TABLE OF CONTENTS

SECTION 1  INTRODUCTION
ABOUT THIS MANUAL.................................................................................................................5
MISSION STATEMENT, VISION, & VALUES.................................................................................6
PRODUCTS..................................................................................................................................7

SECTION 2  MEMBER ELIGIBILITY VERIFICATION
IDENTIFICATION/VERIFICATION OF MEMBER ELIGIBILITY STATUS........................................8
SAMPLE ID CARDS (MEDICAID, HARP, CHP, QHP, AND FIDELIS FAMILY PLANNING).............9

SECTION 3  ABUSE AND NEGLECT INCIDENT REPORTING
ABUSE AND NEGLECT ................................................................................................................11
VULNERABLE PERSONS ...............................................................................................................12
MANDATED REPORTERS...............................................................................................................12
REPORTING ABUSE AND NEGLECT TO THE VULNERABLE PERSONS CENTRAL REGISTER ......13
LAWS PERTAINING TO THE JUSTICE CENTER...........................................................................14
REPORTING CHILD ABUSE AND NEGLECT.............................................................................14

SECTION 4  MEDICAID
MEMBER RIGHTS ......................................................................................................................16
ROLES AND RESPONSIBILITIES OF ALL PROVIDERS............................................................16
ADDITIONAL ROLES AND RESPONSIBILITIES OF PCPS.......................................................17
PCP PANEL CLOSING ..................................................................................................................18
PCP INITIATED PANEL CHANGES............................................................................................18
SPECIAL CONSIDERATION FOR OB/GYNS.............................................................................18
MEDICAL RESIDENTS AND FELLOWS .................................................................................19
ACCESSIBILITY STANDARDS.....................................................................................................19
MEDICAL MANAGEMENT ..........................................................................................................20
CARE COORDINATION AND CARE MANAGEMENT.................................................................20
MEMBER IDENTIFICATION .........................................................................................................20
COVERED AND NON-COVERED SERVICES ..............................................................................21
NURSING HOME .......................................................................................................................21
REFERRALS..................................................................................................................................22
AUTHORIZATIONS ......................................................................................................................22
EMERGENCY PROCEDURES.......................................................................................................22
ACCESS TO SPECIALTY CARE .................................................................................................23
CONTINUITY OF CARE ..............................................................................................................24
RECIPIENT RESTRICTION PROGRAM .......................................................................................25
TRANSPORTATION ...................................................................................................................25
PHARMACY MANAGEMENT .......................................................................................................25
UTILIZATION MANAGEMENT .....................................................................................................26
UTILIZATION REVIEW DECISIONS ...........................................................................................25
PRE-AUTHORIZATION ................................................................................................................27
APPEAL OF UTILIZATION REVIEW DECISIONS ........................................................................29
EXTERNAL REVIEW ....................................................................................................................31
SECTION 5 | HEALTH AND RECOVERY PLAN

OVERVIEW ............................................................................................................. 45
ENROLLMENT AND ELIGIBILITY ........................................................................ 45
SAMPLE ID CARDS ................................................................................................ 46
COVERED SERVICES .............................................................................................. 47
BEHAVIORAL HEALTH SERVICES ..................................................................... 47
HOME AND COMMUNITY BASED SERVICES .................................................... 49
ACCESSIBILITY STANDARDS ............................................................................. 54
HEALTH HOMES ................................................................................................... 55

SECTION 6 | MEDICARE

OVERVIEW ............................................................................................................. 56
ENROLLMENT AND ELIGIBILITY ........................................................................ 57
SAMPLE ID CARDS ................................................................................................ 57
BENEFIT INFORMATION ....................................................................................... 58
MEMBER PROCEDURE FOR TRANSPORTATION ............................................ 59
REGULATORY REQUIREMENTS FOR MEDICARE ADVANTAGE .................. 60
AFFINITY’S MODEL OF CARE ........................................................................... 61
MEDICAL RECORDS ............................................................................................. 63
APPOINTMENT AVAILABILITY STANDARDS/ACCESS TO MEDICAL CARE ...... 64
TERMINATION AND SUSPENSION ..................................................................... 64
BILLING AND CLAIMS ......................................................................................... 65
GRIEVANCES AND APPEALS ............................................................................. 65
PRIOR AUTHORIZATION ....................................................................................... 71
MEMBER RIGHTS AND RESPONSIBILITIES ...................................................... 72
# SECTION 7 QUALIFIED HEALTH PLAN

OVERVIEW .................................................................................................................... 74
ENROLLMENT AND ELIGIBILITY .................................................................................. 74
BENEFIT INFORMATION ................................................................................................. 74
MEDICAL RECORDS ........................................................................................................ 75
APPOINTMENT AVAILABILITY STANDARDS/ACCESS TO CARE ................................. 76
TERMINATION AND SUSPENSION .................................................................................. 76
BILLING AND CLAIMS ...................................................................................................... 77
GRIEVENCES AND APPEALS .......................................................................................... 77
PHARMACY MANAGEMENT ............................................................................................ 79
MEMBERS RIGHTS AND RESPONSIBILITIES .................................................................. 80
SAMPLE ID CARDS .......................................................................................................... 81

# SECTION 8 CASE MANAGEMENT PROGRAMS

CASE MANAGEMENT PROGRAMS .................................................................................... 82

# SECTION 9 RESTRICTION ROSTER

SAMPLE RESTRICTION ROSTER ...................................................................................... 83

# SECTION 10 PCP INFORMATION ABOUT BEHAVIORAL HEALTH

PCP INFORMATION ABOUT BEHAVIORAL HEALTH ....................................................... 84

# SECTION 11 FRAUD WASTE AND ABUSE

DEFINITIONS ..................................................................................................................... 87
EXAMPLES OF MEMBER FRAUD, WASTE AND ABUSE .............................................. 87
EXAMPLES OF PROVIDER FRAUD, WASTE AND ABUSE ............................................ 87
FEDERAL AND STATE FALSE CLAIMS ACT AND OTHER RELEVANT LAWS .................. 88
PROTECTION FOR REPORTS OF FRAUD, WASTE AND ABUSE ................................. 90
PROHIBITED AFFILIATIONS ............................................................................................. 91
OWNERSHIP, DEBARMEMENT AND CRIMINAL CONVICTIONS .................................. 91
SANCTION SCREENINGS ................................................................................................. 91
GENERAL COMPLIANCE & FRAUD, WASTE AND ABUSE TRAINING .......................... 92
HOW TO REPORT COMPLIANCE CONCERNS, INCLUDING FRAUD, WASTE AND ABUSE .... 93

# SECTION 12 SERVICES REQUIRING AUTHORIZATIONS

SERVICES REQUIRING AUTHORIZATIONS ...................................................................... 94
QUICK REFERENCE GUIDE ............................................................................................... 94
INTRODUCTION

ABOUT THIS MANUAL

Thank you for joining the Affinity Health Plan (“Affinity”) network. This Provider Manual is provided to orient you and your staff on the policies, procedures and expectations related to your network participation; the Provider Manual is not intended to alter or modify any benefits to which an Affinity Member (“Member”) is entitled. To the extent that policies, procedures and expectations are unique to a particular product, they are delineated in the product line addenda at the end of this Provider Manual. This Provider Manual will be amended as our operational policies change. The most current version of the Provider Manual is always available on our website at www.affinityplan.org, where you can also access our Provider Portal (https://affinityportal.affinityplan.org) to check out Member eligibility, claim status, primary care provider (“PCP”) panel assignment, etc. 24 hours a day, 7 days a week. The Provider Portal registration process will be required and takes only a few minutes where you can establish a secure user name and password.

If you have any questions that are not addressed in this Provider Manual and cannot be answered or resolved through our website, please call our main switchboard at (866) 247-5678. For your convenience, a quick reference guide is also included on the final page of this Provider Manual.

We value your contribution to your Patients and our Members; we are dedicated to making your participation a success!
ABOUT AFFINITY HEALTH PLAN

Affinity (originally known as Bronx Health Plan) opened for business in 1987 with an idea to work closely with community health centers and other primary care practices in order to offer affordable high quality health coverage to “underserved” New Yorkers. Today, Affinity works with more than 10,000 primary care and specialty care providers to ensure our Members receive the services they need.

Our Mission, Vision and Values:

Mission

To improve the health and wellbeing of our Members, their communities and families in cooperation with primary care providers.

Vision

Affinity strives to be the health plan of choice for its Members and its providers; to be known for assuring access to high quality cost-effective care, to deliver the best customer experience and to significantly contribute to achieving a patient-centered health care system.

Values

We recognize and accept the importance of shared personal values in achieving our mission, in increasing personal effectiveness, and in demonstrating our commitment to our members, providers, and employees. The values that are most important to us are:

- Commitment to improving health and healthcare
- Integrity and honesty during interactions
- Respect and care for others
- Partnership with organizations and those who share our values and goals
- Pride in our communities, our daily work, and our accomplishments
- Promoting constructive change and innovative environment
- Encouragement and support of personal and organizational achievements
AFFINITY PRODUCTS

We currently offer the following Healthcare coverage programs:

- **Medicaid Managed Care ("MMC")**: a federal/state health insurance program for low-income individuals, families and children.

- **Health and Recovery Plan ("HARP")**: a specialty line of business for adults enrolled in Medicaid, 21 years or older, meeting the targeting criteria and risk factors for Serious Mental Illness (SMI) and Substance Use Disorders. In addition to the existing mainstream benefit package and the carved-in Behavioral Health services, an enhanced benefit package of Behavioral Health Home and Community Based Services (BH HCBS) will be offered for enrolled individuals who meet both the targeting and need-based criteria.

- **Child Health Plus ("CHP")**: a New York State sponsored health insurance program for children under the age of 19 who do not qualify for Medicaid.

- **Qualified Health Plan ("QHP")**: a federal/state insurance program that is certified by the Health Insurance Marketplace. It provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets additional regulations.

- **Essential Plan ("EP")**: a federally authorized Basic Health Program ("BHP") operated by New York State and offered through the New York State of Health marketplace for qualified lower-income NYS residents and certain legally present immigrants. Provides essential health benefits, has a zero or 20 dollar premium (depending on income level), no deductible, and follows established limits on cost-sharing.

- **Family Planning Benefit**: for certain CHP Members of Fidelis Care NY®, family planning services such as advice about birth control, pregnancy prevention and testing, testing and treatment for sexually transmitted diseases, abortion, birth control or other family planning prescriptions filled at a pharmacy, and HIV counseling and testing when done during a family planning visit.

- **Medicare Advantage HMO**: a type of Medicare Advantage Prescription Drug (MAPD) Plan. Membership is open to all Medicare eligible beneficiaries. Our three MAPD plans are Medicare Advantages, **Affinity Medicare Essentials**, **Affinity Medicare Select**, and **Affinity Medicare Elite**.

- **Dual Special Needs Plans ("SNPs")**: a type of Medicare Advantage Plan (like an HMO or PPO) in which Membership is limited to individuals with specific diseases or characteristics. Our two SNPs, **Affinity Medicare Ultimate** and **Affinity Medicare Solutions**, are (remove are) for New Yorkers who are dually eligible for Medicare and Medicaid.

- **Medicaid Advantage**: in order to better integrate care delivery, Medicaid Advantage provides a defined set of Medicaid wraparound benefits to Affinity Medicare Ultimate SNP plan benefits.

In as much as we continue to explore ways to **enhance our product** offerings, the above list (like other elements of this Provider Manual) is subject to change.
MEMBER ELIGIBILITY VERIFICATION

IDENTIFICATION/VERIFICATION OF MEMBER ELIGIBILITY STATUS

You are encouraged to verify Member eligibility status at each time of service since claims for non-eligible individuals, subject to limited exceptions, will be denied. The following mechanisms are available for this purpose:

- Looking up the Member’s eligibility for Medicaid and CHP on the Provider Portal at [https://affinityportal.affinityplan.org](https://affinityportal.affinityplan.org)

- Looking up the Member’s eligibility for AFFINITYACCESS on the Provider Portal at [affinityQHPproviderlogin.com](affinityQHPproviderlogin.com)

- Conducting an ePaces inquiry (for MMC and Members) at [https://www.emedny.org/epaces/](https://www.emedny.org/epaces/), using code “Eligible PCP 82”

- For CHP and MMC participants - contact Affinity Health Plan at (866) 247-5678

- Fidelis - Family Planning Services participants ONLY, you may contact Affinity Health Plan (866) 247-5678

- AFFINITYACCESS - contact Affinity Health Plan at (888) 543-6973

Examples of the ID cards we issue to our Members are shown below. Even when an ID card is presented, a Member’s current eligibility must still be confirmed.

NOTE: The program codes on the ID cards are as follows: ME (Medicaid), CH (Child Health Plus), and FD (Family Planning Benefit).
ABUSE AND NEGLECT INCIDENT REPORTING

ABUSE AND NEGLECT

New York law defines abuse and neglect of vulnerable persons in broad terms, including both actual harm and the risk of harm. The following are a list of terms and some examples of abuse and neglect.

- **Physical Abuse** - Intentional contact (hitting, kicking, shoving, etc.) corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time, or the frequency over time.

- **Psychological Abuse** - Taunting, name calling, using threatening words or gestures.

- **Sexual Abuse** - Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation.

- **Neglect** - Failure to provide supervision, or adequate food, clothing, shelter, health care; or access to an educational entitlement.

- **Deliberate misuse of restraint or seclusion** - Use of these interventions with excessive force, as a punishment or for the convenience of staff.

- **Controlled Substances** - Using, administering or providing any controlled substance contrary to law.

- **Aversive conditioning** - Unpleasant physical stimulus used to modify behavior without person-specific legal authorization.

- **Obstruction** - Interfering with the discovery, reporting or investigation of abuse / neglect, falsifying records or intentionally making false statements.
VULNERABLE PERSONS

Vulnerable persons are individuals with special needs who are receiving supports or services at state operated, licensed and certified facilities and programs.

MANDATED REPORTERS

New York State and the New York State Child Protective System recognize certain professionals as holding the important role of mandated reporter. These professionals can be held liable by both the civil and criminal legal systems for intentionally failing to make a report.

Mandated reporters are required to report instances of suspected abuse or maltreatment only when they are presented with reasonable cause to suspect abuse or maltreatment in their professional roles.

You are a mandated reporter if you are part of the following two groups:

1. Custodians:
   Custodians are individuals who are employed by, or volunteer at, state operated, licensed or certified facilities or agencies under the Justice Center’s jurisdiction. Consultants, volunteers or contractors of organizations or companies that contract with facilities and agencies under the Justice Center’s jurisdiction are also considered to be custodians if they have regular and substantial contact with a service recipient.

2. Human Service Professionals: (Medical/Clinical Professionals, Education Professionals, Law Enforcement Professionals)
   Child Care or Foster Care Worker; Chiropractor; Christian Science Practitioner; Coroner; Dental Hygienist; Dentist; District Attorney or Assistant District Attorney; Emergency Medical Technician; Hospital Personnel engaged in the admission, examination, care, or treatment of persons; Intern; Investigator employed in the office of the district attorney; any other Law Enforcement Official; Licensed Creative Arts Therapist; Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Occupational Therapist; Licensed Physical Therapist; Licensed Practical Nurse; Licensed Psychoanalyst; Licensed Speech-Language Pathologist/Audiologist; Medical Examiner; Mental Health Professional; Nurse Practitioner; NYS Office of Alcoholism and Substance Abuse - all persons credentialed by OASAS; Optometrist; Osteopath; Peace Officer; Physician; Podiatrist; Police Officer; Psychologist; Registered Nurse; Registered Physician’s Assistant; Resident (medical); Social Services Worker; Social Worker; Surgeon, and School Official, including but not limited to: School Teacher, School Guidance Counselor; School Psychologist; School Social Worker; School Nurse; School Administrator; or other school personnel required to hold teaching or administrative license or certificate.

Please be aware that there may be changes to this list, the current list is at Section 413 of the New York State Social Services Law.
REPORTING ABUSE AND NEGLECT TO VULNERABLE PERSONS CENTRAL REGISTER

The trained call center representative who answers your call will ask you for as much information as you can provide about the suspected abuse, neglect or maltreatment and the location where it occurred. Below are examples of some of the questions you might be asked when you call.

- What is the victim’s name?
- What happened to the victim?
- Who caused the harm?
- Where did the incident occur?

When a caller makes a report, the call center representative carefully enters all details of the incident into an automated case management system. The trained call center representative will first determine if an emergency response is necessary and/or if the person receiving services faces imminent danger. If it is an emergency situation, the representative will instruct the caller to phone 9-1-1 immediately, if this has not yet occurred. Serious abuse and neglect cases will be investigated by the Justice Center, with lesser offenses generally delegated to the appropriate state agency for investigation. If criminal conduct may be involved, the Justice Center's Special Prosecutor/Inspector General will investigate and prosecute offenders when the evidence warrants such action.

All calls made to the Vulnerable Persons Central Register Hotline are recorded for quality assurance however, all reports are confidential. The law provides protections against the disclosure of a reporter’s identity, subject to limited exceptions such as consent from the reporter or in the event of a court order. The law grants immunity to voluntary reporters and Mandated Reporters from any legal claims which may arise from a good faith act of providing information to the Vulnerable Persons Central Register Hotline. An employer or agency is prohibited from taking any retaliatory action against a person who has made a good faith act of providing information to the hotline.

Reports of suspected abuse and neglect of a person in state care should be made immediately—at any time of the day or night and on any day of the week—by telephone to the Vulnerable Persons Central Register Hotline (sometimes referred to as VPCR). If an individual is in immediate danger you will be asked to hang up and call 9-1-1.

The telephone numbers to contact the VPCR hotline are:

**Vulnerable Persons Central Register (VPCR) Hotline Number:**
- TOLL FREE: 1-855-373-2122
- TTY: 1-855-373-2123

**INCIDENT REPORTING FORM:**
[https://vpcr.justicecenter.ny.gov/WIRW/#/](https://vpcr.justicecenter.ny.gov/WIRW/#/)

**Justice Center for the Protection of People with Special Needs:**
LAWS PERTAINING TO THE JUSTICE CENTER

The “Protection of People with Special Needs Act” created new safeguards for people with special needs who are served by state operated, licensed or certified facilities and programs. These standards and practices have been implemented to protect individuals in state care against abuse, neglect or other conduct that would jeopardize their health, safety and welfare.

The agencies include: the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS); the Office of Children and Family Services (OCFS), certain adult homes overseen by the Department of Health (DOH) and residential schools and programs overseen by the State Education Department (SED).

Chapter 501 of the Laws of 2012 defines abuse and neglect, vulnerable persons and the process and procedures regarding Justice Center investigations, outcomes and records.

REPORTING CHILD ABUSE AND NEGLECT

Reports of suspected child abuse or maltreatment should be made immediately -- at any time of the day and on any day of the week -- by telephone to the New York Statewide Central Register of Child Abuse and Maltreatment (sometimes referred to as the State Central Register or SCR).

The Child Protective Specialist who answers your call will ask you for as much information as you can provide about both the suspected abuse or maltreatment and the family about which you are calling. Below are examples of some questions the Child Protective Specialist might ask you when you call. Even if you have very little information available to you, please call the SCR. The specialists will analyze the information you do have and determine if it is sufficient to register a report. Below are examples of some of the questions you might be asked when you call.

- What is the nature and extent of the child's injuries, or the risk of harm to the child?
- Have there been any prior suspicious injuries to this child or his/ her siblings?
- What is the child's name, home address, and age?
- What is the name and address of the parent or other person legally responsible who caused the injury, or created the risk of harm to the child?
- What are the names and addresses of the child's siblings and parents if different from the information provided above?
- Do you have any information regarding treatment of the child, or the child's current whereabouts?
The Child Protective Service (CPS) unit of the local department of social services is required to begin an investigation of each report within 24 hours. The investigation should include an evaluation of the safety of the child named in the report and any other children in the home, and a determination of the risk to the children if they continue to remain in the home.

CPS may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment. Based upon an assessment of the circumstances, CPS may offer the family appropriate services. The CPS caseworker has the obligation and authority to petition the Family Court to mandate services when they are necessary for the care and protection of a child.

CPS has 60 days after receiving the report to determine whether the report is "indicated" or "unfounded". The law requires CPS to provide written notice to the parents or other subjects of the report concerning the rights accorded to them by the New York State Social Services Law. The CPS investigator will also inform the SCR of the determination of the investigation.

According to Section 240.50 of the New York State Penal Law, falsely reporting an incident to the State Central Register is a Class A misdemeanor. If you are the victim of a false report, you should contact your local District Attorney's office to discuss what options are available.

Child Abuse Hotline Number:
TOLL FREE 1-800-342-3720

If you are reporting abuse or maltreatment of a child by a parent or other person legally responsible for that child, or by a day care program, please call the NY Statewide Central Register of Child Abuse and Maltreatment at 1-800-342-3720. Additional information can be found on the:


Within 48 hours of an oral report, a written report must be written using form LDSS 2221A:

http://www.ocfs.state.ny.us/main/forms/cps/
MEMBER RIGHTS

While enrolled in Affinity, Members healthcare rights are an important part of their participant services. Throughout your participation, you must allow Members to:

- Obtain clear, complete and current information with regard to diagnoses, treatments and prognoses in terms the Member can understand. When it is not advisable to give such information to the Member, the information must be made available to an appropriate person acting on the Member’s behalf.
- Receive information as necessary to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment (to the extent permitted by law) and to be informed of the medical consequences of that action.

ROLES AND RESPONSIBILITIES OF ALL PROVIDERS

As a participating provider, you must:

- Provide services that adhere to accepted medical practice standards.
- Refrain from discriminatory practices, actions or language against any Member on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services, or payment that you will receive.
- Cooperate with and comply with Affinity’s reimbursement, quality assurance, utilization review, referral, complaint/grievance, and all other processes/functions.
- Adhere to all laws related to obtaining informed consent for treatment.
- Comply with all laws related to advance directives and provide care and treatment according to the wishes of the Member.
- Make reasonable efforts to assure timely and accurate compliance with other mandated reporting requirements, including the following:
  - Infants and toddlers suspected of having a developmental delay or disability.
  - Suspected instances of child abuse; and
  - Additional reporting requirements pursuant to State law and, for contractors operating in New York City, the New York City Health Code.
- Maintain standards for documentation and confidentiality, and retain these medical records as required by applicable law, allowing QHP/AffinityAccess to view said records, as needed.
• Maintain appointment availability and appointment waiting times in accordance with Affinity standards (set forth below)

• Report encounters in a timely manner

• Report communicable diseases, immunizations, lead testing, etc., consistent with New York State requirements

• Notify Affinity of any changes to the information contained in your application, including address, phone number, office hours, on-call arrangements, insurance, and the like

• Notify us of all emergency admissions within 24 hours (applicable to emergency room or admitting hospital)

ADDITIONAL ROLES AND RESPONSIBILITIES OF PCPS

Primary care includes those services that are necessary and appropriate to promote, preserve, and restore optimal health.

Primary Care Providers (PCPs) are required to:

• Supervise and coordinate medically necessary care not directly delivered

• Maintain 24/7 telephone coverage. Answering machine must direct to a live voice

• Comply with all standards of care applicable to PCPs that are described in Affinity’s Quality Assurance Program and are consistent with generally accepted standards of medical practice

• Conduct Child/Teen Health Program screening for MMC children and adolescents and behavioral health screenings for all MMC Members as appropriate

• Coordinate, provide, monitor, and supervise the delivery of all healthcare services, including inpatient care, for any Member assigned

• Provide health counseling and advice

• Conduct baseline and periodic health examinations

• Diagnose and treat conditions not requiring the services of a specialist

• Refer for consultations with specialists, laboratories, and radiological services when necessary

• Admit Members for inpatient care, as needed, based upon medical needs and best practices

• Coordinate findings of consultants and laboratories, then interpret and explain such findings for the Member

• Coordinate the medical care of Members who have sought medical services at emergency rooms and refer to participating specialists, as necessary, following emergency treatment
• Provide periodic assessments and Member education, as clinically necessary, including preventive care measures

• Contact Affinity immediately in the event that you are no longer able to provide services to a Member. Additionally, you must provide a written notice explaining same to the affected Affinity Member(s)

PCP Panel Closing

A PCP’s panel will be closed upon reaching the maximum number of Members permitted under New York Department of Health standards based on a 40-hour, full-time employment status. A PCP's panel may also be closed:

• Per PCP request, so long as the PCP has already accepted a minimum of 400 Members before closing the panel or as specified in the agreement between the Primary Care Provider and Affinity

• By Affinity, if at any time the PCP is no longer able to care for additional Members

We will notify a PCP prior to closing his/her panel.

PCP-Initiated Panel Changes

In the event that a PCP determines that he/she is no longer able to provide services to a Member, he/she must make a written request to remove the Member from the roster. Affinity will approve the request if the PCP has sufficiently demonstrated good cause, examples of which include:

• Fraudulent acts in obtaining services

• Abuse to the PCP or his/her staff

At no time shall the volume of services requested or utilized by the Member be considered a valid reason for transfer of a Member.

SPECIAL CONSIDERATIONS FOR OB/GYNS

Female Members are afforded direct access to primary and preventive obstetrics and gynecology services, follow-up care as a result of a primary and preventive visit, and any care related to pregnancy from participating providers of their choice, without referral from a PCP. Additionally, family planning and reproductive health services may be accessed in the following manner:

• MMC Members may receive such services from any qualified Medicaid provider, regardless of whether the provider participates with Affinity, without referral from a PCP and without approval from Affinity.
MEDICAL RESIDENTS AND FELLOWS

Only attending physicians and nurse practitioners may be assigned as a Member’s PCP. Residents are not credentialed as PCPs or Specialists by Affinity Health Plan and therefore may not be assigned as a Member’s PCP.

Nurse Practitioners may not act as attending preceptors for the resident physicians. Residents are restricted to acting under the supervision of the Member’s PCP or by a fully licensed Affinity-credentialed physician. Responsibility for care of the Member rests with the attending PCP or Specialty provider. An attending PCP may not supervise more than four (4) residents at one time. Members have the right to request an appointment with their assigned PCP, and must be informed of this right and the underlying resident/attending physician relationship.

ACCESSIBILITY STANDARDS (Appointments and Timeframes)

You must have an appointment system that meets the following standards for appointment availability:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td>Urgent medical</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Non-Urgent sick visits</td>
<td>Within 48-72 hours, as clinically indicated</td>
</tr>
<tr>
<td>Routine, non-urgent or preventive care (including well child visit)</td>
<td>Within 4 weeks of request</td>
</tr>
<tr>
<td>Adult baseline and routine physical examination</td>
<td>Within 12 weeks of enrollment</td>
</tr>
<tr>
<td>Specialist referrals (non-urgent)</td>
<td>Within 4 to 6 weeks of request</td>
</tr>
<tr>
<td>Ancillary services</td>
<td>Same day as visit, if medically necessary</td>
</tr>
<tr>
<td>Initial family planning visits</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Initial prenatal visit</td>
<td>Within 3 weeks of request during first trimester, 2 weeks during second trimester, and 1 week thereafter</td>
</tr>
<tr>
<td>Initial newborn visit to PCP</td>
<td>Within 2 weeks of hospital discharge</td>
</tr>
<tr>
<td>Pediatric routine visits</td>
<td>Within 4 weeks</td>
</tr>
<tr>
<td>Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits (as included in the benefit package)</td>
<td>Within 5 days of request, or as clinically indicated</td>
</tr>
<tr>
<td>Non-urgent mental health or substance abuse visits (as included in the benefit package)</td>
<td>Within two 2 weeks of request</td>
</tr>
<tr>
<td>Assessments for the purpose of making recommendations regarding ability to perform work when requested by a LDSS</td>
<td>Within 10 days of request for MMC Members</td>
</tr>
</tbody>
</table>

WAIT TIMES

Appointment waiting times should not exceed 1 hour for scheduled appointments. A walk-in Member with non-urgent needs should be seen within 2 hours or be scheduled for an appointment. Walk-in Members with urgent needs should be seen within 1 hour.
MEDICAL MANAGEMENT

CARE COORDINATION AND CARE MANAGEMENT

Affinity is focused on providing the Member with the best care management experiences in coordination with their PCP and Specialists to ensure they maintain optimum health and wellness. We practice Member-centric care coordination and care management approach. In addition, we encourage Member engagement in appropriate intensive specialty care management programs that target specific population needs and diseases.

Our case managers work with our Members/your Members to assist with coordination of care, such as referrals to specialists, home care services, psychosocial issue resolution, medication compliance/adherence, and utilization of services based on best practices and evidence-based guidelines. The care management process includes a thorough assessment, interventions to address identified needs, evaluation of the interventions, and outcome analysis, all to ensure that the Member is receiving optimal benefits from the mutually agreed-upon comprehensive plan of care. Our care management efforts also include a comprehensive Transition of Care program to assist Members in the (remove this) transition from an inpatient setting to back to home.

Care management services are most effective when the Member, the provider and the case manager work together. Our case managers are available to discuss Members’ plans of care and to assist with coordination of services prescribed. We welcome referrals for care management from our providers and thus welcome your outreach to us to engage your patient in care management by calling us or faxing in a request.

Health Homes

Affinity participates with many Health Homes in its service area. A 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 so that needed services are provided timely. In concert with Affinity Health Plan, the health home services are provided through a network of organizations - providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual "Health Home."

Member Identification

NYS DOH is using a risk stratification model to identify Members with the greatest needs that should be managed by a Health Home. The identified list of Members (assignment file) is sent to the various Health Plans who in turn collaborate with Lead Health Homes in their service delivery area to manage these Members.

Members Receive the Following in a Health Home:

- Comprehensive care coordination by a dedicated case manager
- Comprehensive individualized care plan developed for each Member
- Help and encouragement in getting necessary tests
- Help and follow-up when discharged from the hospital
- Personal support and support for their caregiver or family
- Referrals and access to community and social support services
COVERED AND NON-COVERED SERVICES

A Benefit Grid detailing the benefits we currently cover for each product, organized by product line, is available at www.affinityplan.org. This Benefit Grid also indicates which services require prior-authorization.

- You may not bill Members for services covered by Affinity, except for applicable co-payments, co-insurance, or deductibles; and
- You must advise Members, prior to initiating service, when a particular service is not covered by Affinity, and to state the cost of the service.

Best Practices

Current plan members of Affinity Health Plan will not be dis-enrolled if they require long-term placement. Affinity Health Plan will continue to provide coverage and will also manage all of their nursing home services. No plan member will be required to change nursing homes as a result of this transition.

New placements will be based upon the needs of the individual.

The individuals in long term placement facilities will receive the following services:

- Medical supervision
- 24-hour nursing care
- Assistance with activities of daily living
- Physical therapy
- Occupational therapy
- Speech – Language pathology

Advantage of MCOs overseeing Nursing Home Population:

- Expert Case Management
- Coordinated efforts among clinical professionals
- Cost-effective Utilization Management
- Managing and monitoring cost:
  - Diagnosis
  - Treatment
  - Trending

Medical Management will follow the same process for a Nursing Home admission request as the existing process for an elective admission to a facility. The request for admission must meet medical necessity along with a review of the UAS, PASRR and PRI. If approved, the member will be reassessed every 6 months for continued stay which includes the information obtained via the UAS. An approval by the Medical Management department can be revoked based on the review of the LDSS on the member’s financial eligibility. If this occurs the entire or part of the approved service can be denied at a future date from the date of approval. Members who are not denied by the LDSS will be handled by Affinity’s Case Management for safe discharge.
REFERRALS

PCPs may refer Members to any Specialists or ancillary providers within the Affinity network. Referral forms are not required when a PCP requests that a member be evaluated and/or treated by a specialist or ancillary provider. Members are advised to visit their PCP for specialty care, except for services that Members may access directly.

Referral forms are not required. However, it is important that a primary care provider documents the reason for the referral in a member’s record, as well as the name of the specialist or ancillary provider. In lieu of a referral form, it is suggested, but not required, that the primary care provider write a prescription or note to the member to present to the specialist. This will assist the specialist in understanding the source of the referral and why the member was referred. It is equally important that the specialist document the source and the reason of the request in the member’s record.

AUTHORIZATIONS

In order to determine the medical necessity of a service, you may be required to submit clinical information. Once clinical information is received, an authorization number will be assigned for billing purposes. In order for the claim to be eligible for reimbursement, the service authorized must match the service on the claim. The timeframes and processes associated with determinations related to authorization requests are highlighted in the Utilization Review portion of this Provider Manual.

Please note that Affinity continues to require authorizations for specific services. Information on authorizations, as well as a detailed description of the benefits covered under each Affinity product, can be found on our website at: http://www.affinityplan.org/authorizations/

Denials of Pre-Authorized Services

There are instances when a provider requests and receives authorization, but by the time, the claim is submitted circumstances have changed. We reserve the right to deny claims for authorized services in a manner consistent with INS § 3238.

EMERGENCY PROCEDURES

An “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 behavioral health condition, placing the health of such person or others in serious jeopardy
- Serious impairment to such person’s bodily functions; serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person. “Emergency Services” means health care procedures, treatments, or services needed to evaluate or stabilize an Emergency Medical Condition, including psychiatric stabilization and medical detoxification from drugs or alcohol
Emergency Services are not subject to prior approval and may be obtained from a non-participating provider without penalty. Affinity maintains telephone coverage utilizing a toll free 24/7 number answered by a live person, to advise Members of procedures for accessing services for Emergency Medical Conditions.

PCPs and OB/GYN providers must also provide Members with access to a live person 24 hours per day, 7 days per week for after-hours emergency consultation and care. If the provider uses an answering machine after-hours, the message must direct the Member to a live person.

ACCESS TO SPECIALTY CARE

Members may self-refer for certain specialist services such as OB/GYN care (e.g., prenatal care, 2 routine visits per year and any follow-up care, acute gynecological condition).

MMC Members may additionally self-refer for:

- One mental health visit and one substance abuse visit with a participating provider per year for evaluation
- Vision services with any participating provider
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from a participating provider or Medicaid provider

For those services for which Members may not self-refer, PCPs have the responsibility to identify specialist providers within the Affinity network for each instance when such services are determined to be medically necessary for the Member. Subject to any applicable appeal right, Affinity reserves the right to recoup the cost of services rendered by a non-participating provider from the Affinity referring provider.

Out-of-Network Referral Exception

Referral to a non-participating provider may occur when: a) the Affinity network does not include an available provider with the appropriate training and experience to meet the needs of Members; or b) medically necessary services are not available through Affinity network providers. The referral must be approved by Affinity and will be made pursuant to a treatment plan approved by Affinity, the PCP, and the non-participating provider. In general, Members may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment.

If a member is Native American and the member chooses to access primary care services through his/her tribal health center, the PCP authorized by Affinity to refer the member for services included in the Benefit Package must develop a relationship with the member’s PCP at the tribal health center to coordinate services for said Native American members.

Standing Referral

Members who need ongoing care from a specialist may receive a standing referral to such specialist. If we (or the PCP in consultation with Affinity’s Chief Medical Officer and the specialist, if any) determine that such a standing referral is appropriate, the associate request will be approved. Such referral will be pursuant to an Affinity-approved treatment plan in consultation with the PCP, the specialist, and the Member or his/her designee.
**Specialist as PCP**

A Member diagnosed as having a life-threatening disease or condition, or a degenerative and disabling disease or condition, either of which requires specialized medical care over a prolonged period of time, is eligible for a specialist to serve as the Member’s PCP. This is contingent upon the agreement of Affinity, the PCP, and the specialist pursuant to a treatment plan. We encourage Members and providers to request having a specialist serve as a PCP when clinically indicated.

**Referral to a Specialty Care Center**

A Member diagnosed with having a life-threatening disease or condition, or a degenerative and disabling disease or condition, of which requires specialized medical care over a prolonged period is eligible for referral to a specialty care center. This is contingent upon the agreement of Affinity, the PCP, and the specialist pursuant to a treatment plan.

In order to request any of the above, call Affinity’s customer service at (866) 247-5678.

**CONTINUITY OF CARE**

In order to preserve continuity of care, Members may continue to see a non-participating provider for a transitional care period, as described below.

**New Member**

A new Member, whose current provider does not participate in the Affinity network, may request approval to continue an ongoing course of treatment with that provider for a transitional period. If the Member has a life-threatening disease or condition and/or a degenerative and disabling disease or condition, the transitional period is up to 60 days. If the Member has entered her second trimester of pregnancy at the effective date of enrollment, the transitional period includes the provision of post-partum care related to the delivery.

**Existing Member**

When a provider leaves the Affinity network, a Member or the provider can request approval to continue an ongoing course of treatment for a transitional period of 90 days. The transitional period begins on the date the provider’s contractual obligation to provide services to Affinity terminates and ends no later than 90 days (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 (866) 247-5678. Requests will only be approved if the provider agrees to:

- Accept Affinity rates applicable to transitional care
- Adhere to our quality assurance program and provide medical information related to the Member’s care
- Adhere to our policies and procedures, including referrals, obtaining pre-authorization, and developing a treatment plan approved by Affinity
RECIPIENT RESTRICTION PROGRAM

The Recipient Restriction Program ("RRP") is a medical review and administrative mechanism whereby selected Members with a demonstrated pattern of abusing or misusing services may be restricted to one or more providers. The objectives of the RRP include: a) reducing the cost and inappropriate utilization of health care resulting from patterns of Member abuse or misuse of services, and b) providing Members with coordinated medical services, thus improving the quality of their care.

We restrict access to non-emergent covered services only. We do not restrict access to emergency services or deny coverage of emergency services based upon a Member being in the RRP. When a restriction has been imposed, the Member will be permitted to access only certain covered services through one or more Affinity-selected providers ("RRP Provider(s)"), except when the Member has been referred to an alternate provider authorized by Affinity or the RRP Provider.

If a restricted Member sees a provider outside of his/her restriction, the associated claim will be denied. As a participating provider you agree to cooperate with us in the management and care of Members in the RRP program. Also, as a participating provider you will receive notification when one of your Members has been added to the AHP RRP. A sample roster reflecting restricted Members is attached as Section 7.

TRANSPORTATION

The Transportation benefit for our Medicaid population that was remaining for the Long island counties is now being managed- along with all of the other counties in Affinity's service area by Logisticare through the State,- effective December 1, 2015.

Affinity will no longer have a transportation benefit for our Medicaid population managed through Affinity. It will be managed by the State through Logisticare directly.

We will continue to maintain our Medicare transportation benefit through Logisticare.

PHARMACY MANAGEMENT

Pharmacy Network

We provide Members with access to a broad network of community pharmacies. Through pharmacy benefits, Members can fill prescriptions for covered pharmaceuticals and supplies at any participating network pharmacy. We also work together with CVS Caremark Specialty Pharmacy Services and other specialty pharmacies that have accepted Caremark’s specialty rates to supply certain high-cost biotech and injectable drugs to Medicaid recipients and our Members.

Prescriptions and Benefit

Pharmacies may dispense covered pharmaceuticals, including over-the-counter (OTC) drugs and supplies when covered, only with a prescription. Prescribers are required to use their National Provider Identifier (NPI) number on all prescriptions. A facility NPI number is not acceptable. Prescriptions for all Members may be filled only if accompanied by the Member’s Affinity ID card. Early refills for lost or stolen medication may be covered on a case by case basis if requested from the prescriber for non-controlled drugs only. Early refills for vacation supply will not be covered.
Vaccines are covered for all Members over the age of 19. The vaccine cost will not be covered for Members younger than 19 years of age since the vaccines are available from Vaccine for Children (VFC) program. Adult Members have the option to receive administration of flu and pneumococcal vaccines from network pharmacies without a prescription.

**Formulary Management**

Pharmacies may dispense only items found in our formulary. The formulary differs by product line and some formulary agents require prior authorization. The Member’s PCP or participating specialist may request exceptions through our PBM by calling 1(877) 432-6793.

**Electronic Prescribing and Authorizations**

You are encouraged to prescribe electronically and submit electronic authorizations requests. These options are available through our pharmacy benefits manager, CVS Caremark. Related to electronic authorization requests, you will be able to answer required criteria and after submission, if the authorization cannot be approved immediately, you will get a response back electronically following review by a clinician. Even with electronic authorization, you will still get a fax notice so that you can easily update your patient chart. Allscripts®, ePrescribe®, and NaviNet® are among the systems currently supported and new systems are constantly being added. If your electronic prescribing tool does not support electronic authorization, a portal version is available. To learn more or to get started, visit [www.caremark.com/epa](http://www.caremark.com/epa).

A list of participating pharmacies, our formularies, coverage rules (e.g., step therapy, quantity limits, etc.) and drug specific authorization forms can be found on our web site at [www.affinityplan.org](http://www.affinityplan.org).

**UTILIZATION MANAGEMENT**

**UTILIZATION REVIEW DECISIONS**

“Medically Necessary” means care and services that are necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person’s capacity for normal activity, or threaten some significant handicap. **For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.** “Utilization review” means the review to determine whether healthcare services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services, are medically necessary.

The sections that follow summarize our policies and procedures related to our utilization review decisions, which occur during pre-authorization, concurrent, and retrospective reviews.

For questions about utilization review:

<table>
<thead>
<tr>
<th>Toll Free Phone Number</th>
<th>Facsimile Number</th>
<th>Address</th>
</tr>
</thead>
</table>
| 1-866-247-5678         | 718-794-7822     | Affinity Health Plan  
ATTN: Medical Management  
1776 Eastchester Rd  
Bronx, New York 10461 |

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.
Pre-Authorization

- We will make a decision and notify the Member and the provider by phone and in writing
- Within three (3) business days of receipt of necessary information

For MMC, as quickly as the Member's condition requires and: a) within three (3) business days of receipt of an expedited authorization request; or b) in all other cases, within three (3) business days of receipt of necessary information, but no more than fourteen (14) days of the request.

Concurrent Review

We will make a decision and notify the Member and the provider by phone and in writing:

- Within one (1) business day of receipt of necessary information
- For MMC, as quickly as the Member's condition requires and: a) within one (1) business day of receipt of necessary information, but no more than three (3) business days of an expedited authorization request; or b) in all other cases, within one (1) business day of receipt of necessary information, but no more than fourteen (14) days of the request.

Retrospective Review

We will make a decision within thirty (30) days of receipt of necessary information. For MMC, notice will be mailed to the Member on the date of a payment denial, in completely or in part.

Additional Information

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

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

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

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

- The reasons for the determination, including the clinical rationale, if any
- Instructions on how to initiate internal appeals (standard and expedited) and eligibility for external appeals
- Notice of the availability, upon request of the Member, or the Member's designee, of the clinical review criteria relied upon to make such determination
• What, if any, additional necessary information must be provided to, or obtained by, Affinity in order to render a decision on the appeal

For MMC, notice will also include:

• A description of Action to be taken

• A statement that Affinity will not retaliate or take discriminatory action if an appeal is filed

• The process and timeframe for filing/reviewing appeals, including the Member’s right to request expedited review

• The Member’s right to contact DOH, with 1-800 number, regarding his/her complaint

• Fair Hearing notice, including aid to continue rights

• A statement that notice is available in other languages and formats for special needs and how to access these formats

• For Medicaid Advantage, offer of choice of Medicaid or Medicare appeal processes if the service is determined by Affinity to be covered either by Medicare or Medicaid, with notice that:

  o The Medicare appeal must be filed sixty (60) days from denial

  o Filing the Medicare appeal means the Member cannot file for a State Fair Hearing

  o The Member may still file for Medicare appeal after filing for Medicaid appeal, if within the sixty (60) day period

Reversals

We reserve the right to reverse/deny a pre-authorized treatment, service, or procedure on retrospective review pursuant to PHL § 4905(5) when:

• Relevant medical information presented to us or any utilization review agent upon retrospective review is materially different from the information that was presented during the pre-authorization review

• The information existed at the time of the pre-authorization review, but was withheld or not made available

• Affinity or our agent was not aware of the existence of the information at the time of the pre-authorization review

• Had Affinity been aware of the information, the treatment, service or procedure being requested would not have been authorized

Reconsideration

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration will: a) occur within one (1) business day of receipt of the request and b) conducted by the Member’s health care provider and the clinical peer reviewer making the initial determination.
Untimely Review

Our failure to make a utilization review determination within the time periods shown above is deemed to be an adverse determination subject to appeal. For MMC, we will send notice of denial on the date review timeframes expire.

APPEAL OF UTILIZATION REVIEW DECISIONS

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

Appeals must be submitted within sixty (60) business days after notification of our decision. We will acknowledge the appeal within fifteen (15) days. If we require information necessary to conduct a standard internal appeal, we will notify the Member and the provider, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, we will request the missing information, in writing, within five (5) business days of receipt of the partial information.

For MMC, 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 MMC, the review timeframe begins upon first receipt of appeal, whether filed orally or in writing).

Expedited Appeal

An expedited appeal may be filed in support of:

- Continued or extended health care services, procedures, or treatments; or requested homecare following an inpatient stay.

- Additional services for Members undergoing a course of continued treatment

- A provider’s belief that an immediate appeal is warranted

For MMC 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 by phone immediately, followed by written notice in two (2) days, and the review will take place according to standard timeframes. If we require information necessary to conduct an expedited appeal, we 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 reviewer must be available within one (1) business day.

An expedited appeal will be decided within:

- Two (2) business days of receipt of necessary information

- For MMC, as fast as the Member’s condition requires and within two (2) business days of receipt of necessary information but no more than three (3) business days of receipt of appeal

This time may be extended for up to fourteen (14) days upon Member or provider request, or if we demonstrate more information is needed and the delay is in best interest of Member (notice to the Member will be provided).
Written notice of a final adverse determination concerning an expedited utilization review appeal will be transmitted to the Member within twenty four (24) hours of rendering the determination. For MMC, we will make reasonable efforts to provide oral notice to the Member and provider at the time the determination is made. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

**Standard Appeal**

We will make a standard appeal determination within:

- Sixty (60) days after receipt of necessary information
- For MMC, as fast as the Member’s condition requires, and no later than thirty (30) days from receipt of the appeal

This time may be extended for up to fourteen (14) days upon Member or provider request, or if we demonstrate more information is needed and the delay is in best interest of the Member (notice to the Member will be provided).

We will notify the Member, the Member’s designee, and the provider in writing of the appeal determination within two (2) business days of when we make the decision.

**Notice**

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”
- Affinity 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
- 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 number
- A statement that notice is available in other languages and formats for special needs and how to access these formats

A clinical peer reviewer will conduct expedited and standard appeals. A clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination will review appeals.
Untimely Review

Our failure to make a determination within the applicable periods in this section shall be deemed a reversal of the adverse determination.

Waiver

The Member and Affinity 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.

EXTERNAL REVIEW

A Member or a Member’s designee has the right to request an external appeal within 4 months of the Plan’s issued Final Adverse Determination letter. A provider on his own behalf also has the right to request an external appeal but within sixty (60) days of the Plan’s issued Final Adverse Determination. To request an external appeal, an application form must be completed and sent to the New York State Department of Financial Services. To obtain an external appeal Instructions and Application, provider can call the Department of Financial Services at 800-400-8882 or by login to WWW.dfs.ny.gov

An external appeal may be filed when:

Medical Necessity –

• 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:
  o Affinity rendered a final adverse determination with respect to such health care service
  o Both Affinity and the Member have jointly agreed to waive any internal appeal

Experimental/Investigational –

• 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 the basis that such service is experimental or investigational and:
  o The denial has been upheld on appeal or both Affinity and the Member have jointly agreed to waive any internal appeal
  o 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; 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 or rare disease treatment
  o 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, in the case of a rare disease, based on the physician’s certification and such other evidence as the Member, the Member’s designee or the Member’s attending physician may present, that the requested health service or procedure is likely to benefit the Member in the treatment of the Member’s rare disease and that such benefit to the Member outweighs the risks of such 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)

- The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for our determination that the health service or procedure is experimental or investigational.

**Out-of-Network Alternate Treatment**

- The Member has had coverage of the health service (other than a clinical trial), 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 service is out-of-network and an alternate recommended health service is available in-network, and:

  - We have rendered a final adverse determination with respect to an out-of-network denial or both Affinity and the Member have jointly agreed to waive any internal appeal

  - The Member’s attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the Member for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service

**MEMBER SATISFACTION**

**COMPLAINT, GRIEVANCE, AND APPEAL UNIT**

Member satisfaction is extremely important to us. The Complaint, Grievance, and Appeal Unit (“CGA Unit”), within our Quality Management Department, has the primary responsibility for:

- Developing, organizing, implementing, and maintaining efficient and effective processes and procedures to ensure the appropriate resolution of complaints, grievances and appeals filed by Members
- Process improvement initiatives based on outcomes and trending of Member issues
- Managing claim appeals requiring medical review
COMPLAINT PROCESS

A Member, or his/her designee, may file a complaint regarding any dispute with Affinity orally or in writing. Our toll free Customer Service phone number for filing complaints orally is 1-866-247-5678. We will provide written acknowledgement of any complaint not immediately resolved within 15 business days of receipt. When applicable the acknowledgement will identify any additional information required to make a determination. Qualified personnel review complaints, with complaints relating to clinical matters reviewed by one or more licensed, certified, or registered healthcare professionals in addition to non-clinical staff. Whenever a delay would significantly increase the risk to a Member’s health, a complaint will be resolved within 48 hours after receipt of all necessary information, and no more than 7 days from the receipt of the complaint. All other complaints will be resolved within 45 days after the receipt of all necessary information, and not more than 60 days from receipt of the complaint. We are available to assist Members in filing their complaints; however, Members are free to contact the New York Department of Health directly with their complaint. Complaints about a particular provider are noted in the provider’s credentialing file and considered during the re-credentialing process.

If you have a complaint in your individual role as a provider regarding your participation with us, please contact your Provider Relations Representative.

Appeals

Members have 60 business days 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. Qualified personnel (licensed, certified, or registered healthcare professionals) who did not make the initial determination, at least one of whom will be a clinical peer reviewer, will decide complaint appeals of clinical matters. Qualified personnel will determine complaint appeals of non-clinical matters with greater seniority than the personnel who made the original determination. Complaint appeals will be decided (with notification to the Member):

- No more than 2 business days after receipt of all necessary information when a delay would significantly increase the risk to a Member’s health
- Within 30 business days after the receipt of all necessary information in all other instances

FAIR HEARINGS

MMC/ Members may avail themselves of a fair hearing process in accordance with applicable federal and state laws and regulations. To request a fair hearing, Members can call 1-800-342-3334. Affinity Health Plan abides by and participates in New York State’s fair hearing process and complies with determinations. Members may request a fair hearing regarding:

- Adverse LDSS determinations concerning enrollment, disenrollment, and eligibility
- The denial, termination, suspension, or reduction of a clinical treatment or other covered services by Affinity. A Member may also seek a fair hearing for a failure by Affinity to act with reasonable promptness with respect to such services
**Aid Continuing**

We are required to continue the provision of covered services that are the subject of the fair hearing to a Member if so ordered by the New York Office of Administrative Hearings (“OAH”) under the following circumstances:

- Affinity has or is seeking to reduce, suspend, or terminate a treatment or benefit package service currently being provided
- The Member has filed a timely request for a fair hearing with OAH
- There is a valid order for the treatment or service from a participating provider

Affinity provides aid continuing until the matter has been resolved to the Member’s satisfaction or until:

- The administrative process is completed and there is a determination from OAH that the Member is not entitled to receive the service
- The Member withdraws the request for aid continuing and/or the fair hearing in writing
- The treatment or service originally ordered by the provider has been completed, whichever occurs first

If the services and/or benefits in dispute have been terminated, suspended, or reduced and the Member timely requests a fair hearing, we will, at the direction of either the New York Department of Health or LDSS, restore the disputed services and/or benefits consistent.

Member may seek redress of determination simultaneously through our internal appeal processes and the fair hearing process. In the event our denial is upheld at a fair hearing, the Member will be liable for the underlying service(s) and the cost of any aid continuing provided pursuant to a hearing request may be recouped.

To file appeals, please contact our Complaints, Grievances, and Appeals Unit at:

<table>
<thead>
<tr>
<th>Toll Free Phone Number</th>
<th>Facsimile Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-888-543-9069</td>
<td>718-536-3358</td>
<td>Affinity Health Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attn: CGA Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metro Center Atrium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1776 Eastchester Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bronx, NY 10804</td>
</tr>
</tbody>
</table>
Quality Assurance

QUALITY ASSESSMENT ORGANIZATIONAL ARRANGEMENTS/ONGOING PROCEDURES

To help ensure that Members receive high-quality care, we have developed and implemented a Quality Management program that is: a) supervised by our Chief Medical Officer; b) approved by the New York Department of Health; c) meets CMS quality guidelines for Medicare; and d) includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery to Members. The program incorporates practice guidelines consistent with current standards of care, and our decisions for utilization review, Member education, coverage of services, and other areas follow these guidelines. The guidelines include, but are not limited to, the following conditions:

- Acute Tuberculosis Treatment
- Adolescent Health Care
- Adult Health Maintenance
- Asthma Management
- Behavioral Health (e.g., depression, anxiety, etc.)
- Breast Feeding Promotion
- Cardiac Health
- Chronic Obstructive Pulmonary Disease
- Depression Screening, Diagnosis and Treatment
- Diabetes Care
- Domestic Violence Identification
- Fall Prevention
- Geriatric Assessment
- Hepatitis C
- HIV/AIDS
- Latent Tuberculosis Infection: Targeted Screening and Management
- Pediatric Anemia: Algorithm for Work-Up
- Pediatric Health Maintenance (Child/Teen Health Plan (CHILD/TEEN HEALTH PROGRAM)
- Pediatric Preventive Services: Periodicity Schedule
- Postpartum Depression Screening, Diagnosis and Treatment
- Prenatal Care
- Preventive Health Guidelines for Children and Adults
- Sexually Transmitted Infection Screening and Treatment
- Smoking Cessation
- Syphilis Screening

Further details of our Quality Management program, and quality assurance-related provider responsibilities, are available on our web site at [www.affinityplan.org](http://www.affinityplan.org). Contact the Quality Management staff to learn about the various clinical performance improvement initiatives and primary care incentive programs. Where Affinity’s performance as a plan is less than the statewide average or another standard as defined by the New York Department of Health, we will develop and implement a plan for improvement.
CREDENTIAILING/RE-CREDENTIAILING

Affinity has a formal process in place; consistent with New York Department of Health Recommended Guidelines for Credentialing Criteria, for credentialing participating providers on a periodic basis (not less than once every 3 years). This process includes, but is not limited to, primary verification of training and experience. Each healthcare professional must be credentialed by Affinity prior to rendering services to Members.

It is your responsibility to ensure that we have the correct address to contact when re-credentialing is due. If you fail to re-credential, your network participation will be terminated.

Our credentialing/re-credentialing processes are overseen by our Chief Medical Officer and our Credentialing Committee reviews credentialing information and makes recommendations. We will complete credentialing activities and notify providers within 90 days of receiving a completed application. Our notification to providers will inform them as to whether they are credentialed, whether additional time is needed, or that we are not in need of additional providers. If additional time is needed, we notify the provider as soon as possible, but no more than 90 days from our receipt of the application.

You must immediately notify us in writing if any of the following occur:

- Your ability to practice medicine is restricted or impaired in any way
- An investigation is initiated by any authorized agency
- There is a new or pending malpractice actions
- Your clinical privileges at any hospital has been reduced, restricted, or denied
- Any other adverse action that reasonably relates to your credentialing

You are also responsible for ensuring that all ancillary staff: a) are appropriately licensed, registered, or certified in their field, b) practice in accordance with all applicable laws and regulations, c) are appropriately supervised, and d) do not exceed those responsibilities set forth in applicable New York State laws and regulations for such practices.

UPDATED CREDENTIALING/DIRECTORY LISTING FOR ID/AIDS/HIV PROVIDERS:

AIDS/HIV providers may be listed in the Affinity provider directories as AIDS/HIV Specialists or as “HIV Experienced Providers” if they meet the criteria listed below:

- An MD or Nurse Practitioner providing ongoing direct clinical or ambulatory care of at least 20 HIV infected persons who are being treated with antiviral therapy in the preceding 12 months
- A provider who has met the criteria of one of the following accrediting bodies:
  
  A) The HIV Medicine Association (HIVMA) definition of an HIV experienced provider.
  B) HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM).
  C) Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

Documentation to support “HIV Experienced Provider” status can be submitted to your Affinity Provider Relations representative.

Specific credentialing requirements may be found on our web site at www.affinityplan.org.
MEDICAL RECORDS

“Medical Record” means a complete record of care rendered by a provider, including inpatient, outpatient, and emergency care, in accordance with all applicable federal, state and local laws, rules and regulations.

As a participating provider, you must:

- Maintain a separate Medical Record for each Member
- Ensure that each Medical Record is signed by the medical professional rendering the services reflected therein
- Retain Medical Records for a period of 6 years after the date of service rendered to Members
- and for a minor, 3 years after majority or 6 years after the date of service, whichever is later
- Prenatal Care Only: maintain a centralized medical record for the provision of prenatal care and all other related services.
- Provide access to Medical Records, at no charge, to: a) Affinity and or its delegates/IPAs for Utilization Review and Quality Assurance purposes; and b) the New York Department of Health, CMS and LDSS

Each Medical Record must comply with the following standards:

- Each page contains the Member’s name and date of birth or ID number
- The record contains personal and biographical data, such as address, telephone numbers, marital status and emergency contacts
- All entries contain author identification (may be handwritten or written unique electronic identifier)
- All entries are dated
- The record is legible to someone other than the writer
- Significant illness and medical conditions are indicated on the problem list
- Medication allergies and adverse reactions are prominently noted in the record
- Use of cigarettes, alcohol and illicit substances, as well as sexual practices for those older than 13 years old, are noted
- The history and physical documents appropriate information for presenting complaint
- Diagnostic testing is ordered, as appropriate, and reports are filed in the chart and noted to have been reviewed by the primary care physician
- Working diagnoses and treatment plans are consistent with findings
- Follow-up care with a specific time of return visit is noted
- Unresolved problems from previous visits are addressed in subsequent visits
- If a consultation is requested, a note from the consultant is in the record
- Referral specialist records contain evidence of communication with the PCP
- An immunization record is kept for children and immunization history is in the record for adult
- Preventive screening and services, in accordance with standard clinical guidelines, are noted, including education and counseling
ENCOUNTER REPORTING

You must submit encounter for all services provided to Affinity Members within acceptable timeframes either electronically (preferred) or in hardcopy form. Submit all the details related to the service including service date, procedure codes and all diagnosis codes. Affinity reserves the right to withhold capitation payments if encounter reports are not submitted in a timely fashion.

PERFORMANCE EVALUATION

As part of our efforts to improve quality, we periodically conduct performance review studies in conjunction with our Clinical Affairs Committee. Claim, encounter and Complaint data are among the information maintained by Affinity to evaluate the performance/practice of healthcare professionals. Any profiling data used to evaluate the performance/practice of a healthcare professional will be measured against stated criteria and an appropriate reference group of providers serving a comparable patient population. Providers have the opportunity to discuss the unique nature of his/her patient population, which may have a bearing on the provider's profile and to work cooperatively with us to improve performance. We are required to provide information used to evaluate the performance of providers, and any profiling data. We also make available on a periodic basis, and upon the request of a healthcare professional, the information, profiling data, and analysis used to evaluate the provider's performance. The care delivered to Members by providers is reported on an annual basis to the New York Department of Health through the Quality Assurance Reporting Requirements (QARR) and HEDIS. Quality is measured using encounter/claim data, which may be supplemented by medical record reviews, to determine the percentage of Members receiving preventive care and care for certain chronic diseases and services. QARR/HEDIS measures are also used in overall performance evaluation of a practice.

For the Medicare population, Affinity evaluates its performance against the STAR rating benchmarks wherever available. The STAR ratings are used to compare health plan performance in terms of the quality of care they provide to the Members. The STAR ratings include HEDIS measures in addition to other clinical, pharmacy and satisfaction measures.

HIV CONSIDERATIONS- NEW YORK PUBLIC HEALTH LAW, ARTICLE 27-F

Informed Consent for HIV Related Testing

An HIV related test is defined by Article 27-F as any laboratory test or series of tests for any virus, antibody, antigen, or etiologic agent whatsoever, thought to cause or to indicate the presence of acquired immune deficiency syndrome (AIDS).

Unless specifically authorized or required by a state or federal law, providers are prohibited from ordering the performance of an HIV related test without first receiving the informed consent of the individual subject of the test or where the individual lacks capacity, a person authorized by law to consent to health care for such individual. Prior to obtaining informed consent, the provider or person ordering the test must, at a minimum, notify the individual that an HIV related test is being performed. The notification can be oral and must be noted in the patient's record.

Providers are required to have protocols in place to ensure that an individual or his legal representative is advised of the following information when providing informed consent to an HIV related test:

- HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants
- There is treatment for HIV that can help an individual stay healthy
• Individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV
• Testing is voluntary and can be done anonymously at a public testing center
• The law protects the confidentiality of HIV related test results
• The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences
• The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV related test

For a full list of HIV Related Testing requirements, see New York Public Health Law §2781 or http://www.health.ny.gov/diseases/aids/providers/testing/

Confidentiality and Disclosure of HIV Information

“Confidential HIV Related Information” is any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV related information, concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify an individual having one or more of such conditions, including information pertaining to such individual’s contacts.

Confidentiality of HIV-related information requires each provider to develop policies and procedures to assure confidentiality of HIV-related information. Policies and procedures must include:

• 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)
• Procedure for handling requests for HIV-related information
• Protocols to protect persons with or suspected of having HIV infection from discrimination

Providers are also reminded of the following requirements:

• Requires HIV pre-test counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services

A “Release of Confidential HIV Related Information” is a written authorization for disclosure of confidential HIV related information which is signed by the protected individual, or a person legally authorized to consent to health care for the individual. A general authorization for the release of health information shall not be construed as a release of confidential HIV related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV information. HIV information may not be re-disclosed without a signed HIV release form.

NY Public Health Law § 2782 prohibits persons who obtain confidential HIV related information in the course of providing any health or social service, or pursuant to a release of confidential HIV information from disclosing such information, unless a specific exception applies. Exceptions include disclosures to:
• The protected individual or a person authorized pursuant to law to consent to health care for the individual;
• Any person to whom disclosure is authorized pursuant to a release of confidential HIV related information;
• An agent or employee of a health facility of health care provider if; the agent or employee is
• Permitted to access medical records; the health facility of health care provider is itself authorized to
  obtain the HIV related information; the agent or employee provides health care to the protected individual,
  or maintains or processes medical records for billing or reimbursement;
• Third party reimbursement or their agents to the extent necessary to reimburse health care providers for
  health services; provided that, where necessary, an otherwise appropriate authorization for such disclosure
  has been secured by the provide.
• An insurance institution other than a third party reimburse, provided the insurer obtains a dated and written
  authorization, signed by the subject individual or his or her legal representative, which indicates that health
  care providers, health facilities, insurance institutions, and other persons are: (1) authorized to disclose the
  information about the protected individual, (2) the nature of the information to be disclosed; and (3) the
  purpose for which the information is to be disclosed

A full list of exceptions to the disclosure prohibitions can be found in NY Public Health Law § 2782.

Note that failure to comply with Article 27-F can result in the State pursuing civil penalties of up to $5,000 per
occurrence, as well as criminal misdemeanor charges.

Resources

To access informed consent forms and release forms and to learn more about HIV/AIDS-related programs, policies,
and regulations, visit the NYSDOH website at:
www.health.ny.gov/diseases/aids/index.htm

For general information and questions about HIV confidentiality, to report a possible violation of Article
27-F, or to get forms to report a possible violation of Article 27-F call the New York State Department of
Health HIV Confidentiality Hotline at (800) 962-5065.

BILLING, CLAIMS, PAYMENTS

CAPITATION

If contracted reimbursement is on a capitated basis, payment will be due for all Members reflected on the monthly
Membership list we provide you. We typically issue capitation checks at the beginning of each month, and you do not
need to submit invoices/bills for capitation payments. A single monthly check is issued for all Members reflected on a
Membership list, regardless of product line differences. Even if reimbursement for the underlying service is
encompassed in capitation, you must submit a claim for the underlying service (see below) so that the encounter can
be recorded.
CLAIMS

Fee-for-service claims will be processed in a manner consistent with New York Prompt Payment Law (INS § 3224-a). We will pay the lesser of billed charges and contracted rates, unless payment is a global rate or underlying services were otherwise “bundled” for reimbursement purposes.

Submission of Claims

You are encouraged to submit claims electronically. Physicians’ offices should submit a CMS-1500 claim form; hospitals should submit a UB04 claim form (acceptable bills for Ambulatory Surgery, Emergency Room and Ancillary Services include a CMS-1500 or UB 04 form). In order to be payable, the claim must be submitted in a timely manner. For participating providers, the deadline for claim submission is the greater of: a) 90 days from the date of service/discharge; and b) such other deadline set forth in the participation agreement. All claims must fully be documented by providing all information requested, including:

• Member name
• Date of birth
• Member ID #
• Authorization #
• All valid Diagnosis Codes by number
• Present on Admission (POA) indicator
• Date(s) of service
• Place of service
• Quantity/Units
• Valid Procedure Code (CPT and HCPC)
• Charges
• Treating physician’s name, address, telephone number
• National Provider Identifier (NPI)
• Coordination of Benefits (COB) information
• Federal Tax Identification Number (TIN)

<table>
<thead>
<tr>
<th>Electronic Billing (837I/837P)</th>
<th>Paper Claims (CMS-1500 and UB04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Payer ID #: 13334</td>
<td>Submit to: Affinity Health Plan</td>
</tr>
<tr>
<td></td>
<td>PO Box 981726</td>
</tr>
<tr>
<td></td>
<td>El Paso Texas 79938-1726</td>
</tr>
</tbody>
</table>

This is for MMC and CHP only. Please be sure to consult the product line addenda to ensure proper routing of claims for members of other product lines.

For additional information on claim submission, contact your Provider Relations Representative.

Coordination of Benefits

If a Member has coverage in addition to coverage through Affinity (i.e., no-fault, third party health insurance, etc.), we will coordinate the benefits with the other carrier(s) to ensure that our liability does not exceed 100% of our allowable expenses. In the event a claim is initially filed with us for which another carrier is determined to be the primary payer, we will advise you to file with the primary insurer. You agree to provide us with the necessary information for the collection and coordination of benefits when a Member has other coverage.
Status/Adjudication

You may check the status of a claim using our Provider Portal at https://affinityportal.affinityplan.org. Details concerning how a claim was adjudicated will be reflected on our Remittance Advice. Should you disagree with non-clinical/administrative decisions related to a claim, you may appeal through the administrative appeal process described below.

Administrative Appeals

An “Administrative Appeal” is a request by a provider on his/her own behalf to reverse an administrative claims determination, including, but not limited to: a) payment amount; and b) denials in whole or in part due to scope of benefit coverage, Member eligibility, lack of authorization/referral, payor appropriateness, and late claim submission. Requests by providers on behalf of a Member and requests to reverse determinations governed by Article 49 of New York Public Health Law (i.e., clinical/utilization review determinations) are excluded from this definition.

Participating providers have sixty (60) days from receipt of an Explanation of Payments (“EOP”) to submit an Administrative Appeal related to a claim contained therein. A separate Administrative Appeal must be submitted for each claim. To be accepted for consideration, the Administrative Appeal must (in addition to being timely):

- Be in writing
- Contain sufficient information to conduct a review
- Include a copy of the EOP

If an Administrative Appeal fails to include all required elements or is not received at the following address by the submission deadline, Affinity’s payment of the claim will not be revisited:

Affinity Health Plan Claims Department Gracie Station
PO Box 812
New York, NY 10028-0082

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

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

You may not under any circumstances bill a Member unless you have: a) advised the Member, prior to initiating the service, that it is not covered by Affinity under his/her product line; and b) obtained the Member’s written consent agreeing to pay personally for the service. Non-compliance will result in termination of your participation agreement.

OVERPAYMENT

If we identify an overpayment, a written overpayment recovery notice will be provided in accordance with New York State Insurance Law §3224-b (b) and/or your provider agreement prior to any recoupment, including those relating to fraud or abuse. This notice will include the member(s) name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the reason for the proposed adjustment. In response to this overpayment recovery determination, the provider may challenge the finding or remit payment as outlined within the notice.

In order to challenge an overpayment recovery determination, the provider must submit a written letter to the location specified within the overpayment recovery notice along with all relevant supporting documents within (60) sixty calendar days from the date of the overpayment recovery notice, to avoid recoupment. If a provider fails to submit a written letter challenging the overpayment recovery determination within the respective timeframe, recovery may be initiated. Affinity’s recovery process may include, but is not limited to: offsetting the outstanding amount against future claims payment and other collection methods deemed appropriate until the full amount is recouped. Affinity reserves the right to pursue recovery when a written response is not received from the provider thirty (30) days from the date of the notice; during the overpayment challenge process; and/or prior to any final determination made.

FRAUD, WASTE, AND ABUSE

Healthcare fraud, waste, and abuse affect everyone (e.g., Members, providers, taxpayers, Affinity, etc.). As a result, and pursuant to applicable requirements, we operate a comprehensive fraud and abuse program within our Special Investigations Unit. You have a duty to support this program by reporting questionable activities and potentially fraudulent/abusive actions. More information on this important topic, along with instructions on how to report, is presented in Section 9.

Regardless of other contact with Affinity, participating providers have sixty (60) days from receipt of an Explanation of Payments (“EOP”) to submit an Administrative Appeal.

PROVIDER TERMINATION

TERMINATING NETWORK PARTICIPATION

Providers that are sanctioned by the DOH’s Medicaid Program will be excluded from participation in Affinity’s Medicaid panel.

Your network participation may be terminated pursuant to the terms of your provider agreement. We will not terminate (or refuse to renew) your agreement solely because you have:

- Advocated on behalf of a Member;
- Filed a complaint against Affinity;
- Appealed a decision of Affinity;
- Provided information or filed a report pursuant to PHL 4406-c regarding prohibitions by plans; or
- Requested a hearing or review.
We will not terminate the agreement of a participating healthcare professional without providing a written explanation of the reason for the proposed termination and an opportunity for a review or hearing as described below. Notwithstanding the foregoing, a provider terminated due to imminent harm to patient care, a determination of fraud, or a final disciplinary action by a State licensing board of other government agency that impairs the healthcare professional’s ability to practice, is not eligible for a hearing or a review. Regarding the latter, we will immediately remove any provider from the Affinity network who is unable to provide health care services due to a final disciplinary action.

Termination of a hospital’s agreement may be subject to “cooling off period” requirements set forth at PHL § 4406-c.

Content of Notice

In our termination notice, we will include the reasons for the proposed action and:

- Notice that the provider has the right to request a hearing or review, at the provider’s discretion, before a panel appointed by Affinity;
- A time limit of not less than 30 days within which a healthcare professional may request a hearing; and
- A time limit for a hearing date that must be held within 30 days after the date of receipt of a request for a hearing.

Hearing Panel

The hearing panel will be comprised of at least 3 people appointed by Affinity. At least one person on the panel will be in the same discipline and same specialty as the provider under review. The panel can consist of more than 3 people, provided the number of clinical peers constitute 1/3 or more of the total panel make-up. Providers sanctioned by the New York Department of Health will be excluded from participation in the panel.

Decisions

The hearing panel will render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the healthcare professional:

- Reinstatement
- Provisional reinstatement with conditions set forth by Affinity
- Termination

Decisions of termination will be effective not less than 30 days after the receipt by the healthcare professional of the health panel’s decision. In addition, in no event will a determination be effective earlier than 60 days from receipt of the notice of termination.

Member Notice

Members will be notified, as required, when a provider’s participation terminates and alternative arrangements for the provision of care will be made.
HEALTH AND RECOVERY PLAN (HARP)

OVERVIEW

- **Enriched Health Plan** is a managed care product that manages physical health, mental health, and substance use services in an integrated manner for adults with significant behavioral health needs. Enriched Health is an enhanced Medicaid; it includes all of the benefits available under mainstream Managed Care, plus additional support services known as Home and Community Based Services (HCBS). Enriched Health’s goal is to create an environment where Affinity Health Plan, Network Providers, Members, Families, and New York State partner together to help members recover from serious mental illness and substance use disorders, and to prevent chronic medical conditions.

ENROLLMENT AND ELIGIBILITY

Enrollment is based on a member’s history of using certain services. These members have been identified by New York State as benefitting from an additional array of services to assist in reaching their health goals. A prospective Enriched Health member is indicated by New York State’s Target Criteria and Risk Factors:

- **Target Criteria**
  - Medicaid enrolled individuals 21 years old and over;
  - Serious Mental Illness/Substance Use Disorder;
  - Eligible to enroll in Medicaid Managed Care;
  - Not Participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD);
  - Not Medicaid/Medicare enrolled (“duals”).

- **Risk Factors**
  - Supplemental Security Income (SSI) individuals who received an “organized” Mental Health (MH) service in the year prior to enrollment.
  - Non-SSI individuals with three (3) 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.
  - SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three (3) years prior to enrollment.
  - SSI and non-SSI individuals with three (3) or more psychiatric inpatient admissions in the three (3) years prior to enrollment.
- SSI and non-SSI individuals discharged from an Office of Mental Health (OMH) Psychiatric Center after an inpatient stay greater than Sixty (60) days in the year prior to enrollment.

- SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five (5) years prior to enrollment.

- SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four (4) years prior to enrollment.

- Residents in OMH funded housing for persons with Serious Mental Illness (SMI) in any of the three (3) years prior to enrollment.

- Members with two (2) or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.

- Members with one (1) inpatient stay with a Substance Use Disorder (SUD) primary diagnosis within the year prior to enrollment.

- Members with two (2) 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 second diagnosis of SUD within the year prior to enrollment.

- Members with two (2) or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to secondary substance use diagnosis within the year prior to enrollment.

- Individuals transitioning with a history of involvement in children's services.

_The following ID card will identify the Member as being enrolled in the HEALTH AND RECOVERY PLAN (Enriched Health) and will contain important information:_

_The ID card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified at each visit. Failure to verify eligibility may result in non-payment of claims._
To determine eligibility if the Member does not have an identification card, you may call 1-888-543-6973 for verification. New Members may have a copy of their enrollment form as interim proof of Membership until a card is issued and mailed.

COVERED SERVICES

Enriched Health includes all the benefits available under Medicaid Managed Care, the Behavioral Health services that have been carved-in to mainstream Managed Care since October 2015, plus additional support services known as BH Home and Community Based Services. Carving behavioral health into mainstream Managed Care help the members manage their behavioral health and physical health needs in an integrated manner. Medicaid covered services will be available throughout Affinity Health Plan’s service areas and provided by the Enriched Health Plan’s Network Providers. For all modalities of care, the duration of treatment will be determined by the member’s need and his or her response to treatment.

BEHAVIORAL HEALTH BENEFITS FOR ALL MEDICAID POPULATIONS 21 AND OVER

Office of Mental Health

Mental Health Outpatient Clinic is a program for adults, adolescents, and/or children which provides an array of treatment services for assessment and/or symptom reduction or management. The services can include group therapy, and individual therapy.

Inpatient Treatment Programs are a 24 hours per day hospital based program which includes psychiatric, medical, nursing, and social services which are required for the assessment and/or treatment of a person with a primary diagnosis of mental illness which cannot adequately be served in the community.

Continuing Day Treatment is a program which provides seriously mentally ill adults with the skills and supports necessary to remain in the community and work toward a more independent level of functions.

Intensive Psychiatric Rehabilitation Treatment (IPRT) is a time limited rehabilitative program for adults and/or adolescents which focuses on building skills and developing community supports to assist individuals to attain specific goals.

Partial Hospitalization is a program for adults or adolescents which provides active treatment designed to stabilize or improve acute symptoms in a person who would otherwise need hospitalization.

Assertive Community Treatment (ACT) is an evidence based practice model designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional mental health services. An ACT teams are multi-disciplinary and include members from the field of psychiatry, nursing, psychology, social work, substance abuse and vocational habilitation. The ACT team’ members collaborate to deliver integrated services of the individuals’ choice, assist in making progress towards goals, and adjust services over time to meet individuals’ changing needs and goals. The ACT team members service the individual in their natural living settings rather than in hospitals or clinic settings; it is a Mobile Team that provides services 24-hours a day seven days a week.
**Personalized Recovery Oriented Services (PROS)** is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. The program helps to improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, attain higher levels of education, and secure preferred housing.

**Comprehensive Psychiatric Emergency Program (CPEP)** is a hospital based program which provides access to crisis outreach, intervention and residential services; and/or offers beds for the extended observation (up to 72 hours) to adults who need emergency mental health services.

**Crisis Intervention** is an emergency and temporary care given to an individual who is unable to function as they normally would due to unusual stress in his or her life. The purpose of crisis intervention is to increase stabilization of the individual during a difficult situation that he or she cannot cope with on their own.

**Office of Alcoholism & Substance Abuse Services**

**Opioid Treatment Program** is a treatment program that is certified to provide supervised assessment and medication-assisted treatment to individuals who are addicted to opioids. Treatment can exist in many settings, including intensive outpatient, residential and hospital settings.

**Inpatient Rehabilitation** provides intensive management of chemical dependence symptoms and a medical management and monitoring of physical or mental complications from the chemical dependence to individuals who cannot be effectively served as outpatients and are not in need of acute care or medical detoxification.

**Detoxification** is for individuals who are dependent on drugs or alcohol. Medical treatments, usually including counseling are needed to help individuals overcome physical and psychological dependence on alcohol or drugs.

**Medically Managed Detoxification** is offered in an acute inpatient hospital setting to individuals requiring the most intensive level of services usually due to medical or psychiatric complications.

**Medically Supervised Withdrawal (Inpatient)** is a service offered in an inpatient or residential setting to those requiring 24 hour support.

**Medically Supervised Withdrawal (Outpatient)** is a general detoxification offered in an outpatient setting to those individuals with stable social support.

**Outpatient Services** is offered to individuals who need treatment to remain abstinent but are stable enough to remain or return to a supportive and or supervised living situation. There are two types of chemical dependence outpatient services; general outpatient services and outpatient rehabilitation services. Rehabilitation services see clients more frequently and have more staff because the individuals attending rehabilitation service programs have greater needs. The frequency in outpatient services varies during the course of treatment and the progress of the individual. Both outpatient services provide group and individual counseling, education about substance abuse disease and relapse prevention.

**Residential Addiction Services** assists the individuals are unable to maintain sobriety or participate in treatment without the structure of a 24 hour/day, 7 day/week rehabilitation setting but are not in need of inpatient services.
# HOME AND COMMUNITY BASED SERVICES (HCBS)

<table>
<thead>
<tr>
<th></th>
<th>For Whom?</th>
<th>Delivered By?</th>
<th>Service Components Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Habilitation</strong></td>
<td>People in need of functional and social skills building because they might never have had them or have major challenges with attaining them. Some examples are long-term hospitalization or incarceration.</td>
<td>Unlicensed behavioral health staff with minimum HS equivalent education and 1-3 years relevant experience, certification/credentialing not required (e.g. certified peers, credentialed CASAC) supervised by Licensed Mental Health Practitioner or Qualified Health Professional.</td>
<td>Help person to attain skills including communication, self-help, domestic self-care such as housecleaning, personal hygiene, socialization, activities of daily living such as cooking and budgeting, relationship building, use of community resources such as public transportation navigation.</td>
</tr>
<tr>
<td><strong>Psychosocial Rehabilitation (PSR)</strong></td>
<td>People who need to regain functional/social skills they once had. For example, someone who has been through an episode of depression after having a period of stability.</td>
<td>Unlicensed behavioral health staff, but should periodically report to supervising licensed practitioner.</td>
<td>Same as above, but perhaps less intensive support needs because the person once possessed the skill(s), but needs some support to regain them.</td>
</tr>
<tr>
<td><strong>Community Psychiatric Support &amp; Treatment (CPST)</strong></td>
<td>People who are disengaged from site-based services due to behavioral or physical setbacks and need time-limited mobile treatment and/or PSR-type support services.</td>
<td>Providers who have experience providing similar services and are either licensed or utilizing evidence-based or best practices of an off-site treatment model using licensed professionals.</td>
<td>Clinical treatment including prescribing medication and psychotherapy as well as psychosocial rehabilitation/habilitation-type services as described above. This service is not meant to be ongoing or long-term, but until such time as a person can go to a service provider in the community such as a clinic on their own again.</td>
</tr>
<tr>
<td><strong>Family Support &amp; Training</strong></td>
<td>People with a need and preference for engagement with &amp; education/training support for their family</td>
<td>Unlicensed behavioral health staff supervised by Licensed Mental Health Practitioner or Qualified Health</td>
<td>Peer support and counseling on how the family of choice can help in the individual’s recovery; training &amp;</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Peer Support Services</td>
<td>People with a need and preference for peer support. Peer supporters are those who also have behavioral health histories themselves and can help people by using their shared experience such as hospitalization and incarceration. People who may not trust mental health professionals.</td>
<td>NYS OMH certified Peer Specialists and OASAS certified Recovery Peer Advocates supervised by licensed behavioral health practitioner. Advocacy such as helping the individual navigate the public benefits system to get food stamps, outreach &amp; engagement, promote and educate on self-help tools, recovery support, transitional/bridging support from jail/prison/hospitalization, pre-crisis and crisis support.</td>
<td></td>
</tr>
<tr>
<td>Education Support Services</td>
<td>People who want to obtain formal education to become competitively employed. (Competitive employment refers to jobs that any person in the general community can apply for and pays at least minimum wage.)</td>
<td>Education Specialists should possess a BA and two years’ experience supporting individual in pursuing education goals supervised by manager with minimum BA (preferably Masters in Rehabilitation or relevant field) and minimum 3 years’ relevant experience working in behavioral health field preferably as education specialist. Provides person with supports to obtain formal education/training such as TASC, vocational program or post-secondary degree in order to achieve employment goal. Services include finding financial aid, applying to schools, registration, navigating school system, negotiating reasonable accommodations and identifying tutoring resources.</td>
<td></td>
</tr>
<tr>
<td>Pre-Vocational Employment</td>
<td>People who want to prepare for real competitive employment in the general community who have little to no work experience or haven’t worked in a long time.</td>
<td>Employment Specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling. Provides person with time-limited work experience such as paid/unpaid internships and volunteer opportunities. This helps individuals to develop or strengthen work related soft skills including attendance, teamwork, task completion, problem solving, communication.</td>
<td></td>
</tr>
<tr>
<td><strong>Transitional Employment</strong></td>
<td>People who want to prepare for real competitive employment in the general community who have little to no work experience or haven’t worked in a long time.</td>
<td>Employment Specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling supervised by manager with minimum BA (preferably Masters in Rehabilitation or Behavioral Health field) and minimum 3 years’ relevant work experience and minimum 1.5 years management experience.</td>
<td>Provides person with time-limited paid internships offered only by HCBS providers who have Clubhouse and Psychosocial Club programs. Transitional employment slots belong to and are arranged by the providers in a formal agreement with businesses who hire people in the general community. Opportunities help people develop or strengthen work related soft skills such as attendance, task completion and teamwork. Since businesses know who they are working with, transitional employment is a true opportunity for people to experience “the dignity of risk and the right to fail.”</td>
</tr>
<tr>
<td><strong>Intensive Supported Employment</strong></td>
<td>People who want to obtain competitive employment.</td>
<td>Employment Specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling supervised by manager with minimum BA (preferably Masters in</td>
<td>Provides person with employment supports to obtain competitive employment. Services include resume writing, interviewing prep, job search and placement, benefits counseling and advocacy around negotiating reasonable workplace accommodations.</td>
</tr>
<tr>
<td><strong>Ongoing Supported Employment</strong></td>
<td>People who want to retain competitive employment.</td>
<td>Employment Specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling supervised by manager with minimum BA (preferably Masters in Rehabilitation or Behavioral Health field) and minimum 3 years’ relevant work experience and minimum 1.5 years management experience.</td>
<td>Provides person with employment supports to keep a job. Services include understanding HR policies and job responsibilities, supervision, employer/employee expectations, advocacy around workplace accommodations, benefits counseling and disclosure issues.</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
than 72 hours require prior authorization, but it is recommended to contact the managed care plan immediately when a person is admitted into the respite. Individuals requiring longer stays may be evaluated on an individual basis and approved for longer stays based on medical necessity.

| Intensive Crisis Respite (available for all HARP enrollees, HCBS eligibility assessment is not required) | People who are experiencing a behavioral health crisis including suicidality, homicidal ideation and acute escalation of mental health symptoms. People who may have had a bad hospitalization and would prefer to be in more of a home-like setting with peer supports. People who are stepping down from inpatient hospitalization. | Multidisciplinary team including licensed clinicians and unlicensed staff including Certified Peers and other paraprofessionals; agency must possess current license to provide crisis and/or treatment services, i.e. clinic, Comprehensive Psychiatric Emergency Program, Partial Hospital, PROS, Psychiatric Inpatient or have licensed professionals having minimum 1 year experience delivering off-site crisis services including conducting psychiatric evaluations and providing treatment. | Provide supports to help individuals stabilize and learn to manage crisis including psychiatric evaluation, comprehensive assessment including screening for physical health conditions, risk assessment, medication management, individual and group counseling. Stays should be no longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individuals requiring longer stays may be evaluated on an individual basis and approved for longer stays based on medical necessity. Intensive crisis respites are locked facilities. |

A Benefit Grid detailing the benefits we currently cover for each product, organized by product line, is available at [www.affinityplan.org](http://www.affinityplan.org). This Benefit Grid also indicates which services require prior-authorization. Behavioral health services are available on the [Beacon Health Options Provider Manual](http://BeaconHealthOptions.com).
The appointment system for Enriched Health should follow Medicaid’s standards for appointment availability for physical health providers. The appointment availability standard for Behavioral Health Service Types is as follows:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-Urgent MH/SUD</th>
<th>BH Specialist Follow-up to emergency or hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic/PROS Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 week</td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>ACT</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>PROS</td>
<td>Within 24 hrs of request</td>
<td>Within 2 weeks</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>IPRT</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon Presentation</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>CPEP</td>
<td>Upon Presentation</td>
<td></td>
<td>Within 24 hrs of request</td>
<td>Immediate</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Upon Presentation</td>
<td>Within 24 hrs of request</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Community Mental Health Services (There are 599 clinic services offered in the community)</td>
<td>Within 24 hrs of request</td>
<td>Within 1 week</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>OASAS Outpatient Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 week of request</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon Presentation</td>
<td>Within 24 hrs of request</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>SUD inpatient Rehab</td>
<td>Upon Presentation</td>
<td>Within 24 hrs of request</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Opiod Treatment</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Residential Addiction Services</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td>2-4 wks</td>
<td>Within 5 days of request</td>
</tr>
</tbody>
</table>
### Behavioral Health Home And Community Based Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Eligibility</th>
<th>Response Time</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation, CPST, Habilitation, and Family Support and Training</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>Within 5 days</td>
</tr>
<tr>
<td>Short Term and Intensive Crisis Respite</td>
<td>Immediately</td>
<td>Within 24 hours</td>
<td>Immediate</td>
</tr>
<tr>
<td>Educational and Employment Support Services</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>n/a</td>
</tr>
<tr>
<td>Peer Supports</td>
<td>n/a</td>
<td>Within 24 hours for symptom management</td>
<td>Within 1 week of request</td>
</tr>
</tbody>
</table>

### HEALTH HOMES

Affinity participates with many Health Homes in its service area. A 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 so that needed services are provided timely. In concert with Affinity Health Plan, the health home services are provided through a network of organizations - providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual "Health Home." Enriched Health members are eligible for Health Home services; it is an elective service so it is the member’s decision if they wish to receive services from a Health Home.

- Eligibility for Health Home Services
  - One single qualifying condition: HIV/AIDS or a Serious Mental Illness (SMI)
  - Two or more chronic conditions such as:
    - Substance abuse
    - Heart Disease
    - Diabetes
    - Asthma
    - Hypertension
    - Obesity
MEDICARE

OVERVIEW

• **Affinity Medicare Ultimate (HMO SNP)** is a Medicare Advantage Special Needs Plan for people who have both Medicare and full Medicaid benefits. All the services covered under Original Medicare are included in this plan, as well as additional benefits, such as vision and dental care. Any copayments, as well as the cost of services covered by Medicaid but not Affinity Medicare Ultimate, should be billed to fee-for-service Medicaid. Affinity Medicare Ultimate also includes Medicare Part D prescription drug benefits.

• **Affinity Medicare Ultimate with Medicaid Advantage (HMO SNP)** covers all the same Medicare benefits as Affinity Medicare Ultimate, as well as most of the Medicaid benefits available through fee for service Medicaid. For these Members, Affinity manages both Medicare and Medicaid benefits, so any copayments should be billed to Affinity.

• **Affinity Medicare Solutions (HMO SNP)** is a Medicare Advantage Special Needs Plan for people with Medicare and Medicaid. Some Members will have full Medicaid benefits and others will have assistance from the state with Medicare Part B premiums. For Members with full Medicaid benefits, NYS Fee for Service covers the cost-sharing amount for Service Medicaid. Members that do not have full Medicaid benefits are responsible for the cost-sharing amount associated with the plan. See the Medicare Advantage Benefit Grid for cost sharing amounts.

• **Affinity Medicare Essentials (HMO)** is a Medicare Advantage Prescription Drug (MAPD) Plan any Medicare eligible beneficiary.

• **Affinity Medicare Select (HMO)** is a Medicare Advantage Prescription Drug (MAPD) Plan any Medicare eligible beneficiary.

**Affinity Medicare Elite (HMO)** is a Medicare Advantage Prescription Drug (MAPD) Plan any Medicare eligible beneficiary.
ENROLLMENT AND ELIGIBILITY

For a Medicare-eligible beneficiary to enroll in an Affinity Medicare Advantage plan, the prospective Member must:

• Live in the Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Orange, Rockland and Suffolk
• Entitled to Medicare Part A
• Enrolled in Medicare Part B
• Not have End Stage Renal Disease (ESRD)
• Receive either full Medicaid benefits (Full Dual) or receive assistance from the State in paying the Part B premium (Partial Dual)

The following ID card will identify the Member as being enrolled in an Affinity Medicare Advantage plan and will contain important information:

If a Member uses his/her Medicare Card instead of his/her Affinity Health Plan ID, even though he/she is a Member of Affinity Health Plan, the Medicare program will not pay for these services and neither will Affinity Health Plan. The Member will have to pay the full cost for services.

Please Note: The ID card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified at each visit. Failure to verify eligibility may result in non-payment of claims.
To determine eligibility if the Member does not have an identification card, you may call 1-877-234-4499 for verification. New Members may have a copy of their enrollment form as interim proof of Membership until a card is issued and mailed.

If a Member has full Medicaid, providers may bill Medicaid fee for service for the applicable cost sharing amounts. For Members with Affinity’s Medicaid Advantage wrap around product, provider should bill Affinity direct Members who do not have full Medicaid benefits are responsible for the cost sharing amounts associated with the plan.

**BENEFIT INFORMATION**

Please consult our web site at [www.affinitymedicareplan.org](http://www.affinitymedicareplan.org) for the Affinity Medicare Advantage Benefit Grid.

*Emergency and Urgent Care*

In the cases of emergency and/or urgently needed care, Affinity Health Plan does not require prior authorization. All claims billed for an emergent or urgent visit will be considered for payment. Please see Section Four for more information about Emergency and Urgently Needed Care.

*Renal Dialysis and Post-stabilization Care*

In the cases of emergency and/or urgently needed care, Affinity Health Plan does not require prior authorization. All claims billed for an emergent or urgent visit will be considered for payment. Please see Section Four for more information about Emergency and Urgently Needed Care.

*Renal Dialysis and Post-stabilization Care*

As an HMO, Affinity has procedures to authorize payment of out-of-network services. However, particular services will be monitored for timely processing of payment. These services include out-of-plan Emergent and Urgent Care services, Renal Dialysis and Post-stabilization services.

*Women’s Care*

Women have direct access to in-network mammography as well as to women’s health care specialists within the network for women’s routine and preventative health care services. Women may also have access to services outside of the Affinity network. Members are not required to obtain a referral or authorization to visit an OB/GYN. A complete listing of OB/GYN providers is found in the Provider Directory.

*Vaccines*

Members have coverage for Part B and Part D vaccines. Part B vaccines can be billed to the plan as a medical expense (i.e., flu, pneumococcal, hepatitis B for high risk Members, and tetanus for wound treatment. Both Part D and Part B vaccines may be billed to the Pharmacy Benefit Manager (PBM) by providers enrolled in TransactRx Vaccine program (https://enroll.mytransactrx.com.)

Members have direct access to influenza vaccines. No additional co-payment beyond an office visit co-payment if applicable may be charged for influenza vaccines or the pneumococcal vaccine.
Non-Emergent Transportation

Affinity contracts with Logisticare, a non-emergency transportation company, to manage transportation benefits.

- **Affinity Medicare Ultimate with Medicaid Advantage**
  Affinity covers non-emergent transportation essential for a Member to obtain necessary medical care and services. Transportation includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Member’s medical condition and a transportation attendant to accompany the Member, if necessary. Medical necessity must be established for all non-public transportation modes of transport. Coverage limitations are consistent NYS Medicaid Fee for Service non-emergent transportation benefits.

- **Affinity Medicare Solutions**
  Non-emergent transportation is covered for up to twelve (12) round trip(s) to plan approved locations every year.

- **Affinity Medicare Ultimate**
  Non-emergent transportation is not covered

- **Affinity Medicare Essentials**
  Non-emergent transportation is not covered

- **Affinity Medicare Select**
  Non-emergent transportation is not covered

- **Affinity Medicare Elite**
  Non-emergent transportation is not covered

**Member Procedure for Transportation**

Members should call Logisticare, toll-free, at 1-866-712-1054 three business days before their appointment. For TTY, call 1-866-288-3133. Members can call Monday through Friday, 8:00 am to 5:00 pm. Members should have the following information ready:

Affinity ID number
Date and time of appointment
Date of birth
Name and telephone number of the doctor/health center
Pick up time and location
Number of people you want to travel with you

Also, please let Logisticare customer service representative know if a Member needs help walking, or some other physical help.

If the ride is late or for urgent appointments after hours, including weekends, Members can call Logisticare toll-free at 1-866-712-1055. For TTY, call 1-866-288-3133. This number is available 24 hours a day, seven days a week. Members may also call this number from your office if the Member needs a ride home from the appointment and the Member is not sure what time the appointment will be over.

Also, please note Members can:

- Have a family Member, health care provider, or caregiver call for them
- Travel with someone, if they need help and if there is room in the car
REGULATORY REQUIREMENTS FOR MEDICARE ADVANTAGE

Affinity Health Plan (Affinity) is subject to certain requirements as set forth by the Centers for Medicare and Medicaid Services (CMS) for contracted health plans. The Affinity Provider agreement requires compliance with federal regulations governing Medicare Advantage health plans and the plan’s policies and procedures. These requirements are set forth in the Affinity Provider contract, this manual and in provider newsletters and other communications and notices sent by Affinity.

- An Affinity Provider is prohibited from contracting or employing individuals who have been excluded from participation in the Medicare Program.

- If an Affinity provider files an affidavit with CMS stating they will furnish Medicare-covered services to Medicare beneficiaries only through private (direct) contracts with the beneficiaries under Section 1802(b) of the Social Security Act (i.e. they will not accept payment from Medicare), then their contract with Affinity will terminate concurrently. Providers must notify the plan within five (5) days of giving this type of notice to CMS.

- Affinity providers must provide Covered Services to all Members, including those with ethnic backgrounds, physical or mental disabilities, and limited English proficiency, in a culturally competent manner.

- Affinity providers must provide disabled covered persons with the assistance necessary to effectively communicate with the participating provider and their staff, as required by the Americans with Disabilities Act.

- Providers shall comply with all applicable Medicare laws and regulations.

- Providers understand that Affinity is responsible for overall administration of the health plan including all final coverage determinations and monitoring of its contracted provider’s compliance with federal regulations.

- Affinity is responsible for all marketing of the health plan and providers are not authorized to act as agents of Affinity in marketing. Only Affinity (and CMS) approved marketing materials may be provided to beneficiaries to explain the Affinity program.

- Providers will comply with Affinity’s Medical Policies as well as its Utilization/Medical Management Policies and Procedures.

- Providers will comply with Affinity’s Quality Management Programs.

- No balance billing of Members is permitted with the exception of applicable co-payments or coinsurances.

- An Affinity contracted provider agrees not to impose any charges on any Affinity Member for Covered Benefits. Further, contracted providers agree to accept Affinity’s payment as payment in full and agree not to seek compensation from a Member for services, even in the event of non-payment by Affinity.

- Services shall be provided in a culturally competent manner consistent with professionally recognized standards of care. Providers shall not discriminate based upon health status factors. Providers shall ensure that their office hours do not discriminate against Medicare Members.
• Providers must ensure that Members are not unlawfully discriminated against based on race, color, creed, national origin, ancestry, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by state or federal law.

• Affinity requires that all providers participate in periodic audits and/or site surveys for evaluating compliance with Affinity’s Quality Management standards and regulatory requirements.

• Providers agree to audits and inspections by CMS, the U.S. Department of Health and Human Services and/or its designees, and to cooperate, assist and provide information as requested.

• Providers must provide all covered benefits in a manner consistent with professionally recognized standards of health care.

• Providers must cooperate with the plan’s grievance and appeals procedures that protect beneficiary and Member rights.

• Providers have specific continuity of care obligations in the event that the Provider’s Affinity Agreement terminates for any reason, as described in the Affinity Provider Agreement.

• Affinity Health Plan receives federal payments under the Medicare Advantage program. It complies with all laws and regulation applicable to entities receiving federal funds including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

• Payment and incentive arrangements specified between Medicare Advantage Organizations, providers, first tier, & downstream entities are specified in Affinity contract(s).

• Affinity monitors and discloses to CMS quality and performance indicators including but not limited to: Member satisfaction, disenrollment, and health outcomes.

• Affinity discloses to CMS all information necessary to (i) administer and evaluate the Medicare Advantage program; (ii) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. Participating Provider will provide such data and other information requested by Affinity in furtherance of its obligations thereunder.

**AFFINITY’S MODEL OF CARE**

**Background:**

The Medicare Modernization Act of 2003 established Medicare Advantage SNP plans that are specifically designed to provide targeted care to individuals with special needs. These Special Needs Plans (SNPs) focus on the needs of the most vulnerable populations, 1) institutionalized beneficiaries; 2) dual eligible; and/or 3) individuals with severe or disabling chronic conditions as specified by CMS. SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Affinity’s Medicare Advantage SNP plans are Dual Eligible SNPs.

**Model of Care**

The MIPPA Act of 2008 mandated all SNPs comply with additional requirements to implement an evidence-based Model of Care and evaluate the effectiveness of its care management.
Affinity’s Model of Care is designed to improve Members’ access to medical, social and mental health services while improving transitions of care across health care settings.

**Key Components of Affinity’s Model of Care**

- **Appropriate Staff**: Affinity must ensure it has appropriate staff with clearly defined roles to provide the infrastructure necessary to run the Model of Care.
- **Case Management Program**: Affinity Members are automatically enrolled in our Case Management program; a Member may choose to opt out at any time.
- **Comprehensive Health Risk Assessment (HRA)**: Affinity must conduct an HRA for every Member within 90 days of enrollment. The HRA asks Members questions about their current health status. In addition, Affinity must conduct a re-assessment for the Member at least annually, but more often if necessary.
- **Individualized Care Plans (ICP)**: Affinity develops ICPs based on HRA information, available claims, utilization and pharmacy data, if available.
- **Interdisciplinary Care Team (ICT)**: Affinity collaborates with an ICT regarding the Members care plan.
- **Provider Network**: Affinity’s network has special expertise to provide a broad provider representation from the medical, diagnostic, and treatment arenas to care for our Dual Eligible SNP Members. Providers use nationally recognized evidence-based clinical guidelines.
- **Performance and Health Outcomes**: Affinity monitors performance and health outcomes measure to evaluate effectiveness of the model of care and make changes as necessary.

Affinity has identified specific measurable goals for the Model of Care

- **Improve service access to medical, mental health and social services**. Affinity strives to ensure that all SNP Members have timely and ready access to the full array of medical, behavioral health and social services required to maintain and improve their health.

- **Improve access to affordable care**. Affinity tracks and trends grievances related to benefits and co-pay issues in order to assure Member have access to affordable care.

- **Improve coordination of care through an identified point of contact**. Affinity SNP Members require enhanced coordination of care, particularly because of the prevalence of chronic, co-morbid medical and behavioral conditions within this population.

- **Affinity’s staff coordinates care across all levels**. Improve seamless transitions of care across healthcare settings. The Affinity case management team promotes seamless care transitions across healthcare settings and ensures Members understand the updated care plan once a transition occurs.

- **Improve access to preventive health services**. Prevention is an important feature of the Affinity Model of Care and is achieved through a combination of Member education, provider education, increased availability of preventive services and quality improvement efforts.

- **Assure appropriate utilization of services**. Affinity monitors the utilization of services through prospective, concurrent, and retrospective review using Milliman criteria, CMS guidelines and clinical judgment of Medical Directors and external experts, when needed.

- **Assure cost-effective service delivery**. The effectiveness of the quality improvement activities are monitored and evaluated on an ongoing basis. The overall performance of the SNP Model of Care is assessed and reported to the Clinical Affairs Committee on an annual basis.
• **Improve beneficiary health outcomes.** Affinity’s Model of Care strives to achieve improved health outcomes as measured by objective clinical data as well as Member self-reporting.

**Summary**

Affinity’s Model of Care offers the opportunity for the Plan to work together with the provider network for the benefit of the Member. Through enhanced communication, focus on special needs, and effective care management programs, we can develop a plan of care to improve the health status and quality of life of our Members.

If you have any questions regarding the Affinity Health Plan’s SNP Model of Care orientation, please contact your Provider Relations representative or call Provider Customer Service at 1-866-247-5678.

**Training**

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage SNP plans provide their Medicare provider network with information and yearly training on their Special Needs Plan (SNP) Model of Care. To ensure training is complete CMS requires a yearly attestation be signed.

If you have not done so already, please go to [http://www.affinityplan.org/uploadedFiles/Affinity/Providers/For_Providers/Model%20of%20Care%20Training%20Attestation%20Form.pdf](http://www.affinityplan.org/uploadedFiles/Affinity/Providers/For_Providers/Model%20of%20Care%20Training%20Attestation%20Form.pdf) and access the Training Attestation Form upon completion of your review of Affinity’s Model of Care.

Attestations and attendance sheets may be faxed to the Provider Relations Department at **718-794-7808** or mailed to:

Affinity Health Plan  
Provider Relations  
1776 Eastchester Road  
Bronx, NY 10461

**Medical Records**

Provider agrees to safeguard beneficiary privacy and confidentiality and certify completeness, truthfulness, and accuracy of beneficiary health records.

- All providers must maintain documents for at least (10) ten years.
- Files must be kept private in accordance with HIPPA guidelines.
- Providers will only provide copies of medical records to other providers and insurance companies if the Member has signed a release form allowing them to do so.
- Provider must transfer these records in a timely manner.
- Provider agrees to reviews by Affinity to monitor and assess Member records with respect to improving content, legibility, organization, and completeness of the records.
- Provider agrees to maintain Member health records in accordance with standards established by Affinity, which shall take into account professional standards. Member health records shall:
  - Identify the Member, including name, Member identification number, date of birth and sex, and legal guardianship.
  - Identify all providers who participate in the Member’s care and information on services furnished by these providers.
• A problem list, including significant illnesses, significant procedures, medical and psychological conditions for the Member.
• Presenting complaints, diagnoses, and treatment plans for the Member.
• Prescribed medication, including dosages and dates of initial or refill prescriptions for the Member.
• Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reaction)
• Document in a prominent place if an individual has executed an advanced directive.
• Past medical history, physical examination, necessary treatments, and possible risk factors for the Member relevant to the particular treatment.
• All entries must be dated and signed.
• All medical records must contain an immunization history and information on Smoking / ETOH (ethyl alcohol)/substance abuse.
• The record must reflect the primary language spoken by the Member and translation needs of the Member.
• Medical record must contain record of emergency care and hospital discharges summaries.

Appointment Availability Standards/Access to Medical Care
Providers must be accessible 24 hours a day, 7 days a week. All providers agree to provide appropriate backup in the event of an absence. Please see Page (12) of the Provider Manual for more detailed requirements.

Network Adequacy
Affinity will identify the providers necessary to ensure the adequacy of the network to provide access to Covered Services, as per CMS regulations. Affinity will evaluate the network, taking into consideration a Member’s ability to access commonly used services within the regular mandated travel time, or as reasonable patterns of care would allow.

Termination and Suspension
Affinity reserves the right to suspend or terminate a provider’s 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
• There is an imminent harm to patient care

Affinity will make good faith effort to notify all affected Members of the termination of a provider contract within 30 days of notice of termination by plan or provider. Please see Section 9 of the Provider Manual for a detailed description of the Provider termination process.
BILLING AND CLAIMS
All providers must agree to safeguard beneficiary privacy and confidentiality, assure accuracy of beneficiary health records, and encounter data.

Submission of claims/encounter data must be done through the standard HIPAA formats. Each form type has its own required fields, depending on provider type. All institutional providers submitting paper claims must use the UB04 format. The professional services should be submitted on HCFA-1500. Please see Section 8 of the Provider Manual for detailed information on Billing and Claims.

CLAIMS SUBMISSION ADDRESS
Electronic claims
Medicare claims:
Payer ID 13333
Paper Claims – (CMS-1500 and UB40)
Affinity Medicare claims:
Affinity Health Plan (HMO)
P.O. Box 4018
Scranton, PA 18505-6018

THE ABOVE IS FOR MEDICARE. PLEASE BE SURE TO CONSULT THE MAIN BODY OF THE PROVIDER MANUAL AND ANY OTHER PRODUCT LINE ADDENDA TO ENSURE PROPER ROUTING OF CLAIMS FOR MEMBERS OF OTHER PRODUCT LINES.

Grievances and Appeals
A grievance is any complaint or dispute expressing dissatisfaction, other than an organization determination, that a Member has regarding any aspect of Affinity’s services, operations and/or the healthcare delivery processes, including the provider network. It may include issues regarding the timeliness, appropriateness, access to and/or setting of a provided health service, procedure, or item. A Member or their representative may file the complaint or dispute either orally or in writing to Affinity.

The Member must contact Affinity Customer Service by telephone, fax or in person to file a grievance or complaint. Customer Service Staff handle most grievances or complaints if they can be resolved within 72 hour of receipt. However, the following are excluded and forwarded to the Complaint, Grievance, and Appeal Unit (CGA) on a daily basis. They are:

- Written complaints
- Quality of care
- Those related to medical benefits, to request for medical services or to payment for medical services
- Expedited grievances

A grievance is handled on an expedited basis when a Member complains that the Plan:
- Refused to expedite an organizational determination (initial determination) or reconsideration (appeal) request
- Requested to extend the timeframe of an organizational determination or reconsideration
CGA classifies each issue received from Customer Service to determine whether the case represents an appeal, a grievance, or both. The Member can access Affinity during business hours, which are Monday through Friday, 8:00 a.m. to 8:00 p.m., and on Saturday, 9:00 a.m. to 3:00 p.m. The Medicare Customer Service phone number is 1-877-234-4499. To send a written complaint, Members or their representatives may send complaints to:

Affinity Health Plan  
1776 Eastchester Road  
Bronx, NY 10461  
Attention: Complaint, Grievance, and Appeal Unit

No Member who files a complaint with Affinity will be discriminated against and no retaliation will be taken by Affinity or its staff in response to the filing of a grievance by an Affinity Member. All written grievances will be acknowledged in writing within fifteen (15) business days of its receipt at Affinity. The Member will receive a written resolution to the grievance, within thirty (30) calendar days of its receipt at Affinity.

Organization Determinations and Reconsiderations
When Affinity receives a request for payment or to provide services to a Member, it must make an organization determination to decide whether coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the Member has the right to request a reconsideration or appeal. A Member who disagrees with a practitioner’s decision about a request for a service or a course of treatment has a right to request an organization determination from Affinity.

Affinity is required to make organization determinations and process appeals as expeditiously as the Member’s health status requires and within the following timeframes:

- **Standard Determinations** – within 14 calendar days (the 14-day deadline may be extended by an additional 14 calendar days if the Member requires the extension or Affinity justifies the need for additional information which will benefit the Member)

- **Expedited Determinations** – within 72 hours (the 72-hour deadline may be extended by an additional 14 calendar days if the Member requires the extension or Affinity justifies the need for additional information which will benefit the Member)

A Member has a right to appeal if the Member believes that:

- Affinity has not paid for emergency or urgently needed services;
- Affinity has not paid a bill in full;
- Health services have been furnished by a non-contracting medical provider or facility or supplier that the Member believes should have been provided, arranged for, or reimbursed by Affinity;
- Services that the Member feels are the responsibility of Affinity to provide or pay for have not been received or paid;
- Health services have been discontinued or reduced, but the Member believes the services are still medically necessary;
- An organization determination has not been made within the appropriate time frames; or
- Services that should be provided by, arranged for, or reimbursed have not been provided, arranged for, or reimbursed.

All appeal requests must be made in writing within sixty (60) calendar days from the date of the notice of organization determination. Affinity may extend the time frame for filing a request for reconsideration for good cause.
A Member or a Member’s representative must request a standard appeal request of an organization determination in writing. A Member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases others authorized under state law may act on behalf of the Member. The Member or Member’s appointed representative can file an appeal by calling Affinity at 1-888-543-9069 or by fax at 1-718-536-3358.

If further information about the Member’s appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner to allow for resolution within regulatory periods.

**Expedited Organization Determinations and Appeals**

An Affinity Member or that Member’s Provider may file an Expedited Appeal if a delay would significantly increase risk to the Member’s health. The Member or the Member’s appointed representative may request an Expedited Appeal by calling Affinity at the number above.

If Affinity denies the request to expedite the Appeal, Affinity will notify the Member and/or Member’s representative and review the appeal using the Standard Appeal process. If a provider requests, or supports the Member’s request for an expedited determination or appeal, Affinity must automatically expedite the review.

The period for appeal resolution may be extended up to fourteen (14) days if the Member, the Member’s designee or the Member’s provider requests an extension orally or in writing.

Affinity will make a determination with regard to a STANDARD appeal within thirty (30) days from the date we received the appeal. Affinity will make a determination with regard to an EXPEDITED (fast-track) appeal within 72 hours of receipt of the appeal.

If Affinity reverses an adverse organization determination, then services will be provided as expeditiously as the Member’s health condition requires, but no later than thirty (30) calendar days after the date the request for appeal was received. For payment-related requests, payment will be made no later than sixty (60) days after the appeal request was received.

If Affinity upholds an initial adverse organization determination, then the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review. If the IRE upholds the decision, the IRE will notify the Member in writing and explain further appeal options that may be available to the Member.

If Affinity does not complete an expedited appeal process within seventy-two (72) hours or a standard appeals process within thirty (30) calendar days, the case will be automatically referred to CMS’s contractor for an independent review.
Appeals for Affinity Medicare Ultimate with Medicaid Advantage Members

Affinity Medicare Ultimate with Medicaid Advantage Members have benefits under both Medicare and Medicaid, and have different options when filing an appeal. For services covered under the Medicare portion of the benefit package, Members must follow Medicare appeal rules. For services covered under the Medicaid portion of the benefit package, Members must follow the Medicaid rules. For services covered by both Medicaid and Medicare, Members can follow either Medicare or Medicaid rules. If a Member chooses to pursue Medicaid appeal rules to challenge organization determination or action, he/she has sixty (60) calendar days from the date on the Notice of Denial of Coverage issued by Affinity to pursue Medicare appeal, regardless of the status of the Medicaid appeal. However, if a Member chooses to follow Medicare rules, they may not file an appeal under Medicaid rules. Affinity determines whether Medicaid, Medicare, or both cover a particular service.

SNF/HHA/CORF Provider Service Terminations

For Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers, pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage to Medicare managed care Members prior to the cessation of services, regardless of the reason for cessation. The delivery must be made to the managed care Member two (2) days prior to the termination of the covered services and will not be considered valid until the Member signs and dates the notice. If the Member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the Member’s legal authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e., the family Member involved in the plan of treatment). The provider must fax the signed NOMNC to the MM dept. as soon as it is signed.

Although the caregiver is not a legal authorized representative, he/she has assumed responsibility for the Member’s medical treatment. If the Member has no legal authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the Member. In addition, it is important that you understand that Affinity will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and secure a Member’s signature.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF Provider Service Terminations

A Member receiving skilled provider services in a SNF, HHA or CORF who wishes to appeal an Affinity decision to terminate such services because care is no longer medically necessary must request an immediate QIO review of the determination in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage

Once the QIO receives an appeal, it must issue a notice to Affinity that a Member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, Affinity is responsible for issuing the Detailed Explanation of Non-Coverage – a written notice that is designed to provide specific information to Medicare Members regarding the end of their SNF, HHA or CORF care. Affinity must issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the Member no later than the close of business when the QIO notifies Affinity that a Member has requested an appeal. Affinity is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and Affinity.
Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the Member’s request, the QIO must notify Affinity and the provider that the Member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day of the appeal request date. Affinity must supply a copy of the Notice of Medicare Non-Coverage, Detailed Explanation of Non-Coverage and any medical information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day that the QIO notifies Affinity of an appeal. If a Member requests an appeal on the same day the Member receive the Notice of Medicare Non-Coverage, then Affinity has until close of business the following day to submit the case file. The QIO must solicit the views of the Member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary and notify the Member, the provider, and Affinity by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, Affinity, or both. If the QIO does not receive the information it needs to sustain the Affinity decision to terminate services, then the QIO may make a decision based on the information at hand, or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by Affinity will continue and the QIO will refer violations of notice delivery to the CMS regional office.

Notification to Members of Non-Coverage of Inpatient Hospital Care

Where Affinity has authorized coverage of the inpatient hospital admission of a Medicare Member, either directly or by delegation (or the admission constitutes emergency or urgently needed care), Affinity is required to issue the Member a written notice of non-coverage only under the circumstances described below.

Hospital Discharge Notification Process

There is a two-step notification process where Medicare beneficiaries are notified that services will be discontinued and/or their original Medicare or Medicare Advantage Plan will no longer pay for their benefits. Affinity delegates the issuance of discharge notices to all of its contracted hospitals.

The hospitals are required to:

- Issue a revised version of the Important Message from Medicare (IM) and explain discharge rights to beneficiaries within two (2) days of admission. Hospitals must also obtain the signature of the beneficiary or his/her representative. If a Member refuses to sign the notice, the hospital must annotate the refusal;
- Deliver via fax a copy of the signed notice not more than two (2) days prior to discharge. In short stay situations, when inpatient stays are five (5) days or less, hospitals are not required to deliver a follow-up notice as long as the initial notice was delivered within two (2) days of discharge.

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A Member remaining in the hospital who wishes to appeal the Affinity discharge decision that inpatient care is no longer medically necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A Member will not incur any additional financial liability if he/she:

- Remains in the hospital as an inpatient;
- Submits the request for immediate review to the QIO that has an agreement with the hospital;
- Makes the request either in writing, by telephone or fax; and
- Makes the request before the end of the day of discharge.
The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the Member's request, the QIO must notify Affinity that the Member has filed a request for immediate review;
- Affinity and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax or in writing by the close of business of the first full working day immediately following the day the Member submits the request for review;
- In response to a request from Affinity, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day Affinity makes its request;
- The QIO must solicit the views of the Member who requested the immediate QIO review;
- The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the Member, the hospital, and Affinity by close of business of the first working day after it receives all necessary information from the hospital, Affinity, or both.

A Member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Affinity.

Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the Member or Member representative in accordance with this section entitles the Member to automatic financial protection by Affinity. This means that if Affinity authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, Affinity continues to be financially responsible for the costs of the hospital stay until noon (12 p.m.) on the calendar day following the day the QIO notifies the Member of its review determination.

Part D – Medicare Prescription Drug Coverage

Coverage Determinations
All of Affinity’s Medicare plans offer Medicare prescription drug coverage (Part D). Generally, the Members must share the costs for their prescription drugs (in Affinity Medicare Ultimate, generic drugs are free). Drugs on the formulary are grouped into the following tiers:

- Tier 1 Preferred Generic
- Tier 2 Non-Preferred Generic
- Tier 3 Preferred Brand and some Non-Preferred Generics
- Tier 4 Non-Preferred Brand
- Tier 5 Specialty

Coverage determinations include exception requests. An exception request is the way a Member can request lower cost sharing for a formulary drug, or coverage of a non-formulary drug. A supporting statement must accompany an exception request from the prescribing provider.

Affinity strongly encourages and recommends that a prescribing provider review the current Medicare Part D formulary to identify the drugs that are covered for Affinity Members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the Member. In general, the lower the drug tier the lower the cost of the drug.
Prior Authorization

Affinity Health Plan requires a Member or his/her provider to request prior authorization for certain drugs. This means the Member must obtain prior approval for a prescription from Affinity before the prescription is filled. If you do not obtain approval, Affinity may not cover the drug.

Quantity Limits

For certain drugs, Affinity limits the amount of the drug that Affinity will cover.

Step Therapy

In some cases, Affinity requires you first try certain drugs to treat your medical condition before we will cover another drug for that condition. Affinity’s Medicare formulary, which includes Prior Authorization, StepTherapy, and Quantity Limit criteria, can be found at www.affinitymedicareplan.org.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department in one of the following ways:

CALL CVS Caremark at 855-344-0930, Toll Free 24/7
FAX CVS for Coverage determinations, 855-633-7673, Toll free 24/7

Medicare Part D Appeals

A Member, a Member is appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Timeframe begins upon receipt of the request. A Member may appeal an adverse coverage determination; however, if an exception request for a non-formulary drug is approved the Member cannot request an exception to the copayment they are required to pay for the drug.

A Member has a right to appeal if he or she believes that Affinity/CVS Caremark did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit;
- Decided not to reimburse a Member for a part D drug that he/she paid for;
- Asked for payment or provided reimbursement with which a Member disagrees;
- Denied the Member’s exception request;
- Made a coverage determination with which the Member disagrees.

Appeals for Part D Prescription Drugs

CALL CVS Caremark at 866-362-4002, Toll free 24/7
FAX CVS Appeals at 855-633-7673, Toll free 24/7

Complaints about Part D Prescription Drugs

CALL CVS Caremark at 866-362-4002, Toll free 24/7

If Affinity/CVS Caremark fails to meet coverage determination or redetermination time frames, it must automatically forward the Member’s request(s) to the Independent Review Entity (IRE) contracted by CMS. If the IRE upholds the Affinity adverse coverage determination, the IRE will notify the Member in writing and explain further appeal options that may be available to the Member.
Time Frames for Coverage Determinations and Appeals
Affinity/CVS Caremark is required to make coverage determinations and process appeals as expeditiously as the Member’s health status requires but no later than is indicated in the following chart:

**Pharmacy Coverage Determinations (Initial Decision)**

Standard Determination – 72 hours  
Expedited Determination - 24-hours  

**First Level of Appeal (CVS Caremark)**

Standard Redetermination - 7-day time limit  
Expedited Redetermination - 72-hour time limit  

**Second Level of Appeal (Independent Review Entity (IRE))**

Standard Redetermination - 7-day time limit  
Expedited Redetermination - 72-hour time limit  

**Third Level of Appeal (Administrative Law Judge)**

Standard Decision - 90-day time limit  
Expedited Decision - 10-day time limit  

**Fourth Level of Appeal (Medicare Appeals Council – MAC)**

Standard Decision - 90-day time limit  
Expedited Decision - 10-day time limit  

**Final Level of Appeal – (Judicial Appeal – Federal District Court)**

Note: Each appeal level requires Member or Member’s representative to file the appeal within 60 days of previous determination.

**MEMBER RIGHTS AND RESPONSIBILITIES**

**Member Rights**

- Members have the right to be treated with courtesy, respect, dignity and with protection for privacy including the protection of medical records and personal health information.
- Members have the right to a prompt and reasonable response to questions and requests.
- The right to know who is providing medical services and who is responsible for your care.
- You have the right to know what Member support services are available, including whether an interpreter is available (if you need assistance in English).
- The Member has the right to know what rules and regulations apply to your conduct.
- The Member has the right to refuse any treatment. Except as otherwise provided by law.
- The right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for your care.
- Medicare Members have the right to know, upon request and in advance of treatment, whether
• the health care provider or health care facility accepts the Medicare assignment rate or Medicare Advantage Insurance and a reasonable estimate of charges for medical care prior to treatment.
• Members have the right to express grievances regarding any violation of their rights, through the grievance procedure of the health care provider or health care facility, which served you, and to the appropriate state licensing agency.
• Members have the right to make complaints, which are either appeals or grievances related to their coverage or care.
• Affinity Health Plan Members have the rights to see Plan Providers, get covered services and get your prescriptions filled within a reasonable period.
• Members have the right to get more information about their rights by calling Customer Service at the number listed in Member materials or 1 800 MEDICARE (1 800 633-4227) TTY users should call 1 877 486-2048, Or you can call CMS( 24) hours a day (7) days a week. Also, visit the official government website for Medicare information: www.medicare.gov on the web to order Medicare Rights and Protection or print it directly forms your computer.

Member Responsibilities

• Member is responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible. Including premiums, if any, and Co-payments that patient may owe for covered services. You must also meet the financial responsibilities that are described in the Evidence of Coverage.
• Member is responsible to act in a way, supports the care given to others in the provider office, and helps the smooth running of their doctor’s office, hospital and other offices.
• Member is responsible to informed unexpected changes in his/her condition to the health care provider.
• Member is responsible for following the treatment plan recommended by the health care provider.
• Member is responsible for their actions if they refuse treatment or do not follow the health care provider’s instructions.
• Member is responsible for providing to the health care provider, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health.
• Member is responsible for following heath care facility’s rules and regulations affecting his/her care and conduct.

The Centers for Medicare and Medicaid (CMS)

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that administers the Medicare program. The CMS contracts with, and regulates, Medicare Health Plans (including Affinity) and Medicare Private Fee-for-Service organizations. Here are ways to get help and information about Medicare from CMS:

PHONE

1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048. (You need special telephone equipment to use this number.) Calls to these numbers are free.

INTERNET

The official government website for Medicare information is www.medicare.gov. This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.
Qualified Health Plan

OVERVIEW

Qualified Health Plan (QHP) - A federal/state insurance program that is certified by the Health Insurance Marketplace. Provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold. A quick reference guide of key contact information can be found towards the end of manual on page 96.

ENROLLMENT AND ELIGIBILITY

For an eligible beneficiary to enroll in an Affinity Qualified Health plan, the prospective Member: Should reside within Affinity Health Plan’s servicing area (Bronx, Kings, and New York, Queens, Richmond, Nassau, Suffolk, Orange, Rockland and Westchester counties), including citizens or permanent legal residents.

BENEFIT INFORMATION

Please consult our web site at www.affinityplan.org/HIX-Summary-of-Benefits for the QHP/ AffinityAccess Benefit Grid.

The Benefit Grid located at the end of Manual indicates which services require prior authorization. Please see page 91 for detailed list.

Emergency and Urgent Care

In the cases of emergency and/or urgently needed care, Affinity Health Plan does not require prior authorization. All claims billed for an emergent or urgent visit will be considered for payment. Please see Section Four for more information about Emergency and Urgently Needed Care.

Women’s Care

Women do not need a PCP referral to see a network OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

REGULATORY REQUIREMENTS FOR QUALIFIED HEALTH PLANS

Affinity Health Plan (Affinity) is subject to certain requirements as set forth by the Centers for Medicare and Medicaid Services (CMS) and the New York State of Health Marketplace (NYSOH) for contracted health plans. The Affinity Provider agreement requires compliance with state and federal regulations governing Qualified Health Plans and the plan’s policies and procedures. These requirements are set forth in the Affinity Provider contract, this manual and in provider newsletters and other communications and notices sent by Affinity.

- An Affinity Provider is prohibited from contracting or employing individuals who have been excluded from participation in the QHP/AFFINITYACCESS Program.
• Affinity providers must provide Covered Services to all Members, including those with ethnic backgrounds, physical or mental disabilities, and limited English proficiency, in a culturally competent manner.
• Affinity providers must provide disabled covered persons with the assistance necessary to effectively communicate with the participating provider and their staff, as required by the Americans with Disabilities Act.
• Providers shall comply with all applicable laws and regulations.
• Providers understand that Affinity is responsible for overall administration of the health plan including all final coverage determinations and monitoring of its contracted provider's compliance with federal and state regulations.
• Affinity is responsible for all marketing of the health plan and providers are not authorized to act as agents of Affinity in marketing. Only Affinity (and NYSOH) approved marketing materials may be provided to beneficiaries to explain the Affinity program.
• Providers will comply with Affinity’s Medical Policies as well as its Utilization/Medical Management Policies and Procedures.
• Providers will comply with Affinity’s Quality Management Programs.
• No balance billing of Members is permitted for Covered Services with the exception of applicable deductibles, co-payments or coinsurances.
• Services shall be provided in a culturally competent manner consistent with professionally recognized standards of care. Providers shall not discriminate based upon health status factors. Providers must ensure that Members are not unlawfully discriminated against based on race, color, creed, national origin, ancestry, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by state or federal law.
• Affinity requires that all providers participate in periodic audits and/or site surveys for evaluating compliance with Affinity’s Quality Management standards and regulatory requirements.
• Providers agree to audits and inspections by CMS, the U.S. Department of Health and Human Services and/or its designees, or the NYSOH, and to cooperate, assist and provide information as requested.
• Providers must provide all covered benefits in a manner consistent with professionally recognized standards of health care.
• Providers must cooperate with the Affinity’s grievance and appeals procedures that protect beneficiary and Member rights.
• Providers have specific continuity of care obligations in the event that the Provider’s Affinity Agreement terminates for any reason, as described in the Affinity Provider Agreement.
• Affinity monitors and discloses to NYSOH and CMS quality and performance indicators including but not limited to: Member satisfaction, disenrollment, and health outcomes.

Medical Records

Provider agrees to safeguard beneficiary privacy and confidentiality and certify completeness, truthfulness, and accuracy of beneficiary health records.

• All providers must maintain documents for at least (10) ten years.
• Files must be kept private in accordance with HIPAA guidelines.
• Providers will only provide copies of medical records to other providers and insurance companies if the Member has signed a release form allowing them to do so.
• Provider must transfer these records in a timely manner.
• Provider agrees to reviews by Affinity to monitor and assess Member records with respect to improving content, legibility, organization, and completeness of the records.
• Provider agrees to maintain Member health records in accordance with standards established by Affinity, which shall take into account professional standards. Member health records shall:
- Identify the Member, including name, Member identification number, date of birth and sex, and legal guardianship.
- Identify all providers who participate in the Member’s care and information on services furnished by these providers.
- A problem list, including significant illnesses, significant procedures, medical and psychological conditions for the Member.
- Presenting complaints, diagnoses, and treatment plans for the Member.
- Prescribed medication, including dosages and dates of initial or refill prescriptions for the Member.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reaction)
- Document in a prominent place if an individual has executed an advanced directive.
- Past medical history, physical examination, necessary treatments, and possible risk factors for the Member relevant to the particular treatment.
- All entries must be dated and signed.
- All medical records must contain an immunization history and information on Smoking / ETOH (ethyl alcohol)/substance abuse.
- The record must reflect the primary language spoken by the Member and translation needs of the Member.
- Medical record must contain record of emergency care and hospital discharges summaries.

Appointment Availability Standards/Access to Medical Care

Providers must be accessible 24 hours a day, 7 days a week. All providers agree to provide appropriate backup in the event of an absence. Please see Page 11 of the Provider Manual for more detailed requirements.

Network Adequacy

Affinity will identify the providers necessary to ensure the adequacy of the network to provide access to Covered Services, as per NYSOH regulations. Affinity will evaluate the network, taking into consideration a Member’s ability to access commonly used services within the regular mandated travel time, or as reasonable patterns of care would allow.

Termination and Suspension

Affinity reserves the right to suspend or terminate a provider’s 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
- There is an imminent harm to patient care

Affinity will make good faith effort to notify all affected Members of the termination of a provider contract within 30 days of notice of termination by plan or provider. Please see Section 9 of the Provider Manual for a detailed description of the Provider termination process.
BILLING AND CLAIMS
All providers must agree to safeguard beneficiary privacy and confidentiality, assure accuracy of beneficiary health records, and encounter data.

Submission of claims/encounter data must be done through the standard HIPAA formats. Each form type has its own required fields, depending on provider type. All institutional providers submitting paper claims must use the UB04 format. The professional services should be submitted on HCFA-1500. Please see Section 8 of the Provider Manual for detailed information on Billing and Claims.

Electronic claims
AFFINITYACCESS claims:
Payer ID 23334

Paper Claims
AffinityAccess (QHP) claims:
AffinityAccess
P.O. Box 981650
El Paso, TX, 79998-1650

GRIEVANCES AND APPEALS

Grievances
A grievance is any complaint or dispute expressing dissatisfaction, other than an organization determination, that a Member has regarding any aspect of Affinity’s services, operations and/or the healthcare delivery processes, including the provider network. It may include issues regarding the timeliness, appropriateness, access to and/or setting of a provided health service, procedure, or item. A Member or their representative may file the complaint or dispute either orally or in writing to Affinity.

The Member must contact Affinity Customer Service by telephone, fax or in person to file a grievance or complaint. Customer Service Staff handle most grievances or complaints if they can be resolved within 72 hour of receipt. However, the following are excluded and forwarded to the Complaint, Grievance, and Appeal Unit (CGA) on a daily basis. They are:

- Written complaints
- Quality of care
- Those related to medical benefits, to request for medical services or to payment for medical services
- Expedited grievances
- Aged-out complaints (those not resolved within the 72-hour window)

A grievance is handled on an expedited basis when a Member complains that the Plan:

- Refused to expedite an organizational determination (initial determination) or reconsideration (appeal) request; or
- Requested to extend the timeframe of an organizational determination or reconsideration.
CGA classifies each issue received from Customer Service to determine whether the case represents an appeal, a grievance, or both. The Member can access Affinity during business hours, which are Monday through Friday, 8:00 am to 6:00 pm Eastern Time. The AFFINITYACCESS Customer Service phone number is 1-888-543-9069. To send a written complaint, Members or their representatives may send complaints to Affinity Health Plan at 1776 Eastchester Rd, Bronx, New York 10461, Attention Complaint, Grievance, and Appeal Unit.

No Member who files a complaint with Affinity will be discriminated against and no retaliation will be taken by Affinity or its staff in response to the filing of a grievance by an Affinity Member. All grievances not meeting the excluded criteria above, whether verbal or written, will be acknowledged in writing within fifteen (15) business days of its receipt at Affinity. The Member will receive a written resolution to the grievance, within thirty (30) calendar days of its receipt at Affinity.

**Organization Determinations and Reconsiderations**

When Affinity receives a request for payment or to provide services to a Member, it must make an organization determination to decide whether coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the Member has the right to request a reconsideration or appeal. A Member who disagrees with a practitioner’s decision about a request for a service or a course of treatment has a right to request an organization determination from Affinity.

Affinity is required to make organization determinations and process appeals as expeditiously as the Member’s health status requires and within the following timeframes:

- **Standard Determinations** – within 15 calendar days (the 15-day deadline may be extended by an additional 15 calendar days if the Member requires the extension or Affinity justifies the need for additional information which will benefit the Member)
- **Expedited Determinations** – within 72 hours (the 72-hour deadline may be extended by an additional 15 calendar days if the Member requires the extension or Affinity justifies the need for additional information which will benefit the Member)

A Member has a right to appeal if the Member believes that:

- Affinity has not paid for emergency or urgently needed services
- Affinity has not paid a bill to the full extent after deductible, co-payments, co-insurance and out of pocket maximums have been factored
- Health services have been furnished by a non-contracting medical provider or facility or supplier that the Member believes should have been provided, arranged for, or reimbursed by Affinity
- Services that the Member feels are the responsibility of Affinity to provide or pay for have not been received or paid
- Health services have been discontinued or reduced, but the Member believes the services are still medically necessary
- An organization determination has not been made within the appropriate time frames
- Services that should be provided by, arranged for, or reimbursed have not been provided, arranged for, or reimbursed

All appeal requests must be made in writing within one hundred eighty (180) calendar days from the date of the notice of organization determination. Affinity may extend the time frame for filing a request for reconsideration for good cause.
A Member or a Member’s representative must request a standard appeal request of an organization determination in writing. A Member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases others authorized under state law may act on behalf of the Member. The Member or Member’s appointed representative can file an appeal by calling Affinity at 1-888-543-9069 or fax at 718-536-3358.

If further information about the Member’s appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner to allow for resolution within regulatory periods.

Expeditied Organization Determinations and Appeals

An Affinity Member or that Member’s Provider may file an Expedited Appeal if a delay would significantly increase risk to the Member’s health. The Member or the Member’s appointed representative may request an Expedited Appeal by calling Affinity at the number above.

If Affinity denies the request to expedite the Appeal, Affinity will notify the Member and/or Member’s representative and review the appeal using the Standard Appeal process. If a provider requests, or supports the Member’s request for an expedited determination or appeal, Affinity must automatically expedite the review.

The period for appeal resolution may be extended up to fifteen (15) days if the Member, the Member’s designee or the Member’s provider requests an extension orally or in writing.

Affinity will make a determination with regard to a STANDARD appeal within fifteen (15) days from the date we received the appeal. Affinity will make a determination with regard to an EXPEDITED (fast-track) appeal within 72 hours of receipt of the appeal.

If Affinity reverses an adverse organization determination, then services will be provided as expeditiously as the Member’s health condition requires, but no later than thirty (30) calendar days after the date the request for appeal was received. For payment-related requests, decision will be made no later than sixty (60) days after the appeal request was received.

PHARMACY MANAGEMENT

Pharmacy Network

We provide Members with access to a broad network of community pharmacies. Through pharmacy benefits, Members can fill prescriptions for covered pharmaceuticals and supplies at any participating network pharmacy. We also work together with CVS Caremark Specialty Pharmacy Services to supply certain high-cost biotech and injectable drugs to AFFINITYACCESS members.

Prescriptions and Benefit

Pharmacies may dispense covered pharmaceuticals, including over-the-counter (OTC) drugs and supplies when covered, only with a prescription. Prescribers are required to use their National Provider Identifier (NPI) number on all prescriptions. A facility NPI number is not acceptable. Prescriptions for all Members may be filled only if accompanied by the Member’s Affinity ID card. Early refills for lost or stolen medication may be covered if requested from the prescriber for non-controlled drugs only. Early refills for vacation supply will not be covered.

Vaccines are covered for all Members over the age of 19. The vaccine cost will not be covered for Members younger than 19 years of age since the vaccines are available from Vaccine for Children (VFC) program. Adult Members have the option to receive administration of flu and pneumococcal vaccines from network pharmacies without a prescription.
**Formulary Management**

Pharmacies may dispense only items found in our formulary. The formulary differs by product line and some formulary agents require prior authorization. The Member’s PCP or participating specialist may request exceptions through our PBM by calling 855-722-6228

**Electronic Prescribing and Authorizations**

You are encouraged to prescribe electronically and submit electronic authorizations requests. These options are available through our pharmacy benefits manager, CVS Caremark. Related to electronic authorization requests, you will be able to answer required criteria and after submission, if the authorization cannot be approved immediately, you will get a response back electronically following review by a clinician. Even with electronic authorization, you will still get a fax notice so that you can easily update your patient chart. Allscripts®, ePrescribe®, and NaviNet® are among the systems currently supported and new systems are constantly being added. If your electronic prescribing tool does not support electronic authorization, a portal version is available. To learn more or to get started, visit www.caremark.com/epa.

A list of participating pharmacies, our formularies, coverage rules (e.g., step therapy, quantity limits, etc.) and drug specific authorization forms can be found on our web site at www.affinityplan.org/Plans/Health_Benefit_Exchange/Pharmacy_Information.aspx.

**MEMBER RIGHTS AND RESPONSIBILITIES**

**Member Rights**

- Members have the right to be treated with courtesy, respect, dignity and with protection for privacy including the protection of medical records and personal health information.
- Members have the right to a prompt and reasonable response to questions and requests.
- The right to know who is providing medical services and who is responsible for your care.
- You have the right to know what Member support services are available, including whether an interpreter is available (if you need assistance in English).
- The Member has the right to know what rules and regulations apply to your conduct.
- The Member has the right to refuse any treatment. Except as otherwise provided by law.
- The right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for your care.
- Members have the right to express grievances regarding any violation of their rights, through the grievance procedure of the health care provider or health care facility, which served you, and to the appropriate state licensing agency.
- Members have the right to make complaints, which are either appeals or grievances related to their coverage or care.
- Affinity Health Plan Members have the rights to see Plan Providers, get covered services and get your prescriptions filled within a reasonable period.
- Members have the right to get more information about their rights by calling Customer Service at the number listed in Member handbooks.
Member Responsibilities

- Member is responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible. Including premiums, if any, and Co-payments that patient may owe for covered services. You must also meet the financial responsibilities that are described in the Evidence of Coverage.
- Member is responsible to act in a way that supports the care given to others in the provider office, and helps the smooth running of their doctor’s office, hospital and other offices.
- Member is responsible to inform of any unexpected changes in his/her condition to the health care provider.
- Member is responsible for following the treatment plan recommended by the health care provider.
- Member is responsible for their actions if they refuse treatment or do not follow the health care provider’s instructions.
- Member is responsible for providing to the health care provider, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health.
- Member is responsible for following health care facility’s rules and regulations affecting his/her care and conduct.

The following ID card will identify the Member as being enrolled in a AFFINITYACCESS and will contain important information:

Please Note: The ID card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified at each visit. Failure to verify eligibility may result in non-payment of claims.

To determine eligibility if the Member does not have an identification card, you may call 1-888-543-6973 for verification. New Members may have a copy of their enrollment form as interim proof of Membership until a card is issued and mailed.
CASE MANAGEMENT PROGRAMS

Populations targeted for care management include, but are not limited to:

- Members with multiple co-morbid conditions
- Transplants (excluding Corneal Transplants)
- Diabetics
  - Unstable: Two admissions or more admissions within 90 days
  - Non-healing wounds
  - Multiple co-morbidities
  - New diabetics identified through hospitalization
- Congestive heart failure Stage 3 and 4 with or without co-morbid conditions
  - Unstable: Two admissions or more admissions within 90 days
  - New CHF Members identified through hospitalization
- Discharged Members for Transition of Care follow-up
- HIV/AIDS
  - Confirmed diagnosis
- High Risk Pregnancy
  - Late entry into prenatal care
  - Multiple gestation
  - Co-morbidities which may impact pregnancy
  - Prior history of high risk pregnancy

Case Managers are dedicated specifically to managing these defined populations in order to ensure the most favorable health outcomes. Cases are identified through various sources including but not limited to:

- Daily Hospital Census – Admits/Re-Admits/Discharges
- Case Rounds
- Internal predictive risk modeling reports
- Internal utilization resource reports
- Home Assessments
- Physician Referrals

Interventions include but are not limited to:

- Monitoring inpatient admissions to assist with discharge planning activities and transition to home
- Referral to community-based resources to address psychosocial needs
- Referral to our behavioral health vendor for case management assessment
- to Specialty Care Programs (e.g., Cardiac Rehab, Pulmonary Rehab, Diabetic Programs, Fitness Programs, Wound Care Centers, etc.), as appropriate
- Facilitating the referral process/coordinating care as needed
- High Risk Drug Therapy (e.g., Hereditary Angioedema (HAE), Hepatitis C, Immune Globulin (IVIG), Hemophilia Products)
### SAMPLE ROSTER REFLECTING RESTRICTED MEMBERS

| GROUP | PCP NUMBER | PCP NAME | MEMBER Status | CARRIER | LAST NAME | FIRST NAME | DOB | IEX | MEMBER NUMBER | MEDICARE CON | EFF DATE | PCP REG DATA | RECON DATE | MED & CBOA | MEMBER PHONE | RESTRICTED | MEMBER REMARKS |
|-------|------------|----------|---------------|---------|-----------|------------|-----|-----|--------------|-------------|----------|--------------|------------|-----------|--------------|------------|-------------|----------------|------------|
|なんで | 3203021320 | なんで | なんで | なん | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで | なんで |
|なんて | 3203021320 | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて |
|なんて | 3203021320 | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて | なんて |

*Member restrictions refer to restrictions based on Medicare Part B (MBS) for further member restrictions see date.

**Unrestricted members are members that are not restricted or have restricted status pending further notice.**
PCP INFORMATION ABOUT BEHAVIORAL HEALTH

Beacon Health Strategies, (Affinity Health Plan’s managed behavioral health partner), has developed a toolkit to assist PCPs in the diagnosis and treatment of mental health and substance use disorders. Delivering behavioral health services in a primary care setting can help reduce the stigma and discrimination associated with mental health diagnoses. It’s also more cost-effective to treat common BH disorders in primary care settings.

Primary care settings are also becoming the first line of identification for behavioral health issues and PCPs are the center of care for many patients who have both physical and behavioral health disorders. To supports PCPs, this online toolkit will assist in identifying BH conditions through well-known screening tools, as well as decision support. Condition-specific fact sheets, as well as other patient-centered information, are included within the toolkit so PCPs can help their patients understand their diagnosis and take the right steps to become and stay healthy.

The conditions included in the toolkit are:

- Alcohol and other drugs
- Anxiety
- ADHD
- Depression, adolescent depression and postpartum depression
- Eating disorders
- OCD
- PTSD
- Schizophrenia

The toolkit also has forms that will allow PCPs to share relevant patient information with other providers, including BH providers, to facilitate better integration of care. Beacon’s PCP toolkit is an excellent resource for PCPs as they diagnose and treat behavioral health conditions. It can be found on Beacon’s website at http://www.beaconhealthstrategies.com/pcp_toolkit/pcp_toolkit.aspx.

Affinity recognizes the crucial role primary care physician’s play in the diagnosis and treatment of depression and promotes the use of the Patient Health Questionnaire (PHQ-9) as a screening tool to assist its PCPs in identifying Affinity members with symptoms of depression who may be appropriate candidates for consultation or referral to a behavioral Health Specialist.

The PHQ-9 should be used at the baseline appointment, at the annual preventative care visit and when alerted to possible signs of depression. A copy of the questionnaire should be kept in the member’s medical records. This tool is not intended to replace a complete mental health evaluation and assessment. Primary Care Physicians can refer members to behavioral health specialists for a complete evaluation.

Behavioral Health services include:

- Medically necessary supervised outpatient withdrawal (OASAS services)
- Outpatient clinic and opioid treatment program(OTP)services(OASAS services)
- Outpatient clinic(OMH services)
- Comprehensive psychiatric emergency program
- Continuing day treatment
- Partial hospitalization
- PROS
- ACT
- Intensive case management/supportive case management
- Health Home Care Coordination and Management
- Inpatient hospital detoxification(OASAS Service)
- Inpatient medically supervised inpatient detoxification(OASAS Service)
- Inpatient treatment(OASAS Service)
- Rehabilitation services for residential SUD treatment supports(OASAS Service)
- Inpatient psychiatric services( OMH Service)
- Rehabilitation services for residents of community residences

**FEP**

First episode psychosis simply refers to the first time someone experiences psychotic symptoms or a psychotic episode. People experiencing a first episode may not understand what is happening. The symptoms can be highly disturbing and unfamiliar, leaving the person confused and distressed. A psychotic episode occurs in three (3) phases. The length of each phase varies from person to person.

- **Phase 1: Prodome** - The early signs may be vague and hardly noticeable. Each person’s experience will differ and not everyone will experience all of the following "common signs."
  - Reduced concentration
  - Decreased motivation
  - Depressed mood
  - Sleep disturbance
  - Anxiety
  - Social withdrawal
  - Suspiciousness
  - Deterioration in functioning
  - Withdrawal from family and friends
  - Odd beliefs/magical thinking

- **Phase 2: Acute** - The acute phase is when the symptoms of psychosis begin to emerge. It is also known as the "critical period." The person experiencing psychosis can become extremely distressed by what is happening to them or behave in a manner that is so out of character that family members can become extremely concerned and may start to seek help. Before this stage the individual may have been experiencing a more gradual decline. Clear psychotic symptoms are experienced, such as:
  - Hallucinations
  - Delusions
  - Confused thinking.
• **Phase 3: Recovery** - With effective treatment most people will recover from their first episode of psychosis and may never have another episode. It is important to remember that psychosis is a treatable condition and if help is sought early, an individual may never suffer another episode. Initially, some of the symptoms that are apparent in the acute phase may linger in the recovery phase but with appropriate treatment most people successfully recover and return to their normal, everyday lives.

**Cultural Competence**

Cultural competence represents the ability to interact effectively with people of different cultures and conditions.

Affinity services a diverse member population and it is important that our network providers understand and are prepared for the cultural context of the communities they serve.

Providers must ensure that services and information about treatment are provided in a manner consistent with the member’s ability to understand what is being communicated. Members of different racial, ethnic and religious backgrounds as well as individuals with disabilities, should receive information in a comprehensible manner that is responsive to their specific needs. If foreign language barriers exist, a family member, friend or healthcare professional who speaks the same language as the member may be used (at the member’s discretion) as a translator.

**Coordination of Care and Services**

Primary Care providers are responsible for coordinating all of the care a member receives and are expected to refer members to specialists in the Affinity network for care that is outside of the scope of primary care. Because the PCP is the member’s first contact with Affinity, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions and recommending them in Care Management for intensive services.

PCPs are responsible for coordinating primary and specialty care, ancillary services and other covered healthcare services and collaborating with Affinity case managers and other providers involved in the member’s care.

Arranging for behavioral health services through the Affinity Behavioral Care Unit or the member’s designated behavioral healthcare management organization.

Arrange for transportation services, as needed, to ensure that members are able to access healthcare services.
GENERAL COMPLAINT & FRAUD, WASTE, AND ABUSE ADDENDUM

Definitions

**Fraud** — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Waste** – Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program, Medicaid program, or Affinity. Waste is generally the misuse of resources.

**Abuse** — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

EXAMPLES OF MEMBER FRAUD, WASTE, AND ABUSE

- Consistently switching Providers in an effort to obtain prescriptions for controlled substances
- Prescription forging or prescription modification to obtain controlled substances, other medications, or more medication than prescribed
- Members sharing their Affinity ID cards with nonmembers
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies

EXAMPLES OF PROVIDER FRAUD, WASTE, AND ABUSE

- Lack of medical necessity for medical services, home health care, durable medical equipment, and prescription drugs billed
- Services not provided, but billed
- Upcoding of CPT and DRG codes to obtain a higher rate of reimbursement
- Inappropriate use of CPT codes and/or modifiers to seek higher reimbursement
- Unbundling CPT codes to obtain higher reimbursement
- Not checking Member ID’s resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed to increase reimbursement
- Billing for services outside of your medical qualifications
- Using Member lists for the purpose of submitting fraudulent claims
- Duplicate billings for services rendered
- Drugs billed for participating Members as if they were non-participant Members
- Payments stemming from kickbacks or Stark Violations
- Retaining overpayments made in error by Affinity
- Balance billing of Members after Affinity has paid the approved state fee-for-service and/or contracted fee for services rendered.
Affinity routinely monitors claims data and reviews medical records to look for billing discrepancies. When found, an investigation is initiated and if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or Provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Legal action

THE FEDERAL AND STATE FALSE CLAIMS ACT AND OTHER RELEVANT LAWS

Federal False Claims Act

Using the False Claims Act (FCA), you can help reduce fraud against the federal government. The Act allows everyone to bring “whistleblower” lawsuits on behalf of the government — known as “qui tam” suits — against businesses or other individuals that are defrauding the government through programs, agencies, or contracts.

As amended in 2009, the False Claims Act addresses those who:

A) Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval
B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim
C) Conspires to commit a violation of any other section of the False Claims Act
D) Has possession, custody or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property
E) Is authorized to make or deliver a document certifying receipt of property used, or to be used by the Government, and intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true
F) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a Member of the Armed Forces, who lawfully may not sell or pledge property
G) Knowingly makes, used, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government

“Knowingly” is defined as acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. An example would be if a health care Provider, such as a hospital or a physician knowingly “upcodes” or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.
The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, Affinity is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Act, and other laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling Affinity business.

The time for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date, the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

New York State False Claims Act

The New York State False Claims Act (FCA) is modeled after the Federal FCA and is effective for all claims filed or presented on or after April 1, 2007. Similar to the information above, the New York State FCA includes the remedies, whistleblower protections, and non-retaliation provisions.

Other fraud-related New York Laws

- **Article 175 of the Penal Law** makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime, it is punishable as a felony.

- **Article 175 of the Penal Law** also makes it a misdemeanor knowingly files a false instrument with a government agency. If the instrument filed with the intent to defraud the government, the activity is punishable as a felony.

- **Article 176 of the Penal Law** makes it a misdemeanor to commit a “fraudulent insurance act,” which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds $1,000, the crime is punishable as a felony.

- **Article 177 of the Penal Law** makes it a misdemeanor to engage in “health care fraud,” which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds $3,000, the crime is punishable as a felony.

- **Section 403 of the Insurance Law** authorizes the Insurance Department to impose civil penalties for any action that constitutes a fraudulent insurance act under Article 176 of the Penal Law. Civil penalties may be up to $5,000 plus the amount of the claim for each violation.
Section 740 of the Labor Law prohibits an employer from taking any retaliatory action against an employee because the employee (i) discloses or threatens to disclose to a supervisor or government agency any illegal policy or practice of the employer that threatens public health or safety, or constitutes health care fraud, (ii) provides information to or testifies before any government agency conducting an investigation into such a policy or practice, or (iii) objects to or refuses to participate in any such policy or practice. However, retaliatory action is prohibited only if the employee, prior to providing information to a government agency, notifies his or her supervisor of the illegal policy or practice and affords the employer a reasonable opportunity to correct the problem. An employee subject to illegal retaliation may file a civil action against the employer and is entitled to reinstatement, lost wages and attorney fees.

Federal Anti-Kickback Statute

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. (42 U.S.C. §1320a-7b)

Federal Stark Law

Under the Federal Stark Law, and subject to certain exceptions, Providers are prohibited from referring federal health care program Members for certain designated health services to an entity with which the physician or an immediate family Member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. (42 U.S.C. §1395(a) and §1903(s))

Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347)

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act enacted as part of the American Recovery and Reinvestment Act of 2009 imposes notification requirements on covered entities, business associates, vendors of personal health records (PHR) and related entities in the event of certain security breaches relating to protected health information (PHI).

PROTECTION FOR REPORTERS OF FRAUD, WASTE, AND ABUSE

In addition, federal and state law and Affinity’s policy prohibit any retaliation, or retribution, or intimidation against persons who report suspected violations of these laws to law enforcement officials or who file “whistleblower” lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution, or retaliation, or intimidation should also report this to our Special Investigation Unit.

Additional information on the False Claims Act and our fraud, waste, and abuse policies can be found on www.affinityplan.org.
PROHIBITED AFFILIATION
Affinity is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities. Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than 5% ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify Affinity immediately as outlined in this Manual.

OWNERSHIP, DEBARMENT, AND CRIMINAL CONVICTIONS
Before Affinity enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status and any criminal convictions related to federal health care programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by using the contact information in the reporting section below. If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request. If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

All requests for disclosure of ownership, controlling interest, business transactions, or related information made by Affinity or a governmental agency must be fulfilled within 35 days of the date of a request.

SANCTION SCREENING
It should be noted that at minimum, Affinity providers, vendors, and business partners must review the Social Security Administration’s Death Master File, the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), the General Service Administration (GSA) Excluded Parties Lists System (EPLS), and the New York State Office of Medicaid Inspector General (OMIG) Medicaid Terminations and Exclusions list prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream, and Related Entity (FDR) to ensure that none of these persons or entities are excluded or become excluded from participation in federal or state programs. The LEIE and EPLS screenings must also occur at least monthly thereafter; the OMIG Medicaid Terminations and Exclusions list must be checked periodically after being hired or contracted.

Note that Affinity providers, vendors, and business partners are required to collect the Date of Birth and Social Security number of employees (regardless of position) and Board members prior to hire or appointment in order to execute this sanction screen requirement as well as other oversight requirements. Additional, Affinity, organizations acting on behalf of Affinity, or a governmental agency must be furnished this information upon request.

For a definition of FDR, refer to the General Compliance & Fraud, Waste, and Abuse Training section of this Section 9.

A ROADMAP TO AVOID MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE
The Office of the Inspector General (OIG) has created free materials for Providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste, and abuse. This brochure can be found on the Office of Inspector General’s website at: https://oig.hhs.gov/compliance
GENERAL COMPLIANCE & FRAUD, WASTE, AND ABUSE TRAINING

Affinity requires that a First Tier, Downstream, and Related Entity (FDR), including providers, vendors, and business partners, receive general compliance and fraud, waste, and abuse (FWA) training as outline by The Centers for Medicare and Medicaid Services (CMS). This training is mandatory, must occur within 90 days of hire/contracting and annually thereafter. The training covers federal requirements FDRs must know about the detection, prevention, and correction of non-compliance and FWA for organizations providing health, prescription drug, or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) Members on behalf of Affinity.

Definitions of FDR:
**First Tier Entity** – is defined as any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organizations (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

**Downstream Entity** – is defined as any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage (MA) benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

**Related Entity** – is defined as any entity that is related to an MAO or Part D sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation; (2) Furnishes services to Medicare Members under an oral or written agreement; or (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

Examples of FDRs include entities performing the any of the following administrative or health care services relating to the Medicare program:

<table>
<thead>
<tr>
<th>Sales and marketing</th>
<th>Customer service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization management</td>
<td>Bid preparation</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>Outbound enrollment verification</td>
</tr>
<tr>
<td>Applications processing</td>
<td>Provider network management</td>
</tr>
<tr>
<td>Enrollment, disenrollment, membership functions</td>
<td>Processing of pharmacy claims at the point of sale</td>
</tr>
<tr>
<td>Claims administration, processing and coverage adjudication</td>
<td>Negotiation with prescription drug manufacturers and others for rebates, discounts or other price concessions on prescription drugs</td>
</tr>
<tr>
<td>Appeals and grievances</td>
<td>Administration and tracking of enrollees’ drug benefits, including Troop balance processing</td>
</tr>
<tr>
<td>Licensing and credentialing</td>
<td>Coordination with other benefit programs such as Medicaid, state pharmaceutical assistance or other insurance programs</td>
</tr>
<tr>
<td>Pharmacy benefit management</td>
<td>Entities that generate claims data and</td>
</tr>
<tr>
<td>Hotline operations</td>
<td>Health care services.</td>
</tr>
</tbody>
</table>

General compliance and FWA training is available on Affinity’s website under the Compliance tab or through the CMS Medicare Learning Network website at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html). FDRs are responsible for reviewing general compliance and FWA materials and are required to maintain a training attestation form as well as documentation to support compliance with FDR requirements. By doing so, this signifies cooperation with Affinity in our efforts to maintain compliance with all regulatory requirements.
To demonstrate compliance oversight, Affinity requires a copy of your attestation for our records on an annual basis. This annual attestation and additional information about this requirement can be found at http://www.affinityplan.org/compliance-training.aspx.

**HOW TO REPORT COMPLIANCE CONERNS, INCLUDING FRAUD, WASTE, AND ABUSE**

It is Affinity’s policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the federal False Claims Act or any federal or state Medicare or Medicare fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit.

Compliance concerns, including fraud, waste, or abuse can be reported anonymously or directly to Affinity. *Options for reporting anonymously:*

Call the Ethics Line at 1-866-528-1505 and follow the appropriate menu option for reporting fraud, waste, or abuse

Go to Affinity’s website and click the Ethics Line hyperlink at https://www.affinityplan.org/Affinity/Providers/Compliance/Fraud_and_Abuse.aspx

Send a written report to:

Affinity Health Plan
Attn: Special Investigations Unit (or Compliance Unit)
1776 Eastchester Rd
Bronx, NY 10461

Options for reporting compliance concerns, including fraud, waste and abuse directly:

• Call the Compliance Officer at (718) 794-5731
• Email a report to compliance@affinityplan.org
• Fax a report to 718-536-3391

When you report fraud, waste, or abuse please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.
SERVICES REQUIRING AUTHORIZATIONS MEDICAID

Prior Authorization request means a service Authorization Request by the Member, or a provider on the Member’s behalf, for coverage of a service, before such service is provided to the Member shall require review for medical necessity. In the below link please find services requiring prior authorization by line of business (services requiring a prior authorization are subject to change):

https://www.affinityplan.org/authorizations/

<table>
<thead>
<tr>
<th>Quick References Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan Website</td>
</tr>
<tr>
<td>Affinity Health Plan Medicare Website</td>
</tr>
</tbody>
</table>

QUICK CONTACTS

https://www.affinityplan.org/Affinity/Contact_Us/Quick_Contact.aspx

Provider Relations E-mail Address

Provider@affinityplan.org

Affinity Health Plan Main Location

Affinity Health Plan
Metro Center Atrium
1776 Eastchester Road
Bronx, NY 10461

Affinity Health Plan Retail Stores

https://www.affinityplan.org/csc_map.aspx
For more information call us toll-free
1.866.247.5678
Monday to Friday, 8:00 a.m. to 8:00 p.m.

TTY/TDD users should call
1.800.662.1220

Visit our web site
AffinityPlan.org