



Provider Manual

Medicare Advantage Prescription Drug (MA-PD) Plan

Dual Special Needs Plans (D-SNP)

Institutional Special Needs Plan (I-SNP)

Managed Long Term Care Plan

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INTRODUCTION

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

You have joined a rapidly expanding network, including over 9,000 licensed independent practitioners and 40 hospitals committed to caring for the frail elderly chronically ill population. AgeWell New York has been serving this population since our inception in 2012. As a. AgeWell New York's Managed Long Term Care Plan (MLTC), Medicare Advantage Prescription Drug Plan (MA-PD), Medicaid Advantage Plus and Special Needs Products are designed to meet the needs of the Medicare or Dually eligible population (Medicare and Medicaid) residing in the boroughs of Queens, Brooklyn, New York (Manhattan), Bronx and the counties of Nassau, Suffolk and Westchester.

Our goal and guiding principles include:

- Offering plan benefits that improve access to appropriate care, including assistance with navigating an increasingly complex health care system
- Shifting the focus of care from the institution to the home and community
- Targeting and customizing interventions based on the needs of the participant

AgeWell New York's Plans provide benefits to eligible members, including Part D covered items for most of its plans. Through its network providers, AgeWell New York members have access to an adequate network of medical and supportive services. All care is either provided directly by AgeWell New York or coordinated through network providers.

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

At AgeWell New York, you are a valued partner in caring for our members, your patients. This manual was designed to assist you in understanding the requirements of AgeWell New York, in addition to serving as a resource for any questions you have about our plans. This manual serves as a supplemental guide to the Provider Agreement. Since changes in Medicare and Medicaid policies and AgeWell New York operations are inevitable over time, changes to policies herein are subject to updates and modifications. If AgeWell New York updates any of the information in this manual, we will provide bulletins, as necessary, and post the changes on our website –

www.agewellnewyork.com. You can also find a copy of this manual on the For Providers section of our website.

AgeWell New York is proud of the relationship with our participating providers and is committed to working with you to provide the support and assistance necessary to meet the needs of your patients. We look forward to a beneficial working relationship.

KEY CONTACTS AND RESOURCES

I. Dedicated Staff to Assist Our Participating Providers

Provider Relations

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

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

Your Provider Relations Representative will assist you by:

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

Provider Claims

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

Utilization Management

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

Quality Assurance

The Quality Assurance Department oversees the following aspects of our participants' healthcare and service provision:

- Quality of care for our members
- Member satisfaction, including the evaluation of grievances and appeals
- Access and availability standards

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

Member Services

Member Services assists members with non-urgent matters and provides excellent customer service and responsiveness to calls from public for information and/or calls from prospective or current members.

The Member Services staff is responsible for:

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

Pharmacy Benefits Operations and Management

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

Enrollment

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

Important Phone Numbers and Addresses

CLAIM SUBMISSIONS

Paper claims: AgeWell New York | P.O. Box 21536 | Eagan, MN 55121

Electronic claims: Change Healthcare (Emdeon) Payer ID: AWCNY6

Provider claims call center: 866-237-2140

Claims and Billing Inquiries 866-237-2140

Processing your claims timely and accurately is of utmost importance to AgeWell New York. The secure provider web portal allows participating providers to process and track claims submissions online, gives you access to useful tools and resources such as prior authorization and referral information, billing status and more.

<https://www.agewellnewyork.com/for-providers/>

PROVIDER RELATIONS

718-484-5000

providers@agewellnewyork.com

1991 Marcus Avenue | Suite M201 | Lake Success, NY 11042

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

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

Member Services, Enrollment & Eligibility Verification 866-586-8044

Medical Management Including Prior Authorization 718-696-0210

Pre-Authorization fax line 1-855-527-5515

Transportation Services (Non-Emergency) CTG: 877-242-7302

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

Vision Services NVA– 844-344-1250

Pharmacy Services

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

Interpreter Services

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

III. Website Information

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

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

VERIFYING MEMBER ELIGIBILITY AND COVERED SERVICES

I. Verifying Member Eligibility

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

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

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

Providers should verify member eligibility as outlined below:

- Call Member Services at 866-586-8044,
- Providers with eMedNY access may check the enrollment of Medicaid members on ePACES where applicable.

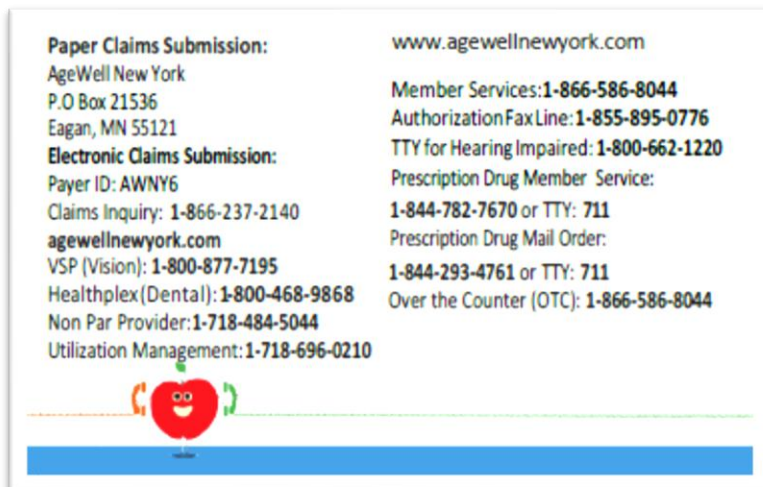
II. Coverage Determination

AgeWell New York offers a wide range of benefits to its Members including inpatient hospital, physician services, durable medical equipment and prescription drugs. Network providers who are

uncertain if a particular service is covered or seeks approval for a service not covered may call AgeWell New York for a coverage determination at 866-586-8044.

III. Member ID Card

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



Some AgeWell New York members have additional insurance coverage, like Medicaid. Members who have dual eligibility should present identification cards for each of their coverages, including any Medicaid benefits that might be administered by another payer. Additional coverage can pay for costs that are not covered by their AgeWell New York plan as long as all services and items are covered by each plan. Members should refer to the Evidence of Coverage documents or service plan for both their AgeWell New York plan and their other insurance to learn what's covered by each plan.

IV. Participant Eligibility

LiveWell- MA-PD

Beneficiaries/Prospective Members are eligible to join the plan as long as:

- Beneficiary is 65 or older
- Person is under 65 with certain disabilities
- Must reside in AgeWell New York's Geographic Area
- Beneficiary has both Medicare Part A and Part B
- Does not have End-Stage Renal Disease (ESRD) Prior to joining the plan

FeelWell- Dual Special Needs Plan, Coordination of Benefits

Beneficiaries/Prospective Members are eligible to join the plan as long as:

- Beneficiary is 65 or older
- Person is under 65 with certain disabilities
- Must reside in AgeWell New York's Geographic Area
- Beneficiary has both Medicare Part A and Part B
- Does not have End-Stage Renal Disease (ESRD) Prior to joining the plan
- Eligible for full Medicaid or Medicare cost-sharing assistance.

CareWell- Institutional Special Needs Plan, Medicaid Advantage ISNP

Beneficiaries/Prospective Members are eligible to join the plan as long as:

- Beneficiary is 65 or older
- Person is under 65 with certain disabilities
- Must reside in AgeWell New York's Geographic Area
- Beneficiary has both Medicare Part A and Part B
- Does not have End-Stage Renal Disease (ESRD) Prior to joining the plan
- Eligible for Medicare and have Full Medicaid Benefits through New York State Medicaid
- Must reside in a contracted ISNP Skilled Nursing Facility

MEMBER RIGHTS AND RESPONSIBILITIES

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

I. Member Rights

- Each member has the right to be treated with respect and with consideration of their dignity and privacy.
- Members' with physical disabilities have a right to reasonable accommodations when receiving care and treatment.
- Each member has the right to be treated fairly regardless of their race, religion, gender, ethnicity, age, disability or source of payment. AgeWell New York shall not discriminate against members due to medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
- Each member has the right to have their treatment and other member information kept private and confidential. Only where permitted by law, may records be released without the member's permission.
- Each member has the right to easily access care in a timely fashion.
- Each member has the right to a candid discussion of appropriate or medically necessary treatment, and to receive information on available treatment options and alternatives for their condition, presented in a manner appropriate to the member's condition and ability to understand.
- Each member has the right to receive interpretation services at no cost to the member, including the right to receive information in a language they can understand. Information is available in alternate formats upon request.
- Each member has the right to receive information about AgeWell New York, its practitioners, programs, services, clinical guidelines, its providers and practitioners, their rights and responsibilities as members and their role in the treatment process.
- Each member has the right to receive information about clinical guidelines used in providing and managing their care.
- Each member has the right to ask their provider about their work history and training.
- Each member has the right to give input on the AgeWell New York's Rights and Responsibilities policy.
- Each member has the right to know about advocacy and community groups and prevention services.
- Each member has the right to request certain preferences in a provider.

- Each member has the right to have provider decisions about their care made on the basis of treatment needs.
- Each member has the right to be furnished health care services in accordance with Federal and State laws that pertain to member rights.
- Each member has the right to participate in decisions regarding his or her health care, including the right to receive a second medical opinion, and the right to refuse treatment.
- Each member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.
- Each member has the right to file a complaint/grievance about AgeWell New York, a provider or the care received.
- Each member has the right to file an appeal about an AgeWell New York action or decision.
- Each member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
- Each member is free to exercise his or her rights, and that the exercise of those rights does not negatively affect the way AgeWell and its providers treat the member.
- Each member has the right to receive written information on advanced directives and their rights under State law.
- Each member has the right to decline participation or withdraw from programs and services.
- Each member has the right to know which staff members are responsible for managing their services and from whom to request a change in services.

II. Member Responsibilities

- Each member has the responsibility to treat those giving them care with dignity and respect.
- Each member has the responsibility to give providers and AgeWell information they need in order for providers to deliver quality care and for AgeWell to deliver appropriate service.
- Each member has the responsibility to ask their providers questions about their care. This is to help them understand their care.
- Each member has the responsibility to follow their treatment plan. The plan of care is to be agreed upon by the member and provider.
- Each member has the responsibility to follow the agreed upon medication plan.
- Each member has the responsibility to tell their providers and primary care physician about medication changes, including medications given to them by others.
- Each member has the responsibility to keep their appointments. Enrollees should call their provider(s) as soon they know they need to cancel visits.
- Each member has the responsibility to let their provider know when the treatment plan is not working for them.

- Each member has the responsibility to report abuse and fraud. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.
- Each member has the responsibility to openly report concerns about quality of care

III. Non-Discrimination

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

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

IV. Patient Self-Determination

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

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

conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

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

PROVIDER ROLES AND RESPONSIBILITIES

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

Participating providers agree to provide services to all members in the same manner, in accordance with the same standards and with the same priority as their other patients.

Providers may not discriminate on the basis of color, race, creed, gender, and sexual orientation, place of origin, disability, and source of payment, type of illness or condition or any other prohibited basis. AgeWell New York also requires that network providers assist its members with limited English speaking proficiency and physical disabilities.

The following describes some important responsibilities for our participating providers.

I. Requirements for all Providers

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

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

Non-Discrimination: As described above in section III of members Rights and Responsibilities.

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

Ethical Medical Practice: Provider agrees to provide services within the scope of the provider's license and/or specialty. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association, the Joint Commission, and all other medical and specialty governing bodies. Provider agrees to report to

AgeWell New York any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

Billing Requirements

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

Medical Records and On-site Auditing

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

- Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
- Maintaining medical records in a safe and secure manner that ensures Member confidentiality and medical record confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
- Making the medical record available when requested by AgeWell New York, participants (in writing), and regulatory agencies. Providers are required to allow medical information to be accessed by AgeWell New York, the New York State Department of Health, and the Centers for Medicare and Medicaid Services.
- Keeping medical records for seven years after the death or disenrollment of a Member from AgeWell New York. The records shall be kept in a location and format acceptable with state and federal regulations.

Medical Record Documentation Criteria:

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

- Each page of the medical record contains identifying information for the member.
- All entries must contain author identification and professional title.
- All entries must be dated.
- All entries must be in ink or computer generated.
- Identification of all providers participating in care and information on services furnished are found in the record.
- An up-to-date problem list, including significant illnesses and medical/psychological conditions, is present in the record.
- Each note describes presenting complaints, diagnoses and treatment plan.

- A medication list containing prescribed medications, including dosages and dates of initial or refill prescriptions are present in the record.
- Information on allergies and adverse reactions (or notation that patient has no known allergies or adverse reactions) is contained in the record.
- The record contains documentation of past medical history, physical examinations, necessary treatments and possible risk factors for the member relevant to a particular treatment.
- The record is legible to other than the writer.

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

Conflict of Interest: No practitioner in Medical Management may review any case in which he or she is professionally involved. AgeWell New York does not reward practitioners or other individual consultants performing utilization review for issuing denials of coverage or service.

Reporting Abuse: If a provider suspects abuse, mistreatment or neglect of a member, the provider should immediately initiate the proper notifications to any agency or authority that are required by the law in effect at the time. Please advise AgeWell New York of your concern and action by calling Provider Relations.

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

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

II. Role of Primary Care Provider (PCP)

As a Primary Care Physician (PCP), you are the manager of your patients' total healthcare needs. PCPs provide routine and preventive medical services, authorize covered services for members, and

coordinate all care that is given by AgeWell New York specialists, AgeWell New York participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Pediatricians, Geriatrics, OB/GYNs, physicians that specialize in infectious disease, and Nurse Practitioners in Adult Medicine, Gerontology Family Medicine, Gynecology.

III. Participant Guidelines

One of the cornerstones of AgeWell New York's healthcare philosophy is the availability and accessibility of services. All Primary Care Physicians (PCPs) must:

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

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

IV. Responsibilities of Primary Care Physicians

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

1. All the services of a PCP or other health professional typically received in a PCP's office. These include but are not limited to:

- Treatment of routine illness;
- Health consultations and advice;
- Injections;
- Conducting baseline and periodic physical exams, including any tests and any ancillary services required to make your appraisal;
- Diagnosing and treating conditions not requiring the services of a specialist;

- Initiating referrals from non-primary care service as required by the specific plan in which the member is enrolled;
 - Arranging inpatient care;
 - Consulting with specialists, laboratory and radiological services when medically necessary;
 - Coordinating the findings of consultations and laboratories;
 - Interpreting such findings for the member and his/her family, subject to regulatory requirements regarding confidentiality.
2. Appropriate coverage for your patients who may be in a hospital or skilled nursing facility.
 3. Maintenance of certain standards for your office, service, and medical records.

V. Standards of Timely Access to Care

Access Requirements – Appointment Availability Standards

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

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

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

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

a) Telephone Coverage After Hours

All providers must have either an answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation. (Please be sure that if the on-call number is a beeper number, members understand how to punch in the telephone number.)

b) Telephone Access During Normal Business Hours

Providers are expected to provide an immediate response to all emergent conditions.

Providers should respond to urgent conditions within 4 hours and non-urgent/routine calls within 1-2 business days.

c) Covering Provider

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

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

d) Appointments

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

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

e) Office Waiting Times

Office waiting time for visits should not exceed 30 minutes from the time of the scheduled appointment.

VI. Referring to a Participating AgeWell New York Specialist

Refer members only to AgeWell New York network physicians, ancillary facilities, and providers. If a required specialty is not represented in AgeWell New York's Provider Directory call AgeWell New York's Provider Relations Department at 855-586-8044.

VII. Provider Education

AgeWell New York network providers are required to complete certain training and education courses and requirements based on CMS regulation and certain AWPY policies. As a result, providers must complete a number of requirements. This training and education must be completed initially upon contract within 90 days, and at least annually thereafter. If areas of noncompliance are

determined including, but not limited to, refusal to complete the required training and education, AgeWell New York will take enforcement actions to cure the deficiency and prevent future occurrences. Enforcement actions, such as corrective action plans and/or contract termination, may vary depending upon the severity of the issue.

Providers are required to maintain evidence of completion (i.e., employee training records, CMS certification of completion) for no less than 10 years. AgeWell New York or CMS may request evidence of completion from the provider for these courses.

VIII. Provider Performance Standards and Compliance to Standards of Care

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

- **Quality of Care:** measured by clinical data related to the appropriateness of members' care and outcomes
- **Efficiency of Care:** measured by clinical and financial data related to members' health care costs
- **Member Satisfaction:** measured by members' reports and services regarding accessibility, quality of health care, member-participating provider relations, and the comfort of the practice setting,
- **Administrative Requirements:** measured by the participating provider's methods and systems for keeping records and transmitting information, and
- **Participation in Clinical Standards:** measured by the participating provider's compliance with quality of care standards.

IX. Provider Compliance with Standards of Care

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

- Guidelines established by the Federal Center for Disease Control Prevention (or any successor entity);
- New York State Department of AIDS Institute;

- All federal, state, and local laws regarding the conduct of their profession;
- Participation on committees and clinical task forces to improve the quality and cost of care;
- Referral Policies;
- Preauthorization and notification requirements and timeframes;
- Participating provider credentialing requirements;
- Appropriate release of inpatient and outpatient utilization and outcomes information,
- Accessibility of member medical record information to fulfill the business and clinical needs of AgeWell New York;
- Cooperating with efforts to assure appropriate levels of care;
- Maintaining a collegial and professional relationship with AgeWell New York personnel and fellow participating providers; and
- Providing equal access and treatment to all members.

Compliance Process

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

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

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

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

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

Quality Assurance and Medical Management

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

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

Americans with Disabilities Act (ADA)

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

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

X. Confidentiality and HIPAA

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

Laws Regarding Federal Funds

Payments that participating providers receive for furnishing services to AgeWell New York members are, in whole or part, from Federal funds. Therefore, participating providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of

1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

Sanctions under Federal Health Programs and State Law

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

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

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

Informed Consent and Confidentiality

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

Providers are obligated to, among other things:

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

XI. Closing of Provider Panel

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

- Give AgeWell New York 60 days prior written notice that the practice will be closing to new members as of a specified date,

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

NETWORK SPECIALIST RESPONSIBILITIES

I. Network Specialist Participation Guidelines

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

- Treat all your patients equally;
- Not discriminate because of race, sex, religion, place of residence, health status, or status as a Medicare or Medicaid Member;
- Observe, protect, and promote the rights of AgeWell New York members as patients;

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

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

II. Responsibilities to Your Patients

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

III. Confidentiality and HIPAA

As an AgeWell New York physician, you must maintain medical and non-medical records. You and AgeWell New York agree to maintain confidentiality in compliance with all state and federal laws and

regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with AgeWell New York in the processing of claims and medical treatment. You must also make any medical, financial, or administrative records available to AgeWell New York, as requested, either for AgeWell New York's administrative purposes, quality assurance purposes, or to comply with state and federal law.

UTILIZATION MANAGEMENT

I. Medical Review Criteria

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

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

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

- Peer review medical appropriateness criteria
- Standard quality indicators (National Committee for Quality Assurance (NCQA), Health Effectiveness Data and information Set (HEDIS);
- American Medical Association (AMA) specialty guidelines.
- Governmental agencies such as Center for Disease Control, Food and Drug Administration, Agency for Health Care Policy and Research, National Institute of Health

- Non- for Profit Health Care Organizations (e.g. American Heart Association, American Diabetes Association, American Lung Association)
- Peer review periodicals and journals;
- Consultation with actively practicing physicians who are appointed to teach faculties, research, foundations and/or members of recognized specialty societies; and
- Standards of Practice for Case Management of The Case Management Society of America (CMSA)

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

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

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

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

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

II. Review of Request for Health Care Services

AgeWell New York obtains relevant clinical information and consults with the treating physician when making a determination of coverage based on medical necessity. All information relevant to a member's case is considered when making a decision.

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

AgeWell New York follows established protocols when on-site facility review is necessary. AgeWell New York policy requires that Utilization reviewers abide by the check-in policy for third party reviewed at each hospital, wear a clear AgeWell New York identification badge (picture ID) that is issued upon employment, observe the Joint Commission on Accreditation of Health Care Organizations

requirements that govern each hospital's policy, and observe the individual hospital's policies regarding member's records. Upon employment, each AgeWell New York utilization reviewer receives training and orientation.

III. Levels of Review

Denial Process

The process of review, using established criteria, encompasses first, second, third and fourth levels reviews as described previously. A physician with a current NY State license to practice without restriction with education, training or professional experience in medical or clinical practice, reviews services that are referred, modified or denied by Utilization Management. Any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested is made in accordance with the UM authorization policy and procedure process.

All denial decisions are followed with written notification to the requesting practitioner and member, as described in the policy # "Notification of Utilization Management Decisions". Denial decisions include, in easily understanding language, the rationale for the denial, reference to the benefit provision, guideline, protocol or similar criterion on which a denial decision was based, treatment alternatives, phone number and availability of the practitioner who rendered the decision, notification that the member can, upon request, obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, and information, in writing, about the appeal process, including the member's right independent medical review.

Appeals

The Purpose of an appeal is to provide a formal reconsideration or second look at a denial. The member, practitioner, facility or authorized representative of the member may submit an appeal on behalf of the patient.

Two mechanisms for appeals of Utilization Management exist:

Expedited Appeal

An expedited appeal may be requested to change an adverse determination for urgent care or as a result of concurrent review. Expedited appeal request may be initiated by telephone, fax, AgeWell New York web site, or in writing. Additional Information for review must be submitted, and determinations are made as expeditiously as the medical conditions requires, but no later than three calendar days (72 hours) after request is made.

Standard Appeal:

Standard appeals may be pre-service or post-service. Standard appeals must be initiated by submitting the request with additional information for review by phone, writing, and AgeWell New York website or by fax within 180 days after notification of the denial. Determinations are made within 30 calendars days of receipt or required documentation for review. Appeals are reviewed by the interdisciplinary Grievance and Appeals Committee, which includes a physician not associated with the original review

and who is not the subordinate of any person involved in the initial determination. The Committee may reverse a denial of services on appeal. However, when there is not reversal of the decision and the denial is upheld, the appeal may be reviewed by a specialty-matched, licensed, board certified physician or clinical peer at the reviewing physician’s discretion.

Utilization Management Evaluation and Program Evaluation and Process Monitoring

AgeWell New York evaluates its Utilization Management Program to assess the fairness, consistency and appropriateness and timeliness of its utilization management decisions. The monitor and evaluation process assures that Utilization Management Program does not create a barrier to care and cause unnecessary problems for members and providers.

UM Timeliness and Denials Review.

AgeWell New York monitors and evaluates its utilization review management process to its established policies and procedures. The evaluation process reviews timeline standards, notifications timeframes, and compliance with health plan utilization management policies. AgeWell New York takes action to change its process to meet established guidelines when necessary.

IV. Review of the Utilization Management Program

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

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

1. Determinations –

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

Request Type	Decision Standard	Verbal/e-notification	Written notification to practitioner & member

Services requiring Pre- authorization determinations	Within 3 business days of receipt of the necessary information	Within 3 business days of receipt of the necessary information	Within 3 business days of receipt of the necessary information
(a)Continued or extended health care services (b)Additional services for a participant undergoing a course of continued treatment prescribed by a health care provider (c) Home health care services following a hospital admission	Within 1 business day of receipt of the necessary information for (a) and (b) Within 72 hours of receipt of the necessary information for Home health care services (c) when the day subsequent to the request falls on a weekend.	Within 1 business day of receipt of the necessary information for (a) and (b) Within 72 hours of receipt of the necessary information for (c)	Within 1 business day of receipt of the necessary information for (a) and (b) Within 72 hours of receipt of the necessary information for (c)
Services which have been already delivered	Within 14 calendar days of receipt of the necessary information	Within 14 calendar days of receipt of the necessary information	Within 14 calendar days of receipt of the necessary information
For standard service authorization determinations	As soon as possible but no later than 3 business days of receipt of the necessary information with a possible extension not to exceed 3 additional calendar days	As expeditiously as possible	As expeditiously as possible
For expedited service authorization determinations	As soon as possible but no later than 24 hours of receipt of the necessary information with a possible extension not to exceed 3 additional calendar days.	As expeditiously as possible	As expeditiously as possible

V. Quality Assurance and Medical Management

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

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

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

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

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

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

PROVIDER CREDENTIALING AND TERMINATION

I. Provider Credentialing

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

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

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

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

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

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

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

Delegation of Credentialing

AgeWell New York may choose to delegate provider credentialing and recredentialing in accordance with established policies. However, AgeWell New York is ultimately responsible for credentialing and recredentialing of providers and maintains the responsibility for ensuring that the delegated

functions are being performed according to AgeWell New York standards. We monitor compliance with our policies at least annually.

II. Application Process

AgeWell New York completes credentialing activities and notifies providers within 120 days of receipt of a completed application. The notification to the provider includes whether they are credentialed, whether additional time is needed for review or that AgeWell New York is not in need of additional providers. If additional information is required, AgeWell New York will notify the provider within 10 days of receipt of the application.

III. Initial Credentialing

The applicant is responsible for supplying all requested documentation.

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

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

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

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

IV. Recredentialing

Participating Providers must be recredentialed every three years. Procedures for recredentialed include updating information obtained in initial credentialing that is subject to change and consideration of performance.

V. Off-Cycle Credentialing

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

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

VI. Provider Termination and Disciplinary Action

Discipline of Providers

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

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

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

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

The Medical Director of AgeWell New York may determine at his/her sole discretion that the health of any AgeWell New York member is in imminent danger because of the actions or inactions of a participating provider, or that the provider is committing fraud or has received a final disciplinary action by a state licensing or governmental agency that impairs the provider's ability to practice ("Immediate Action Events") and in such case the Medical Director may immediately suspend or

restrict the provider's participation status, during which time the Credentialing Subcommittee will investigate to determine if further action is required.

Provider Sanctions

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

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

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

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

21st Century Cures Act

All providers must comply with all laws and the rules, regulations and requirements under the 21st Century Cures Act including Medicaid Provider Enrollment under the Managed Long term Care Plan.

VII. Appeal of Disciplinary Action

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

VIII. Procedure for Provider Termination

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

- The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in the AgeWell New York Credentialing program;

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

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

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

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

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

In the event that the Subcommittee's recommendation is to impose any disciplinary action, including, but not limited to, termination of the provider, the Subcommittee shall provide to the provider a

written explanation of the reasons therefore and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action unless the reasons therefore involvement in harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice, in which cases the Credentialing Subcommittee may immediately suspend or restrict the provider's participation in the AgeWell New York provider network.

Subject to the provider's rights to appeal, the Credentialing Subcommittee's recommendations will be forwarded to the Quality Assurance Performance Improvement Committee for final approval.

IX. Review Procedure

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

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

AgeWell New York shall include in the termination notice:

- The reason for the proposed action (and if the appeal is for a AgeWell New York Medicare;
- Advantage provider, only if relevant, the reasons must include, the standard and profiling data used to evaluate the provider and the number and mix of providers needed by AgeWell New York);
- Notice that the provider has the right to request a hearing or review, at his or her discretion, before a panel appointed by the Medical Director;
- The provider has 30 days within which the provider may submit to the Medical Director a written request for a hearing and/or review; and
- A time limit for a hearing date, which must be held within 30 days after the date of the Credentialing Subcommittee receipt of a request for a hearing.

Except for Immediate Action Events, the termination shall not be effective earlier than 60 days from the provider's receipt of the notice of termination.

Upon receipt of a request for hearing or review, the Medical Director shall inform the Credentialing Subcommittee members and shall select a review panel consisting of three (3) persons (the "Review Panel"), at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Subcommittee. The Medical Director may appoint more than three (3) persons to the Review Panel; provided that at least one-third of the Review Panel consists of clinical

peers of the provider under review. The Board shall appoint one of the Review Panel members as chairperson ("Review Panel Chairperson").

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

X. The Hearing

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

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

VENDOR OVERSIGHT

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

AgeWell identifies the activities to be delegated, performs pre-delegation assessment, establishes performance standards consistent with those described in the contract between AgeWell and CMS/NYSDOH and specifies the reporting requirements necessary to monitor the vendor/provider on an ongoing basis. All written agreements, including Letter of Agreement (LOA), Memorandum of Agreement (MOA) and Contracts, that specify delegation of functions contained in the agreement between AgeWell and CMS/NYSDOH are developed, executed and monitored in accordance with CMS and NYSDOH requirements to ensure appropriate quality and compliance. In an effort to avoid vendor/provider performing outside upon the standards AgeWell performs ongoing oversight of delegated activities through its Delegated Oversight Committee. This Committee is chaired by the Chief Compliance officer and meets at least quarterly to ensure vendors are performing in accordance with their contract and AgeWell New York standards.

CORPORATE COMPLIANCE

AgeWell New York has a detailed Corporate Compliance program. In addition to standard compliance oversight, we continually make our program more comprehensive by incorporating communication, trainings, and audits. AgeWell New York strives to continuously improve our processes.

The Centers for Medicare & Medicaid Services (CMS) requires all health plans like AgeWell New York to ensure their participating providers complete Fraud, Waste, and Abuse training annually. AgeWell New York's policy of fraud, Waste and Abuse prevention, mitigation and detection are part of the AgeWell New York Corporate Compliance Program. Fraud, Waste and Abuse training will be administered by AgeWell New York's Corporate Compliance Officer.

AgeWell New York has implemented a Corporate Compliance Hotline where our employees and contracted providers can report suspected fraud, waste and abuse anonymously.

CLAIMS AND BILLING

I. Electronic and Paper Claims Submission

Providers must submit all Claims for Covered Services within one hundred eighty (180) days of the date of service. AgeWell New York may deny payment for Claims not submitted timely.

CMS 1500 PROFESSIONAL CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

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

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

UB04 INSTITUTIONAL CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

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

- Member name
- Payer specific Member ID number. The number will be a total of 11 digits.
- Date of Birth

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

Submit Paper Claims to:

AgeWell New York
P.O. Box 21536
Eagan, MN 55121
1-866-237-2140

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

Submit EDI Claims to:

Change Healthcare/Emdeon, Payer ID: AWCNY6
<http://www.changehealthcare.com>

II. Claims Payment

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

EFT / ERA

AgeWell New York's Electronic Funds Transfer (EFT) program and Electronic Remittance Advice (ERA) are all tools to help streamline operations.

EFT is a fast, easy, secure, and environmentally friendly way to receive payments. ERA offers providers more expeditious payment reconciliations with access to electronic versions of explanation of payments.

A provider can request EFT & ERA through Change Healthcare (formerly Emdeon). Please visit their website or access the EFT/ERA registration form [here](#).

Contact Change Healthcare at 866-924-4634

Providers can also register for only EFT by completing EFT Form and sending by fax to 631-963-4935 or by email. Updates or changes to EFT information can also be requested by utilizing this form.

For assistance with the Provider Portal or EFT/ERA status inquiries please call 866-237-2140.

III. Corrected Claims Resubmission

Submission of corrected claim; (invalid/ missing codes, such as CPT, place of service, missing units, etc.) should contain the original claim number for reference, applicable Bill Type or sequence as applicable for corrected claims. Corrected Claims must be submitted within 180 days of the date of service.

IV. Claims Payment Reconsideration

Denied Claims may be disputed in writing for payment reconsideration within 60 days of the notice of denial. Provider disputes must contain the following information:

- Provider name;
- Claim number;
- National Provider Identifier (NPI);
- Provider contact information;
- Description of the item in dispute, including the Member ID, dates of service, service code billed, units billed, amount billed and reason for contesting the determination and the justification as to why the service should be paid or approved;
- Copies of relevant information and supporting documentation required for review of the determination;

The provider must submit the information required for claim determination review to:

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

Appeal Response

Written determination of dispute resolution will be issued within 60 days of AgeWell New York's receipt of the dispute.

Second Level Appeal

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

V. Claims Status

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

VI. Billing Requirements

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

VII. Provider Preventable Conditions

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