AMIDA CARE
ABOVE AND BEYOND FOR YOU

PROVIDER MANUAL

AMIDA CARE HEALTH PLAN

www.AmidaCareNY.org • 800-556-0674

June 2017

Index

Section		Page
1.	Introduction	3
2.	Amida Care Provider Rights and Responsibilities	7
3.	Our Provider Services Team	26
4.	Our Member Services Team	27
5.	Verifying a Patient's Eligibility	31
6.	Rendering Care and Services to Members	32
7.	Amida Care Benefits/Covered Services Overview	39
8.	Authorizations and Utilization Management	52
9.	Claims, Submission and Payment	65
10.	Credentialing and Delegation	73
11.	Quality Management and Continuous Improvement Program	76
12.	Marketing and Member Outreach	86
13.	Definitions	90

Amida Care Provider Portal Authorizations, Forms, Claims Status, Reference Materials			www.AmidaCareNY.org
Provider Services Phone Number			**800-556-0674**
Plan Type	**Member Eligibility**	**Medical Utilization/Care Management**	**Behavioral Utilization Management**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	800-556-0689 EPACES website www.emedny.org	888-364-6061 FAX: 855-663-6480	866-664-7142

Key Service Providers	Company	Phone Number/Web Address
Behavioral Health	Beacon Health Options	866-664-7142
Dental Services	HealthPlex	888-468-2183 www.healthplex.com
Prescription	Express Scripts Inc.	Medicaid Plans: 800-417-8164
Transportation Services	LogistiCare	Non Emergent Care: 877-564- 5922
Vision Services	Davis Vision	800-773-2847 www.davisvision.com

Plan Type	Medical Claims Address	Medical Claim Electronic Submitter ID #	Provider Services Medical Claim Status Phone Number	Behavioral Claims Address Submitter ID # Claims Status
Medicaid	Amida Care Claims PO Box 21455 Eagan, MN 55121	Amida Care ID #79966	800-556-0674	Amida Care Claims 500 Unicorn Park Drive Suite 401 Woburn, MA 01801-3393

Introduction

1.1 How to use this Manual

Thank you for joining the Amida Care Team that goes above and beyond for its members! Enclosed in this manual is a quick reference of all the materials you will need to care for Amida Care members. The manual is available in paper or electronic form. All forms and reference materials are available in electronic form on the Amida Care Website, http://www.amidacareny.org. If you do not have access to our website, we will be happy to send you a copy; please call us at Provider Services, 800-556-0674.

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

- Targeted mailings to directly-impacted providers;
- New Policy & Alerts, Claims, and Clinical postings to our Provider Services webpage: http://livelifeplus.amidacareny.org/providers-services.htm

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

1.2 Amida Care, INC Above and Beyond for You

Amida Care, Inc. is a private not-for-profit Health Plan with a licensed by the State of New York as a Medicaid Special Needs Plan. Amida Care operates in the five boroughs (Bronx, Brooklyn, Manhattan, Queens, and Staten Island) of New York City, NY. Amida Care is recognized in the health care industry as a high quality health plan that provides comprehensive medical, behavioral, and psychosocial support services to members with multiple chronic conditions.

Amida Care was founded in 2003 by seven community based organizations that offered primary care, licensed adult day health care, skilled nursing facilities, COBRA case management, housing, and other community services. These sponsors are Promesa, BrightPoint, Harlem United, Housing Works, St. Mary's, and Village Care. Today, Amida Care delivers benefits through an expanding specialized integrated network of over 175 HIV primary care providers over 1,700 primary care providers, 6,000 specialists, 200 facilities, 39 Federally Qualified Community Health Centers, and 37 hospitals.

1.3 Our 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 their family.

1.4 Amida Care's Model of Care

Amida Care's Model of Care (MOC) is designed to promote member health and well-being through care coordination and member support. To enable the delivery of high-quality care and timely services to each member, Interdisciplinary Care Teams (ICTs) are at the heart of the MOC. ICTs conduct care planning activities, including the mitigation of barriers to care, to ensure the provision of patient-centered medical, behavioral, and other specialty care services, as well as life-saving medications.

Each member is assigned to an ICT, which is comprised of a team of Amida Care staff that work in collaboration with the member to ensure his or her unique needs are met and their self- identified health-related goals are achieved. The core team of the ICT includes Nurse Care Coordinators and staff content experts in behavioral health, pharmacy, treatment adherence, housing, community based outreach and long term care. Amida Care strongly encourages members to participate in their own care planning within the ICT, and welcomes members to ask their family members and support systems to participate as well.

Providers know our members best and are most equipped to support them in their journey to healthy living. Because of this, and the strong relationship that is formed between provider and patient, Providers are integral to the care planning process and invited and encouraged to participate as team members of the ICT. Providers have a realistic sense of member needs, desires and behaviors, and thus have a unique combination of knowledge and experience to shape member goals and contribute to the care planning process.

This collaborative team of Care Coordinators, content experts, the member and their Provider promotes health, hope and empowerment while assisting each member to get the right care, at the right time, and enough of it to improve health outcomes. The member's Individualized Care Plan (ICP) drives the coordination of care within the ICT. The purpose of the ICP is not to replace the member's Treatment Plan as developed by their Provider, but exists to coordinate the care and services necessary to achieve member's goals. The ICP also identifies barriers to health, such as transportation, childcare and access to nutritious food, and cultivates solutions to overcome present barriers. The development of the ICP is based on a comprehensive assessment the member receives upon enrolling in the Plan, which takes place either by phone or via an In-Home Assessment conducted by a Nurse Practitioner. This comprehensive assessment does not replace any assessment(s) conducted by Providers; rather it is used as a tool to help determine the support and services the member needs to reach their health-related goals. The ICP is created by the ICT, along with the member's and Provider's input, prioritizing member goals when possible, and structured so the member can monitor his/her progress. All interventions are targeted at increasing the member's knowledge of his or her condition and improving his or her ability to manage their health. Based on the member's needs identified within the ICP, the ICT coordinates and provides referrals to supportive services, delivers member education and relevant educational materials. The goal is to increase knowledge and self-efficacy and provide telephonic support to members to address barriers to achieving goals.

Health Plan Member Quick Reference Guide		
Description	**Health Plan Name**	**Eligibility**
Health Plan for Medicaid Recipients Enrollment: Call NY Medicaid Choice: 800-505-5678 Amida Care Members Services: 800-556-0689	**Amida Care Live Life Plus** Medicaid Special Needs Health Plan offering a full range of medical services and prescription drug coverage.	Medicaid recipients (and their related children under the age of 21) who are: • age 21 and over • diagnosed with HIV/AIDS, homeless with an HIV/AIDS diagnosis or homeless (as of January 2014)

2.1 Rights and Responsibilities – Providers and Members

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. Below is our statement of roles, responsibilities, and rights for Amida Care participating providers. Member rights and responsibilities follow immediately after.

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

Provider Rights and Responsibilities	
What Providers Can Expect from Amida Care	**What Amida Care expects from Participating Providers**
• Open, respectful and receptive communication • Knowledgeable and helpful staff • Timely response to questions and concerns • Timely communication of policy changes • Comprehensive orientation, training and educational programs • Timely processing of provider applications • Timely payment for covered services rendered • Responsive to grievance and appeals processes • Feedback on performance and utilization	• 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 obligations • Adherence to accessibility and availability standards • Compliance with utilization management, and quality management and improvement protocols • Timely and accurate claims submission • Cooperative office and administrative staff • Adhere to recovery-oriented principles and including provision of person centered services

Provider Rights

- Amida Care will not discriminate against any health care professional acting within the scope of his or her license or certification under NY state law regarding participation in the network, reimbursement or indemnification, solely on the basis of the practitioner's license or certification. The following circumstances are exceptions to this policy:
  Amida Care may refuse to grant participation status to health care professionals
  in excess of the number necessary to meet the needs of Amida care members;
  - 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; Amida Care providers will be given written notice of these changes at least 30 days before the changes are implemented.

Provider Rights and Responsibilities

- Amida Care will not prohibit, restrict, or otherwise obstruct health care professionals, acting within the lawful scope of his/her practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled in any Amida Care plan. Amida Care will allow healthcare professionals to give unimpeded advice to patients regarding the following:

The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;

- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Provider Responsibilities

- Adhere to Amida Care standards and guidelines as indicated in Sections 2.2 through 2.11, care coordination and treatment as indicated in Section 6, and prior authorization requirements in Section 8.
- Provide information regarding services, both clinical and non-clinical, in a culturally- competent manner. Providers will ensure that information and access is available to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, and/or those with diverse cultural and ethnic backgrounds. Health Care professionals will ensure they have effective communications with participants throughout the health system when making decisions regarding treatment options, including the option of no treatment.
- Ensure the use of communication strategies to meet the needs of members with physical and/or mental disabilities (which include provision of translator services, interpreter services, teletypewriters or TTY connections) so they can make decisions regarding treatment.
- Uphold all terms within the Amida Care provider agreement including compliance, the requirements of Center for Medicare and Medicaid Services, Article 44 of the NY State Public Health Law, and requirements for individuals and organizations receiving Federal Funds.
- Participate in Amida Care's continuous quality improvement program. See Section 11 for provider monitoring, improvement plans and reporting.
- Complete all Department of Health Disease Reporting Requirements, See Section 11.
- Finally, providers are responsible for adhering to Amida Care policies and procedures including observing member's rights and responsibilities. A copy of these rights and responsibilities are in the next section.
- Child/Teen Health Plan Services (C/THP) Screening for children and adolescents.
- Behavioral Health screening by a PCP for all members, including children as appropriate.
- Have a procedure for monitoring HCBS utilization for eligible members, see section 7.3

Amida Care Member Rights and Responsibilities

Member Rights

Amida Care Members have the right to:

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

Member Responsibilities

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

2.2 Amida Care Provider Standards

Amida Care standards for timely access to care and member services are designed to provide excellence in care delivery. We use these standards to measure our effectiveness and in our reporting to our regulatory agencies. Amida Care's Quality Management Department is responsible for the measurement and reporting of these standards. Review Quality Management, Section 11, for information on how providers are measured.

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

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

Waiting Time Standard: Complaints about wait times longer than this standard will be referred to the Director of Network Development and Provider Services for follow-up.

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

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

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

PCP and Physician of Choice Panel Capacity and Roster:

Health Plan PCPs: 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. PCPs are instructed to refer to their rosters and to verify eligibility.

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

Behavioral Health Appointment Standard Quick Reference	
Type of Service	**Appointment Access Requirement**
Mental Health Outpatient Clinic	Urgent – Within 24 hours Non Urgent – Within 1 week
State Operated Outpatient Programs	Within two weeks
Personalized Recovery Oriented Services	Urgent – 24 hours Non Urgent – Within 1 week
Intensive Psychiatric Rehabilitation Treatment	2-4 weeks
Assertive Community Treatment	Within 24 hours of request
Continuing Day Treatment	2-4 weeks
Mental Health Partial Hospitalization	Within 5 days of request
Inpatient Psychiatric Services	Emergency – Upon Presentation
Comprehensive Psychiatric Emergency Program & 9.39 ERs	Emergency – Upon Presentation
Opioid Treatment Programs	Within 24 hours
Inpatient SUD Treatment	Emergency – Upon Presentation Urgent – Within 24 hours
Detoxification (including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification, and Medically Supervised Outpatient Withdrawal	Emergency – Upon Presentation
OASAS Outpatient Clinic	Urgent – Within 24 hours Non Urgent – Within 1 week
Rehabilitation services for residential SUD treatment supports	BH Specialist – 2 -4 weeks
Buprenorphine prescribers	Within 24 hours
Follow-up outpatient visit with Behavioral Health Provider after emergency, hospital discharge and release from incarceration	Within 5 days of request

Amida Care Standard Guidelines Quick Reference	
Asthma Guidelines	National Heart, Blood and Lung Institute: Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma August 28, 2007 http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf
Behavioral Health Guidelines (in partnership with Beacon Health Options, see Section 2.4)	• Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder (July 2007) American Academy of Child and Adolescent Psychiatry -AACAP • Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents (November 2011) American Academy of Pediatrics-AAP • Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders (2007) American Academy of Child and Adolescent Psychiatry • http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.p • Practice Guideline for the Treatment of Patients With Schizophrenia (April 2004)
Diabetes Guidelines	Diabetes Care Clinical Practice Recommendations: American Diabetes Association: Diabetes Care: January 2013; 36 (Supplement 1) http://care.diabetesjournals.org/content/36/Supplement_1
Hepatitis C Guidelines	Diagnosis, Management and Treatment of Hepatitis C: American Association for the Study of Liver Diseases: HEPATOLOGY 2009:49 (4): 1335-1374 http://www.hcvguidelines.org/
High Blood Pressure Hypertension Guidelines	National Heart, Blood and Lung Institute: The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure - Complete Report JNC7 – 2004 http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf

HIV and AIDS Guidelines	NYSDOH AIDS Institute Guidelines
	
	http://www.hivguidelines.org/clinical-guidelines/
	
	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

Amida Care Standard Guidelines Quick Reference	
	• Health-Care Worker Exposure Guidelines • Non-occupational Exposure Considerations • Testing ▪ Revised Guidelines for Counseling, Testing, and Referral
	Department of Health and Human Services/ AIDS info/ Clinical Guidelines http://www.aidsinfo.nih.gov/guidelines • 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 ▪ Non-occupational Exposure Considerations • Testing Revised Guidelines for Counseling, Testing, and Referral
Prevention Guidelines	US Preventive Services Task Force Guidelines http://www.uspreventiveservicestaskforce.org/
Sexually Transmitted Diseases Treatment Guidelines	Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report /mar/ December 17, 2010 / Vol. 59 / No. RR-12 http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf
For Children and Adolescents	• CTH/P for children and adolescents http://www.emedny.org/ • Lead screening • Age appropriate anticipatory guidance to the parents/legal guardians of pediatric and adolescent members as well as pediatric and adolescent members (as appropriate to the child's age) with regard to injury and violence prevention http://brightfutures.aap.org/continuing_education.html • Use of the TIPP sheets produced by the American Academy of Pediatrics as a guide to the age specific injury prevention anticipatory guidance to be provided http://www.healthychildren.org/English/Pages/defaults.aspx

2.4 Beacon Health Options Behavioral Health Clinical Practice Guidelines

Please refer to Beacon Health Options' Behavioral Health Policy and Procedure Manual for Providers, accessed via their web portal, for polices regarding behavioral health clinical practice guidelines: https://www.beaconhealthoptions.com/material/beacon-substance-use-page/

2.5 Experimental & Investigational, Clinical Trials & Rare Disease Treatment

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

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

- A letter of medical necessity is required when requesting experimental or investigational treatment, including information on the recommended course of treatment when available.

- All requests are processed by the Utilization Management Department; reviewers will refer such cases to the Plan's Chief Medical Officer for review and determination.

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

As an example, the AIDS Community Research Initiative of America (ACRIA) at www.acria.org, and Cornell's Clinical Trials Unit (CCTU) at http://aidsinfo.nih.gov are two resources for providers to secure comprehensive listings of HIV and HIV-related clinical trials.

Rare Disease Treatment: "Rare disease" is defined as a life threatening or disabling condition or disease that is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network, or one that affects fewer than two hundred thousand United States residents per year and for which there does not exist a standard health service or procedure covered by Amida Care that is more clinically beneficial than the requested treatment. Request for rare disease treatment requires prior authorization. See Section 8 for authorization details.

2.6 CONFIDENTIALITY

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

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

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

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

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

2.7 Advance Directives Policy

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

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

Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

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

English http://www.health.ny.gov/forms/doh-1430.pdf
Spanish http://www.health.ny.gov/forms/doh-1431.pdf
Chinese http://www.health.ny.gov/forms/doh-1401.pdf
Russian http://www.health.ny.gov/forms/doh-1402.pdf

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

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

2.8 Continuity and Care Coordination

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

Primary Care and Specialist Coordination: Primary Care Providers, when referring to a Specialist within network must indicate to the specialist the purpose of the referral along with any relevant medical information. No referral form is required.

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

- Preventive OB/GYN care
- Prenatal Care, two routine visits per year and any follow-up care, and acute gynecological care
- Vision care with participating provider
- HIV pre-test counseling for all pregnant women
- Diagnosis and treatment of TB by public health agencies
- Outpatient Mental Health or Substance Abuse. Authorization is needed after 30 visits in a calendar year.

Specialists provide specialty services to Amida Care members usually in consultation with the member's PCP. The Specialist is requested to follow up with the PCP in writing or other means to apprise them of consultation results, diagnostic testing results, and treatment plans. A Specialist can serve as the member's PCP to an member diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged a period of time.

When a provider is designated as both a PCP and a specialist, he/she must meet the credentialing requirements for each role, and be dual designated by Amida Care. Physicians with this designation must assume the roles necessary for continuity of care within the network, and submit CPT/HCPCS codes with the modifier AF when performing services as a specialist.

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

Specialty Care Centers: A member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a referral to a specialty care center. Such referral will require prior approval by the managing entity's medical director. A treatment plan must be agreed upon among the PCP, the managing entity's medical director and the provider.

Out of Network Care: The Primary Care Provider (PCP) determines the need for his or her members to receive a referral to an out of network provider. The PCP reviews the Amida Care Provider Directory to determine if there is an appropriate specialist in the Amida Care network. Provider Relations may also be contacted to determine if an appropriate specialist was recently added to the network. If a specialist with appropriate training and experience cannot be found within the network or medically necessary services are not available through network providers, the PCP or a designee will contact Utilization Management to request authorization for out-of-network services.

The out-of-network request will be approved and made pursuant to an approved treatment plan. The PCP, the provider requesting authorization if other than the PCP, the member and the out-of- network provider are all notified by phone and in writing of the approval, in accordance with all regulatory guidelines.

Members may self-refer for specialist services which include ob-gyn care, prenatal care, two routine visits per year and any follow-up care and/or acute gynecological condition. If network services are available within the Amida Care network, Utilization Management will contact the requesting provider to discuss the network options. If the provider continues to request an out- of-network referral after indicating that the services the member requires cannot be provided by an in-network provider, the PCP is asked to submit supportive documentation, and the case is reviewed with the Vice President of Health Services Operations.

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

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

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

Transitions of Care: Amida Care makes every effort to assist new members whose current providers are non-participating and if a member request to continue an ongoing course of treatment with the member's current provider. Amida Care's Care Coordination Department will work closely with the member's PCP to manage transitions of care between facilities and to the home. Copies of discharge plans will be sent to the PCP's office by the discharging facility and confirmed by Amida Care. PCPs are responsible for monitoring and following through on discharge plans for members, including:

- If applicable, post-acute care follow-up, including a face-to-face visit at and/or with a doctor,

within 48 hours of discharge or within 1-2 business days in the event of a Friday discharge.

- Providing an appointment within the first 5-10 days after an acute care episode.
- If the member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days.
- If an enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of post-partum care related to the delivery.

Coordination with Behavioral Health Providers - Mental Health/Chemical Dependency Providers: Amida Care partners with Beacon Health Options to provide a network of physicians and other licensed professionals, community agencies, and inpatient and outpatient facilities to provide a full spectrum of behavioral health care, including mental health and 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.

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

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

2.9. Cultural Competence and Assisting Disable Members

Cultural competency is critical to reducing health disparities and improving access to high- quality health care by providing health care that is respectful of and responsive to the needs of diverse patients. Amida Care membership is racially diverse and consists of people from many ethnic backgrounds as well as individuals with disabilities. Providers are responsible for ensuring that members understand their diagnosis and treatment options, and that cultural and language differences or disabilities do not interfere with provider communication or member understanding. Amida Care has available on its website, material on providing culturally sensitive services as well as an assessment tool to determine if your site is providing culturally competent services. Amida Care recommends that providers offer staff annual cultural competency refresher training. Provider Services is available to assist providers with cultural competency training.

If your office does not have a method for accommodating a member that speaks a foreign language, contact Amida Care's Member Services Department. Member Services will provide assistance for members who do not speak English, either through their multi-lingual staff or by facilitating a connection with a telephone-based language interpretation service. 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 at 711 for our Medicaid and members.

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.

Assisting Disabled Members: Amida Care requires the contracted network of providers and facilities to be in compliance with the Americans with Disabilities Act of 1990 (ADA) as well as Section 504 of the Rehabilitation Act of 1973. Both Title II and Title III of the ADA and Section 504 requires that medical care providers provide individuals with disabilities:

- Full and equal access to their health care services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services).

2.10 Provider Change in Status and/or Availability

Providers who anticipate changes in their status (name, address, hours, languages, and/or site), or take a leave of absence must contact the Provider Services Department at 800-556 -0674. For voluntary terminations, see Section 2.11.

2.11 Provider Disciplinary Action Process

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

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

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

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

2.12 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: Providers that are sanctioned by NYSDOH's Medicaid Program will be excluded from participation with Amida Care's Medicaid SNP plan. The applicable provisions of the individual Provider Agreement or the Hospital Entity/Health Care Services Agreement govern the termination of a provider agreement with Amida Care. All providers voluntarily terminating their affiliation with Amida Care must give written notice of the termination in a timeframe consistent with their individual contract. Written notice must include a termination date. Verbal

notification is not sufficient to initiate the termination process. If Amida Care elects to deny participation status in the Amida Care provider network, or to suspend or terminate a Provider Agreement, written notice will be given that includes some or all of the following:

- The reason for the proposed action;
- The standards and the profiling data the organization used to evaluate the health care professional;
- The number and mix of reviewing health care professionals required by the Amida Care network; and
- The affected provider's right of appeal, and the process and timeframe for requesting a hearing.
- Time limit for a hearing date which must be held within thirty days after the dare of receipt of a request for a hearing.

Subsequent to a written notice of termination being given by a provider or by Amida Care, providers are required to continue the offer of services to Amida Care members for a period consistent with the individual provider contract so that appropriate transition of care 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 up to delivery and through post-partum visit. If the member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days.

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

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

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

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

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

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

the physician conducts practice; and/or
- Discrimination against Amida Care members as outlined in the Provider Agreement.

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

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

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

Under no circumstances will Amida Care initiate termination or non-renewal actions against a provider solely because he or she has:
- Advocated on behalf of a member;
- Filed a complaint against Amida Care with state or federal regulatory bodies;
- Appealed a decision made by Amida Care;
- Provided information or filed a report pursuant to PHL4406-c regarding prohibitions of plans; and/or
- Requested a hearing or review.

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

Reporting Terminated Provider Agreement: If Amida Care suspends or terminates a contract with a physician because of deficiencies in the quality of care, it shall give written notice of that action to licensing or disciplinary bodies, or to other appropriate authorities. Notification shall be submitted to the New York Office of Professional Medical Conduct under the following circumstances:
- Alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare;
- Voluntary or involuntary termination of contract or employment to avoid disciplinary action;
- A determination of fraud or of imminent harm to a patient's health; and
- Termination of an Independent Practice Association subject to the requirements of Public Law Section 4406-d.

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

Amida Care will appoint a Hearing Panel. It will consist of at least three participants, at least one of whom is a clinical peer of the provider in question. A "clinical peer" is defined as a provider having the same or a

substantially similar medical specialty as the provider under review. If the assembled panel has more than three members, at least one third of the panel's membership will be clinical peers.

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

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

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

- 60 days after the notice of intent to terminate is received; or
- Not less than 30 days after the receipt by the health care professional of the hearing panel's decision.

Our Provider Services Team

3.1 Provider Services team and Contract Information

The Amida Care Provider Services team is responsible for contracting, in-servicing and servicing network participating providers. Providers can reach the Amida Care Provider Services Department at 800-556-0674, Monday through Friday, during regular business hours. To aid in a quick response to your needs, other Amida Care Team members, such as care management,utilization management and claims, may be able to assist you. Below is a quick reference of the direct phone numbers and web addresses that can address your needs. Our standard is to respond to your request for information whenever possible within one (1) business day, and in all cases within three (3) business days (unless otherwise noted).

Request	Team Member	Phone Number/Web Address
Forms or questions relating to the use of forms data (may require additional time), Provider Manuals and Provider Directories, Benefit Questions Claims and Billing (may require additional investigation time)	Provider Services Department	800-556-0674 www.AmidaCareNY.org

3.2 Education and Orientation

As an Amida Care provider, we count on you to help us deliver the best care to our members, and to follow the care management models designed by our Chief Medical Officer and Care Management Department. This manual describes the care model and administrative process for the Amida Care Medicaid plan,. Our Provider Services team will provide an initial provider orientation for all new providers, and in-service training to providers and their staff as health plan changes occur or new programs are offered. Periodically, we will send you a provider newsletter with program updates. Our Chief Medical Officer will also provide clinical guideline and care model updates as required. See section 2.3 for more information.

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

3.3 Chief Medical Officer Updates

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

Our Member Services Team

4.1 Member Services Enrollment and Disenrollment

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

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

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

Enrollment Quick Reference Guide		
Plan Type	**Department**	**Hours**
Medicaid Amida Care Live Life Plus Medicaid HIV/Homeless Special Needs	NY Medicaid Choice: Call: 800-505-5678	Monday – Friday 8:00am to 6:00pm Saturday 10:00am to 6:00pm Except National Holidays

Enrollment:. All Medicaid Special Needs applicants must enroll through New York State Medicaid.

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

Enrollment Quick Reference Guide		
Plan Type	**Department**	**Hours**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	NY Medicaid Choice: Call: 800-505-5678,	Monday - Friday 8:00 am to 6:00 pm Saturday 10:00 am to 6:00 pm, except National Holidays

Disenrollment and Enrollment Lock-in Periods: Some plans have lock-in periods that may prevent a

Medicaid recipient from switching plans at any time. Please check the reference guide below for the permissible times.

Enrollment Lock-in Quick Reference Guide	
Plan Type	**When Members can enroll or change plans**
Medicaid Amida Care Live Life Plus - Medicaid HIV/Homeless Special Needs	• First 90 days of enrollment • After 90 days and before 12 months consumers may change to an HIV Special Needs Plan at any time • After 1 year consumers can change plans

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

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

4.2 Members selection and change of Primary Care Provider (PCP)

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

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

4.3 Member Card

Members are issued an Amida Care identification card in advance of their effective date, if possible but no later than, 10 calendar days following receipt of an enrollment request. Requests for replacement cards will be processed within 10 calendar days following the request. Sample Membership cards for each type of plan are below.

4.4 Member Handbook and Evidence of Coverage

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

4.5 Member Complaints, Grievances and Appeals

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

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

Member complaints/grievances are thoroughly investigated by the (Amida Care) Appeals and Grievance Team. Timelines for filing and resolution vary depending on the Member's health plan. Use this Quick reference guide by plan to understand timelines of resolutions.

Member Complaints/Grievance Pre-Service Medical Quick Reference Guide	
Plan Type	**Timeline**

Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs A complaint is any communication by an Amida Care Live Life Plus member to the Plan of dissatisfaction about the care and treatment a member receives from our staff or providers of covered services. Member Services: Medical 800-556-0689 Dental Vision Behavioral Pharmacy	• When a member complaint is urgent (delay would involve a risk to a member's health), the complaint is investigated and resolved between 48 hours and up to 7 days from the date of receipt. Notice of the decision will be given immediately by telephone with written follow-up mailed within 3 business days. • All other complaints will be resolved within 45 calendar days of receipt of all necessary information, and no more than 60 days from receipt of the complaint. • Once a determination regarding a complaint is made, a letter will be mailed to the member within the timeframes noted above. If a member is not satisfied with the attempt to resolve the complaint, they may file an appeal. The appeal may be filed in writing or by telephone. For Medicaid, oral appeals must be followed up by written signed appeal. • Complaint appeals are submitted directly to the A&G department in writing from the date of the resolution letter. Members also have the option of contacting The NY State Dept. of Health (SDOH) (1-800-206-8125) or New York Medicaid CHOICE (1-800-505-5678).

Member Complaints/Grievance Pre-Service Medical Quick Reference Guide	
Appeals Mailing Address: Medical Amida Care Attention: Amida Care Appeals Dept. 2170 W. State Road 434, Suite 450 Longwood, FL 32779	• Members can also file an Action Appeal if he/she does not agree with an action that Amida Care has taken (like denying or limiting services, or not paying for services). This appeal request must be filed within 45 calendar days of the date on the letter notifying the member of the action. Appeals are to be in writing unless an expedited appeal is requested.

Member Eligibility

5.1 Methods for Verifying Patient's Eligibility

For a provider claim to be paid, a member must be eligible at the time of services. Providers are responsible for checking a member's eligibility before any non-emergent services are provided. Member eligibility can be verified on line at the Amida Care website or by calling Member Services. Medicaid eligibility can also be verified on EPACES, the state's web based eligibility verification system.

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

Below is a quick reference guide to be used when checking a member's eligibility.

Eligibility Quick Reference Guide		
Plan Type	Department	Hours
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	EPACES: Eligibility Plan Code is OD	Monday through Friday from 8 am to 6 pm Except for National Holidays

Rendering Care and Services to Members

6.1 The Amida Care Coordination Model - Integrated Care Team (ICT)

Amida Care prides itself on providing member centric care with models of care unique to its member populations. Our Chief Medical Officer and medical directors are responsible for the development and oversight of the care models and care delivery.

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

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

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

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

- Claims or encounter data – identify members with specific diagnoses, high cost members and utilization of services
- Hospital discharge data – identify specific diagnoses, inpatient stay services and readmission patterns
- Pharmacy data
- Data collected through the UM processes – identify members through emergency room visits, hospital admission including current and prior authorization review processes.

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

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

Core team members are listed below and role descriptions in the Section 6.2. Ad Hoc Specialists from Amida Care and external services are called upon as needed and are listed in the third column of the quick reference guide.

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

6.2 Integrated Care Team Members Role Descriptions

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

the Care Coordinator works with the Case Manager for immediate review.

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

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

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

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

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

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

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

6.3 Outreach and Retention in Care Resources

Amida Care's Integrated Care Team includes resources to prevent members from falling out of care and to re-engage members who have done so. It has been well documented that psychosocial factors such as homelessness, mental illness, substance 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 patients connected to medical care. These resources address barriers to accessing regular medical care with a PCP or HIV specialist, and link Amida Care members with community service providers who will afford them ongoing management of their bio-psychosocial needs. These resources include:

- Health Navigators
- CHOWS

Health Navigators. Health Navigators work with members who have fallen out of care, as defined by not having a primary care appointment with an PCP in six months or more, or members who have been identified as being at risk for falling out of care by their PCP, Care Coordinator or other community based provider. 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 and if needed ongoing appointments
- Escort members to PCP appointments
- Provide transportation to members when appropriate
- Follow up with service providers
- Follow up with members

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 members in New York City. All Health Navigators are NYS Mandated Reporters and trained in motivational interviewing techniques.

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

CHOWs provide the following functions:

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

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

6.4 Health Home – Care Coordination/Care Management

Amida Care provides another method of care coordination and management through Health Homes. Health Home is a care coordination model where communication between a Member's caregivers aims to improve Member outcomes. A Health Home-based "care manager" oversees and provides access to all of the services a Member needs to assure they stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or

paper) among providers so that there is no duplication of services or needed services are provided timely. In concert with Amida Care, the health home services are provided through a network of organizations - providers, health plans and community-based organizations. Amida Care works at helping their members get enrolled in Health Homes to ensure they have the comprehensive services offered. Once a member is enrolled the ICT will work with the HH/CMA to communicate new issues identified and progress made.

For more information on Health Home including eligibility see Section 7.4

6.5 Case Management Services

Part of the new member orientation process is to ascertain if a member is receiving Case Management services. If a member has a relationship with a Case Manager, whether that case manager is at an ADHC, Health Home, PCP site or Community Based Organization, the goal of Amida Care is to ensure that the member's services are not disrupted. Case manager selections are communicated to the case management agencies on regular rosters and/or member data records. Rosters identify members that will require outreach, orientation and an initial or follow up Case Management Psycho Social Assessment. All assessments are submitted to the Care Coordination Department. Documents should be mailed or faxed to 646-786-1802, Attention: Case Management Coordination. If a member declines case management services the Amida Care case manager coordinator will reoffer case management services every 180 days when they attempt to conduct a reassessment.

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

Assessments

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

On an ongoing basis the case manager provides case management services (see below) and conducts a reassessment of the member every 180 days.

If the member does not accept case management services it is the responsibility of the ICT to continually attempt to engage the member and coordinate case management services, as the member will allow. The Case Management Coordinator will conduct the 180-day assessment for these members.

Case Management Services

HIV/AIDS social support service providers and other community-based providers offering HIV case management services and non-intensive psychosocial case management provide psycho Social/Non-Intensive Case Management. The Psycho Social Case Manager provides:

- individual or group HIV prevention and risk reduction services, education, and counseling services;
- treatment education to support and promote adherence to treatment regimens;
- chemical dependence treatment readiness
- harm reduction and needle exchange

- counseling and assistance with partner/spousal notification;
- permanency planning and transitional service providers;
- community education;
- housing and supportive services for the homeless;
- shelters and other providers of services for victims of domestic violence;
- services to migrants;
- nutritional services;
- transportation services to supportive services;
- legal services

A Licensed Social Worker must supervise a Psycho Social Case Manager. It is the responsibility of the Psycho Social Case Manager to provide Amida Care with a comprehensive assessment and service plan for all new members and a reassessment every 180 days for each member on their roster.

Case Management Claims Submission

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

If a provider submits claims for case management visits 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.

- G 9 0 1 2 : 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 below
- C P L A N : CM Assessment submissions: to ensure payment Assessments must be submitted to Care Coordination 646-786-1802
- E S C T 1 : Escort, Roundtrip (Professional Staff)
- E S C T 2 : Escort, Roundtrip (Peer)
- G 9 0 0 7 : Care Team Conference, 15 minutes. Indicate number of units utilized when the provider/CM staff conferences Amida Care Care Coordination regarding a member's care and/or services in an effort to establish and implement a plan of action for members who require additional Amida Care support.

Amida Care Benefits Covered Services Overview

Providers can reference a complete summary of benefits including supplemental benefits for all Amida Care products at www.AmidaCareNY.org. Below are quick reference links for direct locations of the summary of benefits on the web. Use these links to access the most up to date copy.

Summary of Benefits Quick Reference Guide	
Plan Type	**Website Links to Summary of Benefits**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	http://LiveLifePlus.amidacareny.org/Collateral/Documents/English-US/Provider_Benefit_Guide_and_UM_Rules.pdf

7.1 Informing Members of Non-Covered Services

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

7.2 Emergency Services

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

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

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

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

their membership identification card, Member Handbook and or Evidence of Coverage.

Emergency services, including CPEP, are not subject to prior approval. Behavioral Health Crisis Intervention and OMH/ OASAS specific non-urgent ambulatory services are not subject to prior approval.

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

Emergency Services Coverage Quick Reference Guide	
Plan Type	**Coverage**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	Covered, UM notification within 48 hours of admission required

7.3 Behavioral Health

Amida Care's network provider for behavioral health services is Beacon Health Options. Beacon's network includes over three thousand providers including specialties in Psychiatry (child, adult, and addiction), Licensed/Clinical Social Work, Counseling, and Psychology. The key components of this managed Behavioral Health Services program are:

- Credentialing of all providers and facilities;
- Ensuring mental health and chemical dependency screening at least annually;
- Utilization management of outpatient and diversionary services;
- 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 dependency assessments are performed for each Amida Care member as a component of the new member assessment process. Primary Care providers are required to conduct at least annually an assessment of mental health and chemical dependence status using a nationally recognized tool. PCP may submit claims for the assessment using the appropriate procedure codes.

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

The member's PCP is responsible for 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 in the summary of benefits; see the quick reference guide and link listed above.

Access to Care: All Amida Care members may self-refer to behavioral health services for outpatient mental health assessments and services, outpatient chemical dependence assessments and services, for inpatient or outpatient detoxification, inpatient rehabilitation, and , inpatient psychiatric hospitalization. Some services may require preauthorization such as Assertive Community Treatment (ACT) and others. . Self-referrals for children may originate at the suggestion of a school guidance counselor or other such professional.

Utilization Management: Behavioral health services are subject to utilization management to ensure that the most appropriate treatment and level of care are being provided to Amida Care members. All behavioral health services utilization management is provided by Beacon Health Options. See Section 8, Authorizations and Utilization Management for phone numbers and timeframes.

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

Buprenorphine Treatment Services: The administration of Buprenorphine is a covered benefit when a certified provider conducts the service. 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 dispenser of this medication. Amida Care will confirm that a provider is certified to render this treatment by checking that the provider's name appears on the listing generated by the Substance Abuse & Mental Health Services Administration (SAMHSA). The provider must qualify as an authorized provider under the Drug Addiction Treatment Act of 2000 (DATA 2000).

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

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

Behavioral Health Care Provider Responsibilities:

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

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

Details including contracting, and credentialing processes for behavioral health providers including OMH licensed and OASAS certified are found in our Behavioral Health Vendor, Beacon Health Options, and provider manual. The Beacon Health Options provider manual also presents all the requirements including quality managements and data and claims submissions. The Beacon Health Options Provider Manual and HARP Provider Manual can be accessed through their web portal at https://www.beaconhealthoptions.com/providers/forms-and-resources/

Amida Care Behavioral Health 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;
  - 45 – 50 minutes;
  - Group/family/couple therapy sessions 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.

COVERED BEHAVIORAL HEALTH BENEFITS:

The following table presents the behavioral health services covered through Beacon Health Options for Amida Care Members as of October 1, 2015.

OASAS (Office of Alcoholism and Substance Abuse Services)	
Inpatient medically supervised inpatient detoxification	Medically supervised outpatient withdrawal
Inpatient substance use rehabilitation treatment	Outpatient clinic and opioid treatment program (OTP) services (Methadone)
Inpatient hospital detoxification	Outpatient clinic services
	Rehabilitation services for residential SUD Treatment

OMH (Office of Mental Health)	
Outpatient Clinic Services	Continuing day treatment (CDT)
Comprehensive psychiatric emergency program (CPEP)	Partial hospitalization program (PHP)
Inpatient psychiatric services	Personalized Recovery Oriented Services (PROS)

	Assertive Community Treatment (ACT)
	Intensive case management (ICM)
	Rehabilitation services for residents of community residences
	Mobile Crisis

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

Amida Care members who are HARP eligible are identified by New York State Department of Health using the following target criteria and risk factors.

A. **The State of New York has chosen to define HARP targeting criteria as:**
   i. Medicaid enrolled individuals 21 and over;
   ii. Serious Mental Illness (SMI)/Substance Use Disorder (SUB) diagnoses;
   iii. Eligible to be enrolled in Mainstream MCOs;
   iv. Not Medicaid/Medicare enrolled ("duals");
   v. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

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

Members who meet these criteria and risk factors will be referred for enrollment in a Health Home. As of January 1, 2016 HARP eligible members may be able to access Home and Community Based Services (HCBS) (Services listed below). For more information on eligibility for these services including the assessment process see Health Home section 7.4.

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[1] An "organized" MH service is one, which is licensed by the NYS Office of Mental Health.

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

Amida Care's HCBS provider network is provided by Beacon Health Options. Details on provider requirements are in the Beacon HARP Provider Manual. Included in the Beacon HARP Provider Manual are:

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

The Beacon Health Options HARP provider manual can be accessed through their web portal at https://www.beaconhealthoptions.com/providers/forms-and-resources/

7.4 Health Home

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

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

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

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

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

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

HEALTH HOME AND HARP/HCBS ELIGIBLITY:
Amida Care members who meet the HARP eligibility requirements may be eligible for additional Home and Community Based Services (HCBS). The Health Home conducts a brief evaluation to determine HCBS eligibility. Those deemed eligible will receive a lengthier conflict-free functional assessment (Community Mental Health Assessment) to determine the medical and psychosocial necessity and level of need for specific HCBS services. Based on the results, HCBS needs are incorporated into a person centered, individualized care plan that is reviewed and approved by Amida Care.

More information on HCBS referral process can be found in the Beacon HARP Provider Manual. The Beacon Health Options HARP provider manual can be accessed through their web portal at https://www.beaconhealthoptions.com/providers/forms-and-resources/

7.5 Pharmacy

Express Scripts Inc. provides pharmacy services. The Formulary Quick Reference guide provides a link to the Amida Care website where you can access the formulary, prescription quantity limits, prior authorization requirements, and step therapy guidelines. The Express Scripts provider line is 1-800-824-0898.

Except where otherwise prohibited by law:

- The Plan will provide immediate access without prior authorizations to a seventy-two (72) hour emergency supply of the prescribed drug or medication for an individual with a behavioral condition experiences an emergency condition.
- Will immediately authorize a seven day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

Formulary Quick Reference Guide	
Plan Type	**Links to Formulary, Quantity Limits, Prior Authorization, Step Therapy**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	http://livelifeplus.amidacareny.org/pharmacy_main.htm Epocrates® (www.epocrates.com) via mobile platforms

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/Formulary 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 consideration, including 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 Provider Services.

Prescription Monitoring – Medicaid Members: Medicaid members, who have requested more than 1 early refill per 365 days, and/or upon recommendation of 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 7-day 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. Amida Care's Restricted Recipient Committee shall determine restriction terms, including length.

7.6 Dental

HealthPlex is the network provider of preventive and dental services for covered benefits under Amida Care Plans. Members seeking care for covered benefits need no referral. Participating dental providers are in the Amida Care Provider Directory. Providers can call HealthPlex at 1-800-468-9868 or access information from their website at www.healthplex.com.

Dental Benefit Quick Reference Guide	
Plan Type	**Summary**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	Provided by Medicaid Fee for Services

7.7 Vision

Members may access these services from any participating Davis Vision provider without a referral. For information regarding provider locations, check the provider directory, call Davis Vision at 1-800-999-5431 or visit their website at www.davisvision.com.

Vision Benefit Quick Reference Guide	
Plan Type	**Summary**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	Routine eye examinations and eyeglasses every 2 years, and replacement frames or lenses as necessary.

7.8 Transportation Benefits

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

Non-emergent transportation services are available to members who require assistance traveling to and from medical or behavioral care based on plan type. A quick reference guide of the non-emergent transportation benefits available by plan is below. In the event a member has been informed that a transportation benefit has been denied, the member can appeal the denial through contacting Member Services at 800-556-0689.

Non-Urgent Transportation Benefit Quick Reference Guide	
Plan Type	**Coverage**
Medicaid Amida Care Live Life Plus Medicaid HIV/Homeless Special Needs	Non-emergency medical transportation (NEMT) is a fee for service Medicaid benefit and is administered by LogistiCare Solutions, New York City's contracted vendor. The standard benefit is through public transportation (subways and buses). Members with disabling conditions may be eligible for car service and/or ambulette transportation. The member's physician must complete a Patient Transportation Restriction form (PTR) and submit it to LogistiCare for approval. LogistiCare manages this benefit. Appointments for transportation can be made by contacting LogistiCare at (877) 564-5922. For your convenience, transportation services can also be requested online at http://www.nycmedicaidride.net/. Public Transportation Reimbursement for mass transit for New York City Medicaid Managed Care members is handled by New York State Department of Health effective November 1, 2013 through the Public Transit Automated Reimbursement (PTAR) program. LogistiCare no longer administers the PTAR Metro Card distribution program. Members can only get Metro Cards from healthcare providers who participate with PTAR. Metro Cards are available when the distance to the providers' office is ten blocks or more from the member's home. Members who live within ten blocks or less are not eligible for a Metro Card. If you are registered as a participating Public Transit Automated Reimbursement (PTAR) provider, your electronic submitted invoice will be reimbursed by the New York State Department of Health's. We encourage non-participating PTAR clinics and programs to enroll into PTAR. To join the PTAR program, send a request to the state by email to MedTrans@health.state.ny.us.

7.9 Consumer-Directed Personal Assistance Services (CDPAS) For Medicaid Members Only

Amida Care supports and promotes the Consumer-Directed Personal Assistance Services (CDPAS) program for members who have the goal of remaining in their community. Members may request CDPAS at any time by contacting their Care Coordinator. The member's Care Coordinator is responsible for reviewing the request and preparing the plan for review by the Care Team. CDPASs are evaluated on at least an annual basis, and it is at Amida Care's discretion as to whether they will continue with a member's individual care plan.

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

a. Be eligible for long-term care services provided by a certified home health agency, long-term home health care program, or private duty nursing services;
b. Have a stable medical condition;
c. Be self-directing or, if non self-directing, has a designated representative;
d. Participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes.
e. Is under the guidance and direction of the primary care physician (PCP).

Amida Care Approval: All CDPAS plans are presented to the Care Team for review and approval, and are under the guidance and direction of the PCP.

8.1 Utilization Management

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

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

- Out-patient Prior Authorization
- Emergency Visit utilization review;
- Pre-Admission and concurrent review of elective admissions;
- Initial and concurrent review of emergent admissions;
- Early initiation of discharge planning;
- Identification of potential quality of care issues; and,
- Coordination of services.

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

Utilization Management Quick Reference Guide Contact Information			
Plan Type	**Medical Utilization Management**	**Behavioral Health Beacon**	**Pharmacy Express Scripts**
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	For Members and Providers, During Business Hours: 888-364-6061 After Hours: Answering service including nights, weekends and holidays.	For Members and Providers, During Business and After Hours 866-664-7142	For Members and Providers, Business Hours: 24 hours /7 days 800-417-8164 Fax: 800-357-9577

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

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

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

8.2 Beacon Health Options Level of Care Criteria

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

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

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

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

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

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

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

8.3 HealthPlex Utilization Review Program

The Utilization Review Program is designed to monitor the frequency and appropriateness of care received by enrollees through utilization reports. These reports compare group norms to historical fee-for-service utilization/service patterns, and comparatively to similar provider utilization patterns. The source document for the utilization report information is the patient encounter form or claim form, which is completed by the provider of services at each patient visit. The data is compiled and reports are analyzed to determine service utilization patterns.

We cannot over-emphasize the importance of encounter data. This data is the only means by which our client can track provision of services to their members who are assigned to capitated offices. This data is the only means by which our client can track provision of services to their members who are assigned to capitated offices.

Once the above analysis is complete, the Utilization Management Committee determines whether a provider is in compliance with group performance standards.

Program Non-Compliance

Providers who are not in compliance undergo review by the Utilization Management Committee to determine the following:

- Reason for Non-Compliance.
  - Circumstances beyond the provider's control. (e.g. few visits that quarter lead to a low utilization rate, and provider has demonstrated appropriate outreach mechanisms).
  - Circumstances within the provider's control. (i.e. provider providing fewer services to managed care recipients than other providers in the peer group, provider over utilizing adult fluoride treatment as compared to peer group, etc.).

- Need for a Corrective Action Plan.
  - Corrective Action Plans may include
    - On-site visits for chart review.
    - On-site visits for staff orientation.
    - Proof of outreach program. This may include demonstration of an active recall system, including written and/or verbal communication with the patient pool, patient education materials, etc.
    - Sanctions against provider – sanctions range from a warning to removal of the provider from the network. All sanctions are subject to the provider's right to due process and appeal.
    - Written statement from the provider outlining and/or confirming their plan to correct any issue

Please refer to HealthPlex Policy and Procedure Manual accessed via their web portal: https://www.healthplex.com/provider

8.4 Evaluation of New Medical Technology

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

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

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

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

regulation or current manual instructions.

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

8.5 Services Requiring Authorization

The services requiring authorization vary by plan type. Please use this quick reference guide to locate the benefit grid for the member's plan. Call the Utilization Management Department if you have any difficulty locating it or if you have a question.

Emergency services, including CPEP, are not subject to prior approval. Behavioral Health Crisis Intervention and OMH/ OASAS specific non-urgent ambulatory services are not subject to prior approval.

Authorization Quick Reference Guide	
Plan Type	Documents that List Services Requiring Authorization
Medicaid Amida Care Live Life Plus – Medicaid HIV/Homeless Special Needs	Web link: http://livelifeplus.amidacareny.org/Collateral/Documents/English-US/Provider_Benefit_Guide_and_UM_Rules.pdf

Confidentiality: The Utilization Management activities at Amida Care remain confidential pursuant to State Law. Amida Care hereby affirms that all individually identifiable information relating to Medicaid members is 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.

8.6 Types of Service Authorization Request Determinations and Timeframes

Below is a quick reference guide on the type of authorizations and timeframes to be expected.

Admissions: Prompt notification of a patient's hospital admission comes from one or more of three sources, including:

- The Admitting Department of the contracted hospital*
- The admitting physician of choice
- The member and/or their representative

Authorization Time Frame Quick Reference Guide		
Type Of Authorization	**Time Frame**	**Extended Review**

Elective Admissions	Medicaid - 3 business days of receipt but no more than 14 calendar days.	
Emergent Admission Notifications	Within 48 business hours of admission	See Extended Authorization request and Retrospective Review for Medicaid only (below)
Pre-Authorization Request	Medicaid: Within 3 business days of receipt but no more than 14 calendar days.	Within 14 days of receipt if the member, designee or provider requests an extension or if Amida Care demonstrates the need for more information
Inpatient Review	For Medicaid Only: A determination regarding admission, will be made within one (1) business day of receipt of all necessary clinical information but no more than 14 calendar days	
Discharge Review	Prior to discharge to determine alternatives to acute care setting	See Discharge Planning and Transitions of Care below
Outpatient Prescription Drugs – non-Formulary and Tiering Exceptions	72 hours standard request and 24 hours Expedited request	

Concurrent Review: Concurrent review procedures allow for continued or extended health care services for the purpose of validating the appropriateness of disposition and/or level of care, medical necessity of treatment and/or procedures, quality of care rendered and information provided during any previous review. Concurrent review determinations will be made as fast as the member's condition requires and within one (1) business day of receipt of necessary information but no more than 14 calendar days.

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

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

Retrospective Review: All retrospective review for services, which have been delivered, is made within thirty (30) days of receipt of the necessary information. Written notification is provided to the member and provider. Amida Care may reverse a preauthorized 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 member on the date of a payment denial, in whole or in part.

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

APPEAL OF UTILIZATION REVIEWS		
Toll-Free Number	**Facsimile Number**	**Address**
1-888-364-6061	1-855-663-6480 Medicaid	Amida Care Appeal Department 2170 W. State Rd. 434 Suite 450 Longwood, FL 32779

Expedited Reviews:
Expedited review requests must be conducted when a provider indicates delay would seriously impact a member's well-being. Members have the right to request expedited review as fast as the member's condition requires. If a member, designee, practitioner acting on member's behalf or practitioner acting on their own behalf is not satisfied with an action, including a medical necessity determination, experimental/investigational determination, rare disease determination or (in certain instances) out-of-network determination - and a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function - the member may request an expedited action appeal.

The member or designee may request expedited review of a prior authorization request or concurrent review request. A determination for Expedited request will be provided within (1) business day or no more than (3) business days from the date of the expedited authorization request date.

An expedited appeal may be filed:

- For continued or extended health care services, procedures or treatments.
- For additional services for member undergoing a course of continued treatment.
- When the health care provider believes an immediate appeal is warranted.
- A denial of action appeal based on medical necessity, experimental or investigational treatment.
- When the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
- Amida Care has rendered a final adverse determination with respect to such health care service or
- both Amida Care and the member have jointly agreed to waive any internal appeal.
- When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, and
- the denial has been upheld on appeal or both the Amida Care 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 health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care 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 have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning
- of PHL 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation,
- and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.
- Note that if Amida Care offers two levels of internal appeals, Amida Care may not require that the health service or procedure is experimental or investigational.
- The member and Amida Care may jointly agree to waive the internal appeal process. If this occurs, we will provide a written letter with information regarding filing an external appeal to the member within twenty four (24) hours of the agreement to waive the internal appeal process.

Process for Filing an Expedited Appeal Review:

- Expedited appeals should be accompanied by a copy of the action, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. If Amida Care requires information necessary to conduct an expedited appeal, Amida Care will immediately notify the member and the provider by telephone or fax to identify and request the necessary information followed by written notification. A clinical peer review must be available within one (1) business day. All oral appeals must be followed up by a written signed appeal. If Amida Care denies the member request, the member has to be notified by phone immediately, followed by written notice in two days.

Adverse Determinations:

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

The written notice of final adverse determination concerning an expedited appeal shall be transmitted (oral or written) to the member within 24 hours of rendering the determination and will make reasonable effort to provide oral notice to member and provider at the time the determination is made. This will include the reason for the final adverse determination, including clinical rationale. The notice will also include:

- The words “final adverse determination”
- A description of additional information required and actions to be taken.
- The process and timeframe for filing/reviewing appeal with Amida Care. The member will be mailed information to explain the member right to file an expedited review.
- Instructions on how to initiate internal appeals (standards and expedited appeals) and eligibility for external appeals.
- Notice of the availability upon request of the members, or the member’s designee, of the clinical review criteria relied upon to make such final adverse determination.
- The member's right to contact DOH, at 1-800-400-8882 regarding his or her complaint.
- A Fair Hearing Notice including aid to continue rights.
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.
- A statement that Amida Care will not retaliate or take discriminatory action if an appeal is filed by a member or a provider.
- The member’s right to designate a representative to file on his/her behalf and formats for special needs and how to access these formats.
- The timeframes that decisions must be made.
- Utilization Management contact person and phone number.
- Member’s coverage information.
- Right of the member to complain to the Department of Health at any time at 1-800-505-5678;
- Health service that was denied, including facility/provider and developer/manufacturer of service as available;
- Statement that the Member may be eligible for external appeal and timeframes for appeal; and
- Standard description of external appeals process.

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

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

The member and/or provider may file an appeal no later than 60 business days from the date the initial request was denied. An appeal may be filed by phone or in writing and provide the reasons for the providers request and any documentation to support a reversal. Amida Care will acknowledge receipt of the Appeal within 15 days in writing.

The review will be conducted by a physician, clinical peer reviewer, who was not involved in the prior determination or initial actions. Determinations will be made within 30 days of the request and may be extended for up to 14 days. Amida Care will notify the member and the provider in writing of the appeal determination within two business days of making the decision. The final determination will include the basis and rationale for Amida Care’s final adverse determination.

Fair Hearing:

A member/representative can request a State Medicaid Fair Hearing within 60 days of a denial for services or treatment. Amida Care will provide instruction for requesting a Fair Hearing with the NYS Office of Temporary Disability Agency (reference OTDA website). The information will be mailed to the member with the Final Adverse

Appeal determination letter.

External Appeal:
A member has a right to an external appeal of a final adverse determination. This request must be submitted within (4) months from the date of the Final Adverse determination. A member will have no less than 60 business days, and no more than 90 days to file an appeal. An external appeal must be submitted within 45 days upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If an enrollee chooses to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.

An external appeal may be filed:

- When the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care services is not medically necessary and;
- The health care plan has rendered the final adverse determination with respect to such health care service or;
- Both Amida Care and the member have jointly agreed to waive any internal appeal.
- The denial has been upheld on appeal or both the MCO and the member have jointly agreed to waive any internal appeal and;
- The member's attending physician has certified that the enrollee has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health plan or (c) for which there exists a clinical trial and;
- The member's attending physician, who must be a licensed board eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on the two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation and
- The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.
- If there are two levels of internal appeals, the MCO may not require the member to exhaust the second level of internal appeal to be eligible for an external appeal.
- The member has 45 days from the final adverse determination to request an external appeal and choosing 2nd level of internal appeal may cause time to file external appeal to expire.

Expedited Appeal:
A member/representative may request an Expedited Appeal when the health status of the member is at risk for or member may suffer temporary and permanent impairment. This process will provide a determination within (3) business days by phone or fax. A (5) day extension is permitted when permitted when necessary for the Expedited Appeal process.

For Medicaid members we will issue a notice whether or not the expedited appeal request was honored or denied. If we deny the request, we will provide notice immediately by telephone, followed by written notice in two (2) days, and the review will take place according to standard time frames. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Standard Appeal:
A Standard Appeal may be filed by the member or the member's designee. A provider may file a UR appeal for retrospective denial. Appeals are filed in writing or by telephone. Oral appeals must be followed up by a written signed appeal. Amida Care will notify the member, the member's designee, and provider in writing of the appeal determination within 2 business days of when Amida Care makes the decision.

Members will have no less than 60 business days, and no more than 90 days to file an appeal after our notice of the complaint determination to file a written complaint appeal. Within 15 business days of receipt of the complaint appeal, we will provide a written acknowledgement that includes, among other items, a list of any additional information necessary to render a determination.

If we require necessary information to conduct a standard internal appeal, the member and the member's health care provider will be notified in writing within 15 days of receipt of appeal to identify and request the necessary information. We will provide written acknowledgement of any complaint not immediately resolved within fifteen (15) business days of receipt. In the event that only a portion of such necessary information is received, the Amida Care shall request the missing information, in writing, within five (5) business days of receipt of the partial information.

For members, before and during the appeal review period, the member, or his/her designee may see the case file and may present evidence to support their appeal in person or in writing. The timeframe for us to make an appeal determination begins upon our receipt of necessary information (for members, the review timeframe begins upon first receipt of appeal, whether filed orally or in writing).

Amida Care must make a standard appeal determination within:

(a) 60 days after receipt of necessary information.

(b) For Medicaid, as fast as the member's condition requires, and no later than 30 days from receipt of the appeal. This time may be extended for up to 14 days upon member or provider request; or if Amida Care demonstrates more information is needed and delay is in best interest of member and so notices member.

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

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

For Medicaid/QHP, the notice will also include:

- Summary of appeal and date filed;
- Date appeal process was completed;
- Description of the Member's fair hearing rights if not included with initial denial;
- Right of the Member to complain to the Department of Health at any time with 1-800-505-5678; and
- A statement that notice is available in other languages and formats for special needs and how to access these formats.
- Provides notice that failure by Amida Care to make a determination with the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.
- The member and Amida Care may jointly agree to waive the internal appeal process; if this occurs,

Amida Care must provide a written letter with information regarding filing an external appeal to member within 24 hours of the agreement to waive Amida Care's internal appeal process.

8.6 Discharge Planning and Transitions of Care – Care Team Support

The Utilization Management Nurses and the Care Coordinator assist in the identification of vulnerable beneficiaries who may require additional care coordination, are at risk for decreased functional capacity, or have a newly identified diagnosis. This is most often through an inpatient admission and transfers to SNFs and other extended health care facilities such as rehabilitation or long term care centers. Failure of Amida Care 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 the review timeframe expires.

The Utilization Management Nurse representing Amida Care will send a work list item in to the care coordinator upon notice of an admission for a member. This allows the care coordinator to work with the hospital or facility staff, discharge planners, the providers, the member, and their caregivers, if applicable, to modify the care plan to reflect the discharge needs. If appropriate, the transitional Long Term Care Nurse (for members unable to go home) will be available throughout the transition process.

As part of the discharge planning, an assessment is made of the member's ability to care for themselves when sent to their home and what supports may be needed for a safe discharge. The Care Team helps to identify resources that maybe needed. This includes home care and other community supports. Referrals may be made to a home health agency for beneficiaries that may need a face-to-face assessment of their home environment and supports. These home visits can help to identify if the member has the support they need to maintain or improve their functional status and to stay safely in their home. Once home, the care coordinator will reach out to the member, and complete an assessment to help determine their current needs.

The assessment can be completed telephonically by a Care Coordinator or by a home health care provider. The focus of the assessment includes:

- Follow-up appointments
- Available caregiver support
- Conduct medication reconciliation
- Status of ability to do activities of daily living
- Identify any barriers
- Knowledge of conditions and changes in their treatment plan.

The Care Coordinator will identify barriers, help the member make follow-up appointments, obtain prescribed medications, identify potential medication issues as a result of the review of all medications, assist with transportation and in the coordination of needed services, communicate with the member's providers, refer to community agencies if needed, and educate the member and their caregivers, if applicable, on their health condition(s), prescribed medications and other treatments. Through the Care Coordinators contact with the member and their caregivers, care coordination needs are identified in a timely manner so that actions can occur to potentially prevent a readmission. This program does not replace or duplicate home nursing services.

For members being discharged from an Inpatient Mental Health or Substance Abuse Facility, the Beacon Case Manager will be available to assist with the discharge planning process. The Beacon Case Manager can help the member make follow-up appointments, obtain prescribed medications, identify potential medication issues as a result of the review of all medications, assist with transportation and in the coordination of needed services, communicate with the member's providers, refer to community agencies if needed, and educate the member and their caregivers, if applicable, on their behavioral health condition(s).

Primary Care Physicians (PCPs) are notified of a member's facility admission by the member's assigned Care Coordinator. This may be by phone, fax or secure email.

Primary Care Physicians (PCPs) are notified of a member's facility admission by the member's assigned Care Coordinator. This may be by phone, fax or secure email.

Amida Care delegates to the attending physician, hospitalist, and/or the sending setting's discharge planner, the responsibility to communicate with the member or responsible party concerning the care transition process, changes in the member's health status and updates to the plan of care throughout the hospital stay, and to summarize the member's health status and plan of care within one day of the transfer. The member's primary care physician (PCP) is notified of changes to the member's health status or plan of care via the hospital discharge summary. Amida Care monitors compliance with this process by following up with the member after discharge, and by following other processes as noted below.

The member's assigned Care Coordinator is responsible for supporting a member's transition between any points in the system within one business day if support is urgent (e.g. acute care hospital to skilled nursing facility, rehabilitation center, or long term care), or within three business days if the support is not urgent. The member has direct access to their Care Coordinator by phone.

It is the responsibility of the sending hospital, skilled nursing facility, rehabilitation center, or other facility to notify the receiving facility of the member's care plan within one business day of the notice of the transition. The member's care plan will include information that will facilitate the communication, collaboration, and continuity of care across settings. The care plan, which is unique to that member and considers his or her health status, may include, but is not limited to, both medical and non-medical information that may impact health care status, such as a current problem list, list of medications, allergies, baseline physical, mental health, or cognitive status, advanced directives, names and contact information for their health care provider(s) and applicable caregiver or designated representative(s).

Care Coordinator is responsible for verifying that the communication of the member's care plan has been received within one business day but no later than 3 business days. The Care Coordinator contacts the member; member's designated representative, and/or applicable caregiver(s) within ten business days of the transition. This communication may occur via telephone or in writing. Another member of the Care Team may be used to communicate with the member, as appropriate. This may include the on-site utilization management staff, Transitional Long Term Care Nurse, Health Navigator, CHOW, or other contracted agencies that have face-to-face contact with the member; member's designated representative, and/or their caregiver(s). For members transitioned to a skilled or custodial care setting, Amida Care's Transitional Long Term Care Reviewer maintains communication with the receiving facility and conducts a concurrent review. Once the member is medically able to be transitioned to a home care setting, the skilled or custodial nursing facility completes a discharge plan of care and communicates the plan of care to the member or responsible representative, and to the primary care physician assuming the member's care upon discharge.

The member's consistent point of contact remains the assigned Care Coordinator as they move throughout the continuum of care. The Care Coordinator reviews and updates the care plan as appropriate and provides a copy to the member and PCP.

8.7 Appeals Process for each Amida Care Plan Type

The appeals process and timeframes vary by Amida Care Plan. Please use the following flow charts as a guide and call the Utilization Management Department if you have any questions about the process

Quick Reference for Appeals Process Medicaid Plans

Action Taken by Plan

Actions by plan include:
- Denial or limitation of services requested by member, member's representative, or member's provider;
- Denial of a request for a referral;
- Decision that a requested service is not a covered benefit;
- Reduction, suspension or termination of services that were already authorized;
- Denial of payment for services;
- Failure to provide timely services; or
- Failure to make grievance or appeal determinations within the required timeframes;
- A denial of action appeal based on medical necessity, experimental or investigational treatment;
- A complaint regarding denial of expedited resolution of an Action Appeal; or
- A complaint, complaint appeal or Action appeal that involves clinical issues.

Member response to Plan: 45 days to Appeal from postmark of notice of action
or
10 days from postmark of notice of action if requesting aid to continue service

Appeal

Standard	Expedited
Within 30 calendar days of receipt of appeal request. **Amida Care will send written acknowledgement of appeal within 15 days of receipt.**	**Within 2 business days of receipt of necessary information or as fast as member's condition requires, but no more than 3 days.**

Extension: This time may be extended for up to 14 days upon member or provider request; or if plan demonstrates more information is needed and delay is in best interest of member and so notices member.

Plan's response to member: The written notice will be sent to the member and provider and will include the reason for the determination, including clinical rationale of a final notice adverse determination, instructions on how to initiate within 24 hours of rendering the determination standard and expedited appeals, a description of additional information required and actions to be taken, the process and timeframe for filing/reviewing appeal with Amida Care including the member's right to file an expedited review, members right to contact DOH, a Fair Hearing Notice, statement that the notice is available in other languages, member's right to designate a representative to file on his/her behalf and the timeframes that decisions must be made.

Member can ask for both Fair Hearing and external appeal; if both requested, Fair Hearing "is the one that counts"

Member appeal to State:	Within 60-90 days. or **45 days if the plan and member agree to waive the internal appeal process**	Within 60 days of the date of the Appeal decision; or Within 10 days of postmark of Appeal decision was sent if requesting aid to continue services
State Response to member:	**External Appeal** **Standard Process:** Within 30 days and within 2 days after **decision is made** **Expedited:** Within 3 days, by phone or fax decision is made	**State Medicaid Fair Hearing** *According to OTDA website, adjournment and reopening possible; in this situation, cases aren't considered abandoned until after a year of no work from the member/member representative*
Extension:	5 days A (5) day extension is permitted when necessary for the External or the Expedited Appeal process.	

Claims Submission and Payment

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.

9.1 General Requirements for Claims Submission and Inquiry

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

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

Medical Claims Addresses and Contact Information by Plan Type				
Plan Type	**Medical Claims Address**	**Medical Claim Electronic Submitter ID #**	**Medical Claim Status Phone Number/Web Address**	**Behavioral Claims Address Submitter ID # Claims Status Phone Number**
Medicaid Amida Care Live Life Plus Medicaid HIV/Homeless Special Needs	Amida Care Claims PO Box 21455 Eagan, MN 55121	Amida Care ID# 79966	1-800-556-0674	Amida Care Claims, 500 Unicorn Park Drive, Suite 401 Woburn, MA 01801-3393 * Beacon Health Options Payer ID# 43323 * Amida Care Plan ID# 29 * 1-866-664-7142

Claims submitted electronically, by mail or facsimile on CMS 1500 or UB-04 forms must be complete and legible. The following information must be included with the claim to ensure timely claims payment.

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

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

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

9.2 Coordination of Benefits

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

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

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

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

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

9.3 Timely Filing of Claims

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

9.4 Explanation of Payment (EOP)

The Explanation of Payment (EOP) describes how claims for services rendered to Amida Care members have been processed. It details the adjudication of claims, 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.

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

9.5 Overpayment Recovery

Amida Care will notify by letter providers when an overpayment has occurred pursuant to the New York State Insurance Law 3224-b. The provider is given 30 calendar 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. Recoveries will be taken from future claim payments or by request for a refund check.

9.6 Member Non-liability

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

9.7 Claim Appeals – Post-Service Drug Claim

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 and mail all claims appeals to the address located in the Claims Quick Reference Guide.

No retroactive authorizations are provided to providers who have rendered services to members. The following process needs to be followed for services rendered without proper authorization:

1. Provider submits a claim for services provided without proper authorization.
2. The claim will be denied by Amida Care.
3. The provider submits a post-service medical claim appeal.
4. Amida Care will review the claim and make a determination.

9.8 Claim Appeals – Post-Service Drug Claim

Providers are allowed 14 calendar days from the date of notification of an adverse determination of a claim to submit an appeal. To inquire about submitting an appeal for post service drug claim, please contact Amida Care's Provider Services Department and mail all claims appeals to the address located in the Claims Quick Reference Guide.

No retroactive authorizations are provided to providers who have rendered services to members. See the process outline in the section above for claims payment without proper pre-authorization.

9.9 Reconsideration of Claims Denied Exclusively for Untimely Submission - Medicaid Only

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

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

9.10 Administrative Denial and Appeals Process – Medicaid Only

Providers are allowed 45 calendar days from the date of notification of an adverse determination of a claim to submit an appeal; this is called an External Appeal. To inquire about submitting an Action Appeal please contact Appeals at 888-364-6041.

Plan Type	Appeals Address	Appeals
Medicaid Amida Care Live Life Plus Medicaid HIV/Homeless Special Needs	Amida Care Appeals – Live Life Plus Amida Care Appeals Department PO Box 21455 Eagan, MN 55121	1-800-556-0674

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

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

Notification of denied claims is included in the 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 45 calendar days of the date of the notification. When requesting a review, state the reason(s) you believe the claim 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 is submitted in writing to the correct address listed in the quick reference guide, above.

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

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

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

As Health Care-Acquired Conditions (HCACs), and formerly referred to as Hospital-Acquired Conditions (HACs), NYSDOH recognizes the following ten HACs for which there will be no payment when the diagnosis is not present on admission (POA):

1. A foreign object retained within a patient´s body after surgery.
2. The development of an air embolism within a patient´s body.
3. A patient blood transfusion with incompatible blood.
4. A patient´s development of stage III or stage IV pressure ulcers.
5. Patient injuries resulting from accidental falls and other trauma, including, but not limited to:
   - Fractures
   - Dislocations
   - Intracranial injuries
   - Crushing injuries
   - Burns
   - Electronic shock.
6. A patient´s manifestations of poor glycemic control, including, but not limited to:
   - Diabetic ketoacidosis
   - Nonketotic hyperosmolar coma
   - Hypoglycemic coma
   - Secondary diabetes with ketoacidosis
   - Secondary diabetes with hyperosmolarity.
7. A patient´s development of a catheter-associated urinary tract infection.
8. A patient´s development of a vascular catheter-associated infection.
9. A patient´s development of a surgical site infection following:
   - a coronary artery bypass graft - mediastinitis
   - bariatric surgery, including, but not limited to, laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery
   - orthopedic procedures, including, but not limited to, such procedures performed on the spine, neck, shoulder and elbow.
10. A patient´s development of deep vein thrombosis or a pulmonary embolism in connection with a total knee replacement or a hip replacement, excluding pediatric patients, defined as patients under eighteen years of age, and also excluding obstetric patients, defined as patients with at least one primary or secondary diagnosis code that includes an indication of pregnancy.

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

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

Other Provider Preventable Conditions that will disallow reimbursement:

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

Credentialing

10.1 Overview

Amida Care is committed to providing health care services to its membership through a high-quality provider network that meets the standards outlined by regulatory and oversight agencies, including the Centers for Medicare and Medicaid Services (CMS), New York State Department of Health AIDS Institute, the National Committee for Quality Assurance (NCQA), and/or the Joint Commission and Accreditation of Healthcare Organizations (JCAHO). Providers are initially credentialed and periodically re-credentialed through approved delegation agreements, or through a credentialing review process conducted by Amida Care. The Plan recruits and credentials providers for its network based on the health care service needs of its members, without regard to a provider age, race, gender, sexual orientation, national origin, nor any other unlawful discriminatory practice. Any provider who has been sanctioned by Medicare or Medicaid, been prohibited from serving Medicaid recipients and/or receiving Medical Assistance payment is excluded from participating.

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

10.2 Initial Application

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

Developed by CAQH, the UPD is an online service that allows practitioners to complete one standardized information set to meet the credentialing needs of all participating health care organizations. Participating practitioners may update their application information at any time via the CAQH Web site, at https://:UPD.caqh.org/UAS.

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

The applicant must submit their CAQH Identifier Number and signed attestations as well as all supporting or applicable documentation and attachments, as required by the minimum requirement guidelines.

10.3 Application – Initial/Re-Credentialing Requirements

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

The credentialing application process for each applicant will be completed by the credentialing staff and submitted to the Credentialing Sub-Committee for approval.

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

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

1. Board Eligibility or Board Certification Status; and
2. Hospital Affiliation (when applicable).

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

1. The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider or
2. HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM) or
3. Advanced AIDS Credited Registered Nurse Credential given by the HIVAIDS Nursing Certification Board

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

Amida Care HIV Specialist PCPs are required to earn thirty (30) hours of approved HIV-specific Continuing Medical Education (CME) credits within a 24 month period 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. This form is available through Provider Services.. This information will be used in annual assessments of HIV Specialist status as well as to investigate and/or address any Quality Management or Continuous Quality Improvement issues.

Case Managers: Case Managers will complete a Case Manager Information/Verification Form to verify qualification standards.

LCSW and LMSW: Licensed Clinical Social Workers (LCSW) and/or Licensed Masters of Social Work (LMSW) must complete Amida Care's Provider Application, as required for credentialing.

10.4 Credentialing Process and Decision

The credentialing staff will make every effort to obtain the necessary documents to complete the process of receipt of the application within 60 days. If additional time is needed, we will make every effort to notify the provider as soon as possible but no more than 45 days from receipt of the application. If the Plan discontinues the credentialing process, the provider will receive written notification of such, within 60 days.

Per NYS law, the initial applications are reviewed within 90 days of receiving a fully completed application, and the provider is notified. Every effort to obtain missing information is made.

10.5 Re-Credentialing

Amida Care requires all practitioners to undergo recredentialing every three years.

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

Six months prior to the credentialing expiration date, practitioners will receive a letter from Amida Care. The letter will recommend them to update their application on file with the Council for Affordable Quality Healthcare's (CAQH) Universal Provider Data source (UPD).

Practitioners should make any changes to their information on the CAQH UPD, update the malpractice claims history accordingly, and include updated copies of their curriculum vitae, State License, Drug Enforcement Agency certification and proof of malpractice insurance coverage with the application.

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

10.6 Delegation of Credentialing and Re-Credentialing Related Activities

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

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

1. Copy of the facility's current JCAHO accreditation certificate, if applicable;
2. 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;
3. "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
4. 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 recredentialing standards.

10.7 Delegated Credentialing Oversight

The Plan's Chief Medical Officer, 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:

1. The responsibilities of the Plan and the delegated entity;
2. The activities being delegated;
3. The process by which the Plan evaluates the delegate's performance; and
4. 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.

10.8 Provider Performance Evaluation

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

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

- validation of performance improvement projects;
- validation of performance measures;
- review of compliance with access and availability, structural and operations standards;
- review of credentialing and recredentialing data records;
- evaluation of member complaints/grievance;
- strategic reports on consumer-reported satisfaction surveys;
- strategic reports of HEDIS/QARR Analysis;
- technical assistance on member information;
- coordination of care;
- evaluation of provider based quality strategy;
- implementation of focused studies and identification of special health care needs;
- dissemination of information to keep key stakeholders within network involved and informed of
- External Quality Review work projects and tasks; development of reports for submittal to regulatory agencies as required;
- will provide providers with any information and profiling data used to evaluate the providers performance; shall make available on a periodic basis and upon the request of the healthcare professional the information, profiling data and analysis used to evaluate the provider's performance; and
- each provider shall be given the opportunity to discuss the unique nature of the provider's professional patient population which may have bearing on the provider's profile and to work cooperatively with the plan to improve performance.

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

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

11.1 Overview of Quality Management and Continuous Improvement Program

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

11.2 Program Purpose - Goals and Objectives

The purpose of this program 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.

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, and 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.

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 and availability;
4. Member outreach, orientation and ongoing education;
5. Provider Manual, orientation and provider continuing education;
6. Clinical Practice Guidelines;
7. Care Coordination/Utilization Management;
8. Case Conferences;
9. Organizational and administrative functions of outreach, enrollment, member services, claims processing, MIS, complaint resolution, appeals management; and
10. 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 Continuous Improvement Program. It ensures that there is an ongoing means of determining the status of the 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 the 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 in the Plan's QMP include:

- QARR, SNPQUAL, HEDIS and STARS measures and Satisfaction Surveys;
- Provider Systems (CAHPS) survey;
- 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 care management services using established quality indicators;
- Pharmacy Utilization Reports as determined by SDOH and CMS;
- Surveys of after-hours access, timeliness of appointment availability and appropriateness of appointment waiting times - PCP and Specialist (conducted per NYSDOH and CMS 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 Physical Health and Behavioral Health reports of inpatient days and inpatient admissions, appeal requests/appeal decisions, member over/under utilization, referral and specialty utilization, and provider practice profiles;
- Sentinel Physical and Behavioral health 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 with 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;
- Member 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.

11.3 Structure of Quality Management and Continuous Improvement Program

A Quality Management Committee has been established, under the co-chairmanship of the Plan Chief Medical Officer and a member of the Board of Directors, to develop, implement and review the QMP. The Directors of Quality Management are 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.

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:

- Network Access and Availability
- Member Education
- Continuity of Care
- Member Satisfaction
- Provider Satisfaction
- Case Management
- Information Systems
- Utilization Management and Care Coordination
- Behavioral Health Services including Home and Community Based
- Health Home

Data Collection Plan: The Data Collection Plan is a 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 HEDIS/QARR guidelines
- Semi-Annual Assessment of Members
- Member Satisfaction Survey results administered through the Membership Division
- Demographic data and visit frequency from Plan database
- Utilization pattern based on submitted claims including behavioral health claims

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 Sub-Committee 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
- Observational Studies

Continuous Quality Improvement Action Plans (IAPs) will be developed and implemented; 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
- Form development or revision

Once an Improvement Action Plan has been deemed 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-mails, memos and informal verbal communication, if deemed appropriate. The Plan's 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 Medicaid 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 Medical Management 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 monitoring function of the QMP determines the effectiveness of the Program measured in patient outcomes and adherence to policies and procedures. The findings of the monitoring processes can identify:

- Care coordination/management policies and procedures or review criteria (for clinical determinations) that may need to be revised
- Providers who need counseling or education including Behavioral health providers through the contracting behavioral health organization, Beacon Health Options
- Clinical practice guidelines that need revision.

11.4 Quality Management Committee and Sub-Committees

The QMC can have up to 16 members. The Board of Directors approves the members of the QMC. In addition to the Plan Chief Medical Officer and a member of the Board of Directors, who serve as co-chairpersons, the QMC membership includes:

- Amida Care Staff
- Chief Executive Officer
- Director of Quality Management
- Vice President of Risk and Network Management
- Vice President of Health Services Operations
- Vice President of Clinical Services
- Vice President of Member Services
- Clinical representatives from Amida Care physical and behavioral health sites including physicians, nurse practitioners, nurses, and case managers.

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 QMC, and is expected to cooperate with Plan Quality Improvement activities.

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 QMC or Sub-Committees.

The provider is obligated to report encounter data as well as the plan's specific reporting requirements as by NYSDOH.

The Amida Care QMC 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, Continuous Quality Improvement 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;
- 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 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 Sub-Committees.

There are six standing Sub-Committees of the Quality Management Committee. The Sub-Committees are the Clinical Sub-Committee, Continuous Quality Improvement (CQI) Sub-Committee, Pharmacy and Therapeutics Sub-Committee, Complaints and Appeals Subcommittee, Member Advisory Sub-Committee, Credentialing Sub-Committee, Behavioral Health Quality Management Sub-Committee

and Behavioral Health Utilization Management Sub-Committee. Written minutes of the Sub-Committee meetings aremaintained and 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.

The BH QM Sub-Committee:

The BH QM Sub-Committee (BHQM) is co-chaired by the Behavioral Health Medical Director and the Behavioral Health Administrator (Amida Care Assistant Director of HARP and Health Homes). Its membership includes:

a) Amida Care Medical Director
b) Amida Care Clinical Director of Behavioral Health
c) Beacon Quality Management Director
d) Amida Care VP of Pharmacy
e) Amida Care Quality Management Director
f) Beacon Network/Provider Services Representative
g) Behavioral Health providers
h) Plan Member and Plan Family Member
i) Plan Peer Specialist

The BHQM Sub-Committee is responsible for:

a. Monitoring the results of QARR and HEDIS BH measures against established benchmarks if available. Measures include but are not limited to:
   - Post inpatient discharge ambulatory follow-up care
   - Initiation and engagement of alcohol and other drug dependence treatment
   - Adherence to antipsychotics for members with Schizophrenia
   - Antidepressant medication management for members with a diagnosis of Major Depressive Disorder

b. Monitoring care and service measures against Amida Care standards to include, but are not limited to:
   - Availability of BH providers (Appointment Availability Survey)
   - Availability of BH providers (Geo-access)
   - Telephonic access to Amida Care and Beacon staff
   - BH member and provider satisfaction survey results

c. Member complaints about BH services, including quality of care complaints, will be tracked and trended in order to develop and implement interventions to address identified opportunities for improvement.
d. Participation in one or more New York State sponsored focused clinical study on selected topics or initiatives affecting people with BH needs annually.
e. Conduct at least one internal Performance Improvement Project (PIP) on a priority BH topic approved by the State.
f. Monitoring the HCBS assurances and sub-assurances for HARP Eligible members as determined by the State
g. Monitoring new recovery outcome measures in areas such as employment, housing, criminal justice status, and functional status for HARP Eligible members
h. Monitoring social outcome measures for HARP Eligible members based on the HCBS eligibility evaluations, re-evaluations, and member self-perception
i. Developing, monitoring and evaluating the BHQM Program on an annual basis.

The BHQM Sub-Committee meets quarterly and reports to the Amida Care QMC on a quarterly basis. The BHQM subcommittee is designed to improve care and services received by all Amida Care members. Minutes are taken to document Sub-Committee findings, recommendations, and follow up actions as well as to record the attendance of specific parties. These include Amida Care and Beacon Health Options staff, Behavioral Health network providers and Amida Care members and family members or caregiver/supports and peer specialists. Meeting minutes will be approved or subsequently revised at the next Sub-Committee meeting. All meeting minutes will be reviewed at the QMC and subsequently forwarded to the Board of Directors.

11.5 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. A copy of these separate standards is available from the Provider Services Department. Providers maintain these documentation standards and ensure adherence to all confidentiality regulations when sharing medical record information with other providers. The medical record verifies that the PCP is responsible and coordinate the care of the member.

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

- 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;
- Given a maximum panel size of 350 (or 500 with Physician Extenders), this typically results in 3 to 15 Medical Record reviews per provider;
- Separate medical record for each enrollee;
- The record verifies that PCP coordinates and manages care;
- Medical record retention period of six years after date of service rendered to enrollees and for a minor, three years after majority or six years after the date of the service, whichever is later; and
- (Prenatal care only): centralized medical record for the provision of prenatal care and all other services

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

- 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.

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

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

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

New York State Law requires that Amida Care and its network physicians comply with HEDIS and QARR initiatives, and that we report the results to the NYSDOH. Supplying the requested records to us for HEDIS/QARR reporting does not violate the HIPAA Privacy Rule, 45 CFR 164.
506 (c) (4).

Your cooperation in completing any requested medical record reviews will help us communicate to the medical and consumer community that we, as a team, are committed to meeting the standards of care above and beyond the required standards.

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

11.6 Incident Reporting, Care Concerns and Investigations

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

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

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

11.7 Communicable Diseases and Public Health Reporting

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

Conditions that must be reported by clinicians or their designees are specified in the New York City Health code and posted at http://www.nyc.gov/html/hra/html/home/home.shtml Health care providers per Section 11.03 of the NY City Health Code, must immediately report by telephone any suspected

outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestations of disease in any individual.

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

Amida Care will make informational material available to providers to post in their offices. Amida Care Marketing Representatives will ensure that any provider or facility that is willing to make available and/or distribute Amida Care marketing materials understands it must be willing to distribute or make available plan sponsor marketing materials for all plans with which the provider participates.

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

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

12. 1 Permissible and Impermissible Marketing Activities for Providers

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

Providers may:

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

Amida Care shall not require providers to distribute Plan-prepared communications to their patients. All Amida Care 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.

12.2 Additional Guidelines:

Amida care conducts its outreach activities in strict compliance with the New York State Department of Health Marketing Guidelines.

Amida Care's marketing 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 with whom they are affiliated, if they choose to provide such information (orally or written) to their patients
- Must not provide lists of potential members to Amida Care and should be aware that Amida Care will not accept lists of potential members from its network of contracted providers

HIV SNP Marketing Rules for Providers:

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

Marketing. Marketing is defined broadly in the HIV SNP contracts, and is not limited to traditional "sales pitches" by health plan marketing representatives. Instead, "marketing" encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

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

Start-Up. No SNP or any of its affiliates or providers may begin marketing until they receive final approval from SDOH.

Summary of Rules for Providers:

Written Marketing Materials: Written marketing materials generated by providers must be approved by DOH, Office of Health Insurance Programs. Materials should first be submitted to the HIV SNP for review and approval.

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

Marketing Encounters

- Marketing encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular HIV SNP.
- All marketing encounters must communicate at least the following information:
  - A statement that participation is mandatory as of September 2010, and that persons with HIV/AIDS may choose an HIV SNP, or join or remain in a mainstream Medicaid health plan.
  - The potential member will have a choice among several plans. Upon enrollment in a SNP, the member will be required to use his/her HIV Experienced Providers and other plan providers exclusively for medical care, except in certain limited circumstances.
  - Newborns of a mother enrolled in a SNP will automatically be enrolled in the mother's HIV SNP. The infant may be disenrolled at any time at the mother's request.

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

Marketing Conduct

- Marketing encounters are to be conducted in a manner that does not disclose nor breach the confidentiality of the potential member's HIV status.
- Providers may not give mailing lists of patients to HIV SNPs.
- Providers may not target mailings to HIV/AIDS patients, or patients with a significant probability of having HIV/AIDS unless the patient has consented in writing to mail contact. This is to protect patient confidentiality.
- Some providers, such as facilities specializing in HIV/AIDS care, should consider handouts of literature rather than a mailing to avoid confidentiality problems.

Dear Patient:

Your Medicaid is changing. From now on, most people including those with HIV/AIDS will have to join a Medicaid health plan or an HIV Special Needs Plan (HIV SNPs). You will receive a letter from New York Medicaid CHOICE telling you that you must join a Medicaid health plan or an HIV Special Needs Plan. If you do not receive SSI benefits, you will have 60 days to choose a health plan for you and your family. You can ask for another 30 days if you need more time to decide. If you have SSI you will have 90 days to choose a plan. If you do not choose a plan, one will be chosen for you. But you do not have to wait for the letter to choose a health plan. You can join a health plan at any time, or stay with regular Medicaid until you get a letter telling you that you must join. When you join a health plan you must go the doctors in the plan for your medical visits. This is why it is important to speak to your doctors or New York Medicaid CHOICE so that you can get into a health plan that works best for you.

If you want to continue to get your health care from providers who work in our Hospital (or Clinic), you must choose a health plan that we work with. We do not work with every health plan. Here is a list of the Medicaid health plans our providers work with:
(Insert name and 800 toll free number for each affiliated health plan).

There are also several HIV Special Needs Plans available for people on Medicaid who have HIV or AIDS. We do not work with every HIV SNP. Here is list of the SNPs we work with:

(Insert name and 800 toll free number for each affiliated health plan).

There are some people who may have special reasons and are not required to join a plan. If you have questions or want to find out if you must join a health plan, call the New York Medicaid CHOICE Helpline at 1-800-505-5678. People with hearing problems can call New York Medicaid CHOICE at 1-888-329-1541 (TTY/TDD).

Our Hospital (or Clinic) staff can also help you. Our staff can be reached at _____.

Sincerely,

Name of Provider

Estimado Paciente:

Su Medicaid está cambiando. De ahora en adelante, la mayoría de las personas incluyendo aquellas con VIH/SIDA tendrán que inscribirse en un plan de salud de Medicaid o en un Plan de Salud para Necesidades Especiales del VIH (SNPs por su siglas en inglés). Usted recibirá una carta de Medicaid CHOICE indicándole que usted tiene que inscribirse en un plan de salud regular de Medicaid o en un Plan Para Necesidades Especiales del VIH. Si usted no recibe SSI tendrá 60 días para escoger un plan de salud para usted y su familia. Usted puede pedir 30 días adicionales si necesita más tiempo para decidir. Si usted recibe SSI tendrá 90 días para escoger un plan. Si usted no escoge un plan, se le asignará uno. Usted no tiene que esperar hasta recibir la carta para escoger un plan de salud. Usted puede inscribirse en un plan en cualquier momento o continuar con su Medicaid regular hasta
recibir la carta indicándole que tiene que inscribirse. Cuando usted se inscribe
en un plan tiene que ir a doctores que estén en su plan para sus visitas médicas. Por lo tanto, es importante que hable con sus doctores o con New York Medicaid CHOICE para que escoja el plan de salud que más le convenga.

Si usted desea seguir obteniendo su cuidado de salud por proveedores que trabajan en nuestro hospital o clínica, deberá escoger un plan de salud que participe con nosotros. Nosotros no participamos con todos los planes de salud. Aquí está la lista de los planes de Medicaid que participan con nuestros proveedores:
(Insert name and 800 toll fee number for each affiliated health plan).

También hay disponibles algunos Planes de Salud para Necesidades Especiales del VIH para personas que reciben Medicaid y tienen VIH/SIDA. Nosotros no trabajamos con todos los SNPs. Aquí está la lista de los SNPs que participan con nosotros:

Algunas personas pueden tener una razón especial por la cual no se les requiere que se inscriban en un plan. Si tiene preguntas o desea saber si usted tiene que inscribirse en un plan de salud, llame a la línea de ayuda de New York Medicaid CHOICE al 1-800-505-5678. Las personas con problemas de audición pueden llamar a New York Medicaid CHOICE al 1-888-329-1541 (TTY/TDD).

Nuestro personal del hospital (o clínica) puede también ayudarlo. Para
comunicarse con nuestro personal llame al
_____.

Atentamente,

(Nombre del proveedor)

Definitions

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

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

SDOI shall mean the New York State Department of Insurance.

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

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

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

NYSDOH shall mean the New York State Department of Health.

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

Emergency Condition shall mean a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person. N.Y. ISC. LAW 4303: NY Code - Section 4303.

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

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

AMIDA CARE COMPLIANCE HOTLINE 888.394.2285

If you suspect fraud, waste, or abuse:

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

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

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

Other options for reporting anonymously:

Compliance mailbox: compliance@amidacareny.org

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

Amida Care, Inc.
14 Penn Plaza, 2nd Floor
New York, NY 10122
800-556-0674
TTY Users, 711
Monday – Friday 9 a.m. to 5 p.m.
www.amidacareny.org