Non-HIV-Specialized Providers](#)
 - Post-Exposure Prophylaxis
 - [Health-Care Worker Exposure Guidelines](#)
 - [Nonoccupational Exposure Considerations](#)

- Testing
 - [Revised Guidelines for Counseling, Testing, and Referral](#)
- Co-morbidity Management Guidelines that include, but are not limited to:
 - Standards for Medical Care in Diabetes by the American Diabetes Association
http://care.diabetesjournals.org/content/34/Supplement_1/S11.full.pdf
 - Guidelines for Treatment and Management of Asthma by the National Heart, Lung and Blood Institute located at <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>
 - Performance Measures for Adults with Hypertension by the American Heart Association available at <http://circ.ahajournals.org/content/124/2/248.full.pdf>
 - Sexually Transmitted Diseases Treatment Guidelines by CDC available at <http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf>

PCP Service Availability

Amida Care Primary Care Providers (PCPs) must be available for appointments at least 16 hours per week at each of their approved primary care sites. Each PCP is also responsible for providing coverage during short-term and long-term leaves of absence (up to 6 months), utilizing Amida Care credentialed providers PCPs as back up coverage.

Twenty Four (24) Hour Coverage

All PCPs and OB/GYNs providers must provide telephone coverage twenty-four (24) hours a day, seven (7) days a week. At a minimum, this shall include telephone answering service answered by a live voice that provides reasonable access to PCP, OB/GYN, or back-up medical care. In addition, responses to members' after-hours telephone calls must be provided within thirty (30) minutes of these calls.

Amida Care has a 24-hour/day-toll free telephone number, which is answered by a live voice: 800 556-0689. All members are provided with an Amida Care identification card containing the name of the member's PCP and his/her telephone number, Amida Care's toll free numbers for Member Services, Provider Services and Medical and Behavioral Health UM; as well as pharmacy benefit information. Members are instructed through the Member Handbook and during orientation on how to obtain services after regular business hours and on weekends.

Distance/Travel Time

Members have a choice of at least three (3) PCPs located within 30 minutes of their primary residence.

Hospitals

All members will have access to at least one general acute care hospital within thirty (30) minutes travel time (by car or public transportation) of the member's primary residence.

Access and Availability

Amida Care considers service accessibility to be one of the key determinants of quality of care and overall member satisfaction. Amida Care will therefore take all necessary measures to ensure compliance with the access standards outlined below (see Appendix A).

The following standards for access to appointments and service apply for all Amida Care members:

- Adult Baseline and routine physicals: within four (4) weeks from enrollment. (Adults >21 years)
- Urgent medical or behavioral problems within 24 hours;

- Non-urgent “sick visits” within 48 to 72 hours;
- Routine, non-urgent or preventive care visits within four weeks;
- Adult baseline and routine physicals within four (4) weeks;
- Specialist referrals within four (4) to six (6) weeks of the request;
- Initial prenatal visits within three (3) weeks during first trimester and two (2) weeks during the second trimester and one (1) week thereafter;
- Initial visit for newborns to their PCP within 48 hours of hospital discharge or the following Monday if the discharge occurs on a Friday.;
- Well childcare visits within four (4) weeks of the request, unless sooner when routine immunizations are due;
- Initial family planning visits within two (2) weeks;
- In-plan mental health follow-up visits (pursuant to an emergency or hospital discharge) within five (5) days, or as clinically indicated. In plan substance abuse follow-up visits (pursuant to an emergency or hospital discharge) within 24 hours, or as clinically indicated;
- All requests for emergent care are referred immediately to a provider or an emergency room at the time of the request. (No prior authorization is required for a member to self-refer in an emergency situation);
- Urgent mental health or substance abuse visits within 24 hours;
- In-plan, non-urgent mental health or substance abuse visits within two weeks;
- Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work when requested by a LDSS: within ten (10) days of request by an MMC Enrollee; and
- An ability to accommodate walk-ins, particularly for adolescents and substance abusers.

Appointment Waiting Time

The following appointment wait time standards apply for all Amida Care members:

- Waiting times will not exceed one hour for a scheduled routine appointment;
- Walk-in patients with non-urgent needs will be seen within two hours or scheduled for an appointment consistent with the Provider’s written scheduling procedures; and
- Walk-in patients with urgent needs will be seen within one hour.

Monitoring Service Accessibility

Amida Care monitors service accessibility through access testing. Indicators include:

- 24 hour and weekend coverage;
- Time in the waiting room;
- Urgent appointment availability;
- Non urgent sick visits, routine appointments and physicals; and
- Mental health services including crisis intervention, psychotherapy, and post-discharge follow up to a psychiatric admission.

Service Accessibility Improvement Plans

Non-compliance with the above accessibility standards triggers in-depth monitoring and review by the Provider Services Department. In addition, in-depth testing for individual providers will be triggered by monitoring the following:

- Significant member complaints;

- Testing scores; and
- Statistically significant patterns of utilization and enrollment.

Reporting of Information to Providers Regarding Improvement Plans

The Director of Provider Services and Network Development will notify providers with their access testing results within fifteen (15) days of each study. For those providers who fail to meet the access testing standards, Amida Care requires that an Improvement Action Plan (IAP) be submitted to the Provider Services Department no later than ten (10) business days after receipt of notification of access testing failure. The IAP will be reviewed and the provider will be re-tested within two (2) months for compliance. If a provider is found to be out of compliance on the re-test, the provider's panel will be closed to new members. At that time, another IAP must be submitted and, once again, a re-test will be made within two (2) months. If the provider is found to be out of compliance on the third re-test, Amida Care will terminate the provider.

Provider Change in Status and/or Availability

Providers who anticipate changes in their status (name, address, hours, languages, and/or site), or who wish to terminate their participation or take a leave of absence, must follow the *Change in Provider Status* policy. To effect a change in status, providers must utilize the *Provider Information Change* Form (See Appendix B). Each provider site should appoint a designee who will be responsible for notifying Amida Care of all departures and changes as identified above. When a provider terminates from Amida Care, he/she must submit to the Plan a letter stating that he/she is terminating from the Plan and note the termination date. The Provider Services Department will request information and recommendations from the provider related to member reassignment/selection of a new network PCP.

Experimental and Investigational Treatments

Experimental Treatments will be considered on a case-by-case basis once regular treatments have been tried. Prior to making referrals for experimental and/or investigational treatments, all PCPs will certify that:

- A member has a life-threatening or disabling condition or disease, for which generally accepted or standard services, procedures, and medication have been determined to be ineffective or medically inappropriate; and
- There does not exist a more beneficial standard health service, which would be covered by the Plan.

When an appropriate experimental or investigational treatment exists, the member's health care provider (either their PCP or a Specialist) will make referrals to that clinical trial. These referrals will be based upon a minimum of two documents from the available Peer Reviewed medical and/or scientific literature, to provide evidence that the treatment is likely to be more beneficial to the member than any covered, standard health service or procedure.

If the experimental/investigational treatment is HIV related, the provider of the treatment must be an HIV Specialist. If the experimental/investigational treatment is not HIV related, the provider of the treatment must be a licensed board-certified or licensed board-eligible and qualified to practice in the specialty appropriate to treat the members life threatening or disabling condition. Prior to making these referrals, PCPs are required to document that the appropriate Institutional Review Board has approved any and all investigational or experimental treatments.

The PCP must request authorization from Amida Care's Utilization Management (UM) Department (888-

364-6061) when referring to a provider who is not a member of Amida Care's provider network.

The Plan's Medical Director will review all requests for experimental/investigative treatment (See Section 7, *Care Coordination and Utilization Management*, for further details on this process).

Clinical Trials

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

The AIDS Community Research Initiative of American (ACRIA) and Cornell's Clinical Trials Unit (CCTU) are two resources for providers to secure comprehensive listings of HIV and HIV-related clinical trials. Providers can access this information by visiting the following websites:

- ACRIA – www.acria.org
- CCTU – www.aidsinfo.org.

Rare Disease Treatments

"Rare disease" is defined as a life threatening or disabling condition or disease that is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than two hundred thousand United States residents per year, and for which there does not exist a standard health service or procedure covered by Amida Care that is more clinically beneficial than the requested treatment. Request for rare disease treatment require prior authorization – see section 7 for details.

Advance Directives Policy

Amida Care providers are expected to adhere to the Advance Directives decisions of its members, including the right to execute Advance Directives and to make decisions regarding his/her health care when accepting or refusing medical or surgical treatment. The provider orientation packet includes information on Advance Directives. The Director of Provider Services and Network Development disseminates guidelines to all affiliated providers and posts this information in the Amida Care website at www.AmidaCareNY.org.

Department of Health Disease Reporting Requirements

(See Section 16- Public Health Reporting).

Primary Care Providers (PCPs)

The PCP is responsible for the provision of initial and basic health care to members, as well as for the supervision and coordination of the member's overall care. As part of this role, the PCP initiates referrals for specialty care and ancillary services and maintains continuity of care. The PCP, working with the member's Case Manager, coordinates access to not only needed medical services but also to all supportive services which may or may not be covered by the Plan.

Amida Care HIV PCPs must meet the AIDS Institute HIV Specialist definition (see Appendix C), be duly licensed, board certified or board eligible, and have successfully completed the Amida Care

credentialing process. Providers who choose to participate as Amida Care PCPs for uninfected children must be duly licensed, board certified or board eligible, and must also have successfully completed the Amida Care credentialing process. Providers must be qualified in the area of general or family medicine, internal medicine, or pediatrics.

Physician Assistants may not serve as PCPs but may work together with a PCP in providing patient care. Please see the Quality Management section of this manual for further details.

PCP Duties PCPs shall:

Access

- Practice at least two (2) days per week (16 hours) per week at each location;
- Provide 24 hour-a-day coverage and a “live voice” answering service, 7 days a week, either directly or through shared coverage arrangements with other Amida Care providers; and
- The Plan may request a waiver form the *New York State Department of Health AIDS Institute* for those PCPs who have <than 16 hours a week per site; if approved, the waived PCPs will be allowed to have a panel of Amida Care members.

Clinical Care

- Provide primary, preventive and urgent care services and/or arrange for care as appropriate to manage conditions outside of the scope of primary care;
- Identify Amida Care members with complex or serious medical conditions, assess those conditions, collaborate with other providers as appropriate on treatment plans and follow up with the member’s Amida Care Care Team;
- Educate Amida Care members about the appropriate use of health care services, health risks, prevention of sexually transmitted diseases, HIV prevention, medication adherence, and achieving and maintaining optimal physical and mental health; and
- Promote adherence to prescribed treatment regimens, and assist in the development of an individualized treatment adherence plan that is integrated into the continuum of care services for each enrollee and monitor the member’s response to treatment.

Preventive Care

- Provide or arrange for all age, gender, and disease appropriate screenings and preventive care including but not limited to CTH/P for children and adolescents, pneumonia and influenza immunizations, smoking cessation counseling, tuberculosis screening, lead screening for children, Pap smears, mammography, and glycohemoglobin testing, if appropriate, for members being treated for diabetes; and
- Maintain compliance with established primary and secondary preventive care standards for adults, adolescents and children as recommended by USPTFS available at <http://www.uspreventiveservicestaskforce.org/recommendations.htm>.

Coordination of Care and Services

- As a member of the Amida Care Care Team, actively participate in the coordination of, and referral to specialty care and ancillary services, and other covered health care services;
- Request authorization for specialty and ancillary services where required by the Plan (see Benefit guide Appendix F); and

- Where appropriate, ensure the provision of information about availability of clinical trials, assist members with enrollment process if requested and coordinate clinical research needs with the primary health care needs of the member.

Nurse Practitioners

A Nurse Practitioner (NP) is defined as a Registered Nurse with Specialty training who is licensed in Family Practice, Pediatrics, Adult Medicine, or Obstetrics/Gynecology. An NP may serve as a PCP for HIV/AIDS infected members if she/he meet the AIDS Institute HIV Specialist standards is licensed and currently registered professionally in the State of New York and is certified under Section 6910 of the Education Law as a NP, has successfully completed the Amida Care credentialing process, and has submitted an approved Collaborative Practice Agreement with an Amida Care participating provider. An NP practicing in conjunction with a PCP or OB/GYN must comply with all standards and responsibilities expected of that provider as well as the terms of their Collaborative Practice Agreement. The Practice Agreement must provide necessary provider back up by Amida Care provider(s), including on-call and inpatient care agreements that assure continuity of care. The Practice Agreement requires quarterly medical record reviews by the collaborating provider and for the resolution of disputes between the collaborating physician and NP.

Nurse Midwives

A Certified Nurse Midwife (CNM) or Certified Midwife (CM) is a graduate of an ACNM-accredited midwifery education program and has been certified by the ACNM Certification Council. A CNM or CM may serve as a Specialist if she/he is licensed professionally in the State of New York and certified/registered by the American College of Nurse Midwives as a CNM or CM, has successfully completed the Amida Care credentialing process, and has submitted an approved Collaborative Practice Agreement with a Amida Care participating provider. Hospital privileges are necessary for a participating midwife only if she/he admits patients as part of the Collaborative Practice Agreement.

A CM practicing in conjunction with an OB/GYN must comply with all standards and responsibilities expected of that provider as well as the terms of their Collaborative Practice Agreement. The Practice Agreement must provide necessary provider back up by Amida Care provider(s), including on-call and inpatient care arrangements, which assure continuity of care. The Midwife must have prescription privileges.

PCP Team

To qualify as a PCP, a provider must practice at least (16 hours) at each of his/her “primary care” sites. Some Amida Care providers are unable to meet this requirement and may opt for participation on a PCP Team. The definition of a PCP Team is as follows:

Two (2) or three (3) providers practicing together to serve as a PCP for Amida Care members. When a member chooses, or is assigned to, a PCP Team, one of the providers must be designated as Lead Provider for that member. All providers in a PCP Team who will serve as PCP to HIV/AIDS infected members must be credentialed by Amida Care and meet the AIDS Institute HIV Specialist criteria. The Team must provide access twenty-four (24) hours per day, seven (7) days per week, and must – as a Team -have a minimum of at least two days per week (16 office hours) at each provider site.

Participating Provider Groups at provider sites may designate Teams of physicians/nurse practitioners to serve as PCPs for members receiving primary care at that site. Each member has the right to choose a

specific PCP within the Team.

If a provider is to participate as a Team member, the names of the other Team members must be included in the appointment and reappointment application. If, subsequent to appointment/ reappointment, the members of the Team change, the Provider Services Department must be informed immediately.

PCP Panel Capacity and Roster

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

Each PCP receives a monthly panel report (roster) indicating the Amida Care members enrolled in the PCP's panel for that month. Amida Care provides assistance with PCP selection and changes. PCP changes are effective on the day of the request. Urgent changes may be permitted in special circumstances. Amida Care members may contact the Member Services Department toll free line at 800-556-0689 to facilitate a change in PCP. PCPs are instructed to refer to their rosters and to verify eligibility through the eMedNY system prior to providing services to a patient or generating a referral. If there is any uncertainty regarding eligibility, the provider should call Amida Care's Member Services Department at 800-566-0689 to verify eligibility.

Restricted Recipient Program

The Restricted Recipient Program (RRP) is a medical review and administrative program whereby selected Amida Care enrollees with a demonstrated pattern of abusing or misusing the Medicaid program may be restricted to one or more program benefits. These restrictions apply to non-emergent covered services; at no time will Amida Care restrict a member's access to emergency services or to a specific provider of emergency services.

Restricted benefits can include, but are not limited to, Pharmacy, Physician and Physician's assistant, Clinic, Hospital, Dentist and provider of Durable Medical Equipment. For members restricted to a specific provider, only prescriptions written by that provider will be covered. If a member is seen by another physician or consultant, medication recommendations should be called in to the Restricted Provider for the official prescription. Amida Care identifies providers that are willing and capable of providing services to restricted members.

Members can become restricted either by transferring into the Plan with restrictions already in place, or by being restricted by the Plan. Transferred restrictions are restrictions that are upheld by Amida Care for members that have already been restricted by the NYS Office of Medicaid Inspector General (OMIG) or by other plans prior to Amida Care enrollment. Members may also be restricted by Amida Care if they have been identified by the RRP Committee which monitors many avenues of benefit data including prescriptions and pharmacy claims, and claims for medical services and equipment. Information on existing and new restrictions will be communicated in writing to any new Providers in a timely fashion.

PCP Education - *Continuing Medical Education (CME)*

Amida Care HIV Specialist PCPs are required to participate annually in a minimum of ten (10) hours of approved HIV-specific Continuing Medical Education (CME) programs that are consistent with NYSDOH/AI

guidelines for HIV specialty care and include management of antiretroviral therapy.

Each HIV Specialist PCP will be required to submit documentation to the Provider Services Department documenting compliance with CME requirements on an annual basis (see Appendix D for Attestation Form). This information will be used in annual assessments of HIV Specialist status, as well as to investigate and/or address any Quality Management or Continuous Quality Improvement issues.

Specialists

Specialists are providers who are contracted with and credentialed by Amida Care to provide medical care

to members in specific specialty areas. A Specialist must be Board certified or eligible in a given specialty. The Specialist provides specialty services to Amida Care members upon referral by a Primary Care Provider. To ensure continuity of care, the Specialist is required to follow up with PCPs in writing or other means to apprise them of consultation results, diagnostic testing results, and treatment plans.

Provider Designated as Both a PCP and a Specialist

An individual provider may be designated by Amida Care as a PCP and Specialist simultaneously. To be so designated, the provider must advise Amida Care of his/her desire for dual designation and must meet all the requirements and be successfully credentialed by Amida Care for each role. For a PCP who serves HIV/AIDS infected members, this includes meeting the AIDS Institute HIV Specialist criteria. When providing services as a specialist it is imperative to submit CPT/HCPCS codes with the modifier AF in order to differentiate between specialty visits and primary care visits.

Use of a Specialist as a Consulting Primary Care Provider

In unique circumstances, providers who are qualified in specialty areas and are credentialed as Amida Care Specialists may be permitted to serve as a consulting PCP for certain members when medically appropriate. This will enable members with special needs to have their care overseen by a provider with special training pertaining to their specific condition. This might occur when a member has a condition or disease that requires prolonged specialized medical care through a Specialist or at a specialty care center.

On a case-by-case basis, the Medical Director will approve the use of a Specialist as a consulting PCP. The member's PCP must be part of this decision-making process, and Amida Care must authorize the transfer of primary care responsibilities to the Specialist. The Specialist will then be accountable for the provision and coordination of primary care services including referring the member to other sub-specialty providers as appropriate, managing health education and preventive care activities, and complying with all guidelines, reporting requirements, medical and case management policies. If a Specialist acting as a PCP is not an HIV Specialist, an HIV Specialist from the member's Amida Care site will form an ongoing consultative relationship and will retain primary responsibility for decisions related to HIV-specific clinical management. Requests for Specialists as a PCP should be made to Amida Care's Utilization Management Department.

OB/GYN Provider Responsibilities

Amida Care OB/GYN providers may be any Obstetrician, Gynecologist, Family Practitioner, or Certified Nurse Midwife with training in Obstetrics and Gynecology who has been credentialed by Amida Care to provide obstetrical and/or gynecological services. Amida Care OB/GYN Specialists-also provides family planning services to Amida Care members.

Female members have direct access to gynecological and obstetric services and may obtain services from

a network provider without a referral from their PCP. General GYN care can be obtained within the network, or female members can choose to access care with non-participating providers who accept Medicaid fee-for-service utilizing their Medicaid card. When a female member is pregnant and has not initiated prenatal care, members are assisted with selecting an OB/GYN provider in the network.

A female member may receive any treatment related to a pregnancy from a qualified obstetrician/gynecologist of her choice from within the Amida Care network. The obstetrician/gynecologist must notify the member's PCP of the pregnancy, the PCP must notify Amida Care's Care Coordination/Utilization Management Department (646) 786-1800 on learning of the pregnancy.

Prenatal care providers will be required to provide ongoing maternal and fetal risk assessment, reductions risk of HIV transmission, initiation of prophylaxis with anti-retroviral therapy as needed. In addition, nutritional screening and counseling are required for all pregnant women. Providers are required to provide HIV pretest counseling with clinical recommendations for all pregnant women. Those women and their newborns must have access to services for management of HIV disease, psychosocial support, case management for medical and social needs, addiction concerns, and PCR or viral culture testing at recommended intervals to rule-out HIV infection in exposed infants.

Mental Health/Chemical Dependency Providers including Alcohol and Substance Abuse Amida Care has a network of physicians and other licensed professionals, community agencies, and inpatient and outpatient facilities to provide a full spectrum of behavioral health care, including mental health and chemical dependency services. These providers include individual licensed practitioners and *New York State Office of Mental Health (OMH)* and *Office of Alcohol and Substance Abuse Services (OASAS)* licensed programs and facilities. Individual mental health and substance abuse providers include psychiatrists, psychologists, psychiatric nurse practitioners, psychiatric clinical nurse specialists and licensed clinical social workers. Mental health and/or alcoholism/substance abuse providers must be certified pursuant to Article 23 or 31 of Mental Hygiene Law. OASAS programs include Certified Drug and Alcohol Counselors, employed only by OASAS licensed programs.

Members can self refer to mental health providers for assessment and treatment.. Members can also self refer for all inpatient detoxification, or inpatient rehabilitation, without a referral in any 12-month period. If a member requires or wishes to obtain any outpatient alcohol and/or substance abuse treatment services, the member can select any provider that accepts Medicaid since these services are carved out to fee-for-service Medicaid.

An Initial mental health and chemical dependence assessment is performed for each Amida Care member as a component of the new member assessment process and reassessment of mental health and chemical dependence status is conducted annually. An Amida Care member may receive chemical dependence counseling or mental health support services at his/her Amida Care primary care site or at another Amida Care network facility or private practice site. The Care Team ensures that inpatient and outpatient behavioral health services are appropriate and coordinated with other necessary care.

Provider Disciplinary Action

Amida Care has developed policies, procedures and standards of care to ensure that high-quality, cost-effective care is provided to all Amida Care members. Disciplinary action may be taken against providers who do not meet Amida Care's standards of care or comply with its policies and procedures. Problems that may indicate the need for disciplinary action include, but are not limited to: 1) quality of care concerns; 2)

non-compliance with access requirements, appointment availability standards or program guidelines; 3) unsatisfactory utilization management; and 4) behavior that is not consistent with Amida Care's managed care objectives. Depending on the nature and the severity of the situation, Amida Care may decide to reduce or suspend the provider's privileges or formally terminate the provider's participation with Amida Care. Disciplinary actions are instituted upon recommendation of Amida Care's Medical Director or the Quality Management Committee. Amida Care follows the reporting obligations of the National Practitioners Data Bank.

The Plan will report to the appropriate state, local and any federal agencies when any of the following occurs:

- A provider is terminated from the Plan for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare;
- The voluntary or involuntary termination of a contract or employment or other affiliation with the Plan to avoid the imposition of disciplinary actions; and
- The termination of a provider from the Plan, when there has been a determination of fraud or imminent harm to the patient's health.

Provider Termination

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

Voluntary Terminations, Terminations without Cause and Continuity of Care

The applicable provisions of the individual Provider Agreement or the Hospital Entity/Health Care Services Agreement govern the termination of a provider agreement with Amida Care. All providers voluntarily terminating their affiliation with Amida Care must give written notice of the termination in a timeframe consistent with their individual contract. Written notice must include a termination date. Verbal notification is not sufficient to initiate the termination process.

If Amida Care elects to deny participation status in the Amida Care provider network, or to suspend or terminate a Provider Agreement, written notice will be given that includes some or all of the following:

- The reason for the action;
- The standards and the profiling data the organization used to evaluate the health care professional;
- The number and mix of health care professionals required by the Amida Care network; and
- The affected provider's right of appeal and the process and timeframe for requesting a hearing.

Subsequent to a written notice of termination being given by a provider or by Amida Care, providers are required to continue the offer of services to Amida Care members for a period consistent with the individual provider contract so that appropriate transition of care may take place. In the case of providers caring for women in the second trimester of pregnancy, the continuity of care/transition period may be extended for up to sixty (60) days post delivery.

Immediate Termination

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

- Final disciplinary action is taken by a governmental regulatory agency that impairs the provider's

ability to practice;

- There is a determination of fraud on the part of the provider; and/or
- Continuation of the provider's participation may cause imminent harm to patients.

Providers terminated due to any of the above situations are not eligible for a review or a hearing.

Termination for Cause

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

- Repeated failure to comply with quality assurance, peer review, and utilization management procedures;
- Unprofessional conduct as determined by the appropriate state professional licensing agency;
- Conviction for a criminal offense related to the practice of medicine or any felony unrelated to such practice;
- Failure to comply with Amida Care's credentialing standards and procedures;
- Revocation, reduction, or suspension of privileges at any participating hospital or any hospital where the physician conducts practice; and/or
- Discrimination against Amida Care members as outlined in the Provider Agreement.

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

Non-Renewal of Contracts

The decision not to renew a contract is not considered a termination. Either Amida Care or a participating provider may elect not to renew an agreement by giving written notice to the other party prior to the expiration date of the respective provider agreement and in a timeframe consistent with the individual provider contract. As indicated in the previous section on voluntary disaffiliation, providers must continue to offer their services until arrangements are made to transition the member's care to another provider. Again, providers will not be expected to continue providing medical services for longer than 90 days, except in situations in which the member has entered the second trimester of pregnancy at the time of contract non-renewal.

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

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

Notification to Members

When a provider elects to terminate a participation agreement with Amida Care, it is expected that the provider will assist by notifying members of this change. Amida Care will notify a member within 5 days of the member's PCP advising Amida Care of his/her status change. Members will be informed of the termination of other participating providers from whom they are receiving a course of treatment/services

within 15 days of the provider advising Amida Care of his/her status change. Members will also be advised as to how they may be able to continue care with such a provider for a defined period of time.

Reporting Terminated Provider Agreements

Amida Care is required by the *New York State Department of Health* to report the termination of a participating provider from the network under the following circumstances:

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

If a provider is terminated or suspended from the network because of deficiencies in the quality of patient care, written notice of the action must be given to the applicable licensing or disciplinary bodies or other appropriate authorities.

Appeal Hearings

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

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

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

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

If the outcome of the hearing is to continue with the termination process, the termination will become final on the later of the following dates:

1. 60 days after the notice of intent to terminate is received; or
2. 30 days after the hearing determination letter has been sent to the provider.

3. PROVIDER SERVICES

Education and Orientation

Amida Care's Provider Services Department works with providers to ensure that they are informed of their responsibilities, as well as to the standards to which they are being held. Provider education and training is continuously available for new and established providers to assist in the development and refinement of their managed care skills and to acquaint them with Amida Care's policies, procedures and operations. Provider Services representatives conduct initial and follow-up orientation sessions for new providers and their staff and schedule additional training as needed or requested. The initial orientation occurs shortly after a provider has been given participation status.

Each Amida Care Provider and his/her front-office staff receive an orientation that includes the following information and materials:

- Provider Manual
- Provider Directory
- Administrative Material
- Amida Care Overview
- Care Coordination Model and Care Team
- Quick Reference Guide
- Treatment Planning Guidelines (for HIV PCPs)
- Pre-Authorization Requirements, Forms, & Instructions
- MetroCard Disbursement Procedure and Reimbursement Procedures
- Provider Information Change Form
- Outreach Guidelines
- Clinical Material
- Access & Availability Standards
- Clinical Standards
- Treatment Adherence and Support Services
- Asthma Action Plan
- HIV Confidentiality
- Family Planning
- Pharmacy Benefits
- Behavioral Health
- Dental Services
- Domestic Violence
- Critical Public Health and Reporting Requirements
- Medical Record Reviews
- Advanced Directives Information

This information is also available on the Amida Care website, www.AmidaCareNY.org, and accessible to providers at any time.

Confidentiality of Member Information and Files

Confidentiality of member information is a basic part of all providers' orientation to the Amida Care network,

as is dissemination of a summary of Public Health Law 27 –F regarding HIV Confidentiality. All participating Amida Care providers must adhere to Public Health Law 27-F regarding confidentiality of HIV-related information, and the Health Insurance Portability and Accountability Act (HIPAA).
http://www.health.ny.gov/diseases/aids/facts/helpful_resources/confidentiality_law.htm

All Amida Care providers will be required to secure signed Release of Information forms from members prior to disseminating confidential HIV-related information. This is required to protect member confidentiality, as well as to prohibit discrimination against members who are persons living with HIV/AIDS. For care coordination, billings and other administrative purposes, provider may share member information with the Plan without a member's signed release of information. Members sign a release of information at the time of enrollment approving communication amongst network providers and the Plan. Providers must also develop a procedure to ensure that access to HIV-related information is limited to trained staff.

Amida Care providers are required to develop policies and procedure to assure confidentiality of HIV-related information and must include the following:

- Initial and annual in-service education and staff and contractors;
- Identification of staff allowed access and limits of access;
- Procedure to limit access to trained staff (including contractors);
- Protocol for secure storage (including electronic storage);
- Procedures for handling request for HIV-related information; and
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

Medical Director Updates & Training

Urgent and/or major developments will be relayed to practitioners as the information is approved and released. Under the direction of the Medical Director or designee, Amida Care will disseminate information via the Amida Care website at www.AmidaCareNY.org, in the Provider Newsletter, via email and other mailings as well as educational meetings, to ensure that Plan PCPs have access to the most current and approved clinical care guidelines, assessment protocols, and instruments for identifying unmet member needs.

Provider Inquires

Inquiries from providers may be directed to the Provider Services Department at 800-556-0674, which will respond whenever possible within one (1) business day, and in all cases within three (3) business days (unless otherwise noted), to requests for information. These requests may include, but are not limited to:

- Requests for forms or questions relating to the use of forms;
- Requests for data (may require additional time);
- Requests for Provider Manuals and Provider Directories;
- Questions or clarifications about policies or procedures;
- Eligibility;
- Benefit Questions;
- Authorization Questions; and
- Claims and billing (may require additional investigative time).

Provider Complaint/Grievance Procedures

All providers have the right to make complaints about any aspect of Amida Care's operations and they have

the right to request information and provider education. However, providers do not have the right to dictate Amida Care's policies and procedures.

There are four general types of provider complaints and grievances:

1. Claims payment grievances;
2. Member complaint and appeals;
3. Utilization of services appeals; and
4. All other provider complaints.

All non-claims and non-utilization management complaints are resolved in the manner described below.

Complaint and Inquiry Definitions

A *complaint* is defined as a matter in which a provider believes that he/she has been aggrieved by Amida Care, or any dispute between a provider and Amida Care. An *inquiry* is defined as a request for information by a provider.

Amida Care Responsibilities Regarding Complaints

- Provider Services staff accepts the filing of a complaint in either oral or written form;
- No adverse or discriminatory action of any kind may be taken against a provider based upon his/her filing of a complaint;
- Upon receipt of the complaint, Amida Care specifies any information that must be provided to Amida Care in order for a determination to be made;
- Within fifteen (15) business days of receipt of the complaint, a written acknowledgment that includes the name, address, and telephone number of the person or department responding to the complaint is sent to the provider by the Director of Provider Services and Network Management;
- The Director of Provider Services and Network Management ensures that all complaints are resolved as expeditiously as possible, but no later than thirty (30) days after receipt of all necessary information; and
- After review by the Director of Provider Services and Network Management, all complaints are filed.

Reporting

Amida Care will keep a record of all complaints, including a copy of the complaint, the complaint determination, and a description of any corrective action taken as a result of the complaint or appeal. Records will be retained by Amida Care for a minimum of three (3) years.

Hearing and Appeals Process

Providers may appeal an administrative, medical, or claims payment decision of Amida Care through Amida Care's Appeals and Grievance Process.

4. RENDERING CARE AND SERVICES

Covered Services

Amida Care has contractual agreements with a range of providers including Primary Care Services, Community Health Centers (CHCs), hospitals, Designated AIDS Centers, individual providers, and other credentialed providers for the provision of primary health care. Needed specialty services are provided through a network of referral sources including tertiary care centers, individual practitioners and group practices. These services are coordinated through a Primary Care Provider (PCP), in conjunction with the member's Care Team, in order to manage and assess the ongoing health care needs of the member population. The PCP is responsible for initiating referrals for specialty care when needed, evaluating the results of those consultations, and instituting appropriate therapeutic modalities. The PCP will work with the member's Care Coordinator or Case Manager regarding all other non-covered supportive services (see Care Coordination Model and Care Team in Section 1).

Amida Care also covers all pharmacy services. See Section 15 for specific information about this coverage including the Plan's formulary and authorization processes.

Amida Care contracts with a network of community based providers for the provision of the Case Management Program (CMP). In addition, staff at Designated AIDS Centers and Community Health Centers provides Case Management. This program provides integrated case management services that are responsive to the changing needs of its members including coordination and access to social and supportive services, such as but not limited to housing, legal assistance, peer groups, harm reduction, as well as medication adherence and other educational programs.

For those services that are not part of the prepaid benefits package, Medicaid members are referred to an appropriate provider who bills Medicaid or other resources for those services.

Amida Care Benefits/Covered Services - Overview

The following is a summary of the Plan's covered benefits and services. For a full list of benefits covered by Amida Care, Medicaid Fee for Service and Amida Care Utilization Management see the Benefit Guide in Appendix F. The Amida Care Quick Reference Guide can be found in Appendix G.

<u>Services</u>	<u>Description</u>
Inpatient Hospital Services	Covered when medically necessary
Ambulatory Services (provided through hospital outpatient departments, D&T centers, etc.)	Covered with no annual limit
Preventive Health Services	Covered with no annual limit
Laboratory Services	Covered when medically necessary
Radiology Services	Covered when medically necessary

EPSDT (Early Periodic Screening, Diagnosis And Treatment) Services/Child/Teen Health Program (C/THP)	Provided to all members up to age 21
Home Health Services (provided by a home health care agency pursuant to an established care plan)	Covered when medically necessary
Private Duty Nursing Services	Covered when medically necessary
Emergency Department Services	Covered when medically appropriate
Foot Care Services	Covered when medically necessary due to disease state; routine foot care provided to Diabetic patients only
Eye Care And Low Vision Services	Covered
Personal Care Attendant services for non-skilled needs	Covered when medically necessary
PERS	Covered when medically necessary
Durable Medical Equipment (DME)	Covered when medically appropriate
Pharmacy includes medical supplies	Covered with prescription
Buprenorphine	Covered when administered by a certified provider
Family Planning And Reproductive Health Services	Covered
Non-Emergency Transportation	Covered
Emergency Transportation	Covered
Dental Services	Provided by Medicaid Fee for Service
Court-Ordered Services	Plan covers Medicaid covered court ordered services
Prosthetics/Orthotics	Covered when medically appropriate
Mental Health Services	Covered
Chemical Dependence Services (Alcohol and Substance Abuse Services)	Covered

Derma Fillers

Derma Fillers are covered for members with Lipoatrophy. Authorization requires evaluation by a mental Health Professional (Psychiatrist, LMSW/LCSW) to determine if the member suffers from an emotional or psychiatric condition caused by their lipoatrophy.

Treatment Planning

To ensure plan-wide coordination and integration of treatment planning and medication adherence strategies, each member will first receive a comprehensive physical exam to be completed by his/her PCP. After the initial history and physical is complete, the PCP shall complete a treatment plan that will address the following:

- Documentation of health status, including TB, OB/GYN, disease staging, medications, other known medical conditions, including STDs;
- Identification and discussion of issues and concerns with medication regimens, including treatment adherence and symptom management;
- Assessment of the client's knowledge, attitude, and beliefs about HIV disease, transmission, risk reduction, and understanding of the NYS laws governing partner notification, Clinical History and Diagnoses;
- Exploration of specific harm reduction strategies as they relate to prevention of HIV transmission and/or re-infection; and
- Alcohol, drug and other substance use history and current usage, as well as harm reduction strategies;
 - Mental health;
 - Base Line viral load and CD4 count;
 - Follow-up Visit Schedule;
 - Specialty Care and Referrals;
 - Additional testing, which may need authorization; and
 - Significant Findings.

Both the comprehensive physical exam and the treatment plan will be completed within the first thirty days from the member's effective date. Treatment planning is done in the medical record progress notes but no form is submitted to the Plan unless requested. Interdisciplinary Case Conferences will be used, as needed, to review treatment plans and identify additional adherence strategies. The Care Coordinator will distribute pertinent member information to the appropriate members of the enrollee's Care Team.

Provider Treatment Adherence Strategies

PCPs will facilitate member compliance with medications through:

- Quantitative Adherence Assessments;
 - Can the client describe or recall his/her medications?
 - Does the client know how to take his/her medication?
 - Did the client miss doses and why?
- Complying with Treatment Planning Guidelines;
- Development of an client specific adherence plan
- Referrals to the Care Coordinator (CC) for additional member education;
- Referrals to the Case Manager (CM) for additional member education or program participation;
- Initiating case conferences to address adherence issues;
- Reviewing the Amida Care Provider Newsletter; and

- Participation in Plan sponsored, or other sponsored educational seminars that address treatment adherence issues.

Specialty Referrals

Amida Care members may access the following services without obtaining a Referral from their PCP:

Female members may self-refer to their Amida Care PCP or OB/GYN provider for routine gynecology services or care for a serious female problem. Self-referral are allowed for two routine visits per year and any follow-up care for an acute gynecological condition. An Amida Care member may also self-refer to obtain prenatal care services from an in-network provider without a referral from her PCP; as well as:

- Routine vision care;
- Diagnosis and treatment of TB by public health agency facilities;
- Family Planning/Reproductive Health Services;

Out-of-Network Specialty Services Referrals

Members may request a referral to an out of network provider when:

- Amida Care network does not include an available provider with the appropriate training and experience to meet the needs of the members; or
- Medically necessary services are not available through network providers.

All out-of-network referrals require pre-authorization from the Plan. PCPs must provide information explaining the need for an out-of-network referral to the UM Department (call 888-364-6061); this information must meet medical necessity for approval. HIV Specialist PCP referrals for specialty services to out-of-network providers should be documented in the treatment plan and or progress notes. Members may not use a non-participating specialist unless there is no Specialist in the Amida Care network that can provide the requested treatment.

Referral Process

Referral to Specialty services is not required for members to access specialty care within the network; however, referral from the PCP is encouraged to ensure communication with specialist and the PCP. PCPs can suggest referral when indicated.

- Referrals should be made to Amida Care Participating Providers. Participating Specialists are listed in the Provider Directory. There is also a provider search tool on the Plan's website at www.amidacareny.org. If you cannot locate a provider in a particular Specialty or wish to refer to a non-network provider, please call Provider Services for assistance.
- Referrals should be made to Specialty providers who can best communicate with the patient.

Guidelines for Amida Care's Referral Process:

- No referral form is required for in-network services, but may be used to help patients get appointments. It can also be used as a form of communication between the PCP and specialist.
- Referrals should be made to Amida Care Participating Providers. Participating Specialists are listed in the Provider Directory or using the provider search function, both of which can be found on the Amida Care website, www.AmidaCareNY.org;
- If you cannot locate a provider in a particular Specialty or wish to refer to a non-network provider, an

authorization is needed. Please contact 888-364-6061 or fax a Referral/Pre-Authorization form to 800-338-4195;

- Referrals should be made to Specialty providers who can best meet the members' needs;
- Referrals are service-specific. The PCP must identify the scope of services to be provided by the Specialist or specialty care center. These may include consultation, treatment, diagnostic procedures, additional visits, or any combination of these services;
- Relevant laboratory and imaging study reports must be forwarded to the Specialist along with the referral. The PCP may also contact the Specialist directly to provide additional clinical information or other relevant details on the patient's condition;
- Specialty providers must forward copies of medical findings and the plan of treatment to the referring
 - PCP or OB/GYN; and/or
 - The Clinical Care Coordinator or Case Manager and/or other primary care site staff may assist the member in making appointments and arranging transportation for Specialty care services. This is important for ensuring patient compliance with specialty referrals and for obtaining timely access to specialty services.

Accessing Care without a Referral

Accessing Family Planning

Members may obtain comprehensive family planning and reproductive health services from either a participating Primary Care Provider, family planning provider or from any appropriate non-participating health care provider of the member's choice. Where geographically available, PCPs and other family planning providers will help to foster access to Maternal/Pediatric Specialized Care Centers and/or HIV Primary Care Medicaid Programs, which have co-located routine gynecological care and HIV primary care services.

Accessing Prenatal and Obstetrical Care

All female members of Amida Care are eligible for direct access to participating providers for obstetrical services. Prenatal care providers will be required to provide ongoing maternal and fetal risk assessment. In addition, nutritional screening and counseling are required for all pregnant women. Providers are required to provide HIV pretest counseling with clinical recommendations for all pregnant women. Those women and their newborns must have access to services for management of HIV disease, psychosocial support and case management for medical, as well as social and addiction services.

The following procedure is outlined for new members who have initiated prenatal care prior to enrollment with non-participating providers:

- A new female member of Amida Care accessing prenatal care through a non-participating provider should be referred to a participating OB/GYN provider of Amida Care. The member should be referred at the time of the first prenatal visit, or at any such time the member presents during the first trimester. If the member has a justified reason for continuing with a non-participating provider, the situation is discussed with the Care Coordination and Medical Director
- A new female member of Amida Care in her second or third trimester already receiving prenatal care from a non-participating provider is allowed to continue receiving prenatal care from that provider throughout the duration of her pregnancy and for one (1) to three (3) postpartum visits. Authorization for these services is provided by the Care Coordination/Utilization Management

Department of Amida Care.

Services Requiring Pre-authorization

Pre-authorization is required for the services listed below. Please refer to Appendix G – Quick Reference guide that identifies the information that must be submitted to the Utilization Management Department by fax at 800-338-4195 or phone at 888-364-6061 before authorization will be considered. A sample Pre-Authorization Form that can be faxed to 800-338-4195 is available in Appendix P.

For Behavioral Health Services call 646-786-8650.

The following are examples of services requiring pre-authorization (see the Benefit Guide in Appendix F):

Outpatient Services:

1. Out-of-network referrals
2. Ambulatory surgery and invasive diagnostic procedures (see below)
3. Durable Medical Devices and Equipment – including orthotics and prosthetics that are greater or equal to \$500
4. Home health services – medically necessary nursing, equipment and appliances, physical therapy, speech/language pathology, occupational therapy, social work services and nutritional services
5. Home Attendant/Personal Care Assistant and/or Personal Emergency Response System (PERS)
6. Plastic and re-constructive procedures for specific conditions
7. Mental health and substance abuse services

Diagnostic Tests and Invasive Studies (including but not limited to):

1. GI studies, e.g. colonoscopy, endoscopy only if performed in an ambulatory setting
2. Cardiac catheterization
3. Sleep study
4. Liver Biopsy

Inpatient Services:

1. Elective hospital admission including video EEG
2. Mental health and substance abuse admission
3. Rehabilitative or sub-acute services
4. Transplantation services

Pharmacy Benefit Items

See Formulary on Plan website (www.amidacareny.org)

See Section 15

Emergency Services

Amida Care members are covered for inpatient and outpatient emergency care services when provided within Amida Care's geographic operating area or when provided to members who are out of Amida Care's geographic operating area. Services must be provided by facilities or practitioners qualified to render emergency medical care and meet medical emergency criteria as defined below.

Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition are NOT subject to prior authorization. If a member believes that a true medical emergency

exists, he or she should call 911 for assistance or go the nearest emergency room, and he or she should contact the PCP as soon as possible.

Definition of an Emergency Medical Condition:

The term “emergency medical condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

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

Emergency services include emergency consultation and care for pregnant members after hours (providers of OB/GYN care only).

Primary Care Provider Role

If the PCP is referring the member for emergency care, the PCP will refer the member to a Amida Care network hospital whenever possible or to the emergency department of the closest hospital depending on the nature of the emergency. The PCP or the on-call provider will try to contact the emergency department by telephone or fax to provide necessary medical information and may attend personally to the member in the ED. Members should be instructed to return to the PCP’s office at the Amida Care site for follow-up after an emergency department visit.

Specialty Care Provider Role

If a Specialty care provider is seeing an Amida Care member who requires emergent care, the provider should notify the member’s PCP as soon as possible after providing or arranging for emergency services. The Specialty care provider should attempt to send the member to a Amida Care network hospital whenever possible or to the emergency department of the closest hospital, depending on the nature of the emergency.

Hospital/Facility Role

Emergency services and emergent inpatient admissions are reimbursed based on the provider’s compliance with Amida Care’s Medical Management policies. All court ordered emergency services will be approved for Amida Care members.

When a Amida Care member presents at the emergency department for care, the hospital is responsible for triaging the member and for providing medically necessary and appropriate treatment. Participating hospitals are requested to make and document attempts to reach the PCP as soon as possible to exchange clinical information that may be necessary to provide the appropriate treatment. Referral to the PCP for follow-up care is a component of the discharge plan.

In all situations, the hospital must notify Amida Care Utilization Management Department of any emergency department visit including visits for behavioral health (mental health and chemical dependence) problems by a Amida Care member within 48 business hours of discharge from the emergency department.

Out of Area Services

If the Amida Care member is out of area at the time urgent care services are required, the PCP should be contacted as soon as possible, but the member should seek appropriate care in the immediate location.

If the member has received emergent or urgent care services out of area and follow-up care is required, the PCP should be contacted in order to coordinate provisions for the care. If follow-up care cannot be safely postponed until the member returns to the network area, the member should seek follow-up care from the appropriate out of area provider in consultation with the member's PCP, if possible.

Hospitalization

When a member is seen by a provider (clinic or physician) and a non-emergent (elective) hospital admission is indicated, the provider must contact Amida Care's Utilization Management Department to obtain pre-authorization for the admission. After the pre-authorization is obtained, the provider contacts the participating hospital to arrange for the admission and pre-admission testing within 72 hours. See Section 7 – Care Coordination and Utilization Management for the preauthorization process or refer to the Quick Reference Guide in Appendix G.

If a member is admitted on an emergent basis, the admitting hospital must notify the Amida Care's Utilization Management Department within twenty-four (24) hours, or the next business day, of the admission. A notification number is generated at the time of the call and the admission is evaluated for medical necessity based on InterQual Criteria.

Ancillary Services

Laboratory Services

Laboratory services ordered by PCPs at Amida Care's primary care sites are provided by Amida Care affiliated laboratories. Participating laboratories are listed in the Amida Care Provider Directory. If not using a participating laboratory, PCPs are responsible for providing laboratories with Amida Care billing information.

Diagnostic Imaging and Related Services

Diagnostic imaging and related services are provided by Amida Care affiliated hospitals and community-based radiological offices. A PCP referral, and if necessary authorization, is required for all diagnostic testing other than laboratory diagnostic tests. The referral serves as the order for the service and the authorization for payment.

Vision Care

Amida Care members are entitled to routine eye examinations and eyeglasses every two years and replacement frames or lenses, as necessary. Members may access these services from any participating Davis Vision provider without a referral from the PCP every two years. Information on the vision care network is provided in the Member Handbook.

The PCP must issue a referral for annual ophthalmologic evaluations for routine screening as well as for the diagnosis and treatment of medical conditions of the eye. Members with Diabetes can self-refer to any participating provider of vision services for an annual dilated eye examination.

Durable Medical Equipment/Supplies

For DME and prosthetics costing less than \$500, only a referral from the PCP is required.

Non Covered Services

If services are not covered by the Plan or Medicaid, the provider must advise the enrollee, prior to initiating service, that the service is uncovered and the cost of the service, which may be covered by other funding sources. Provider must inform Members that they will be personally responsible for all fees related to services that are not covered by the Plan or/and Medicaid, and obtain an executed acknowledgement of financial responsibility from the Enrollee or the Enrollee's legal representative. Only if these steps have been taken shall Provider be entitled to bill the Enrollee and collect for such services.

Special Populations

Services to Pregnant Mothers

Upon learning that a member is pregnant, PCPs or other providers will refer the member to her Case Manager in order to engage the member in early prenatal care and services. The Case Manager or the PCP will notify the Amida Care Care Coordination/Utilization Management Department. In addition, PCPs will begin to monitor and exchange clinical information, consistent with State and Federal policy, to reduce risks of HIV transmission, facilitate the initiation of prophylaxis with anti-retroviral therapy as needed, and encourage early entry into care throughout the prenatal, delivery, and pediatric services. Comprehensive care for all pregnant mothers will include counseling about the provision of anti-retroviral therapies. In addition, PCPs will use PCR or viral culture testing at recommended intervals to definitively rule-out HIV infection in exposed infants.

Services to Newborns

PCP shall accept confirmation of a woman enrollee's enrollment as sufficient to provide Covered Services to her newborn; unless the newborn is excluded from participating in Medicaid managed care. PCP acknowledges that newborns of members shall not be required to present ID cards in order to be seen by PCP.

Amida Care providers will follow the *American Academy of Pediatrics* guidelines for diagnosing and ruling out HIV infection in exposed newborns. Testing to diagnose or rule out HIV infection in exposed newborns will begin within 48 hours of birth and be repeated at age 1-2 months, and age 3-6 months, or until infection is diagnosed per criteria in 4.

Services to Adolescents

Amida Care is committed to providing adolescents with medical, psychosocial, and case management services that are delivered by Network providers who are experienced in adolescent issues, both related to HIV, as well as developmental issues, as relevant to both HIV positive and uninfected adolescents. These services include early and periodic child/teen health screenings, diagnosis and treatment, as well as comprehensive developmental assessments, child/teen health plan services, early intervention services (including physical, speech and occupational therapies), oral health services, access to intravenous infusions, and linkages to clinical trials as medically appropriate.

PCPs experienced in adolescent care will provide an assessment of special needs at the time of enrollment, and on an ongoing basis, since the needs of adolescents are constantly changing in response to both social and maturational issues. Every adolescent, regardless of sero status, will be assigned a Case Manager (CM) who has experience in evaluating the psychosocial needs of adolescents. The Care Team, including the PCP, the CM as well as any behavioral health and other key specialty providers will conference at least quarterly to discuss the adolescent member's psychosocial development, as well as to reach consensus about which Plan services and practice venues (e.g., pediatric verses adolescent or adult) would best serve the member's medical and psychosocial needs.

To facilitate the identification of Network providers who are experienced in working with adolescents, the Plan's credentialing criteria (see Work Experience) will address both knowledge and experience with adolescent issues for all pediatric Specialists (PCPs) and pediatric generalists (per the Plan's Pediatric Model).

Clinical Trials

Through clinical trials, patients may gain access to new treatments not yet available to the general public. The information gained through these studies will ultimately improve the health of people living with HIV/AIDS. Amida Care encourages network providers to keep abreast of available clinical trials and to make this information accessible to their patient's. Amida Care will provide PCP's periodic updates on active clinical trials in the greater New York area.

The AIDS Community Research Initiative of America (ACRIA) and Cornell's Clinical Trials Unit (CCTU) are two agencies that provide comprehensive listings of HIV and HIV related clinical trials available in the greater New York area. ACRIA's website is www.acria.org. CCTU can be found at www.aidsinfo.org.

5. BILLING, CLAIMS AND EXPLANATION OF BENEFITS

This section reviews claims processing, capitation payments, and reimbursement for services provided. All participating Amida Care providers are required to submit claims for services reimbursed according to fee-for-service rates. All claims data must be complete, accurate and submitted in a timely manner. Providers must never bill Amida Care members for covered services.

Payment for services rendered is subject to verification that the member was enrolled in Amida Care on the date of service and to the provider's compliance with Amida Care's Medical Management policies at the time of service. Providers **MUST** verify member status on the date of service to ensure that the member is enrolled in Amida Care. Failure to do so may affect claims payment.

Claims Processing

Claims submitted electronically will be paid within 30 days and paper or facsimile claim submissions will be paid within 45 days. All claims are adjudicated according to the provider's contracted reimbursement method and rates. Amida Care must give providers written notice at least 90 days prior to an adverse reimbursement change to the provider's contract; if the provider objects to the change that is the subject of the notice, the provider may, within 30 days of the date of the notice, give written notice to Amida Care to terminate the contract effective upon the implementation of the adverse reimbursement change.

All claims must be submitted on New York State UB-04 or Form 1500 claim forms. Claims should be submitted to the following address:

Amida Care
P.O. Box 6022
Hauppauge, NY 11788
For Electronic Claims Use Amida Care Payor ID: 24818

Claims for services rendered to eligible Amida Care members will be adjudicated within 30 days, provided they have been authorized by Amida Care's Utilization Management (UM) Department or, in the case of specialty services, the member's PCP.

An Explanation of Payment (EOP) will be distributed along with checks for claims payments and denials. Included with the EOP is information highlighting important issues regarding claims processing. Please contact Amida Care's Provider Services Department at 800-556-0674 for any questions about billing requirements.

Overpayment Recovery

Amida Care gives providers an opportunity to challenge overpayment recovery. The process for challenging overpayment recovery is as follows: when Amida Care identifies an overpayment, the provider is notified by letter and given 30 days from the date of the letter to challenge the recovery. If the provider does not respond, Amida Care will act to recover the funds.

Claims from a Participating Hospital Associated with a Non-participating Provider and Claims from a Participating Provider associated with a Non-Participating Hospital:

Amida Care will not deny a claim from a network hospital solely because an out-of-network provider treated the member. Likewise, Amida Care will not deny a claim solely because a network provider treated a member in an out-of-network hospital.

Claims Inquiries

Providers may contact Amida Care Provider Services at 800-556-0674 to inquire about the status of a claim or to receive a copy of an Explanation of Payment for a processed claim. Whenever possible, an explanation regarding the claim payment will be provided immediately over the telephone; otherwise, the inquiry will be researched and an answer or status update will be provided. Adjustments will be reflected on subsequent payments and will be included on the EOP.

Incomplete Claims

If required information is missing from the claim, the claim is rejected due to being incomplete. Claims may be resubmitted with the missing information provided. Providers are allowed 45 business days to resubmit a claim that was returned because required information was missing.

Claim Appeals

Providers are allowed 60 business days from the date of notification of an adverse determination of a claim to submit an appeal. To inquire about submitting an appeal for medical surgical services, please contact Amida Care's Provider Services Department at 800-556-0674. To inquire about submitting an appeal for inpatient behavioral health services or outpatient detoxification services, please contact Amida Care's Behavioral Health Services at 646-786-8650. The address for mailing all appeals is:

Amida Care
4944 Parkway Plaza Blvd., Suite 110
Charlotte, NC 28217

General Requirements for Claims Submission

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

- Member's name, ID number, and date of birth;
- Provider's name, Tax ID number, and address;
- Provider NPI number;
- Date and place of service;
- Description of procedure and code;
- Procedure charge; and
- Diagnosis code or E&M code, if indicated.

Timely Filing of Claims

Providers must initially submit claims within 120 days after the date of service, unless otherwise specified by the provider's contract or a different timeframe is required by law. If the agreement between the provider and Amida Care has a claim submission timeframe that is different from 120 days, the agreement will prevail, but the time frame cannot be less than 90 days; the statute does not supersede contracts in existence on 1/1/2010 except for timeframes with less than 90 days for claims submission. All authorization requirements must be met.

Reconsideration of Claims Denied Exclusively for Untimely Submission

Where the provider has submitted a claim late and can demonstrate that the late claim resulted from an unusual occurrence *and* the provider has a pattern of timely claims submission, Amida Care must pay the claim. Amida Care may reduce the reimbursement of the claim by up to 25% of the allowed amount. This applies to claims submitted 365 days or more after the date of service. The criteria for determining what constitutes an unusual occurrence are defined as:

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

Facilities Claims Submission

An acceptable claim format is the New York State UB-04. All required fields (see below) must be completed accurately, and all forms **MUST** be legible including an authorization number. Claims will be denied for lack of information if the forms are incomplete or the information included on the claim form is inconsistent. Claims will also be denied if the member is ineligible, the authorization number is incorrect or not included on the form, or if the provided procedure is not included in the Amida Care benefit package. Professional services that are not part of the facility claim should be billed on the HCFA 1500 or the UB-04 for outpatient claims. They may also be submitted electronically. Payment for emergency admissions is contingent upon timely notification to Amida Care and the submission of the required billing/encounter information. Payment to non-participating facilities for emergency admissions is based upon a retrospective determination made by Amida Care regarding whether an emergency condition existed.

Emergency Department Services

Payment for emergency department services is based on the member's signs and symptoms as documented in the medical record, not on the final diagnosis. Services will be reimbursed at an appropriate rate for non-emergent conditions when pre-authorization of treatment was obtained from the PCP.

Ancillary Provider and Vendor Claims

Ancillary providers who render services must submit claims on Form 1500 forms. They will be reimbursed based on the contracted rates if all authorization and information requirements are met. Anesthesia claims must be submitted with anesthesia CPT-4 codes not surgical CPT-4 codes

Community-Based Physicians and Non-Institutional Providers

Community Based and Non-Institutional providers must submit claims on HCFA 1500 forms. Use CPT-4 codes and 2-digit HCFA in place of service codes. The Amida Care provider number must be included.

Administrative Denials and Appeals Process

Providers are allowed 60 business days from the date of notification of an adverse determination of a claim to submit an appeal. To inquire about submitting an appeal for medical surgical services, please contact Amida Care's Medical Services Utilization Management Agent at 888-364-6061. To inquire about submitting an appeal for inpatient behavioral health services or outpatient detoxification services, please contact Amida Care's Behavioral Health Services Utilization Management at 646-786-8650.

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

- Timely Filing Limit Exceeded (claim receipt date and DOS exceeds 90 days);
- Invalid procedure/diagnosis code;
- Member ineligibility on dates of service;
- Duplicate submission of claims;
- No Authorization or Lack of Referral;
- Lack of Clinical Information;
- Member is SSI Eligible;
- Elective Admission;
- Late Notification; and
- Inappropriate Procedure and ICD-9 codes submitted.

Notification of denied claims is included in Amida Care EOP. Providers wishing to appeal administrative denials should submit, in writing, the additional information and/or proper justification for reconsideration of the denied claim.

Appeals must be requested within 60 business days of the date of the notification. When requesting a review, state the reason(s) you believe the claim determination was improperly reduced or denied. Also submit any data, questions, or comments you believe support the appeal as well as any data or information requested by Amida Care. This should be submitted in writing to:

Amida Care
ATTN: Claims Dept. Appeals
4944 Parkway Plaza Blvd., Suite 110
Charlotte, NC 28217

Primary Care Encounters

For PCPs who receive a monthly capitated rate, all capitated encounters must be submitted monthly. Amida Care is required by Federal and New York State regulations to capture and report all encounter data for its Medicaid membership.

PCP encounters should be submitted using either the Amida Care encounter form or any Form 1500 or UB 04 billing form, provided the following data elements are captured:

- Member's ID Number;
- Date of Service;
- Date of Birth
- CPT4 Codes (including immunizations);
- Primary and Secondary Diagnosis Codes; and

- Type of Encounter (visit) e.g., Lab, X-ray, Primary Care, Immunizations.

If possible, please indicate on each encounter submission the word "ENCOUNTER." This will allow us to isolate these from billable claims. Encounters will be tracked, per provider, to validate capitation payments and specialty referral patterns, as well as clinical appropriateness.

Coordination of Benefits

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

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

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

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

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

Overview of Explanation of Payment

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

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

- **Paid Claim Lines:** If the *Paid Amount* field reads greater than zero, the claim was paid in the amount indicated.
- **Denied Claims Lines:** If the *Non Covered* field is greater than zero, the service was denied.
- **Claim Processed as a Capitated Service:** If the amount in the *Prepaid Amount* field is greater than zero, the service was processed as a capitated service.
- **End of Claim:** Each claim is summarized by a claim total. If there are multiple claims for a single patient, the EOP also summarizes the patient total.

Please note that if you wish to request a review and reconsideration of a claim, a copy of the claim along with a copy of the EOP should be submitted to:

Amida Care
P.O. Box 6022
Hauppauge, New York, NY 11718

All claim review requests must be submitted within 60 days of the date of the EOP. Failure to submit a request within 60 days will result in denial of the request.

6. PROVIDER CREDENTIALING

Overview

Amida Care is committed to providing health care services to its membership through a high-quality provider network that meets the guidelines set by the *New York State Department of Health* and the National Committee on Quality Assurance (NCQA). Providers are initially credentialed and periodically re-credentialed through approved delegation agreements with sponsoring hospitals, or through a credentialing review conducted by Amida Care. The Plan recruits and credentials providers for its network based on the health care service needs of its members, without regard to a provider applicant's age, race, gender, sexual orientation, national origin, nor any other unlawful discriminatory practice.

Any provider who has been sanctioned by Medicare or Medicaid and has been prohibited from serving Medicaid recipients or receiving Medical Assistance payment is excluded from participating.

The Plan will credential and re-credential all providers who participate in health care service delivery outside of the inpatient care setting at least once every three (3) years. Through its documented credentialing and re-credentialing processes and policies, the Plan endeavors to contract with providers who meet uniform standards established to ensure the selection of appropriately trained and qualified Plan MDs, DOs, and other licensed independent health care professionals to provide covered services to Plan members in accordance with the Amida Care, Inc./New York City Agreement.

At a minimum, these standards shall include review of practice appropriate education, training and licensure, lack of impairment, lack of sanction activity, and lack of clinical limitations, health care delivery outcomes, as well as access and availability of care.

The Plan will maintain appropriate policies and procedures to ensure timely, accurate and fair processing of all provider applicants seeking network participation. The Plan will review and revise, as necessary, all credentialing and re-credentialing policies and procedures, at a minimum annually.

It is further understood that all information collected, verified, reviewed and discussed in connection with the submission of an initial application or review of a re-credentialing application is not to be disclosed or used for any purpose other than for the rendering of a participation or continuation of participation decision, unless otherwise directed by local, state or federal law. All Amida Care employees will adhere to the Plan's confidentiality policy and procedure.

Initial Application

The applicant must submit a completed *Amida Care, NY State- Approved or CAQH Provider Application* and signed attestations well as all supporting or applicable documentation and attachments, as required by the minimum requirement guidelines. The Provider Services Department reviews each application to ensure completeness. All documents presented to the Credentialing Sub-Committee must be dated within 180 days of the application signature date in order to be considered eligible for Credentialing.

In addition, no application packet may be accepted that contains expired attachments (e.g. DEA, malpractice face sheet, license or registration), with the exception of the office site visit.

Application – Initial/Re-Credentialing Requirements

The applicant must submit the following items in order for the credentialing process to be initiated:

- Applicants will be required to submit the following documentation (at a minimum):
- A copy of the provider's current, valid and unrestricted practice license and registration;
- A copy of the provider's current, valid and unrestricted DEA certificate (as applicable);
- Evidence of current malpractice insurance policy (face sheet), issued by a company authorized to conduct insurance business in New York State, with coverage at a minimum of \$1 Million/3 Million, listing policy effective and expiration date.
- Board Eligibility or Board Certification Status; and
- Hospital Affiliation (when applicable).
- A completed initial application for participation, including a statement regarding the following items:
- Any reasons for inability to perform the essential functions of the position/practice, with or without reasonable accommodation;
- Lack of present illegal drug (substance) abuse;
- History of loss or restriction of license and felony convictions;
- History of loss, suspension or limitation of privileges or disciplinary activity or sanction;
- History of suspension, restriction or exclusion from any Medicare or Medicaid program; and
- Signed and dated attestation and release by the applicant attesting to the accuracy and completeness of the application while providing for unlimited release from liability.
- Completion of highest level of clinical training/education attained and degrees granted (may be supplied on CV). If a Foreign Medical School Graduate, proof of ECFMG certificate.
- If board certified, completion of application section indicating the certification specialty, board name, date(s) of certification and/or re-certification and expiration date(s), if applicable.
- Detailed work history in month and year format (achieved by completing the work history section of the application or by supplying a CV). A minimum of five years history, immediately prior to application submission date should be supplied. If the applicant is new to practice, work history should include the period of time from completion of their clinical training. There should be no unexplained gaps of greater than six (6) months contained in any work history.
- Detailed listing of all of the provider's medical malpractice claims, settlements, judgments and dismissals. Each action should indicate the current status; settlement amount paid by or on behalf of the provider, allegations as to level of involvement and/or alleged level of involvement.

Credentialing of HIV Specialist PCPs

If a Provider is certified as an HIV Primary Care Provider, to provide services for HIV/AIDS infected members, the applicant must complete show evidence of sixteen (16) office hours per week on at least two (2) days per week at the primary care site and submit an HIV Primary Care Provider Attestation Form that indicates that the provider meets the following criteria as outlined in Appendix D:

HIV Medicine Association (HIVMA) definition of an HIV-experienced Provider

- A provider may submit to the Plan satisfactory evidence that the provider meets the HIVMA definition criteria. Providers meeting the HIVMA definition are credentialed for two years; recertification is subject to the same criteria.
 - Direct, ongoing care to 20 or more HIV+ patients over prior 24 months;

AND

- Evidence of 30 hours Category 1 CME in HIV-related topics within the prior 24 months; OR
- evidence of active certification in subspecialty of Infectious Disease in previous 12 months

American Academy of HIV Medicine (AAHIVM) certification as an HIV Specialist

Certification is available to MD, DO and NP practitioners with a current valid license.

- Evidence of direct, on-going care to 20 or more HIV+ patients over prior 24 months; AND
- Evidence of 30 hours Category 1 CME in HIV-related topics within the prior 24 months; or
- Evidence of successful completion of the AAHIVM exam on HIV-specialized medical care.

ACRN Association of Nurses in AIDS Care Provided By HIV/AIDS Nursing Certification Board (HANCB)

- Current license as an RN in the USA or international equivalent
- AT least two (2) years of experience in clinical practice, education, management, research related to HIV Care
- Completion of certification exam in HIV/AIDS Nursing

The provider applicant has the right to review information obtained in connection with the collection and evaluation of the credentialing application, with the exception of references and items that are peer review protected under applicable local, state or federal law.

Credentialing Process

Amida Care will conduct the credentialing process for all Primary Care Providers, Obstetricians/ Gynecologists, Case Managers, and all non-hospital based Specialty Care Providers that submit a completed initial application packet, provide all required documentation and attachments and meet the minimum requirements for application, and if applicable, current network need.

The Credentialing staff will coordinate the credentialing process, including the collection and verification of all related information and documentation. The Credentialing staff will also determine the completeness of each application based on the criteria discussed in this Plan as well as the outcome of all verification activities. This review will be completed within 90 days of receiving the application. If the application is accurate and complete, the credentialing application process for each applicant will be completed by the Credentialing Staff and submitted to the Credentialing Sub-Committee. No application will be considered by the Credentialing Sub-Committee after 180 days from the date of provider's signature on the attestation.

Should Amida Care receive information through our primary source verification activities that substantially differs from the information that was supplied by the applicant, the Plan will contact the provider applicant to obtain clarification.

If an application is incomplete, the Credentialing Staff will Plan will make every effort to obtain such information as soon as possible. However, if the provider does not supply the necessary documents within 90 days of the credentialing process, the Plan discontinues the credentialing process and notifies the provider of same.

At no point will an application remain incomplete and in-house for longer than 90 days and the application will be discontinued. A letter will be sent to the provider indicating that the original application has been discontinued and that any future consideration related to Plan participation would require the submission of a current and complete application and all supporting documentation and be subject to the current

credentialing criteria and network need.

Amida Care will allow newly licensed Health Care Professionals (HCPs) and HCPs relocation from other states to apply for provisional credentialing if the Plan does not approve or deny their complete applications within 90 days. NOTE: This applies only to HCPs who meet the above criteria and have submitted complete applications.

Site Visit Requirements

For PCP and OB/GYNs, an office site visit must be conducted for each office location within the Plan's service area before the provider application is sent to the Credentialing Sub-Committee. Site visits are conducted by Provider Services representatives using a plan-developed audit tool (Appendix I). The following areas are assessed during the site visit:

- Environment, including ADA compliance;
- Administrative;
- Policy and Procedures;
- Access to Care;
- Office Hours; and
- Patient Rights.

For PCPs, including HIV Specialists, site visits will verify that the provider practices at least 16 hours at each approved site.

In order to be approved, a provider must achieve a minimum score of 70%. A provider with a score between 60 to 69 will be passed with a corrective action plan that is approved by the Director of Provider Services and Network Development. Providers with scores below 60 will not be passes and a corrective action plan will need to be submitted and approved by the Director of Provider Services and Network Development. A follow-up site visit will be conducted in 90 days.

Final Review

During the processing of applications, applicants will be kept informed of the status of their application, as appropriate. Upon receipt of a completed application packet, the Credentialing Staff, under the direction of the Plan's Medical Director and/or Credentialing Sub-Committee will conduct primary source verifications in accordance to Plan guidelines.

Re-Credentialing

Amida Care will re-credential all providers, at a minimum, every three (3) years. All participating providers will be required to submit a completed re-application and attestation and disclosure, as well as supply all supporting and/or applicable documentation and attachments, as required by the Plan's credentialing/re-credentialing requirement guidelines. In addition, no re-application packet may be accepted that contains expired attachments (i.e. DEA certificate, malpractice face sheet, license or registration). All documents presented to the Credentialing Sub-Committee must be dated within 180 days of the application signature date in order to be considered eligible for credentialing.

In addition, no re-application packet will be accepted that contains expired attachments. An office site visit must be conducted for each new or differing office location within the Plan's service area, where the provider will deliver health care services to Plan members. There must be one site visit conducted between the date of credentialing and the date of re-credentialing.

At the time of re-credentialing a site visit shall be required for all primary care and OB/GYN providers that have indicated a new or different office location since the last Credentialing determination. Additionally, all PCP's with a patient panel of 50 or more will be subject to a medical record review audit and must achieve a passing score on both the Office Site Visit and, if applicable, the Medical Record Review.

Provider Performance Evaluation

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

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

- validation of performance improvement projects;
- validation of performance measures;
- review of compliance with access, structural and operations standards;
- review of credentialing and recredentialing data records;
- strategic reports on consumer-reported satisfaction surveys;
- strategic reports of HEDISQARR Analysis;
- technical assistance on enrollee information;
- coordination of care;
- evaluation of provider based quality strategy;
- implementation of focused studies and identification of special health care needs;
- dissemination of information to keep key stakeholders within network involved and informed of External Quality Review work projects and tasks; and
- development of reports for submittal to regulatory agencies as required.

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

HIV Specialist Annual Status Assessment

All HIV Specialists must submit, on an annual basis, documentation of at least 30 Continuing Medical Education (CME) credits or the equivalent as defined by the NYS AIDS Institute, and evidence that they meet the 20 patient years requirement, including antiretroviral treatment.

Each Amida Care network provider who is designated as an HIV Specialist PCPs will be reevaluated annually to ensure that s/he meets the Continuing Medical Education (CME) requirement in the HIV Specialist Guidelines.

On an annual basis, the Provider Services Department will review each provider to ensure that they meet the CME standard. If providers do not meet the standard, Amida Care may immediately suspend the provider as an HIV Specialist, and assist members living with HIV/AIDS in selecting a qualified HIV Specialist PCP.

Delegation of Credentialing and Re-Credentialing Related Activities

The Plan may delegate certain credentialing and re-credentialing related activities to another entity, through the use of a formal delegation agreement. However, the Plan will retain ultimate responsibility for ensuring that all of the credentialing and re-credentialing activities are being performed according to its expectations

as well as local, state or federal law, and applicable NCQA standards.

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

All facilities with delegated credentialing and re-credentialing will submit a/an:

- Copy of the facility's current JCAHO accreditation certificate (if applicable);
- Accurate and current list of providers who are to be included for participation in the Amida Care network of providers contracted by the facility to Amida Care;
- "Statement of Credentialing" signed by the President/CEO or an appropriate designee which verifies that the hospital has conducted credentialing in compliance with the facility's credentialing policies and procedures; and
- A copy of their credentialing policies and procedures, and/or by laws.

The hospital will notify Amida Care of changes in provider status by spreadsheet, provider add/change form, and/or written request on facility letterhead. In addition, Amida Care supplies a template of the data elements required per the credentialing and re-credentialing standards.

Primary Care Providers who are part of Delegated Credentialing Facility contracts

Primary Care Providers who are part of a delegated credentialing facility will submit an initial and annual HIV Specialist Attestation, also signed by the facility's Medical or Program Director. They will not be required to submit a Amida Care Provider Application. The Amida Care Medical Director will review the attestation and complete an HIV Primary Care Provider Verification Form. These PCP credentialing files will include:

- Copy of delegated spreadsheet with provider info highlighted;
- Annual HIV specialist attestation signed by the provider and facility medical or program director; and
- Plan's Medical Director annual verification form – completed and signed.

Delegated Credentialing Oversight

The Plan's Medical Director, Director of Provider Services and the Credentialing Sub-Committee will monitor the overall quality and timeliness of all verification activities conducted by the Credentialing Staff, delegated entity or accredited CVO. The Credentialing Sub-Committee and/or the Quality Management Committees at a minimum will report all activities annually.

The Plan will maintain evidence of oversight of the delegated activity. The delegation agreement describes, without limitation:

- The responsibilities of the Plan and the delegated entity;
- The activities being delegated;
- The process by which the Plan evaluates the delegate's performance; and
- The remedies, including termination of the delegated agreement, available to the Plan if the delegated entity fails to meet its obligations.

The Plan retains the right, based on quality issues, to approve new providers and sites and to terminate or suspend individual providers.

7. CARE COORDINATION AND UTILIZATION MANAGEMENT

Amida Care recognizes the complex psychosocial and medical needs of people living with HIV/AIDS and has created a unique care coordination model to address those needs. We believe the best way to keep our members healthy is to keep them engaged in their own healthcare and take advantage of the new treatments available for people living with HIV/AIDS. A team of providers – called a Care Team – works with each member to ensure the delivery of comprehensive, coordinated health care and supportive services, and consists of: Primary Care Provider (PCP), Case Manager (CM), Behavioral Health Case Manager (BHCM), and a Plan Care Coordinator (CC).

Care Coordinators

Care Coordinators monitor services that members receive from Plan providers and facilitate the delivery of all necessary services. These individuals provide an additional level of review when authorization request do not meet clinical criteria. The Care Coordinator utilize additional information such as information documented in Case Management Assessments, clinical information received from various members of the Care Team and claims utilization data to evaluate and facilitate the most appropriate services for the member. Care coordinators also oversee the Utilization Management process. They are responsible for obtaining and reviewing Case Management Assessment and Re-assessments for members and developing strategies to ensure that identified issues/needs are addressed according to the Plan's policy and procedures. In addition, they are trained to identify quality concerns regarding clinical care and/or services and to refer these concerns to the Plan's Director of Continuous Quality Improvement.

Amida Care Case Managers

Amida Care Case Managers are responsible for obtaining and reviewing Case Management Assessment and Re-assessments for members and developing strategies to ensure that identified issues/needs are addressed according to the Plan's policy and procedures. In addition, they are trained to identify quality concerns regarding clinical care and/or services and to refer these concerns to the Plan's Director of Continuous Quality Improvement.

Treatment Planning Process

A comprehensive history and physical (H&P) and treatment plan for each member must be completed by the PCP within 30 days of the member's effective date. After the history and physical is completed, the PCP shall complete a treatment plan and document it in the medical record progress notes. No form is submitted to the Plan unless requested.

PCP's shall inform the Care Coordinator if there has been a change in the member's health status (i.e., new onset diabetes, hepatitis, pneumonia, opportunistic infection, etc.) or a change in the member's ART regimen within 30 days of that change. In the event of a hospitalization, the PCP is to inform the CC within two (2) business days of the admission. Chart documentation, such as a progress notes or a medication list is sufficient for communicating the member's health change or hospitalization.

UM Department

Utilization Review shall be conducted by personnel trained in the principles and procedures of the Amida Care Utilization Management Department. Administrative personnel only perform intake screening, data collection and non-clinical review function and are supervised by appropriate licensed personnel. Licensed certified or registered health care professionals render positive determinations and may not render adverse determination for medical necessity, experimental/investigation, clinical trials or rare disease treatment.

Licensed certified or registered healthcare professionals are able to review and make determinations based on assessment of the health status of members to determine level of care, quantity or delivery method of care. Amida Care's Medical Director and other clinical peer reviewers with similar licensure selected by the Plan may render adverse determinations. All UM personnel are trained in the appropriate principles and procedures.

Toll-Free Telephone Access

Amida Care has a twenty-four hour toll free telephone number, which is answered by a live operator. The number is 800-556-0689 for all members and providers. If the issue does not require immediate action, the Amida Care Representative will take a message and forward it to the Plan the next business day. If the issue requires immediate action, the answering service will contact the Amida Care representative who will resolve the issue in conjunction with the appropriate Plan personnel or providers, when necessary.

All members are provided with an identification card including the name of the member's PCP and his/her telephone number, as well as Amida Care's toll free number.

UM Telephone Access

After hours and during weekends, providers are able to leave a confidential message regarding utilization review matters of a non-urgent matter utilizing the 888-364-6061.

Utilization Management Scope of Work

The Utilization Management Program addresses the health care needs of Amida Care's members by performing the following activities:

- Emergency Visit utilization review;
- Pre-admission and concurrent review of elective admissions;
- Initial and concurrent review of emergent admissions;
- Early initiation of discharge planning;
- Identification of potential quality of care issues; and
- Coordination of services.

In performing Utilization Management, the following parameters are considered by Amida Care:

- Medical necessity of provider directed interventions (based on approved clinical criteria);
- Appropriateness of the level of care;
- Appropriateness of the setting for the delivery of care; and
- Length of stay for inpatient services.

Specific services provided in outpatient settings and subject to preauthorization may include, but are not limited to, the following (See Appendix F – Benefit Guide):

- Out-of-network referrals;
- Ambulatory surgery;
- Amniocentesis;
- Anesthesia Services for Pain Management;
- Antilogous Blood Donation;
- Cardiac Cauterization;
- Cardiac Rehabilitation (outpatient);
- Durable Medical Devices and Equipment for item over \$500;

- Dialysis (outpatient);
- Experimental/Investigational Procedures;
- Growth Hormone;
- Hearing aids;
- Home Health Care;
- IV Infusion therapy;
- Outpatient Rehabilitation (PT, OT Speech Therapy);
- Orthopedic Shoe;
- PET Scans;
- Plastic Surgery/Reconstructive Surgery (Medically Necessary);
- Private Duty Nursing;
- Prosthetics;
- Residential Health Care Facility;
- Sleep Apnea Study; and
- Transplant.

Inpatient Medical Utilization Management Process

Ongoing evaluation at all levels of the care is undertaken to ensure that the provided inpatient care is medically appropriate, provided effectively and efficiently, provided in the most appropriate setting, performed at the appropriate level of care, and meets the Plan's benefit guidelines. Inpatient care includes all hospital admissions, rehabilitation services, and out of state elective procedures.

Inpatient Notification

Comprehensive and timely clinical information is required to support Amida Care's acute care authorization process. Amida Care will make a determination for authorizations within the timelines noted below:

- | | |
|-------------------------------------|---------------------------------------|
| 1. Elective Admissions | 3 Business days prior to admission |
| 2. Emergent Admission Notifications | Within 48 business hours of admission |
| 3. Emergent Admission Review | Within 48 business hours of |

Medical Necessity

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

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

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

On an annual basis, Amida Care reviews and evaluates its current clinical review criteria for revision and

update. The Medical Director, in conjunction with the Director of Care Coordination & Utilization Management receives and reviews any new or updated programs for future incorporation into the Utilization Management Plan.

Amida Care additionally utilizes Medicaid guidelines to identify and access medically appropriate services in alternate care settings and ancillary services.

InterQual Criteria

The InterQual review system is a complete utilization management tool that enables the user to identify:

- The severity of illness;
- The intensity of service;
- Discharge readiness (Discharge Screens); and
- Level of care options.

The ISD (Intensity of Service, Severity of Illness, and Discharge Screens) criteria consist of objective, measurable clinical indicators. These criteria were developed specifically for use by the non-physician clinical Specialists. They address appropriateness of admission to, continued stay in, appropriate discharge planning goals, general and specialty units and selective outpatient services; criteria are categorized by body systems.

Inpatient Review Process

Pre-admission Review (Elective Admissions)

Pre-admission review is conducted prior to admission to determine if the diagnostic and therapeutic services are clinically indicated and scheduled to be performed at the appropriate level of care.

Admission Review (Emergent Admissions)

Admission (initial) review is conducted within 48 hours of admission to determine the medical necessity of the planned treatment and/or services and the selected level of care.

Subsequent Review

Subsequent (continued stay) review is conducted during hospitalization to determine the appropriateness of the continued stay in the selected level of care.

Discharge Review

Discharge review is conducted to determine alternatives to the acute care setting when patients are no longer receiving acute care treatment.

Discharge Planning

Providers are required to comply and cooperate fully with Amida Care's discharge planning process, which begins at the time of the admission.

Prevention Of Hospital Readmission

As part of Amida Care's Re-engineered Discharge Program, a Care Coordinator will call each member within 48 hours of hospital discharge notification to assess the member's level of understanding with the discharge instructions and medications and to ensure follow-up appointment has been made with the PCP within 5 days of discharge

Timeframes

Pre-Authorization Request

For all procedures or treatments that require pre-authorization, notice of determination will be provided to the member or member's designee and the member's health care provider as fast as the enrollees' condition requires, within three (3) business days of receipt of an expedited request or in all other cases within 3 business days of receipt of all materials necessary to make such determinations but no more than 14 days after receipt of the request. Such notice must be provided in writing and by telephone to the member and provider of service.

Continued/Extended Authorization Request

Concurrent review procedures allow for continued or extended health care services for the purpose of validating the appropriateness of disposition and/or level of care, medical necessity of treatment and /or procedures, quality of care rendered and information provided during any previous review. Concurrent review determinations will be made as fast as the enrollees' condition requires and within one (1) business day of receipt of necessary information but no more than three (3) business days of an expedited authorization request. In all other cases, within one (1) business day of receipt of necessary information but no more than 14 days after receipt of the request. Determination notices are provided in writing and by telephone to the member and the provider of service.

Retrospective Review

All retrospective review for services, which have been delivered, is made within thirty (30) days of receipt of all necessary information. Written notification is provided to the member and provider. The Plan may reverse a pre-authorized treatment, service or procedure on retrospective review when: (a) relevant medical information presented to the Plan is materially different from the information that was presented during the pre-authorization review; and (b) the information existed at the time of the pre-authorization review but was withheld or not made available; and (c) the Plan was not aware of the existence of the information at the time of the pre-authorization review; and had the Plan been aware of the information, the treatment, service or procedure requested would not have been authorized. If a claim denial is received, notice must be mailed to the enrollee on the date of a payment denial, in whole or in part.

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

Timeframe Extensions

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

- The member, designee or provider requests an extension; or
- Amida Care demonstrates there is a need for more information and the extension is in the member's interest. Amida Care to notify the member if such an extension is required.

Adverse Determinations

Standards for Adverse Determinations Notification

All adverse medical necessity determinations are made by a Amida Care Medical Director or his/her

Designee. Amida Care attempts to discuss the adverse determination with the health care provider. If an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination.

The written notice of adverse determination shall include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals; and
- states the address and phone number to file an appeal, including internal and external appeals;
- The notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination;
- The notice will specify what, if any, additional necessary information that must be provided to, or obtained by, the Plan in order to render a decision on the appeal.
- Specific details for member or their designee on follow up actions including process and time frames, the right to contact the New State Department of Health, fair hearing notice and availability of notice in different languages; and
- Statement that Amida Care will not retaliate or take discriminatory action if appeal is filed.

Each notice of a final adverse determination of an expedited or standard utilization review appeal is in writing, dated and includes the following:

- A clear statement describing the basis and clinical rationale for the denial as applicable to the member;
- A clear statement that the notice constitutes the final adverse determination;
- The health care plan's contact person and his/her telephone number;
- The member's coverage type;
- The date that the appeal was filed and a summary of the appeal;
- The date the appeal process was completed;
- The name and full address of the health care plan's utilization review agent;
- The utilization review agent's contact person and his or her telephone number;
- A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician and the developer/manufacturer of the health care service;
- A statement that the enrollee may be eligible for external appeal and the timeframes for appeal;
- If the determination was not in favor of the member, a description of the member's fair hearing right, if applicable (if not provided with initial denial);
- The right of the member to contact the New York State Department of Health regarding his or her complaint, including the NYSDOH's toll-free number for complaints;
- A statement that the Plan cannot require the member to exhaust two levels of appeal;
- A statement that is in bold that the enrollee has 4 months from the final adverse determination to request an external appeal and that choosing the second level of internal appeal may cause time to file an external appeal to expire;
- A standard description of external appeals process is attached;

- A statement that the notice is available in other languages and formats for special needs and how to access these formats; and
- The member's right to Fair hearing and information on how to request a fair hearing is sent with the initial and final adverse determination notification.

Appeals Process

A member or a member's designee or the provider on the member's behalf can appeal all adverse determinations and, in the case of retrospective determinations, the member's health care provider may appeal. The member or a member's designee either in writing or can initiate the appeals process by telephone. All telephone or any other oral appeal is required to be followed up by a written, signed appeal.

Expedited Appeals:

Expedited Appeals may be filed by enrollee or enrollee's designee, in writing, by telephone, or by fax, when one of the following applies:

- Need for continued or extended health care services, procedures or treatments;
- Additional services for enrollee undergoing a course of continued treatment; and
- When health care provider believes an immediate appeal is warranted.

Expedited review must be conducted when Amida Care or the provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functions. Members have the right to request expedited review, but Amida Care may deny the request and process the review under standard timeframes.

An expedited appeal must be decided as fast as the member's condition requires within two (2) business days of receipt of necessary information and no later than three (3) business days from receipt of the appeal request. Expedited and standard review timeframes for pre-authorization and concurrent review may be extended for up to 14 days if the enrollee, designee or provider requests an extension; or, the Plan demonstrates there is a need for more information and the extension is in the best interest of the member. Amida Care will send a notice to the member in this situation.

A clinical peer reviewer must be available within one (1) business day. The appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

If Amida Care requires information necessary to conduct an expedited appeal, the Plan will make reasonable efforts to notify the member and the member's health care provider immediately by telephone or facsimile to identify and request the necessary information. Written notification from the Plan will be sent to the member and their provider within 24 hours of rendering the determination. Amida Care will make reasonable effort to provide oral notice to the member and their provider at the time the determination is made.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeals process or through the external appeal process.

Standard Appeals

Standard appeals may be filed by the member or the member's designee. Appeals may be filed in writing or by telephone. All telephone appeals must be followed up with a signed written appeal.

An appeal may be filed within sixty (60) business days after notification to the member, in writing, of the UM decision. Amida Care must acknowledge the appeal, in writing, within fifteen (15) days of receipt of the

appeal. If Amida Care requires more information to conduct a standard internal appeal, Amida Care will notify the enrollee and the enrollee's health care provider, in writing within fifteen (15) days of the receipt of the appeal, to identify and request the necessary information. Amida Care must make a determination as fast as the member's condition requires, and no later than 30 days from receipt of the appeal. This timeframe maybe extended for up to 14 days upon request by the member or provider or if Amida Care demonstrates that more information is needed, that the delay is in the best interest of the member and so notifies the member. The appeal will be reviewed by a clinical peer reviewer other the then clinical peer reviewer who rendered the adverse determination.

If only a portion of necessary information is received, the Plan shall request the missing information in writing within five (5) days of the receipt of the partial information before and during the appeal review period, the member or designee may see the case file. Members may present evidence to support their appeal in person or in writing.

Written notification must occur within two (2) business days of making the decision. Notification must include:

- Notification of decision to enrollee, enrollee's designee and appropriate provider;
- Reasons for decision, and if decision is upheld, the clinical rationale; and
- Notice of additional appeals rights including a description of the external appeal process

Failure of the Plan to make a decision within the applicable time frames shall be deemed a reversal of the adverse determination. Written appeals must be sent to:

Utilization Management Department
Attention: Appeals
Amida Care
4944 Parkway Plaza Blvd., Suite 110
Charlotte, NC 28217

When an appeal of an adverse determination is received, a provider who has a similar specialty to the health care provider who typically manages the medical condition, procedure, or treatment under review is consulted for evaluation and determination.

When an appeal of an adverse determination is received, a provider who has a similar specialty to the health care provider who typically manages the medical condition, procedure, or treatment under review is consulted for evaluation and determination. Members can the toll free number at 800-556-0689.

The Plan and the member may jointly agree to waive the internal appeal process. When this happens, Amida Care will send a letter to the member within 24 business hours of the agreement. This letter will also include information with regard to the process for filing an external appeal.

External Appeal Process

Amida Care members have the right to an external appeal for final adverse determinations. The member shall submit a request for an external appeal within 4 months s of receipt of the final adverse determination. The member, member's designee and, in the case of concurrent and retrospective adverse determinations, the member's health care provider may request an external appeal under the following circumstances:

- The Plan rendered a final adverse determination of the denial of a covered service on the grounds that it was not medically necessary and the Plan and member have jointly agreed to waive any internal appeal; or
- The Plan has rendered a final adverse determination of the denial of a covered service on the grounds that it is experimental/ investigational, clinical trial or rare disease treatment and the Plan and member have jointly agreed to waive any internal appeal; and
- The denial has been upheld on appeal or both the Plan and the member have jointly agreed to waive any internal appeal; and
- The member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard healthcare services or procedures have been
- ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the Plan or (c) for which there exists a clinical trial; and
- The member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must be recommended either (a) a healthcare service or procedure_(including a pharmacological product within the meaning of PHL 4900 (5)(b)(B), that
- based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation; and
- The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the Plan's determination that the health service or
- procedure is experimental or investigational; or
- The services offered by an out of network provider is materially different than the services available in the network

Cost for external appeals:

- Amida Care is financially responsible for the cost of external appeals initiated by the member, the member's designee or the provider when he/she is appealing on behalf of the member as the member's designee.
- When a provider initiates an external appeal in the case of concurrent or retrospective review, if the external appeal agent upholds the Plan's denial, the provider is responsible for the cost of the external appeal.
- Providers are prohibited from seeking payment from members for administrative cost associated with submission of external appeals or for health care services that the external appeal agent determined were not medically necessary.

Alternative Dispute Resolution (ADR):

Facilities licensed under Article 28 of the Public Health Law and the Plan may agree to an alternative dispute resolution in lieu of external appeal under PHL 4906 (2). This does not impact a member's external appeal rights or the right of a member to establish the provider as his/her designee.

Ambulatory Care Services Utilization Management Process

Home Care Services and Eligibility

The services listed below comprise the scope of covered home health care benefits:

- Intermittent or part-time nursing visits rendered by a registered nurse;
- Intravenous therapy as ordered by a physician;
- Home health aide services provided under the direction and supervision of a registered nurse; will be covered for members with skilled nursing needs. Amida Care will provide Interim Home health services to members who have been receiving these services and no longer have a skilled need but do require some assistance with personal care. Interim services with the home health provider will continue while an evaluation is made regarding Personal Care Assistance. An M11Q must be submitted and signed by a licensed physician within 60 of their examination of the member. Once this is received, the plan will arrange for comprehensive nursing assessment (M27r). and
- Durable Medical Equipment, oxygen, respiratory devices, and other equipment and supplies required to care for the member in the home.

In order to be eligible to receive home health care services members must meet the following criteria:

- Member has a plan of treatment that is periodically reviewed by the PCP; and
- In need of intermittent skilled nursing care, physical therapy, speech therapy, or in certain situations, occupational therapy.

Referral and Pre-Authorization Process

Home health care providers are responsible for ensuring the necessary pre-authorization is obtained from Amida Care before providing services. Home health care services must be coordinated with the member's PCP or other Care Team member in accordance with the prescribed plan of care. Medical necessity guidelines (InterQual) are used to determine the appropriateness of home health care. There are instances where a number of home care visits are automatically approved (deliveries, newborns, post hospital discharges) – see Appendix F for details.

Responsibilities of Certified Home Health Agencies

All participating home health agencies must complete the following activities when providing care for Amida Care members:

- Develop a treatment plan based on an assessment of the member's physical, psychological, and social needs. The PCP or other physician must approve the treatment plan;
- If changes to the treatment plan are required within the period for which home health services have been approved, the certified home health agency (CHHA) will notify the physician treating the member and obtain authorization for the changes, if necessary;
- If the duration of the home health care service period needs to be extended, the CHHA shall notify the PCP and shall obtain authorization from Amida Care for the extension. Amida Care will also notify the PCP of authorized changes to the treatment plan or duration of services;
- If DME is a required part of the approved treatment plan, the CHHA shall request separate and simultaneous pre-authorization, if required, of the home health care treatment plan and associated DME from Amida Care;
- Each type of service (Nursing, PT/OT, MSW requires a separate authorization;

- Home Care Services can be requested by a hospital discharge planner of facility as part of inpatient discharge planning; and/or
- Home Care Services can be initiated by the Care Coordinators if issues are identified during the review process of inpatient documentation or Case Management assessments.

Personal Care Assistant Program (PCAs)

Personal Care Assistants are available for assistance with non-skilled needs such as personal hygiene and household activities; this can include bathing, eating, shopping and cleaning. Requests for services can be initiated by the member, Case Manager or Provider. An M11Q within 60 days is required from the provider; once received, a nursing assessment (M27r) is done to determine appropriateness of service and hours needed. Services are approved for periods of up to 6 months and then reassessed as needed.

Personal Emergency Response System (PERS)

PERS is available for appropriate members. It is electronic equipment located in a member's home that can be actively activated in an emergency or passively activated if a timer mechanism has not been reset. Activation of the PERS will summon the specified emergency response organization. Authorization requires a Provider order and is based on the Provider's M11Q and comprehensive nursing assessment (M27r). PERS is only available to Amida Care members receiving home health and/or personal care services who have had three months of Medicaid eligibility.

Continuity of Care - New Member

If a qualifying new member has a life threatening, degenerative, or disabling condition or disease, he or she may continue an ongoing course of treatment for a transitional period of up to sixty (60) days from the effective date of enrollment if the member has the following:

- A life-threatening disease or condition; or
- A degenerative and disabling disease or condition

If the new member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period includes post-partum care directly related to the delivery, up to 60 days post partum.

The care is authorized by Amida Care only if the health care provider agrees to Amida Care's established rates as payment in full. The provider must agree to adhere to Amida Care's Quality Management requirements, provide medical information related to the care and adhere to Amida Care's policies and procedures.

Continuity of Care - Provider Leaves or is Terminated from the Network

If a provider leaves the network for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health care professional's ability to practice, a member may continue an ongoing course of treatment with that provider during a transitional period. The transitional period will continue for up to ninety (90) days from the date of notice to the member of the provider's disaffiliation from the network, or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery. The provider must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care;
- Adhere to the Plan's quality assurance program and provide medical information relevant

- to the member's care;
- Adhere to the Plan's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the Plan.

Access to Specialty Care Outside of Network

All out-of-network referrals require pre-authorization from the Plan. PCPs must submit a letter of medical necessity explaining the need for an out-of-network referral to the UM Department. PCP referrals for specialty services to out-of-network providers should be documented in the treatment plan or progress notes.

Non-network specialty care providers will send the Primary Care Provider (PCP) a consult report within two weeks of the date of service, and will send HCFA 1500 form for services rendered, including an authorization number to Amida Care for processing. All of the information is reviewed by the Utilization Management Department.

Members Requiring Services for Life Threatening Degenerative and Disabling Conditions/Diseases

When members have a life-threatening or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, a Specialist can be authorized to provide and coordinate the member's primary and specialty care. In those cases, the Specialist may make a referral to a specialty care center once he/she has provided Amida Care with a treatment plan, which has been reviewed and approved by Amida Care in consultation with the Primary Care Provider, the Specialist and the member or his/her designee.

Specialists and designated specialty care centers with expertise in treating life-threatening, degenerative and disabling diseases or conditions may be utilized as Primary Care Providers for such conditions, including, but not limited to, the following:

- Blind/Visually Impaired;
- Burns;
- Cancer;
- Cerebrovascular Accident (CVA);
- Chronic Respiratory Disease;
- Congenital Heart Disease;
- Deaf Or Hard Of Hearing;
- Diabetes;
- Ischemic Heart Disease;
- Major Amputations;
- Mobility Impairments;
- Neonatal/Pediatric Complications;
- Neurodegenerative Disorders;
- Organ Transplants;
- Pregnancies;
- Psychiatric And Chemical Dependency;
- Spinal Cord Injury;
- Trauma; and
- Ventilator Dependency.

Out-of-Network Specialists and designated specialty care centers require prior authorization; requests are reviewed by the Utilization Management Department.

Use of Non-Accredited or Designated Specialty Care Center

In select circumstances, members are allowed to access non-participating designated specialty centers with unique clinical expertise. In these instances, the following procedures apply:

- A member cannot elect to use a non-participating center unless Amida Care's network does not include an appropriate center;
- A member cannot elect to use a non-participating Specialist unless Amida Care's network does not include an appropriate Specialist; and/or
- Service at a non-participating specialty center is provided at no additional cost to the member if it is determined by Amida Care that such service is appropriate.

Experimental/Investigational Treatment

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

The member's PCP has certified that:

- The Member has a life-threatening or disabling condition or disease, for which
- accepted or standard services, procedures, and medication have been
- ineffective or medically inappropriate; or:
- There does not exist a more beneficial standard health service, which would be
- Plan; or:
- For which there exists a clinical trial.
- The member's referring provider must be board-certified or board eligible provider qualified to practice in the area of practice appropriate to treat the member's life threatening or disabling condition/disease, must have recommended either:
- A health service or procedure that, based on two peer reviewed documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
- A clinical trial for which the member is eligible; and
- The specific health service or procedure recommended by the attending provider would otherwise be covered except for Amida Care determination that the health service or procedure is experimental or investigational.
- If the provider of the experimental or investigational treatment is not a member of Amida Care provider network, the PCP or referring Specialist must make a referral for out of network services;
- A letter of medical necessity is required when requesting experimental or investigational treatment including information on the recommended course of treatment when available; and
- All requests are processed by the Utilization Management Department; reviewers will refer such cases to the Plan's Medical director for review and determination.

Rare Disease Treatment

The Plan will review request for rare disease treatment, in addition to the clinical information the follow information is required:

- A physician's attestation (board certified or board eligible) other than the treating physician who specializes in the area of practice appropriate to treat the member's rare disease; the attestation should indicate either that the member's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases or that the rare disease affects fewer than

200,000 US residents per year; and

- Two (2) documents of medical and scientific evidence to support clinical trials or rare disease treatment and the reason the treatment is likely to be more beneficial than treatment covered by AmidaCare.

Transportation

Non-emergent transportation services are available to all members who require assistance to travel to and from medical or behavioral care. These services include ambulance ambulette, livery service and public transportation. Providers can contact Amida Care participating transportation providers directly. If a member will require ongoing livery services, the provider is required to inform the Care Coordinator by calling 646-786-1800.

Emergency Transportation

Amida Care members are eligible for emergency transportation benefits. When there is an emergency condition, the member will call 911 for emergency transportation to the nearest emergency facility.

Public Transportation

The member's Case Manager or PCP is responsible for ensuring the distribution of a round-trip MetroCard or equivalent in New York City and for each verifiable visit for services and maintaining Providers may utilize the PTAR system to submit invoices to the Amida Care for reimbursement or the manual, Transportation Reimbursement Rosters, which are submitted to Amida Care for reimbursement of funds on a monthly basis.

Confidentiality

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

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

8. CASE MANAGEMENT PROGRAM

Overview

Amida Care case management services have been designed to ensure the success of its comprehensive array of HIV/AIDS services, both on an individual member level and with regard to the long-term viability of the Plan itself. The advent of managed care has transformed the role of HIV/AIDS case management, a change that the Plan incorporates into its own case management program. The HIV/AIDS case manager must nowadays assist the person with HIV/AIDS in navigating and accessing the various providers of the managed care plan, as well as ensuring that essential non-covered and covered services do in fact get delivered. Moreover, as central coordinator of non-medical services, the HIV/AIDS case manager must also educate the member on his/her rights and responsibilities under the Plan, as well as on both the opportunities and limitations the Plan imposes on the care it provides.

Amida Care's unique use of community-based Case Managers as both advocate/facilitator for the member and representative and facilitator for the managed care plan is not a conflicting or contradictory one. Rather, the innovative, patient-centered design of the Plan, which recognizes the preeminent role of HIV case management as a guarantor of quality care, ensures that such potential conflicts do not occur, and that the important needs of both member and Plan are met, without compromising either individual member care or the Plan's viability.

External Case Managers play the leading role on each member's interdisciplinary Care Team, which, at a minimum, also includes the member's PCP and the Plan-based Care Coordinator. As dictated by each member's needs, this Care Team may include other providers of service such as mental health or substance abuse providers. As leader of each interdisciplinary team, the External Case Manager coordinates and expedites all the various services required by the member and ensures that both member and providers fulfill their respective parts in the care relationship. When necessary, the Case Manager facilitates communication between provider(s) and member, as well as ensures that necessary information is promptly transmitted among the various providers caring for the member. With active input from both the member and involved providers, the Case Manager assembles an HIV services plan that meets the member's unique needs.

Case management functions are focused through the unique prism of HIV/AIDS and the special challenges daily facing people living with this infection.

Most importantly — the Case Manager serves as the member's advocate, an objective partner with the member in his/her care.

Goals and Objectives

Amida Care assures that the Case Management Program is implemented uniformly across all Plan providers to meet the following goals:

- To provide periodic, comprehensive, family-centered assessment of medical, mental health, substance abuse treatment and psychosocial needs;
- To develop Service Plan based on Case Management Assessment and to address the medical, behavioral health and psychosocial needs of the member while ensuring coordination of care;
- To provide appropriate referrals for both covered and non-covered services to meet the identified service and treatment needs;

- To provide ongoing follow-up activities to ensure the timely and appropriate delivery of necessary medical care and social services;
- To monitor and reassess the service and treatment needs of the member in a timely fashion; and
- To provide education, information and support to promote the independent functioning of the member and his or her family.

The Plan's spectrum of case management activities includes determination of the need for intensive versus non-intensive case management, supportive counseling, crisis intervention, primary and secondary prevention education, health promotion assistance, assistance with housing and supportive services, and partner/spousal notification assistance.

Types of Case Management

In keeping with the Amida Care mission and vision of an integrated, community-based service delivery system, experienced care and service providers, in the consumer's own neighborhood and of the consumer's choosing, contracts with the Plan to deliver case management services to its members. The Plan ensures that each member receives client- and/or family-centered case management in a timely and coordinated fashion and that necessary resources are utilized to maintain an individual's ability to function independently in the community. Amida Care case management program assures that each member has access to a full range of services through one or more of the following case management models:

- Supportive case management; or
- Comprehensive case management called COBRA case management by linkage with licensed provider agency.

Psychosocial Case Management is the traditional process completed by a social worker or case worker to ensure that members have access to the full range of mental health, substance abuse, social, legal and other services identified in the member's Service Plan needs. As an integral part of the benefits of the Plan, contracted providers who meet the standards adopted by the Plan in accordance with AIDS Institute guidelines provide non-intensive psychosocial case management services.

Medical Case Management is the direct provision of Primary Care Services and overall care management of medical services. The member's PCP is responsible for Medical Case Management.

Comprehensive Case Management or COBRA Case Management is an enhancement of the traditional non-intensive process, completed by a social worker or caseworker. Intensive Services are provided if the member has one or more concrete, functional or clinical needs that are determined to be urgent and immediate. COBRA services are not included in the Amida Care benefit package. Members are referred to COBRA providers, when appropriate, through linkage agreements with COBRA case management providers. The Plan oversees the coordination of COBRA case management services through the care managers.

Assignment of the Member to a Case Management Provider

Part of the enrollment process is to ascertain if a member is receiving Case Management Services. If a member has a relationship with a Case Manager the goal of Amida Care is to ensure that the member's

services are not disrupted. Amida Care will assign a community-based Case Manager for members request these services and are not yet receiving them. On a monthly basis the contracted Community Based Organizations (CBOs) that perform Case Management for Amida Care members are sent a roster identifying new members that will require outreach and initial Case Management Assessment within 60 days of the member's enrollment to Amida Care. The CBOs are also responsible for continued reassessment of these members every 180 days. It is the responsibility of the Case

Manager and/or site Designee to submit initial Case Management Assessments and Case Management reassessments every 180 days to Amida Care Care Coordination/Utilization Management Department. Documents should be faxed to 646-786-1802 Attention Case Management. .

External Case Management Activities

The Case Manager conducts the following case management activities:

- Assessment;
- Service Plan Development;
- Service Plan Implementation;
- Reassessment;
- Crisis Intervention;
- Inpatient Discharge Planning as needed; and
- Case Closure.

These services ensure access to, and coordination of, medical and behavioral health care and social and other needed services. The case manager works with the member and his or her family to support the independent functioning of that member and his or her family.

In addition, the Plan ensures that appropriate coordination of all medical services is provided to its members, that the continuum of care is seamless, and that each member's entire service team responds appropriately to changes in the member's needs. The PCP holds the primary responsibility for coordination of medical services. The Plan's Care Coordinators work in conjunction with the PCP to monitor the member's medical case management activities.

Documentation and Time Frames

Amida Care staff/Case Manager will perform an initial case management assessment within 30 days of member's enrollment. The External/psycho-social Case Manager will complete a Comprehensive Assessment and a Service Plan within 60 days. The external/psycho-social Case Managers will also perform and submit reassessments every 180 days. Additionally, they will submit copies of member Assessment, Reassessments, Service Plans and Service Plan Updates to the Amida Care Case Management team. All other documentation, including case contact dates and summaries, shall be maintained in the member's Case Management file on-site and made available during for scheduled audits as requested by Amida Care and/or as a component of regulatory audits conducted by the *New York State Department of Health* or by an agency on behalf of the *New York State Department of Health*.

Case management assessments and reassessments should be faxed to Care Coordination at 646-786-1802.

Supportive Case Management Documentation

The following is the Plan's standard for chart documentation of case management services. All visit documentation should contain at a minimum these components:

- Client Status or Issue(s) Identified;
- Goal progression;
- Visit start and end-time;
- Action(s) taken; and
- Follow up.

Visit Criteria Description

Case management services may be reimbursed on a fee-for-service or capitation basis. Guidelines for visits are as follows:

- Minimal Intervention (15 minutes): Member's issue(s) can be easily resolved; documentation that reflects follow up activities regarding the goals articulated in the member's service plan; 1 – 2 telephone calls interactions
- Moderate Intervention (30 minutes): Member has 3 or more issues that require action and follow up, coordination is required crisis intervention is not required
- Extended Intervention (45 minutes): Complex issues identified require multiple interventions; documentation that supports the need for crisis intervention (i.e. urgent medical need, pregnant member with no evidence of prenatal visits, housing crisis)

Claims Submission (HCFA 1500):

Case management visit thresholds have been established based on the benefit package which is defined as supportive case management. Providers may bill up to:

- 4 units per date of service per member (1 unit = 15 minutes); and
- 10 units per month per member.

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

- **G9012**: CM session(s), 15 minutes. Indicated # of units (Excludes travel time); Note CM sessions should not be billed when providing escort services see acceptable Escort codes bellow
- **CPLAN**: CM Assessment submissions: to ensure payment CM must be submitted to Care Coordination 646-786-1802
- **ESCT1**: Escort, Roundtrip (Professional Staff)
- **ESCT2**: Escort, Roundtrip (Peer)
- **G9007**: Care Team Conference, 15 minutes. Indicate number of units – utilized when the provider/CM staff conferences Amida Care Care Coordination regarding a members care and/or services in an effort to establish and implement a plan of action for members who require additional Amida Care support.

9. QUALITY MANAGEMENT AND CONTINUOUS IMPROVEMENT PROGRAM

Overview of Quality Management and Continuous Improvement Program

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

Purpose

The purpose of this plan is to set forth a coordinated approach to addressing quality assessment and process improvement at Amida Care, Inc. The program has established as its mission the providing of access to comprehensive medical and social services in partnership with its providers to improve the quality of life of its members.

Goals and Objectives

QMP is a systematic, plan-wide process for planning, designing, measuring, assessing and improving performance with the following objectives:

- Develop a planning mechanism incorporating baseline data from external and internal sources (i.e. medication, laboratory and appointment data);
- Emphasize design needs associated with new and existing services, member care delivery, work flows and support systems which maximize results and satisfaction on the part of the members, providers and staff;
- Evolve and refine measurement systems for identifying trends in care by regularly collecting and recording data;
- Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered (i.e. the SNP QARR and utilization reports);
- Focus on improving quality by encouraging data driven participatory problem solving with the plan and its providers;
- Promote communication throughout the Plan's network of providers with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement; and
- Strive to establish collaborative relationships with diverse community agencies for the purpose of collectively promoting the general health and welfare of the community served.

Provider Responsibilities

In accordance with the Amida Care provider contract, providers are accountable to the Quality Management Committee (QMC) for providing services to members in accordance with Amida Care's policies and the Quality Management Plan set forth by the Quality Management Committee. Participating providers are given the opportunity to petition the QMC for membership. Providers are encouraged to participate in the Amida Care Quality Management Program or Quality Management Committee or Sub-Committees, contact the Amida Care Director of Continuous Quality Improvement at 646-786-1800.

Structure of Quality Management and Continuous Improvement Program

The Amida Care, Inc. Board of Directors is responsible for oversight of healthcare services. This leadership group approves the performance improvement plan, and reviews quality improvement activities during its regular meetings. A Quality Management Committee has been established, under the co-chairmanship of the Plan Medical Director and a member of the Board of Directors, to develop, implement and review the QMP. The Director of Continuous Quality Improvement is also responsible for managing the resources allocated to the QMP; the day-to-day functioning of the QMP activities; interactions with governing regulatory agencies regarding completion and submission of required surveys, studies and data collection and submission of required reports and data.

The Plan Member Advisory Council (MAC) assists in the quality improvement activities and participates in specific projects as appropriate. Two representatives from the MAC are members of the Board of Directors and participate in the meetings. The Member Handbook includes an invitation to consumers to participate in the development of the Plan's policies through participation in the Member Advisory Council.

The Amida Care Care Coordination (utilization management/utilization review) Program is designed to promote the effective management of the type, level, appropriateness, continuity and timeliness of medical services provided to members in compliance with accepted standards and criteria in order to ensure quality of care, member and provider satisfaction. The Care Coordination Program is a structural component of the QMP. The monitoring function of the QMP determines the effectiveness of the Care Coordination Program measured in patient outcomes and adherence to policies and procedures. The findings of the monitoring processes can identify:

- Care coordination policies and procedures or review criteria (for clinical determinations) that may need to be revised;
- Providers who need counseling or education; and/or
- Clinical practice guidelines that need revision.

In addition to the Plan Medical Director and a member of the Board of Directors, who serve as co-chairpersons, the Quality Management Committee membership includes the Amida Care Chief Executive Officer, the Director of Continuous Quality Improvement, the Director of Provider Services and Network Management, the Director of Care Coordination and Utilization Management, the Director of Member Services, and clinical representatives from Amida Care sites including physicians, nurse practitioners, nurses, and case managers with a total membership of 9 – 16 members. The Board of Directors approves the members of the QMC.

The Amida Care Quality Management Committee meets at least 4 times a year. A majority of the designated members participating in person or by teleconference constitutes a quorum of the Committee. Any vote presented is adopted with a simple majority vote of the members participating. Written minutes of the Quality Management Committee are documented and approved by the Committee. Approved minutes with any referenced written reports and Sub-Committee minutes (Clinical and Credentialing Sub-Committees) are submitted to the Board of Directors for final review, discussion and recommendations.

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

Quality Management/Improvement Content

The program is designed to address quality content regarding the following major functional areas:

- Clinical Primary Care;
- Network Access;
- Member Education;
- Continuity of Care;
- Member Satisfaction;
- Provider Satisfaction;
- Case Management;
- Information Systems;
- Utilization Management and Care Coordination; and
- Pharmacy and Therapeutics.

Data Collection Plan

Selection of performance measures for the major functional areas and the important aspects of care and service. Regular review of data for performance measures from a variety of sources will occur as scheduled. Data sources will include but not be limited to:

- Clinical Measures based on established HEDISQARR and SNPQUAL guidelines;
- Member Satisfaction Survey results administered through the Membership Division;
- Demographic data and visit frequency from Plan database; and
- Utilization pattern as prepared by the MSO, RHC, and pharmacy use as prepared by the Plan PBM ESI.

Assessment and evaluation of the data will be performed to determine if the data warrants further evaluation. Based on this ongoing review, priorities will be set and opportunities for improvement identified.

Development of Improvement Action Plans

Once an opportunity for improvement has been identified continuous quality improvement methodology will be utilized and will include but not be limited to the following:

- PDSA (Plan/Do/Study/Act) root cause analysis, barrier identification led by a CQI Team with oversight by Plan Quality Management Committee and with the approval of the Board of Directors as necessary for specific interventions with financial, governance, and/or vendor/provider contract implications;
- Brainstorming; and
- Observational Studies.

Continuous Quality Improvement Action Plans (IAPs) will be developed and implemented and the improvements may include:

- System redesign;
- Education;
- Clinical guidelines review, revision or development that serve as a basis for provider and Plan staff orientation and ongoing education, standards of care and the indicators for the Plan quality monitoring activities. They promote a unified and current approach to patient care and support services. Clinical practice guidelines are adopted by Amida Care in compliance with the Amida Care Quality Management Policy and Procedure on Clinical Practice Guidelines and Performance Standards;

- Procedure and policy changes; and
- Form development or revision.

Once an Improvement Action Plan has been successful a regular monitoring schedule will be implemented to determine whether the plan remains successful over time. All Improvement Action Plans will be communicated to relevant staff, members/patients, groups and agencies via meetings, e-mail, memos and informal verbal communication if deemed appropriate.

Quality Management Committee and Sub-Committees

The Amida Care Quality Management Committee, co-chaired by the Plan Medical Director and a member of the Board of Directors, is charged by the Amida Care Board of Directors with the responsibility for:

- Developing, approving and implementing the Quality Management Program and the Quality Management Policies and Procedures;
- Developing, approving and implementing the Care Coordination Plan and Care Coordination Policies and Procedures;
- Approving the Credentialing Policies and Procedures;
- Oversight of the activities of the Quality Management Sub-committees (Clinical and Credentialing);
- Approving Care Coordination Policies and Procedures and Clinical Practice Guidelines;
- Receipt, review and analysis of quality monitoring findings;
- Planning and implementing quality improvement action plans;
- Assignment and oversight of Continuous Quality Improvement Teams;
- Reviewing reports of utilization and provider practice patterns;
- Recommending follow up actions or policy changes in response to Medical Management reports of utilization and provider practice patterns;
- Receipt of oral and written reports of peer review activities in relationship to Care Coordination and
- Quality Management functions/activities related to authorization and denial decisions and activities;
- Record review as a component of indicator monitoring or clinical studies and review of provider practice patterns;
- Receipt of the Clinical Sub-committee minutes and reports for review and recommendations prior to submission to the Board of Directors for final approval;
- Receipt of all Credentialing Sub-Committee minutes and reports, including providers approved/provisionally approved to be credentialed, for review, input, and approval prior to submission to the Board of Directors;
- Providing the Board of Directors with regular reports of all Quality Management Committee and
- Sub-committee meetings including but not limited to copies of Quality Management Committee and
- Sub-committee minutes and reports; and
- Communicating any Board of Director input to the appropriate Quality Management Sub- committees.

There are two standing Sub-Committees of the Quality Management Committee. The Sub-Committees are the Clinical Sub-Committee and the Credentialing Sub-Committee.

Clinical Sub-Committee

The Clinical Sub-Committee is chaired by the Plan Medical Director and is responsible for:

- Reviewing and discussing current literature on specific elements of clinical practice;
- Recommending revisions to the Plan's Care Coordination policies and procedures and clinical practice guidelines;
- Recommending clinical monitoring elements of the QMP to the Quality Management Committee;
- Reviewing the findings of clinical monitoring and making recommendations for action plans/continuous quality improvement teams;
- Reporting Subcommittee activities to the Quality Management Committee for review and input, including possible revisions to the quality improvement activities and recommendations for action plans and continuous quality improvement teams; and
- Approval of the panel of Clinical Peer Reviewers for medical services.

In addition to the Plan Medical Director, who serves as Chairperson, the Clinical Sub-Committee membership includes the Director of Continuous Quality Improvement, Director of Care Coordination/Utilization Management, consumer representation (an Amida Care Member) and site Medical Directors and Care Team Members.

The Clinical Sub-Committee of the Quality Management Committee meets at least bi-annually or as recommended by the Medical Director or by network providers' request. A majority of the designated members participating in person or by teleconference constitutes a quorum of the Sub-Committee. Any vote presented is adopted with a simple majority vote of the members participating.

Written minutes of the Clinical Sub-Committee meeting are maintained. The Clinical Sub-Committee minutes and any relevant reports and attachments are submitted to the Quality Management Committee for review. The content and review of the Clinical Sub-Committee minutes is included in the Quality Management Committee minutes, which are submitted to the Board of Directors for final review and input regarding any significant findings and actions taken, planned or recommended.

Credentialing Sub-Committee

The Credentialing Sub-Committee, chaired by the Plan Medical Director, is responsible for:

- Developing the Credentialing Policies and Procedures for recommendation to the Quality Management Committee;
- Supervising of all activities carried out to complete credentialing and re-credentialing of Plan providers in compliance with the Plan's Credentialing Policies and Procedures and relevant regulations;
- Making credentialing and re-credentialing decisions and decisions relative to expansion, limitation and termination of privileges as indicated by official reports of changes in professional status, ongoing education, and monitoring results;
- Ensuring the adequacy of the Plan network and appropriateness of individual provider panel size; and
- Providing the Quality Management Committee with reports of the status of credentialing work process, the status of individual providers (as indicated), overall network composition and any anticipated problems with provider network size or composition.

In addition to the Plan Medical Director, who serves as Chairperson, the Credentialing Sub-Committee membership includes the Director of Provider Services and Network Management, and representatives from the network provider sites. The Chairperson appoints the members of the Sub-Committee.

The Medical Director is responsible for provisionally credentialing providers who submit all required documentation, meet all requirements for being credentialed including acceptable responses to regulatory inquiries. These providers are formally credentialed at the next scheduled Credentialing Sub-Committee meeting. The Credentialing Sub-Committee meets quarterly. A majority of the designated members participating in person or by teleconference constitutes a quorum of the Sub-Committee.

Written minutes of the Credentialing Sub-committee meetings are maintained. The Credentialing Sub-committee minutes with any referenced written reports and attachments are submitted to the Quality Management Committee for review. Credentialing Sub-committee minutes are approved by the Quality Management Committee and summarized in reports to the Board of Directors for final review and input regarding any significant findings and actions taken or planned and final approval of credentialing determinations.

Quality Management and Continuous Improvement Program Components

The following are the major components of the Amida Care Quality Management and Continuous Improvement Program.

Structural Components

The structural components ensure that the administrative and support processes of the Plan are designed to promote quality of care and supportive services. They ensure an adequate and well prepared network of providers; members who are oriented to the Plan and its procedures and standards; procedures and protocols that support member, provider and Plan administrative staff interactions; and activities, processes and resources that support the provision of quality care. They are as follows:

1. Provider credentialing/re-credentialing;
2. Network development, contracting and maintenance;
3. Service accessibility;
4. Member outreach, orientation and ongoing education;
5. Provider Manual, orientation and provider continuing education;
6. Practice Guidelines;
7. Care Coordination/Utilization Management;
8. Retention in Care
9. Electronic Laboratory Data, claims system, pharmacy data;
10. Case Conferences;
11. Organizational and administrative functions of outreach, enrollment, member services, claims processing, MIS, complaint resolution, appeals management; and
12. Quality Management Work Plan.

The Quality Management Work Plan provides a framework of scheduling and responsibility for all of the work and output elements of the Quality Management and Improvement Program. It insures that there is an ongoing means of determining the status of work that has been identified as essential to ensuring the quality of all Plan services.

Monitoring Components

The monitoring components of the QMP provide an organized system for assessment of performance of all functions related to the Plan's provision of health and supportive care services and determination of possible problems related to the quality of health and supportive care and services or Plan administrative and organizational services. These components are developed and carried out under the supervision of the Plan's Quality Management Committee.

The components of Quality Monitoring included in the Plan's QMP include:

- Annual reviews conducted by the site Care Team (PCP, Clinical Care Coordinator and Case Manager) with a member of the Medical Director's office. These reviews of patients assigned to the team include assessment of quality of medical care and case management services using HIV QARR and other established quality indicators;
- Pharmacy Utilization Reports as determined by SDOH;
- Surveys of after-hours access, timeliness of appointment availability and appropriateness of appointment waiting times - PCP and Specialist (conducted per *NYSDOH* specifications);
- Surveys of verification of eligibility and continuity of care conducted by IPRO as a contractor to SDOH AIDS Institute;
- Survey of providers to determine their satisfaction with all plan organizational and administrative functions and systems;
- Annual survey of members to determine member satisfaction as specified by the AIDS Institute;
- Complaint reports including fraud and abuse reports filed directly with the Plan or filed with the *New York State Department of Health, New York City Departments of Health and Mental Hygiene* or the *New York State Department of Insurance*;
- Recipient Restriction Program reports monthly as specified by SDOH and OMIG;
- Patient care management reviews conducted by site Care Team using indicators determined by the Quality Management Committee. The Quality Management Committee supervises site patient care reviews;
- Regulatory surveys of Member Services Lines and Provider Directory Information;
- Regulatory statements of deficiency or citations relative to any component of Amida Care's performance of its contract as an HIV SNP;
- Yearly HEDISQARR and SNPQUAL indicator reports;
- Utilization Management reports including reports of inpatient days and inpatient admissions; appeal requests/appeal decisions; enrollee over/under utilization; referral and specialty utilization and provider practice profiles;
- Sentinel clinical event monitoring;
- Reports of investigation of potential quality issues identified by Care Coordination staff in the process of medical management (utilization management/utilization review) or network providers;
- Medical Management reports of inter-rater reliability of application of review criteria, compliance with standards and timeliness for reviews, determinations, denials and appeals; compliance with pre-authorization telephone answering standards;
- Focused clinical studies as approved by the AI and internal studies conducted by the Plan;
- Administrative and Organizational Quality Monitoring Indicators as set by the Plan;
- HIV MEDS data accuracy and sufficiency reports from the *New York State Department of Health*;
- Enrollee PCP Assignment reports quarterly to the *New York State Department of Health*, and

- Member Clinical Care/Treatment Follow-Up Reports (reports of members who have not presented for care/treatment within a 6 month period).

Findings from these monitoring components are reviewed by the Quality Management Committee in compliance with the Amida Care Quality Management Policy and Procedure on Analysis of Problems Identified by Quality Monitoring.

Medical Records Standards and Reviews

All providers rendering health care services to Amida Care members must maintain a member health record in accordance with standards adopted by Amida Care and in compliance with NCQA Guidelines for Medical Record Review. Providers maintain these documentation standards and ensure adherence to all confidentiality regulations when sharing medical record information with other providers.

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

- Medical Record Reviews will be completed annually by the Plan for all PCPs,;
- Medical records of 5% of each PCP's roster will be reviewed at least annually, with a minimum of 3 records and maximum of 20; and
- Given a maximum panel size of 350 (or 500 with Physician Extenders), this typically results in 3 to 15 Medical Record reviews per provider.

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

- Oversight of trimester patient care management review reports;
- Credentialing and re-credentialing;
- Quality of clinical care investigations;
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations and review billing issues; and
- Reporting for Quality Improvement and Peer Review Organization studies, HEDIS and SNPQUAL performance

10. MEMBER SERVICES

Member Services Department

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

It is the policy of Amida Care to provide all members and providers with courteous, accurate, and timely service for their requests and needs. Amida Care receives a wide variety of calls throughout the day relating to the provision of services to our members. The Member Services Department serves as a centralized resource providing support for member education on managed care and Amida Care's benefits and services. In addition, the Department responds to member inquiries and complaints and facilitates access to appropriate medical and preventive health services and health education programs. Specially trained multi-lingual staff are available 40 hours per week, Monday through Friday from 9am to 5pm at 800-556-0689. Member and providers that need help after hours, on weekends and holidays, should call us at the same number and our live voice after-hours service will provide assistance, or take a message for the Amida Care Member Services Staff.

Enrollment

Amida Care will achieve outreach and enrollment goals in strict compliance with the SNP contract and all regulations set forth by the *New York State Department of Health*.

Enrollment Lock-In Period

Members may change their managed care plan at any time within the first 90 days of enrollment. After 90 days, and before 12 months, they may only change to another HIV Special Needs Plan. After one year of enrollment, consumers may change their managed care plan. In special circumstances, members may request exemption from the lock-in period.

Member Loss of Eligibility

Members who are disenrolled from the Plan due to a loss in Medicaid eligibility and who regain eligibility within three (3) months will automatically be re-enrolled in the Plan on a prospective basis.

Newborn Enrollment

Members who give birth while covered by Amida Care automatically have health care coverage for their newborn, unless the mother specifies that she does not want the child enrolled. Amida Care must submit the necessary paperwork to the local *Department of Social Services (HRA)* to ensure that the newborn is enrolled in the Plan.

Language Needs

During the enrollment process, information concerning the member's language and/or communication requirements (e.g., special visual and/or hearing requirements) are ascertained. The Member Services Department employs bilingual staff to accommodate most language needs. In the event that the multi-lingual staff cannot accommodate a language need, third party Language Line interpreters will be utilized.

In addition, the Member Services Staff attempts to match members to providers with similar language capabilities. Providers should utilize staff interpreters, when necessary, to assist in communicating with a member during visits.

Provider Selection

Member Selection of PCP

Members usually select a PCP at the time of enrollment. Members are advised to contact Member Services to make their selection. If the member does not select a provider within 30 days of their effective date, members are advised that a provider will be selected for them by the Plan.

Plan Selection of PCP

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

Member Change of PCP

Plan members (unless part of the restricted recipient program) may change their PCP for any reason by calling the Member Services Toll Free number at 800-556-0689 or submitting a written request. The Member Services Department, upon request by the member, processes the PCP change. Consistent with the initial enrollment process, the member is offered a choice of three (3) PCPs based on geographic convenience to the member, PCP panel size, and/or language capability.

PCP Information/Status Changes

Amida Care will notify members of any of the following PCP changes:

- Termination from Amida Care's network; and
- Change in address, telephone, name.

The Plan will notify the member by mail within 5 business days of the provider notifying Amida Care. In the case of a PCP termination, the written notice advises members to contact Amida Care to select a new PCP. The notice also advises the member that if Amida Care does not hear from them, the Member Services Department will automatically assign a new PCP within thirty (30) days. When indicated by the primary care site, the provider's panel may be reassigned to other providers at the facility. Members are advised that they have been reassigned to another provider, due to their provider leaving the network. Members still have the option of changing their provider if this reassignment is not acceptable to the member.

Selection of Case Manager

Part of the enrollment process is to ascertain if a member is receiving Case Management services. If a member has a relationship with a Case Manager the goal of Amida Care is to ensure that the member's services are not disrupted. Unless declined, Amida Care will assign a community based Case Manager for members who are not receiving Case Management services. On a monthly basis the contracted Community-Based Organizations that perform Case Management for Amida Care members are sent a roster identifying new members that will require outreach, orientation and initial Case Management Assessment within 45 days of the member's enrollment to Amida Care and submit to the Care Coordination/Utilization Management Department. Documents should be faxed to 646-786-1802, Attention: Care Coordination.

Member Services Activities

Orientation and Health Risk Assessment

Amida Care attempts to contact each new member to conduct a health risk assessment and the new member outreach and orientation within 30 days of their enrollment effective date. When necessary, the orientation team member will arrange a home visit to conduct the assessment to ensure that members will receive timely and appropriate orientation and initial need assessment. All new Amida Care members also receive written orientation materials and are invited to attend scheduled orientations conducted at the Amida Care central offices. The sessions focus on explaining benefits, rights and responsibilities to members. All members receive a Member Handbook and a Provider Directory that includes a listing of primary care, OB/GYN, specialty, behavioral health, case management, transportation, DME, family planning, radiology, laboratory, home care, dialysis, and vision care providers as well as hospitals, skilled nursing facilities, inpatient psychiatric and chemical dependency facilities and other supportive services at community organizations.

Member orientations include presentations on the following:

- Covered Benefits and Services;
- How to Access Care;
- How to access the pharmacy benefits
- The Role of the Care Team;
- The Role of the Primary Care Provider;
- Services for which members may self-refer;
- Complaint and Appeals Procedures;
- Access to services paid for by Medicaid fee for service;
- Member Rights and Responsibilities; and
- Disenrollment protocol

Identification Cards

Members are issued an Amida Care identification card (see Appendix K) within 14 business days of their effective date. The PCP name, telephone number and Amida Care's 24-hour toll-free hotline number are clearly identified on the card. ID Cards also include the member's pharmacy benefit information through Express Scripts. Members can call 800-556-0689 for a replacement card when necessary.

Member Handbook

Once enrollment in Amida Care is effective, the member is sent a Member Handbook, which describes eligibility, benefits, referrals and the role of the PCP as part of their orientation package. In addition, other topics such as the functions of the Member Services Department and how members can access such services are addressed in the Handbook.

Disenrollment

All Amida Care members are eligible for expedited disenrollment. Disenrollment from the Plan is customarily initiated with the consensus and signature of the member or head of household if the member is a dependent.

All Amida Care members under voluntary enrollment have the right to disenroll and return to fee-for-service Medicaid in accordance with the guidelines specified. Disenrollment as a result of a complaint or problem will be evaluated in accordance with the complaint process. Any member who has a problem should be

encouraged to first call Amida Care's Member Service's Department at 800-556-0689 for assistance. When a member contacts Member Services, every effort is made to resolve any issues that would allow the Plan to retain the member.

If the problem cannot be resolved and the member wants to disenroll, he/she must call the *New York City Medicaid Choice* Helpline at 800-505-5678 to request a disenrollment. *New York City Medicaid Choice* will send the member a disenrollment form to complete and mail back. Disenrollment requests take between two (2) and six (6) weeks to process, depending on when the request is received. Expedited disenrollment is also an option. A member may request expedited disenrollment by contacting *New York City Medicaid Choice* at 800-505-5678. Expedited disenrollment will take effect by the first of the next month in most cases.

Involuntary Disenrollment

Medicaid recipients may lose eligibility in Amida Care involuntarily. This disenrollment customarily results from a member's loss of Medicaid eligibility. Amida Care becomes aware of an involuntary disenrollment when the State transmits its monthly report of active membership to Amida Care. These members who are involuntarily disenrolled will be returned to active membership status if they are approved for Medicaid benefits usually within a three-month window following their original loss of eligibility. Members who do not regain Medicaid eligibility within these three-months are considered by the State to have "cycled-out" and must re-enroll in order to resume coverage with Amida Care. When a member is disenrolled from Medicaid, the Case Manager will assist with transition to fee-for-service or other available resources.

Plan Initiated Disenrollment - Change in Member's Circumstances

This category includes situations in which a change in a member's circumstance is now considered an exclusion from Amida Care. Examples of such circumstances include but are not limited to: dual eligibility in Medicare/Medicaid, comprehensive third party health insurance, residence in State-operated psychiatric facilities and residential treatment facilities, residence in a nursing home, member death, incarceration or a relocation by the member outside of the Plan's service area.

Plan Initiated Disenrollment - Abusive or Habitually Non-Compliant Members

Plan initiated disenrollment will be limited to circumstances where there is clear and consistent documentation that the individual is verbally or physically abusive and/or causes harm to other members or to the Plan providers and staff, or is habitually non-compliant. *Member disenrollment may not be initiated for refusal to accept a specific treatment, or for behavior related to an underlying medical condition, alcohol or substance abuse, mental illness, mental retardation or other developmental disability.*

If any provider feels an administrative disenrollment of this nature is warranted, he/she should present a written statement or provider grievance outlining the problem to Amida Care's Provider Services Department. Provider Services will then bring the matter to the attention of the Director of Member Services. The Director of Member Services in consultation with the QMC will advise Provider Services of any additional information that is needed.

Health Promotion and Prevention Education

The key to building a successful patient health education program is teamwork between Amida Care and its providers. The health education of Amida Care's members may be accomplished through a variety of methods such as group classes, monthly events, community outreach, member education, downloadable materials on the Amida Care website (www.AmidaCareNY.org), as well as through video and written

education materials.

PCPs, Case Managers, and when appropriate other specialty providers must assure member access to the preventive care services.

An important objective of managed care is the promotion of health and well being. To support this goal, specific “enhanced” services considered to be essential for promoting wellness and preventing illness are addressed in Amida Care’s health education and promotion program. The Members Services Department assists in producing health education and promotion workshops. Providers are welcome as volunteers to assist in conducting these workshops.

Examples of the educational programs are:

1. General Health Education
2. Grief / Loss Support
3. Pneumonia and Influenza Immunization
4. Smoking Cessation Counseling
5. Exercise Programs/Body Awareness
6. Stress Management/Reduction
7. Staying on Schedule with Your Medicine
8. Drug Use Support Groups
9. HIV/AIDS Support Groups
10. Hypertension Control
11. Harm Reduction/Needle Exchange
12. Healthy Eating
13. Alternative Therapies
14. Diabetes Self Management
15. Pre-natal and Baby Care
16. Domestic Violence Services
17. Dental/Oral Health
18. Mental Health Services
19. Skin Care
20. Body Awareness
21. Sexually Transmitted Disease (STD) Testing & Protecting Yourself from STDs
22. HIV Specific Legal Services (such as Permanency Planning)

PCP Role in Health Education

The PCP is ultimately responsible for the health education and health promotion of the Amida Care member assigned to that provider. Amida Care will provide each PCP with available educational programs and materials when necessary. In addition, the Case Manager will be available to assist the PCP with education, as it’s appropriate.

Members with Disabilities or Special Needs

Amida Care’s objective is to comply with the Americans with Disabilities Act (ADA), which provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied access to, benefits or services, programs or activities of Amida Care or be subject to discrimination

by Amida Care. Health Services provided through Amida Care must be accessible to all who qualify for the program.

The Member Services Department has necessary auxiliary aids to communicate with members who have visual or hearing impairments. The TTY/TDD technology is available to members through Amida Care's toll free number at 800-662-1220 . Key educational materials such as the Member Handbook are available on compact disc and in Braille and large print.

If a provider wants to communicate to Amida Care that a member has a disability, he/she may direct that information to the Member Services or Care Coordination Department.

11. COMPLAINTS and APPEALS

Amida Care seeks to serve our health plan members well. But if a member has a concern or problem, as the Member Handbook advises, the member should:

- First talk with their PCP, or their Case Manager if the PCP is unavailable; or
- Call Member Services at 800-556-0689 or write the Plan at 248 West 35th Street, 7th floor, New York, NY 10001.

Most problems can be resolved right away. Problems that can not be resolved right away (over the phone or any complaint that comes in the mail) will be handled according to the Plan's complaint and appeal procedure, as described within this section of the Provider Manual and also outlined the Member Handbook.

Who Can Submit a Complaint or Appeal?

Once enrolled in Amida Care, a member has the right to file a complaint and/or appeal. A member can submit a complaint or ask someone they trust (such as a legal representative, a family member or friend) to file the complaint for him or her.

Assistance from the Plan

Members are asked to please let Amida Care know what the Plan can do to help them get the care that they need. If a member has a concern about a referral or a covered benefit, or any other concerns, the member should call Member Services at 800-556-0689. If a member needs help because of a hearing or vision impairment, or if they need translation services, Amida Care can assist the member.

Amida Care will not take any action against a member if they file a complaint. Nor will Amida Care make things difficult for a member because s/he filed a complaint.

How a Member Can File a Complaint

Amida Care does not require that complaints be written. For example, a member may file a complaint over the phone, mail, fax or in person. Anytime a member has a concern about a referral or a covered benefit, or any other concerns, they should call Member Services at 800-556-0689. The Plan will send the member a written notice of the complaint procedure anytime Amida Care denies a member access to a referral or determines that a requested benefit is not covered.

Written complaints are sent to: Amida Care's Administrative Offices at 248 West 35th Street, 7th Floor, New York, NY 10001. Member Services staff are available 9am to 5pm, Monday through Friday. If a member calls after business hours, they may also leave a message with our live voice after-hours service. The Plan will call the member back by the next business day.

A member may also contact the *New York State Department of Health* directly at 800-206-8125 for complaints relating to the quality of medical care and the *New York City Medicaid Choice Helpline* at 800-505-5678 for all other issues. If appropriate, a member may also have the right to request a fair hearing from the local *Department of Social Services agency (HRA)*.

A member may also write a letter to Amida Care describing their problem. The member is requested to make sure to date the letter and explain their problem completely. The member should mail the letter to:

Amida Care Health Plan
Attn: Member Services – Complaints
248 West 35th Street, 7th Floor
New York, NY 10001

What happens once a complaint is received?

All complaints will be resolved as quickly as possible. Amida Care will tell the member within 15 working days of the receipt of the complaint:

- Who is working on the member's complaint;
- How to contact that person; and
- If the Plan needs more information from the member and/or medical providers.

After Amida Care receives all the information the Plan needs:

- When the member complaint is urgent (when a delay would risk their health), the Plan will call the member with a decision within 24 hours (1 day). Then the Plan will send the member a letter within 3 working days;
- If the member's complaint is about a referral or a covered benefit, Amida Care will communicate the Plan's decision to the member in writing within 15 days; and/or
- Amida Care resolves complaints involving all other instances within forty-five (45) calendar days after the receipt of all necessary information, and no more than 60 days from receipt of the complaint.

When Amida Care calls or writes a member about the Plan's decision, Amida Care will communicate the reasons for the decision to the member. Amida Care will also tell a member how to appeal the Plan's decision and include any forms that a member may need to file an appeal.

A member may also file a complaint anytime by calling:

- The *New York State Department of Health* at 800-206-8125;
- In New York City, by calling *New York City Medicaid CHOICE* at 800-505-5678; or
- By writing to the *New York State Department of Health, Bureau of Certification and Surveillance*, Corning Tower, Albany, NY 12237.

Appeals

When a member is not satisfied with the Plan's decision regarding a complaint, the member has 60 business days, after hearing from the Plan, to file an appeal. A member can submit an appeal himself or herself, or ask someone whom they trust to file the appeal for them. A member must submit an appeal in writing (or by using the Plan's form). The Member Handbook explains that a member can call Member Services at 800-556-0689 for assistance with how to file an appeal. A member should send written appeals to:

Amida Care
Attention: Member Services - Appeals
248 West 35th Street, 7th Floor
New York, New York 10001

If for some reason, a member cannot give Amida Care their appeal in writing, the member may ask

Member Services for assistance. Once Amida Care receives a written appeal from a member, the Plan will send the member a letter within 15 working days. The letter will tell the member:

- Who is working on their appeal;
- How to contact that person; and
- If we need more information.

The member's appeal will be decided by:

- When the appeal is about a clinical matter, a licensed, certified, or registered health care professionals, who did not work on the member's original complaint; and
- For all other appeals, a qualified Plan professional who works at a higher level than the professional who worked on the original member complaint.

After Amida Care receives all the information that the Plan needs to address an appeal:

- When a delay would risk a member's health, Amida Care will communicate the Plan's decision within 2 working days; and
- For all other appeals, Amida Care will communicate the Plan's decision within 30 days.

Amida Care will provide the member with the reasons for the Plan's decision and the appropriate clinical rationale. If a member is still not satisfied, the member can file a complaint with the *New York State Department of Health* at 800-206-8125 or the *New York City Medicaid CHOICE Helpline* at 800-505-5678. A member can also write to the *New York State Department of Health, Bureau of Certification and Surveillance*, Corning Tower, Albany NY 12237

Complaint and Appeal Files

Amida Care will maintain a file on each member complaint that includes the following:

- The date the complaint was filed;
- A copy of the complaint, if written;
- The date of receipt and copy of enrollee's acknowledgement, if any;
- The complain determination including the date of the determination, as well as the titles of the personnel and credentials of the clinical personnel who reviewed the complaint;
- The date and copy of the enrollee's appeal;
- The determination and date of determination of the appeal; and
- The titles of the personnel, and the credentials of clinical staff, which reviewed the appeal.

State Fair Hearings

A member must first file a complaint and an appeal with Amida Care, prior to requesting a State fair hearing. If, after reviewing the complaint and appeal, Amida Care concurs with the Plan's medical provider/s, in some cases, a member may request a State fair hearing, such as if:

- The member is not satisfied with a decision by the local Department of Social Services or the State Department of Health regarding continued enrollment or disenrollment from the Plan;
- The member is not happy with a decision that Amida Care made about medical care that the member was receiving from the Plan. The member feels that this decision stops or limits his/her Medicaid benefits, or that Amida Care did not make a decision in a reasonable amount of time;

- The member is not satisfied with a decision Amida Care made, which resulted in a denial of requested medical care. The member feels that this decision limits his/her Medicaid benefits; and/or
- The member is dissatisfied with their doctor's decision not to order the services that the member requested. The member feels that the doctor's decision stops or limits his/her Medicaid benefits.

A member can use one of the following ways to request a Fair Hearing:

- By phone, call toll-free 800-342-3334;
- By fax, 518-473-6735;
- By internet, www.otda.state.ny.us/oah/forms.asp;
- In person:

Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

or

Office of Temporary and Disability Assistance
Office of Administrative Hearings
330 West 34th Street, 3rd Floor
New York, New York 10001

and/or

- By mail:
Fair Hearings
NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings (OAH)
P.O. Box 1930
Albany, NY 12201

A member may bring a lawyer, relative, or friend to the fair hearing to assist in explaining why the member's point of view about the Plan's decision.

The Plan will continue to provide a member with Benefit Package services that are the subject of a fair hearing if so ordered by the New York State Office of Administrative Hearings (OAH) under the following circumstances:

- The Plan has or is seeking to reduce, suspend or terminate a treatment or Benefit Package service currently being provided;
- The member has filed a timely request for a fair hearing with OAH; and
- There is a valid order for the treatment or service from a participating provider.

The Plan will provide aid continuing until the matter has been resolved to the member's satisfaction or until the administrative process is completed and there is a determination from OAH that member is not entitled

to receive the service; the member withdraws the request for aid continuing and/or the fair hearing in writing; or the treatment or service originally ordered by the provider has been completed, whichever occurs first.

If the services and/or benefits in dispute have been terminated, suspended or reduced and the member timely requests a fair hearing, the Plan shall, at the direction of either the New York State Department of Health or the New York City Department of Health and Mental Hygiene, restore the disputed services and/or benefits consistent with the provisions of the SNP Model Contract.

A member may be required to repay the Plan for services received if the fair hearing decision is adverse to the member.

A member can submit complaints to *the New York State Department of Health* by calling 800-206-8125 or they can write to the *New York State Department of Health, Bureau of Certification and Surveillance*, Corning Tower, Albany New York 12236. In some cases, a member can continue getting their care the same way, while the member waits for their fair hearing.

A member is also encouraged to call Member Services at 800-556-0689 any time they have questions, concerns or need assistance with complaints, appeals or requesting a State fair hearing. A member may also call the *New York Medicaid Choice* Helpline at 800-505-5678 to get assistance with questions regarding complaints, appeals, and State fair hearings.

Information on filing complaints and appeals as well as requesting a Fair Hearing can be found on the Amida Care website at www.AmidaCareNY.org.

12. OUTREACH

Outreach Goals

Amida Care's primary outreach goals are to establish strong name recognition for the Plan throughout the city, to grow and expand the Plan, and to develop a reputation as a high-quality Special Needs Plan.

Amida Care will achieve its outreach goals in strict compliance with the *New York State Department of Health Outreach/Advertising Guidelines*.

Given that providers will be important to Amida Care's outreach activities, Amida Care will educate participating providers about HIV SNP outreach guidelines during the initial Plan orientation session and as needed in response to questions from provider or changes in regulation.

Amida Care's outreach policies mandate that providers:

- Are not permitted to have conversations or conduct any activities for the sole purpose of persuading persons to join Amida Care;
- Must identify the all Health Plans including Special Needs Plans with whom they are affiliated if they choose to provide such information (orally or written) to their patients;
- Must not provide lists of potential members to Amida Care and should be aware that Amida Care will not accept lists of potential members from its network of contracted providers and providers with whom there are memorandums of understanding; and
- May not target mailings regarding their affiliation with Amida Care to HIV/AIDS patients or patients with a significant probability of having HIV/AIDS.

Permissible and Impermissible Education/Outreach Activities for Providers

- Providers who wish to communicate with their patients about managed care options must advise patients taking into consideration ONLY the MCO that best meets 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 plan over another;
- May display the Plan's Outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the provider has a contract;
- Providers may not conduct "cold call" solicitations;
- Providers may not provide mailing lists of their patients to managed care organizations;
- Providers may give permission to Amida Care Member Services Field Representatives to conduct member services and outreach activities at their facility. If providers are in multiple plans and allow one plan to conduct outreach in their facilities or want to let their patients know of their affiliation with one or more Medicaid Health Plan, they must prominently display a list of all other managed care plans operating in the county or borough with whom they are affiliated.;
- Neither the provider nor the Plan's Member Services Field Representatives may provide outreach materials in emergency room facilities, treatment rooms, or hospital patient rooms;
- Amida Care shall not require providers to distribute Plan-prepared communications to their patients.
- In the event a provider is no longer affiliated with Amida Care, but remains affiliated with other participating managed care organizations, the provider may notify his/her patients of the new status and the impact of the change on the patient;
- All Member Services Field Representatives shall conduct themselves in an orderly, non-disruptive manner, and shall not interfere with the privacy of potential members or the general

community; and

- Providers shall not target individuals and families who are already enrolled in managed care plans.

Inducements to Enroll

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

Specifically, providers may only: 1) make reference in outreach materials and activities to the benefits/services offered under the program; and 2) offer only nominal gifts pre-approved by Amida Care and the *New York State Department of Health*, with a fair market value of no more than \$5.00, with such gifts being offered regardless of beneficiary's intent to enroll.

Providers shall not pay any individual, or accept in payment from a Medicaid health plan, any commission, bonus, or similar compensation that uses numbers of Medicaid eligible persons enrolled in the managed care plan as a factor in determining compensation.

Non-Discrimination Practices

Outreach activities do not discriminate on the basis of a potential member's health status, prior health service use, or need for future health status screening, nor do outreach staff ask potential clients questions about their health status or prior utilization of health services.

13. BEHAVIORAL HEALTH SERVICES

Overview

Amida Care has a network of licensed behavioral health professionals including psychiatrists, psychologists and licensed social workers, community agencies, and inpatient and outpatient mental health and chemical dependency facilities. The key components of managing the Behavioral Health Services program are:

- Credentialing of all providers and facilities;
- Ensuring mental health and chemical dependency screening at least annually;
- Utilization management of outpatient mental health services and pharmacy reviews;
- Utilization management of inpatient mental health services, inpatient chemical dependence services and outpatient detoxification services; and
- Quality management of all behavioral health services to ensure that members are being served appropriately.

Initial screening and comprehensive mental health and chemical dependence assessments are performed for each Amida Care member as a component of the new member assessment process and reassessment of mental health and chemical dependence status is conducted at least annually by the member's PCP. An Amida Care member may receive chemical dependence counseling or mental health support services co-located at his/her PCP site or another location.

The member's PCP is responsible for providing oversight of the member's behavioral health services and for facilitating access to appointments, when requested by the member. The Care Team ensures that inpatient and outpatient behavioral health services are appropriate and coordinated with the member's other care.

Benefits

Behavioral health benefits available to Amida Care members are listed below. Please refer to the Benefit Guide in Appendix F for additional information. Basic behavioral health benefits covered by Amida Care:

- Unlimited outpatient mental health visits;
- Unlimited inpatient care combined for mental health and chemical dependence services;
- Inpatient Mental Health Services;
- Inpatient Rehabilitation and Detoxification Services;
- Outpatient Detoxification (ETOH);
- Outpatient Mental Health Services;
- Psychological Testing

Buprenorphine Treatment Services

The administration of Buprenorphine is a covered benefit when the service is conducted by a certified Primary Care Provider. The management of Buprenorphine is conducted for the maintenance or detoxification of patients with chemical dependency. Buprenorphine is administered as part of a clinic or office visit. In order for a provider to obtain reimbursement for rendering these services, the provider must be contracted for this service and also be a certified dispense of this medication. Amida Care will confirm that a provider is certified to render this treatment by checking that the provider's name appears on the listing generated by the Substance Abuse & Mental Health Services Administration (SAMSA). The provider must qualify as an authorized provider under the Drug Addiction Treatment Act of 2000 (DATA 2000).

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

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

Services Covered by Medicaid Fee for Service (carved out):

- Intensive Psychiatric Rehabilitative Treatment;
- Adult Day Treatment;
- Day Treatment Programs Serving Children;
- Intensive Case Management;
- Partial Hospitalization;
- Rehabilitation Services for Residents of State-Licensed Community Residences;
- Family-Based Treatment Programs for Children with Serious Emotional Disturbances;
- Outpatient Substance Abuse Treatment Including Methadone Maintenance Treatment;
- Outpatient Alcohol Clinic Services;
- Outpatient Alcohol Rehabilitation;
- Outpatient Chemical Dependence for Youth Programs;
- Chemical Dependence (Including Alcohol and Substance Abuse) Services Ordered By the Department Of Social Services; and
- Various Alcoholism, Detoxification, Long Term Behavioral Health Care, And Community Residence Treatment Services.

For more information on Behavioral Health Services covered by the Plan and specific pre-authorization requirements refer to the Benefit Guide in Appendix F. Authorization requests for Behavioral Health services can be made by calling 646-786-8650.

Access to Care

All Amida Care members may self-refer to behavioral health care services for mental health assessments, and for chemical dependence assessment for all inpatient detoxification, inpatient rehabilitation, or outpatient detoxification. Self-referrals for children may originate at the suggestion of a school guidance counselor or other such professional.

Amida Care members may access behavioral health care services provided by Medicaid (carved-out services noted in the previous table) by directly contacting Medicaid providers of these services and presenting their Medicaid card. Amida Care members' Care Teams are prepared to assist members in accessing these services. Members needing care, or providers wishing to arrange these services for Amida Care members, may call the member's PCP or the Amida Care Behavioral Health Hotline at (646) 786-8650 for assistance.

Utilization Management Guidelines

Behavioral health care services are subject to utilization management to ensure that the most appropriate treatment and level of care are being provided to Amida Care members. Refer to the Benefit Guide in Appendix F for additional information.

For Emergency Room visits for behavioral health, notification to the Medical Services Utilization Management is required within 48 business hours of discharge.

Behavioral Health Care Provider Responsibilities

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

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

Amida Care Treatment Principles

Amida Care has developed general treatment principles and guidelines for outpatient behavioral health care services. They are consistent with established clinical practice and standards for behavioral health care. The principles are as follows:

- **Therapeutic Environment:** An appropriate therapeutic environment must include face-to-face, in-person contact between the therapist and the patient in a room or area that allows for privacy and confidentiality.
- **Duration of Therapy Sessions:** Individual therapy sessions vary in length of time according to the member's needs and psychosocial situation. A session may last:
 - 20 – 30 minutes (CPT Code: 90804);
 - 45 – 50 minutes (CPT Code 90806);
 - Group/family/couple therapy sessions (CPT Code 90853) are usually required to run between 45 and 90 minutes unless they are for crisis intervention;
 - Crisis intervention sessions ordinarily should not exceed two hours per day for individual therapy or three hours per day for family therapy.
- **Individual Psychotherapy:** Only one therapist should provide individual psychotherapy to a patient. When a primary therapist is not available, an alternate therapist working in collaboration with the primary therapist may provide coverage. Ordinarily, no more than two family members should receive individual therapy from the same provider. When more than two family members require treatment, the provider would be expected to use family therapy as the treatment of choice.
- **Composition of Therapy Group:** Group therapy sessions usually consist of 12 or less patients unless they are multifamily or multi-couple groups.
- **Pharmaceuticals:** While some individuals may benefit from psychopharmacological medication alone, the Plan recognizes the benefit of combining medication with psychotherapy services that support the understanding and resolution of the individual's underlying issues and concerns that impact his/her health and well-being. The use of prescription medications should follow national professional standards.
- **Documentation:** Documentation regarding the patient's progress should reflect movement toward defined treatment goals with measurable objectives. When a patient's diagnosis or treatment plan is changed, the documentation should include clinical information substantiating the reasons for the change.

14. DENTAL

Medicaid Benefits

Amida Care Medicaid benefits do not include dental services. This is a carved-out benefit. All dental providers should bill Medicaid directly for services rendered to Medicaid members. Amida Care will provide PCPs with lists of dental providers who have HIV experience (see Appendix M).

An updated list of HIV-experienced dental providers can be secured from the Provider Services Department or Member Services Department at 800-556-0689. Case Managers can provide additional assistance with referring members to dental providers.

15. PHARMACY

HIV Special Needs Plans

The HIV SNP benefit package includes pharmacy services as of 10/01/2011.

Medicaid Benefits

Pharmacy Services are provided through Amida Care in conjunction with Express Scripts, the Amida Care Pharmacy Benefit Manager.

Pharmacy Options

Amida Care members, or their providers, can contact Member Services or a Care Coordinator at 1-800-556-0689 for assistance with pharmacy related matters.

Formulary

The Amida Care formulary can be found on the Amida Care Website and is accessible on Epocrates® (www.epocrates.com) via desktop and mobile platforms. The Amida Care formulary is updated on a quarterly basis upon the recommendation of an advisory Pharmacy and Therapeutics Committee which also holds quarterly meetings.

Formulary Status

The Amida Care formulary divides drugs into four general categories.

- 1) Preferred Drugs- do not require a Prior Authorization and will be dispensed at the Point of Service with dispensing contingent upon availability, validity of prescription, eligibility of member and appropriateness of care.
- 2) Preferred Drugs that require a PA- requires a Prior Authorization. These drugs are preferred, but will not be dispensed unless the prescriber establishes medical necessity as determined by plan prior to dispensing. Upon receipt of the PA, the drug can be dispensed to a member contingent upon availability, validity of the prescription, eligibility of the member and appropriateness of care.
- 3) Non-Preferred Drugs- these drugs are not preferred by AC for prescribing or dispensing and will not be dispensed at the Point of Service. Prescribers who wish to prescribe these medications must contact AC in order to present, document and establish medical necessity.
- 4) Step Therapy Drugs- these drugs will be dispensed at the Point of Service if a similar drug or drug in the same drug class has been used within the last 90 days from the date of service, and the member did not have an appropriate or sufficient clinical response to the drug. A provider can obtain a Prior Authorization for drugs listed in this category to be dispensed if it is determined that it is medically necessary for the patient to receive the medication and Step Therapy is inappropriate based on the patient's medical history.

Prior Authorization

The Prior Authorization process is a utilization management tool that ensures appropriate prescribing based on current medical guidelines and regulations. Medications that require a PA must be deemed medically necessary and prescribers must adhere to FDA approved indications and dosing unless off label use is determined to be medically necessary.

Prior Authorization Attainment

1. Contact Express Scripts for a Prior Authorization AFTER the patient has dropped the prescription off at the pharmacy; or
2. Contact Express Scripts for a Prior Authorization BEFORE the patient has dropped the prescription off at the pharmacy.

- A provider can call Express Scripts at 800.417.8164 or fax a completed Prior Authorization form to 800.357.9577.
- The necessary, member specific information must be available so that the request can be processed. The Express Scripts website, <http://www.express-scripts.com/services/physicians/pa/#P>, the Amida Care Website and Epocrates® desktop and mobile platforms have a listing of medications that commonly require a Prior Authorization.
- Additionally, the Amida Care website and the Express Scripts website have forms available that can be filled out and faxed to Express Scripts in order to complete the PA process. Using these forms, a provider can fill out the information and fax it to Express Scripts prior to the member submitting the prescription at the pharmacy or after the prescription has been submitted for processing at the pharmacy. A general form can be filled out in order to obtain Prior Authorization for medications that are not specifically listed on the website.
- A provider can call Express Scripts, 24 hours/day in order to obtain a Prior Authorization for any medication.
- Be aware that if the fax option is used and all necessary information is not provided on the form, this can lead to delays in processing and ultimate approval or denial.

Pharmacy and Therapeutics Committee

The Amida Care Pharmacy and Therapeutics Committee (P&T committee) will monitor the pharmacy management system on behalf of both health care providers and recipients of pharmacy services to ensure appropriate and effective drug prescribing and drug utilization. The Preferred Drug List will serve as the working, living document of the P&T committee inclusive of any applicable protocols.

The P&T committee shall meet periodically to act in an advisory capacity for the purpose of the development and maintenance of a preferred drug list that is based on both current and relevant scientific data. Clinical evidence that is presented should take into considerations to include, but not limited to the following: efficacy, safety, cost-effectiveness, quality and comparative effectiveness.

For more information about the Amida Care Pharmacy and Therapeutics Committee including inquiries related to upcoming meetings, topics or membership, contact the Director of Pharmacy.

Prescription Monitoring/Restricted Recipient

Members who have requested more than 1 early refill per 365 days and/or upon recommendation their provider; will be referred to the Prescription Monitoring Program. The prescription monitoring program will restrict the quantity of medication that a patient can get at one time from a 30 day supply maximum to a 7 day supply maximum for a length of time determined by the Restricted Recipient Committee. Members will be required to pick up their medication in 7day increments at a provider site or clinic as specified by and in conjunction with Amida Care.

Members may be restricted to receive their pharmacy benefits at one pharmacy due to documented abuse of the pharmacy benefit package including but not limited to excessive loss of medication, inappropriate filling of medication or upon recommendation by their provider. Restriction terms, including length, shall be determined by Amida Care's Restricted Recipient Committee.

16. REPORTING REQUIREMENTS

Why, What and How to Report to the New York City Department of Health and Mental Hygiene

Why report?

Clinicians are required by Article 11 of the New York City Health Code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (NYCDOHMH).

Who must report?

The scope of persons required to report to the Department was broadened in a 2009 amendment to the Health Code to include physicians, dentists, doctors of osteopathy, physician's assistants, nurse practitioners and persons in charge of hospitals and clinics or their designees.

What to report?

Conditions that must be reported by clinicians or their designees are specified in the New York City Health Code and posted at <http://www.nyc.gov/html/doh/downloads/pdf/hcp/hcpreporting.pdf> Health care providers should also be aware that, per Section 11.03 of the New York City Health Code, immediate reporting by telephone is required of a suspected outbreak among three or more persons of *any* disease or condition (whether or not it is listed among reportable conditions) and of any unusual manifestations of disease in an individual.

During times when the Department is monitoring an emerging condition or assessing and responding to an emergency, new reporting requirements or instructions may be issued even before these conditions are defined in the Health Code. So that clinicians remain abreast of emergencies and other situations of public health concern, the Department strongly encourages them to register on NYC MED to receive timely Health Alerts and advisories; these advisories are also sent to hospitals and posted on the NYCDOHMH website.

When to report?

Certain conditions, as specified in the list of reportable conditions posted at <http://www.nyc.gov/html/doh/downloads/pdf/hcp/hcpreporting.pdf> and require immediate reporting by telephone to the Department whether confirmed or suspected. All other reportable conditions must be reported within 24 hours of a confirmed diagnosis.

Report to whom?

Except for nosocomial outbreaks, physicians need report these conditions only to the NYC DOHMH, not to the New York State Health Department. The NYCDOHMH is responsible for reporting diseases and conditions for the city to the New York State Health Department; the city is an independent reporting jurisdiction and therefore reports directly to the Centers for Disease Control and Prevention, as well as to the State.

Any nosocomial outbreak or increased incidence of hospital-associated infection, however, must be reported to both the NYCDOHMH and the New York State Health Department, as stated in the Universal Reporting Form instructions <http://www.nyc.gov/html/doh/html/hcp/hcp-urf.shtml>

Reports of nosocomial outbreaks should be submitted via the Nosocomial Outbreak Reporting Application (NORA) system located on the NYS Health Provider Network (HPN) at <https://commerce.health.state.ny.us/hpn/infecontrol/forms.html>.

The appropriate NYSDOH Regional Epidemiology office or NYC DOHMH office will follow up with the facility making the report. For questions regarding nosocomial reporting, please contact the appropriate NYSDOH Regional Epidemiology office as listed at

http://www.health.state.ny.us/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm

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To reach NYSDOH after hours, call 1-866-881-2809.

How to report?

Electronic Reporting

Almost all diseases, conditions and events can be reported to NYCDOHMH via an online system known as Reporting Central (formerly known as the electronic Universal Reporting Form [eURF]).

Registration to access Reporting Central is quick and easy:

1. Enter the NYC MED web address into the browser window: <http://www.nyc.gov/nycmed>
2. To create a new user ID, select the link Not yet a user? Click here to register, found
3. on the right side of the page.
4. Enter the required information, indicated by a red asterisk (*). You will be asked to
5. select a user ID and password.
6. When prompted, be sure to indicate that you need access to the URF (Universal Reporting Form).
7. It is also advisable to elect to be a part of the Health Alert Network (HAN) to receive up-to date information on urgent and emergent public health situations.
8. Return to the NYC MED web page to confirm user ID and password are functional: <http://www.nyc.gov/nycmed>

For any user ID/password or login problems, please call 1-888-NYC-MED9.

To enter a disease, condition or event using Reporting Central:

1. After registering as per above instructions, go to <http://www.nyc.gov/nycmed> and enter user ID and password. Choose the Reporting Central link on the left side of the page.
2. Click on the Report a Disease or Condition link and select the disease to be reported from the drop-down list.
3. Complete all required (*) fields, and other information if known, on each page.
4. After using the Verification Page to confirm that all information was entered accurately, click 'submit'. Receiving an ID number following submission of a report verifies that the report has been successfully received by the Department.

For more detailed instructions on using Reporting Central, send an email request to eurf@health.nyc.gov or call 212-313-5134.

Paper Reporting

While the preferred method for reporting to the NYCDOHMH is electronic, paper reports can be submitted in certain circumstances. The Universal Report Form (URF) is used to notify the Department of almost all communicable conditions for which reporting is mandated, including tuberculosis and sexually transmitted infections, as well as various types of poisonings. The URF includes the mailing address for sending the report in hard copy. The URF may be downloaded from <http://www.nyc.gov/html/hct/hct-urf-shtml> Health care providers can also call the Provider Access Line (1-866-NYC-DOH1; 1-866-692-3641) to have URF forms mailed or faxed to their offices; allow two to three weeks for delivery. The URF *cannot* be used to report HIV/AIDS and known contacts of persons with HIV/AIDS; window falls and animal bites: instructions for reporting these conditions and events are given below.

Reporting immediately, and obtaining consultation, by telephone

Certain conditions, as designated on the URF form and list of reportable conditions, should be reported immediately by telephone: during normal working hours, health care providers can rapidly report all conditions by calling the Provider Access Line (1-866-NYC-DOH1/1-866-692-3641); if a provider needs to report a condition outside of normal working hours, he or she should call the Poison Control Center (1-212-POISONS/1-212-764-7667).

Reporting to the Provider Access Line or to a Department program, however, is not a substitute for reporting in writing or on-line. If immediate reporting is not required, cases should be reported within 24 hours or on the next working day. Health care providers can also call the Provider Access Line (1-866-NYC-DOH1; 1-866-962-3641) to consult with expert medical staff, access the immunization and other DOHMH registries, and obtain information or publications.

Reporting considerations relevant to specific conditions and events

Tuberculosis

Information on clinical and laboratory criteria that help define reportable suspected and confirmed tuberculosis cases: this information may also be accessed at

http://www.nyc.gov/html/doh/downloads/pdf/tb/reporting_requirements_for_tuberculosis.pdf.

The NYCDOHMH Bureau of Tuberculosis Control publishes a Clinical Policies and Protocols Manual which may be accessed at <http://www.nyc.gov/html/doh/downloads/pdf/tb/manu.pdf>.

The Department also maintains a TB Hotline (212-788-4162) for questions related to tuberculosis or latent TB infection.

HIV/AIDS and known contacts of persons with HIV/AIDS

New York State Public Health Law Article 21, Title III, requires named reporting of diagnoses of HIV and AIDS and all known sex and needle-sharing partners and contacts. Detailed instructions on how to report a case can be obtained by accessing the NYC DOHMH HIV Epidemiology Program's web site at

<http://www.nyc.gov/html/doh/html/dires/hivepi.shtml> or by calling the program's HIV Provider Call Line (1-212-442-3388). Copies of the Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF) that must be used to report HIV/AIDS diagnoses and partner information are included as Attachment 4.

The forms can be ordered from the New York State Department of Health Bureau of HIV/AIDS Epidemiology (1-518-474-4284) or downloaded at

http://www.nyc.gov/html/doh/html/dires/hcpreporting_how.shtml

or

http://www.nyc.gov/html/doh/downloads/pdf/dires/prf_sample.pdf.

For assistance on how to report a case, use the PRF, or to arrange for collection of a completed PRF by a NYCDOHMH Public Health Advisor, call the NYC DOHMH HIV Epidemiology Program at 1-212-442-3388. *Forms may not be mailed, Faxed or e-mailed.* Providers can also call the NYC Contact Notification Assistance Program (CNAP) at 212-693-1419 for assistance with partner elicitation and notification. If outside of NYC, call the NYS Department of Health's Partner Notification Assistance Program (PNAP) at 1-800-541-2437.

Animal Bites

Health care providers must report animal bites immediately, preferably by using Reporting Central, or alternatively by using the Universal Reporting Form or the Form VPHS55 for providers who still have the VPHS55 Form in stock.

Animal bites can be reported on-line at <http://www.nyc.gov/html/doh/html/vet/vetegp.shtml>.

Additionally, animal bites can be reported by calling DOHMH's Animal Bite Unit at 212-676-2483 or 311.

For consultation on rabies prophylaxis, health care providers should call the Provider Access Line (1-866-NYC DOH1 or 1-866-692-3641) or, after normal working hours, the Poison Control Center (1-212-POISONS/1-764-7667).

Window Falls

Falls must be reported by telephone to the Window Fall Prevention Program at 1-212-676-2903/2158 during the business hours of 9:00 AM – 5:00 PM Monday to Friday. All reports occurring outside of business hours must be reported by telephone to the Poison Control Center at 1-212-POISONS/1-212-DOH Approved 04/11

764-7667. After reporting by telephone, first responders(NYPD, FDNY, hospital staff and physicians) must complete and mail a copy of the **ChildWindow Fall Report**; a copy of this report may be faxed to 1-212-442-2629. A supply of report forms may be requested by calling the Window Fall Prevention Program. Please note that the color of the report form has been changed from blue to yellow.

Vital Events

Terminations of Pregnancy

The New York City Health Code Article 203 requires that all terminations of pregnancy in New York City, whether they are spontaneous or surgically or medically induced, be reported to the New York City Department of Health and Mental Hygiene within 5 business days after the event. If a permit to dispose of the conceptus is required or requested, the termination of pregnancy certificate must be submitted within 24 hours of the event.

Questions on legal requirements for filing termination of pregnancy certificates should be directed to the Birth and Death Registration Unit at 1-212-788-4545.

Deaths

The New York City Health Code Article 205 requires that all deaths occurring in New York City be certified by the reporting physician within 24 hours after the death and registered with the DOHMH within 72 hours after the death. All deaths occurring in the City at facilities reporting 25 or more deaths per year shall be reported to the NYCDOHMH electronically by means of the Electronic Death Registration System (EDRS), as furnished by the NYCDOHMH. All facilities at which fewer than 25 deaths are reported per year may, at their election and upon approval by the NYC DOHMH, implement EDRS or continue to report deaths on approved paper forms. Physicians and administrators should be aware that as of January 1, 2010, all medical facility-based users of the EDRS must complete an e-Learning Module on proper cause of death documentation at <http://www.nyc.gov/html/doh/media/video/icdr/index.html>.

Questions on legal requirements for filing death certificates should be directed to the Birth and Death Registration Unit at 1-212-788-4545. Questions regarding use and enrollment of EDRS should be directed to 1-212-788-4575.

Live Births

The New York City Health Code Article 201 requires that all live births occurring in New York City be reported within 5 business days after the birth. All live births occurring in the City at facilities reporting 100 or more live births per year shall be reported to the NYC DOHMH electronically by means of the Electronic Vital Events Registration System (EVERS), as furnished by the NYCDOHMH. All facilities at which fewer than 100 live births are reported per year may, at their election and upon approval by the NYCDOHMH, implement EVERS or continue to report births on approved paper forms.

Questions on legal requirements for filing birth certificates should be directed to the Birth and Death Registration Unit at 1-212-788-4545. Questions regarding use and enrollment of EVERS should be directed to 1-212-788-4575.

Reporting to NYC DOHMH Registries

Immunizations

The New York City Health Code (section 11.04 and subsection [d] of 11.07) mandates that health care providers who order the administration of immunizations to children and adolescents from birth through age 18 years in New York City must report the immunizations to the Citywide Immunization Registry (CIR) within 14 days of administration.

Immunizations administered to individuals aged 19 years or older may be reported to the CIR, with the

patient's written consent. Consent may be obtained by having the patient sign the consent form. As of January 1, 2009, New York City health care providers are required to report immunizations electronically from their own system or to report through the Web-based Online Registry. It should be noted that providers must report to the CIR in order to receive vaccines through the Vaccines for Children Program. Health Care Providers may also use the Online Registry to report immunity to, or history of, vaccine-preventable disease, vaccine adverse events, and blood lead test results. For more information, or to set up on-line access to the CIR for reporting immunizations and/or for obtaining patient or plan member immunization and lead test histories, call 1-212-676-2323.

Health care providers should be aware that New York State Public Health Law 2168 at http://www.health.state.ny.us/prevention/immunization/information_systems/laws_and_regulations/public_health mandates reporting statewide. Under this State law, New York City providers continue to report to the CIR, even if the patient lives outside of New York City. The CIR and NYS Immunization Information System will exchange data regularly on shared patients. Federal law requires that Vaccine Information Statements be handed out to the patient or authorized individual before any vaccine is administered.

Lead Test Results

The New York City Health Code requires health care providers to report all blood lead levels (BLLs) 10µg/dL within 24 hours. This prompt notification allows the Lead Poisoning Prevention Program to quickly initiate services. For providers that use a point-of-care device (e.g. *LeadCare*) to analyze blood lead specimens in their office, BLLs <10µg/dL must also be reported within 5 days.

Reporting BLL results electronically via the Online Registry is now the preferred method of reporting for children. However, if unable to report electronically, results for children can be faxed to 1-212-676-6326. Reports of BLLs >10µg/dL in pregnant women should be faxed to 1-212-676-6386.

School Health Reporting

Health care providers who see school age children can facilitate their entry into school and improve the continuity of care they receive by timely completion of the following two forms:

- Child and Adolescent Health Examination Form
- Guidelines for the Provision of Health and Educational Services for students in the New York City Public Schools available @ the NYC Education website:

<http://schools.nyc.gov/Offices/Health/default.htm>

A downloadable, pre-completed Child and Adolescent Health Examination Form (211S) with immunization and lead test results already entered can be created by the Citywide Immunization Registry (CIR). Go to <http://www.nyc.gov/health/cir>.

A downloadable, blank form can be found at <http://www.nyc.gov/html/doh/downloads/pdf/hcp/hcp-ch205.pdf> Parents should receive two copies of completed forms downloaded from the Internet or they may request a duplicate form by contacting the local school.

Reporting *by Laboratories* to the New York City A1C Registry

Health care providers should be aware that, pursuant to the New York City Health Code, most laboratories are required to report the results of A1C blood tests to the NYCDOHMH. Please see the NYC DOHMH Diabetes Prevention and Control Program website, www.nyc.gov/health/diabetes, for examples of reports that providers and facilities can receive by enrolling as users of the A1C Registry. Information about the A1C Registry may also be obtained by calling 212-788-4125.

Reporting to the New York State Office for Children and Families

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Child Abuse and Neglect/Maltreatment

New York State Law (Social Services Law, Section 413) requires that any health care professional who suspects (or has reason to suspect) that a child is being endangered or maltreated must report his/her suspicion to the New York State Central Register of Child Abuse and Neglect/Maltreatment (SCR)

<http://ocfs.ny.gov/main/prevention/faqs.asp>.

Hysterectomy and Sterilizations

Permanent sterilization procedures performed on both male and female patients must be reported to the NYCDOHMH using form LDSS-3134. NYS Medicaid requires an LDSS -3113, Acknowledgement of Hysterectomy Information be attached to the MR and claim for payment of any individual with NYS Medicaid coverage, including Medicaid Managed Care, undergoing a hysterectomy for whatever the cause. Both forms are available online in English and Spanish at

http://www.health.ny.gov/health_care/medicaid/publications/ldssforms.htm.

17. RETENTION IN CARE UNIT

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

Community Health Outreach Workers (CHOW)

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

CHOWs provide the following functions:

- Escort - assist to and from appointments;
- Community Canvasser - outreach to members who have failed to attend their initial appointments;
- Translator- clarify benefits and access; and
- Buddy - check on assigned caseload regularly to assess progress in adherence to care plan and assist with any emerging needs.

Training of CHOWs is completed by the Director of Retention in Care Unit. However, peers already certified as outreach workers by another HIV/AIDS Community Based Organization may have training requirements waived at the discretion of the Director of Retention in Care Unit.

The Director of Retention in Care Unit closely supervises CHOWs. To refer a member for CHOW services, contact the Director of Retention in Care Unit at (646) 745-1025.

Health Navigators

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

Health Navigators provide the following functions:

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

Health Navigators are professional staff, all of whom have a background in HIV case management and/or have knowledge of the benefits and services entitled to PLWHA in New York City. To refer a member for Health Navigation services, contact the Health Navigator Supervisor at (646) 784-5469.

Mobile Engagement Teams (MET)

Through the Social Innovation Fund, Amida Care sponsors Mobile Engagement Teams at three community based sites who work with members experiencing co-occurring mental health and/or substance abuse issues. The goal of the program is to stabilize clients in order to engage them in regular primary medical care and mental health/substance abuse treatment. METs provide field based services to clients using motivational interviewing to incite change behavioral. MET sites include:

- Harlem United-responsible engaging clients in Manhattan
- Housing Works-responsible for engaging clients in Brooklyn
- Help/PSI-responsible for engaging clients in the Bronx

Each Mobile Engagement Team consists of an Outreach Worker/Health Educator, Intensive Care Manager, and either a Licensed Clinical Social Worker or a Psychiatric Nurse Practitioner. Team staff provides field based services to Amida Care members who have difficulty maintaining regular primary care due to an underlying mental health or substance abuse problem. Services are individualized and intensive and include the following services:

- Assessments and Service Plans
- Psychiatric Evaluation
- Monitoring of Goals
- Case Management
- Housing Assistance
- Arrangement of PCP visits
- Arrangement of Mental Health/Substance Abuse Services
- Appointment Escorts
- Health Education

To refer an Amida Care member for MET services, contact the Outreach Liaison at (646) 545-2758.