**Eddy SeniorCare Provider Manual**

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## DEFINITIONS

1. **Plan** means the evidence of coverage issued by Plan that describes its obligations to arrange for the delivery of medical care to Members of Eddy SeniorCare who are eligible for such services pursuant to the terms of Plan's contract with Member and the New York State Department of Health and Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services.

2. **Covered Service** means those services which are medically indicated, and which Members are entitled to receive under the terms of the Plan approved with the advice and consent of the New York State Department of Health and Centers of Medicare and Medicaid Services that are set forth in the Attachment entitled "COVERED SERVICES."

3. **DSS** means the Department of Social Services.

4. **DOH** means the New York State Department of Health.

5. An **Emergency** medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:
   - Serious jeopardy to the health of the individual;
   - Serious impairment to bodily functions; or
   - Serious dysfunction of any organ or part.

6. **ESC** means Eddy Senior Care.

7. **CMS means** the Centers for Medicare and Medicaid Services.

8. **Medically Indicated Services** means those health care services, or items defined by the Plan's medical director or designee that:

   i. Provide for the diagnosis, prevention, or direct care of a medical condition;
   ii are appropriate and necessary, for the diagnosis, prevention, or treatment of a medical condition and could not be omitted without adversely affecting the Member's condition;
   iii. are within standards of good medical practice recognized within the organized medical community;
   iv. are appropriate to and consistent with the Member's diagnosis and, (except for Emergency Services or Urgent Services) the Member’s plan of care;
   v. would be likely to materially improve or to help in maintaining the Member’s physical condition; or

vi would be likely to materially improve or to help in maintaining the Member's ability to engage in essential activities of daily living and

vii. are not primarily for the convenience of the Member or his/ her family, his/ her physician, or another care provider; and

viii. are the most appropriate and economical level and source of care or supply that can be provided safely.

**9.** **Member** means any person who is eligible to receive Covered Services through Eddy SeniorCare/PACE.

**10.** **Multidisciplinary Team** means a group of health professionals or care givers composed of the primary care physician, nurse practitioner, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, activity coordinator, dietitian, PACE Center manager, home health care coordinator, home health aides/ personal care attendants, and drivers.

**11.** **PACE** means the Program of All-Inclusive Care for the Elderly. It offers a benefit plan to frail seniors who are nursing home eligible who live at home with the support of PACE services. PACE is an integrated comprehensive program that combines the services of an adult day center with a medical outpatient clinic on-site, home health care, and a specialty network of providers including inpatient hospital and nursing home care. Funding combines both Medicare and Medicaid capitation for payment of services.

**12.** **Participating Agency** means an agency or health care provider that has signed an Eddy SeniorCare Service Agreement.

**13.** **Plan** means Eddy SeniorCare (ESC).

**14.** **Primary Physician** means any physician or nurse practitioner, professional service corporation or partnership who or which has agreed to provide specific primary health services to Members and to coordinate the overall health care of Members as their primary care physician.

**15.** A **Provider** means those individual providers of services under the conventional fee-for-service systems who are contracted vendors. The Provider must meet applicable New York state licensure, certification, or registration requirements in which they practice.

**16.** **Quality Assurance Performance Improvement (QAPI):** ESC has a quality assurance performance improvement committee consisting of its leadership team, physicians, nurse practitioners, medical director and other clinical and non-clinical professional staff as deemed appropriate by ESC**.**

**PARTICIPANT BILL OF RIGHTS - Below are the Rights of our Participants:**

**Right #1 Each participant has the right to be treated with respect and to protection from discrimination.**

Each participant has the right to be treated with dignity and respect, to have his/her care kept private, and to get compassionate, considerate care, respectful care from all PACE employees and contractors at all times and under all circumstances.

**Discrimination is against the law.** Eddy SeniorCare complies with all applicable Federal and NYS civil rights laws.

Each participant has the right to not be discriminated against in the acceptance of eligible applicants for enrollment and in the delivery of required PACE Services based on race, creed, ethnicity, religion, marital status, military status, national origin, religion, sex (including gender dysphoria), age, mental or physical ability (including gender dysphoria), developmental disability, national origin, sexual orientation, type of illness or condition, or source of payment.

If a participant thinks he/she has been discriminated against for any of these reasons, Eddy SeniorCare's Director should be contacted at: 518-382-3290. The participant can also file a grievance in person or by mail, fax or email. If he or she has additional questions, contact the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. A participant can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/ lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Each participant has the right:

1. To get all healthcare / comprehensive healthcare, in a safe and clean environment and in an accessible manner.

2. To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care and be provided humane care.

3. To be free from harm. This includes physical or mental abuse, neglect, physical or corporal punishment, being placed alone against his/her will or involuntary seclusion, excessive medication, and any physical or chemical restraint that is used for discipline or convenience of staff that a participant does not need to treat medical symptoms or to prevent injury.

4. To be encouraged and to get help, if needed, to exercise rights in the PACE program, including the Medicare and Medicaid complaint and appeal processes, as well as civil and other legal rights.

5 To be encouraged and helped in talking to PACE staff about changes in policies and services you think should be made.

6. To have reasonable access to use a telephone while at the PACE Center.

7. To not have to do work or be required to perform services for the PACE program.

**Right #2 Each participant has a right to information and assistance**

Each participant has the right to receive accurate, easily understood information and to receive help in making informed health care decisions. Participants have the following rights:

1.To have someone help a participant with a language or communication barrier so he/she can understand all information given.

2.To have the PACE program interpret the information into a preferred language in a culturally competent manner, if his/her first language is not English and the participant can't speak English well enough to understand the information being given.

3.To get marketing materials and PACE rights in English and in any other frequently used language in his/her community. To get these materials in Braille, if necessary.

4.To get a written copy of rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.

5.To be fully informed in writing of the services available from the PACE organization, including identification of all services that are delivered through contracts, rather than furnished directly by the PACE organization at the following times:

- Before enrollment
- At enrollment
- When he/she needs to make a choice about what services to receive or there is a change in services.
- At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

6.To have the enrollment agreement fully explained in a manner understood by the participant.

7.To examine, or upon reasonable request, to be helped to examine the results of the most recent review of the PACE organization conducted by the Centers for Medicare and Medicaid Services, or the State administering agency and any plan of correction in effect.

8.To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care or delivery of a service.

**Right #3 Each participant has a right to a choice of providers.**

Each participant has the right to choose a health care provider within the PACE program's network, that is sufficient to ensure access to appropriate high-quality health care. You have the right:

1. To choose a primary care physician/nurse practitioner and specialists from within the PACE network.

2. To request that a qualified specialist for women's health services furnish routine or preventive women's health services.

3. To have reasonable and timely access to specialists, as indicated by his/her health condition and consistent with current clinical practice guidelines.

4. To receive necessary care in all care settings, up to and including placement in a long-term care when the PACE organization can no longer provide the services necessary to maintain him/her safely in the community.

5. To disenroll from the program at any time and have such disenrollment be effective the first day of the month following the date the PACE program receives notice of voluntary disenrollment as set forth in Section 460.162(a).

**Right #4 Each participant has a right to access emergency services.**

Each participant has the right to access emergency services when and where he/she needs them without the PACE program's approval or prior authorization by the PACE interdisciplinary team. A medical emergency is when he/she thinks their health is in serious danger—when every second counts. The participant may have a bad injury, a

sudden illness quickly getting much worse. Each participant can get emergency care anywhere in the United States.

**Right #5 Each participant has a right to participate in treatment decisions.**

Each participant has the right to participate fully in all decisions related to treatment. If he/she cannot fully participate in treatment decisions or wants to have someone trusted have the right to serve as a designated representative. Each participant has the right:

1. To have all treatment options explained in a culturally competent manner and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.

2. To have the PACE organization explain advance directives and to establish them, if so desired.

3. To be fully informed of his/her health and functional status by the interdisciplinary team.

4. To participate in the development and implementation of the plan of care.

5. To request a reassessment by the interdisciplinary team.

6. To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (that is, due to medical reason or for his/her welfare, or that of other participants). The PACE organization must document the justification in the participant's medical record.

**Right # 6 Each participant has a right to have his or her health information kept private / Confidentiality of health information**

Each participant has the right to communicate with health care providers in confidence and to have the confidentiality of his or her individually identifiable health care information protected under State and Federal laws. Each participant also has the right to review and copy his or her own medical records and request amendments to those records. Specifically, each participant has the following rights:

1. To be assured of confidential treatment of all information contained in the health record, including information contained in an automated data bank.

2. To be assured that his or her written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.

3. To provide written consent that limits the degree of information and the persons to who information may be given.

There is a patient privacy rule that gives participants more access to his/her own medical records and more control over how your personal health information is used. If participants have any questions about this privacy rule, they may call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

**Right #7 Each participant has the right to file complaints and appeals**

Each participant has a right to complain about the services received or that he/she needs and doesn't receive, the quality of care, or any other concerns or problems with your PACE program. Each participant has the right to a fair and timely/efficient process for resolving differences with the PACE organization, including a rigorous system for internal review by the organization and an independent system of external review. Each participant has the following rights:

1. To a full explanation of the complaint process. To receive the grievance and appeal process in writing and have it explained in a clear and understandable manner before enrollment, at the time of enrollment, and at least annually.

2. To be encouraged and assisted to voice complaints to PACE staff and outside representatives of his or her choice, free of any restraint, interference, coercion, discrimination, or reprisal by the PACE staff. Each participant must not be harmed in any way for telling someone his/her concerns. This includes being punished, threatened, or discriminated against.

3. To appeal any treatment decision of the PACE organization, its employees, or contractors.

**Right #8 Each participant has a right to leave the program.**

If, for any reason, a participant does not feel that the PACE program is what he/she wants, the participant has the right to leave the program at any time.

The Bill of Rights and responsibilities, as they pertain to a participant determined to be incompetent in accordance with New York State law, are passed on to their designated representative on behalf of the participant.

## PATIENT REFERRALS/ SERVICE AUTHORIZATION

The Eddy SeniorCare/PACE Primary Care physician/nurse practitioner is responsible for ordering services for participants. Each PACE Primary Care physician/nurse practitioner order generates an authorization number. Providers are responsible to include authorization numbers on claims submitted to Eddy SeniorCare.

Providers must only provide services as authorized by the Eddy SeniorCare. Any services that may be necessary need to be authorized by Eddy SeniorCare as evidenced by an authorization number. Unauthorized services will not be paid by Eddy SeniorCare.

## BILLING

When billing Eddy SeniorCare directly, a HCFA 1500 Form must be used. Services must be billed within 30 days of the date of service but no later than 120 days from the date the service was rendered to the Member. Provider agrees that Eddy SeniorCare, shall not be responsible for claims of service not billed within 120 days.

Claims should be submitted to:

Eddy SeniorCare
Finance Department
433 River Street, Suite 3000
Troy, NY 12180
Phone: (518) 270-1735

Claims may also be faxed to: (313) 924-4520.

At this time, Eddy Senior Care cannot accept electronic claims.

The following information should appear on the bill to ensure timely and accurate payment of services:

Member: Name, Address, Phone
Provider Information: Name of Provider, Address, Phone, NPI, Tax ID, Dates of Service, Description of Service(s), valid HCPCS & NDC codes, Units or Visits, Rate, Total Amount Due, Eddy SeniorCare Authorization number.

When all of the information is present and the service has been pre-approved, the bill will be paid thirty (30) days from the date of the invoice. Payments made by Eddy SeniorCare will be payments in full. You may not charge or collect any fee or co-payment for such service from Medicare, Medicaid, any Commercial Insurer, or from any Member, DOH, or DHHS.

Dates of service prior to the Member being capitated with Eddy SeniorCare for Medicaid or Medicare, should be billed directly to Medicare and/or Medicaid, as appropriate on a

1500 HCFA Form, depending on the service provided. Even when billing Medicare or Medicaid directly, ESC requires a medical release to obtain documents supporting the services provided for Member's Medical Record. The Eddy SeniorCare accounting assistant or controller will contact the Provider when a participant becomes capitated under Medicaid or Medicare and billing should be sent to Eddy SeniorCare directly on HCFA 1500 Forms.

If you can demonstrate that a late claim resulted from an unusual occurrence and that a pattern of timely claims submission exists than Eddy SeniorCare will reconsider the claim for payment. However, Eddy SeniorCare may reduce the claim up to a maximum of 25% of the amount that would have been paid had the claim been submitted in a timely manner. The right to reconsider shall not apply to a claim submitted 365 days after the service. Claims submitted after the 365 days shall be denied in full.

Should it be determined by Eddy SeniorCare that an overpayment has been made, the provider will have an opportunity to challenge the overpayment recovery by contacting the Director of Finance at the numbers noted below. If one is dissatisfied after using Eddy SeniorCare's complaint process, the Provider may ask for a review by St. Peter's Health Partners' Chief Medical Officer – Continuing Care. The determination of St. Peter's Health Partners' Chief Medical Officer – Continuing Care shall be final.

A minimum of 90 days written notice will be required should an adverse reimbursement change be implemented. Exceptions to this notice requirement will occur if:

1. the change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
2. the change is provided for in the contract through the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

The following is a list of contacts at Eddy SeniorCare who can address the prior authorization of services: Director of Operations (Rotterdam or Latham), Supervisor of Social Work Services, Executive Director, Medical Director and Director of Finance. These individuals can be contacted by phone at (518) 382-3290.

**PRE-ENROLLMENT SERVICES**

Individuals who have chosen to enroll in Eddy SeniorCare's PACE program will have an effective date of enrollment on the first of the month following signature of the Enrollment Agreement. Providers shall bill services prior to the effective date of the individual's enrollment in Eddy SeniorCare PACE directly to Medicare and/or Medicaid/the individual's existing insurer. Services authorized by Eddy SeniorCare shall be billed to Eddy SeniorCare as of the effective date of enrollment.

## PROHIBITION ON USE OF FEDERAL FUNDS FOR LOBBYING

1. Provider agrees, pursuant to Section 1352, Title 31, United States Code, and 45 CFR Part 93 not to expend Federally appropriated funds received under this contract to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal Grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement. Provider agrees to complete and submit the "Certification Regarding Lobbying", attached hereto as Appendix B and incorporated herein, if this Agreement exceeds $100,000.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer of employee of Congress, or an employee of a member of Congress in connection with this contract or the underlying Federal grant and the Agreement exceeds $100,000 Provider agrees to complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities", attached hereto as Appendix C and incorporated herein, in accordance with its instructions.

3. Provider shall include the provisions of this Section in all subcontracts under this agreement and require that all subcontractors whose contract exceeds $100,000 certify and disclose accordingly to Eddy SeniorCare.

## MONITORING AND EVALUATION

1. ESC, DOH, CMS and their designees shall each have the right, during provider's normal operating hours, and at any other time a contractor function or activity is being conducted, to monitor and evaluate, through inspection or other means, provider's performance, including, but not limited to, the quality, appropriateness, and timeliness of services provided under this agreement.

2. Provider shall cooperate with and provide reasonable assistance to ESC, DOH, DHHS and their designee in the monitoring and evaluation of the services provided under this agreement.

## PACE PHYSICIAN/NURSE PRACTITIONER ORDERS

1. Provider shall recognize written Eddy SeniorCare primary care physician/nurse practitioner orders which, for each Member, may include: diagnosis, drugs, activities, diet, prognosis, and an ESC plan of care that may include treatment by other disciplines involved in the Member's care. ESC is responsible for ensuring that written physician/nurse practitioner orders are received by Provider within 48 hours of the time service is requested to be initiated, unless required sooner based upon the member's condition.

2. The protocol and procedure for renewal of professional orders, as well as changes in the ESC plan of care shall be in accordance with this Agreement. Services to Members are mutually agreed upon by the ESC primary care physician/nurse practitioner ordering the care or service and the Provider, provided that services are within the scope and limitations set forth in the ESC plan of care, and will not be altered in type, amount, frequency, or duration, except in the case of adverse reaction.

## RECORD KEEPING AND MEDICAL RECORDS

1. Access to Medical Records

   a. Provider shall maintain adequate medical records for Members treated by Provider. Subject to all applicable statutory and legal privacy and confidentiality requirements, such medical records shall remain available to each physician and other health professionals treating the Member, and upon request to any committee of Provider of ESC Plan for review to determine whether their content and quality are acceptable, as well as for peer review or grievance review.

   b. ESC Plan, New York State Department of Health, CMS, or the Comptroller of the State of New York or the authorized representatives have the right, upon request, to inspect during normal business hours the accounting, administrative, and medical records maintained by Provider pertaining to the ESC Plan, the Member, and to the Provider's participation hereunder during the term of this agreement and for ten (10) years thereafter. Provider shall comply with all applicable state and federal law regarding access to books and records.

2. Record Retention

a. Provider shall keep and maintain all records relating to the Eddy SeniorCare Program in compliance with applicable requirements of DOH and CMS. These records include but are not limited to:

(1) records related to services provided to Members, including separate Medical Record for each Member;

(2) all financial records and statistical data that DOH and any other state or federal agency may require including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received, and expenses incurred under this Agreement; and

(3) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of Provider or its subcontracts, if relevant, to bear the risk of potential financial losses; and

(4) personnel records.

b. Eddy SeniorCare shall maintain all financial records and statistical data according to generally accepted accounting principles.

c. Provider agrees to preserve records related to this Agreement for the term this Agreement is in effect and for ten (10) years thereafter, with disposal by Provider of any records during said period permitted only upon prior written approval by ESC and DOH. Records involving matters in litigation shall be kept for a period permitted only upon prior written approval by ESC and DOH. Records involving matters in litigation shall be kept for a period of not less than three (3) years following the termination of the litigation, in addition to the previously specified ten-year requirement. Microfilm copies of records may be substituted for the originals with the prior written approval of ESC and DOH, provided that the microfilming procedures are accepted by ESC and DOH as reliable and are supported by an adequate retrieval system.

d. All provisions of this Agreement relating to maintaining and retention of records shall survive the termination of this Agreement and shall bind Provider until the expiration of the records retention period.

3. Access and Audit of Records

a. At all times during the period that this Agreement is in force and for a period of ten (10) years thereafter, Provider shall provide all authorized representatives of the state and federal governments with full access to its records which pertain to services performed, and determination of amounts payable under this agreement, including access to appropriate individuals with knowledge of financial records (including providers independent public auditors) and full access to any additional records they may process which pertain to services performed and determination of amounts payable under this Agreement, permitting such representatives to examine, audit and copy such records at the site at which they are located. Such access shall include both announced and unannounced inspections and on-site audits.

b. All records and information obtained by ESC pursuant to the provision of this Agreement whether by audit or otherwise, shall be usable by ESC in any manner, in its sole discretion, it deems appropriate, and provider shall have no right of confidentiality or proprietary interest in such records or information.

c. Notwithstanding the preceding sentence, ESC agrees, in those instances in which it has discretion, not to disclose outside of its agency the following data:

(1) any resume or other description of qualification which includes the name of an individual;

(2) any individual's actual salary;

(3) provider's indirect rates including labor, overhead, G&A and fee; and,

(4) the methodology for calculating those indirect rates including the allocation base.

d. ESC will use or disclose Medicaid recipient identifiable information obtained pursuant to this Section only as authorized under applicable provisions of federal and state law.

(1) Provider shall promptly notify ESC of any request for access to any records maintained pursuant to this Agreement.

(2) All provisions of this Agreement relating to record maintenance and audit shall survive the termination of this

Agreement and shall bind provider until the expiration of a period of ten (10) years commencing with termination of this Agreement or if an audit is commenced, until the completion of the audit, whichever occurs later.

## RECOVERY OF OVERPAYMENTS

1. a) Consistent with the exception language in Section 3224-b of the Insurance Law, Eddy SeniorCare shall have and retain the right to audit Participating Providers' claims for a ten (10) year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This ten (10) year limitation does not apply to situations in which fraud may be involved or in which the provider or an agent of the provider prevents or obstructs the Contractor's auditing.

   b) The parties acknowledge that the New York State Office of the Attorney General, the Department, the Office of the Medicaid Inspector General (OMIG) and the Office of the State Comptroller (OSC) have the right to recover overpayments, penalties, and other damages from Participating Providers as a result of any investigation, audit or action commenced by the New York State Office of the Attorney General, the Department, OMIG, and OSC, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq.

   c) It is agreed that where Eddy SeniorCare has previously recovered overpayments from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation or audit.

2. Nothing in this Agreement shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or the Department to investigate, audit or otherwise obtain recoveries from any Participating Provider.

## UTILIZATION MANAGEMENT

Provider agrees to comply with all ESC Plan utilization management policies and procedures as part of the Plan's Quality Assurance Performance Improvement system that relate to the provision of services under this agreement, including, but not limited to criteria regarding the appropriateness and medical necessity of services.

## COORDINATION OF BENEFITS (COB)

1. Provider agrees to assume responsibility to identify the primary health benefit carrier of the Member, and if by reason of the Providers' license, certification, or service area, such member is not eligible for coverage under that carrier's requirement, then Provider agrees to assist in the transfer of care or services to a provider which enables eligibility, or Provider shall hold the member and ESC Plan harmless for resulting claims.

2. If COB is involved, or if it has been determined that ESC Plan is the carrier, Provider agrees to bill ESC Plan within 60 days of receipt of other payors COB, or the date it is determined ESC is the primary Plan.

## CIVIL RIGHTS

1. Nondiscrimination: Provider shall operate their program in compliance with all existing state and federal nondiscrimination laws and shall not unlawfully discriminate on the basis of Color, race, creed, age, gender, sexual orientation, and disability, place of origin, source of payment or type of illness or condition and shall observe, protect and promote the rights of Members as participants.

2. Employment practices:

    a. Provider agrees to comply with the nondiscrimination clause contained in Federal Order 11246, as amended by Federal Executive Order 11357, relating to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, the implementing rules and regulations prescribed by the Secretary of Labor at 41 Code of Federal Regulations, Part 60 and with the Executive Law of the State of New York, 219-299 thereof and any rules or regulations promulgated in accordance therewith. Provider shall likewise be responsible for compliance with the above-mentioned standards by subcontractors with whom Provider enters into a contractual relationship in furtherance of this Agreement.

    b. Provider shall comply with regulations issued by the Secretary of Labor of the United States in 20 Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758, and with the Federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Provider shall likewise be responsible for compliance with the above-mentioned standards by subcontractors

with whom Provider enters into a contractual relationship in furtherance of this Agreement.

3. Affirmative action: Provider agrees to comply with all applicable federal and state nondiscrimination statutes including:

   a. The Civil Rights Acts of 1964, as amended; Executive Order No. 11246 entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor Regulation 41 CFR Part 60; Executive Law of the State of New York, Sections 290-299 thereof, and any rules or regulations promulgated in accordance therewith; Section 504 of the Rehabilitation Act of 1973 and the Regulations issued pursuant thereto contained in 45 CFR Part 84 entitled "Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance"; and the Americans with Disabilities Act (ADA) of 1990, 42 USC Section 12116, and regulations issued by the Equal Employment Opportunity Commission that implement the employment provisions of the ADA, set forth at 29 CFR Part 1630.

   b. The Provider is required to demonstrate effective affirmative action efforts, and to ensure employment of protected class members. The Provider must possess and may upon request be required to submit to the Department a copy of an Affirmative Action Plan which is in full compliance with applicable requirements of Federal and State statutes.

   c. Providers and subcontractors shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, affirmative action shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.

   d. Prior to the award of a contract, the Provider shall submit an Equal Employment Opportunity (EEO) Policy Statement to the contracting agency within the time frame established by that agency.

   e. The Provider shall agree to adhere to Eddy SeniorCare’s Equal Employment Opportunity Policy Statement as follows:

(1) The Provider will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing programs or affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its workforce on State contracts.

(2) The Provider shall state in all solicitations or advertisements for employees that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

(3) At the request of the contracting agency, the Provider shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Provider's obligations herein.

(4) Except for construction contracts, the Provider shall submit to the contracting agency a staffing plan of the anticipated work force to be utilized on the contract or, where required, information on the Provider's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency. The form of the staffing plan shall be supplied by the contracting agency.

(5) After an award of a contract, the Provider shall submit to the contracting agency a work force utilization report, in a form and manner required by the agency, of the work force actually utilized on the contract, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency.

f. In the event that the Provider is found through an administrative or legal action, whether brought in conjunction with this contract or any other activity engaged in by the Provider, to have violated any of the laws recited herein in relation to the Provider's duty to ensure equal employment to protected class members, the Department may in its discretion, determine that the Provider has breached this Agreement.

Additionally, the Provider and any of its subcontractors shall be bound by the applicable provisions of Article 15-A of the Executive Law, including Section 316 thereof, and any rules or regulations adopted pursuant thereto. The Provider also agrees that any goal percentages contained in this contract are subject to the requirements of Article 15-A of the Executive Law and regulations adopted pursuant thereto. For purposes of this contract the goals established for subcontracting/ purchasing with Minority and Women-Owned business enterprises are 0% to 5%. The employment goal for the hiring of protected class persons is 5%.

The Provider shall be required to submit reports as required by the DOH concerning the Provider's compliance with the above provisions, relating to the procurement of services, equipment and or commodities, subcontracting, and staffing plans and for achievement or employment goals. The format of such reports shall be determined by the Office of Equal Opportunity Development (OEOD) of the Department. The Provider agrees to make available to OEOD, upon request, the information and data used in compiling such reports.

It is the policy of the DOH to encourage the employment of qualified applicants/ recipients of public assistance by both public organizations and private enterprises who are under contractual agreement to the DOH for the provision of goods and services. The DOH may require the Provider to demonstrate how the Provider has complied or will comply with the aforesaid policy.

4. Omnibus Procurement Act of 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as contractors, subcontractors, and suppliers on its procurement contracts.

The Omnibus Procurement Act of 1992 requires that by signing this Agreement, the Provider certifies that whenever the total contract is greater than $1 million:

a. The Provider has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors on this project, and has retained the documentation of these efforts to be provided upon request to the state;

b. The Provider has complied with the Federal Equal Opportunity Act of 1972 (Pub. L. 92-261), as amended;

c. The Provider agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Provider agrees to document these efforts and to provide such documentation upon request;

d. The Provider acknowledges notice that New York State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

5. Nondiscrimination in Employment in Northern Ireland: In accordance with Chapter 807 of the Laws of 1992, the Provider agrees that, if it or any individual or legal entity in which the Provider holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership in the Provider, has business operations in Northern Ireland, the Provider, or such individual or legal entity, shall take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity, and shall permit independent monitoring of its compliance with such Principles.

**PROVIDER COMPLAINTS**

The Provider agrees to abide by Eddy SeniorCare's Grievance and Appeals Procedures. All efforts will be made to resolve complaints to the mutual satisfaction of both parties. Problems related to service allocations and prior approval should be discussed with the Eddy SeniorCare Director of Operations, Executive Director and/or the Medical Director immediately. Appeals relating to specific billing and claims processing should be directed to the Eddy SeniorCare Finance Supervisor. The Provider may be asked to submit the complaint in writing.

Eddy SeniorCare will provide a written response within 15 days to confirm receipt of complaints, and ESC will seek to resolve the appeal within 30 and summarize the resolution in writing.

If one is dissatisfied after using Eddy SeniorCare's complaint process, the Provider may ask for a review by St. Peter's Health Partners' Chief Medical Officer – Continuing Care. The determination of St. Peter's Health Partners' Chief Medical Officer – Continuing Care shall be final.

**QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) AND UTILIZATION REVIEW (UR)**

A. Eddy SeniorCare's multidisciplinary team performs a critical element of quality assessment performance improvement. The process of service delivery in the PACE model requires the team to identify Member problems, determine appropriate treatment goals, select interventions, and evaluate efficiencies of care on an individual basis. This activity is the foundation for all subsequent QAPI activities.

B. Eddy SeniorCare maintains a written QAPI Plan and Utilization Review Policy that provides a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and services. The QAPI plan identifies specific and measurable activities to be undertaken. The QAPI plan includes, at a minimum, the following essential elements:

1. Standards that are performance benchmarks, established in conjunction with the Provider, and are incorporated into the Provider Manual as appropriate. Such performance benchmarks may include measures of access and availability of service including:
   a. response time to referrals
   b. timelines of treatment
   c. implementation of plan of care

2. Performance goals provide a framework for QAPI activities, evaluation, and corrective action. These goals should be reviewed periodically and should be supported by data collection activities focusing on clinical and functional outcomes, encounter and utilization data, and Member satisfaction.

3. Performance Improvement indicators need to be single outcome measurable variables related to the required services provided by Eddy SeniorCare. The methodology should assure that all care settings (e.g., Eddy SeniorCare's contracted Providers, PACE Center, and home health care settings) are included in the scope of

services being measured and monitored. Quality performance indicators should be selected for review on the basis of high volume, high risk, diagnoses or clinical procedures, adverse outcomes, functional outcomes, or other problem related indices.

4. Process to review the effectiveness of Eddy SeniorCare's multidisciplinary team in its ability to assess participant's care needs, identify the participant's treatment goals, assess the effectiveness of interventions, evaluate adequacy and appropriateness of service utilization and reorganize a plan of care as necessary.

5. Process for aggregating data for purposes of conducting overall program utilization analysis and provider performance analysis. Contracted Providers are asked to complete and communicate feedback via the Contract Providers Survey and provide written summaries of participant care and service delivery.

6. Policies and procedures related to establishing quality committees that:
   a. evaluate data collected pertaining to quality indicators; include contracted service providers, NYS DOH survey results and quarterly care conferences per contract request.
   b. address the process and outcomes of the QAPI plan; and
   c. provide input related to ethical decision-making including end-of-life issues and implementation of the Patient Self-Determination Act.

   These procedures should define a process for taking appropriate action to resolve problems identified as part of quality assurance and improvement activities, including providing feedback to appropriate staff and monitoring effectiveness of corrective actions.

   The policies should be established that define qualifications of individuals participating on these committees. The system should incorporate review of the care delivery process by appropriate clinical professionals as well as non-clinical staff.

   The policies shall include a process for selecting and reviewing medical records, patient complaints and other data sources.

7. Participant, contracted service providers and caregiver involvement in the QAPI plan and evaluation of Member satisfaction with services.

8. Board of director's level of accountability for overall oversight of the QAPI plan, annual review and approval of the plan by oversight

committees of the program board with periodic feedback to Board on review process.

9. A designated individual to coordinate and oversee implementation of the QAPI activities.

## CULTURAL COMPETENCE

All providers are to promote and ensure the delivery of services in a culturally competent manner to all participants, including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds, as well as participants with diverse sexual orientations, gender identities and members of diverse faith communities. Cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by participants and their communities.

Each year, the New York State Department of Health requires managed Medicaid / PACE Program network providers to certify completion of cultural competency training for all staff who have regular and substantial contact with Eddy SeniorCare members.

Eddy SeniorCare shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters. The State will provide cultural competence training materials upon request. Some resources provided by the State can be found at https://omh.ny.gov/omhweb/cultural_competence/resources.html.

## MEMBER GRIEVANCE AND APPEAL PROCEDURES

Eddy SeniorCare (ESC) will make every effort to address any concerns a participant may have in a prompt and courteous manner. Participant concerns will be kept confidential and will in no way adversely affect his/her care or services.

*Each participant has the right to voice a grievance or use the appeals process without any fear of reprisal, interference, coercion, or discrimination by Eddy SeniorCare staff. Participants can be assured that grievances or appeals will be handled confidentially. Services will not be taken away because a participant filed a grievance.*

If a participant does not speak English or is hearing or visually impaired, assistance will be provided to facilitate the grievance and/or appeals process.

## HOW PACE PARTICIPANTS CAN MAKE A FORMAL GRIEVANCE:

**Definition: a grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.**

This process will be reviewed with each participant upon enrollment, annually reviewed with his/her social worker, and whenever a participant files a grievance.

To file a grievance, a participant or designated representative can discuss his/her concern with any Eddy SeniorCare staff member or contracted provider. It is important to give as much accurate information as possible so that we can resolve the grievance in a timely manner.

Eddy SeniorCare staff in Schenectady can be reached by calling: (518) 382-3290.
Eddy SeniorCare staff in Albany can be reached by calling: (518) 213-7526.
You can also call toll-free: 1-855-376-7888 between 8:00 a.m. to 4:30 p.m. Monday through Friday.
After hours (including holidays and weekends) you may discuss your concern with the administrator on call by calling the same phone number.

A participant may also file a grievance by writing to us:
Director of Operations or Executive Director at:
Eddy SeniorCare-Schenectady: 1938 Curry Road, Schenectady, NY 12303
Eddy SeniorCare-Latham: 385 Watervliet Shaker Road, Latham, NY 12110

## DOCUMENTING THE GRIEVANCE

The staff member who receives a grievance will provide a participant with documentation of it, along with a time frame of our response. The Director of Operations will coordinate an investigation. Eddy SeniorCare staff that has not been part of the incident in question will review grievances. When you file a grievance (verbally or in writing), it is important to include the following information:

- Date grievance is made
- Participant name, address, and phone number
- Nature of the grievance

## RESPONDING TO AND RESOLVING GRIEVANCES

Eddy SeniorCare will review the grievance and provide a written response within 15 days. The response will include a description of the grievance investigation findings and the decision rendered by Eddy SeniorCare.

If the participant is unhappy with the decision rendered, the participant may ask for the grievance to be looked at again. The Eddy SeniorCare Director of Operations must

hear from the participant within 30 days of the decision. The participant can use the same phone number or address as the original grievance. The participant will be informed of the Director of Operation's decision within 30 days.

## APPEALS PROCESS

Definition: An appeal is a participant's action (verbal or written) taken with respect to Eddy SeniorCare for noncoverage of or nonpayment for, a service including denials, reductions or termination of services.

## Eddy SeniorCare Internal Appeal Process

The internal appeal process will be reviewed with each participant upon enrollment, annually with his/her social worker and whenever the team denies a request for services or payment.

If a participant wishes to appeal a decision, he/she must notify Eddy SeniorCare, either verbally or in writing, within 30 days of any decisions by Eddy SeniorCare of noncoverage or nonpayment of services.

## How to file an appeal

- The participant or his/her designated representative may discuss his/her wish to appeal with any staff member. Give complete information so appropriate staff can initiate the appeal process in a timely manner.

- Eddy SeniorCare staff may be reached by calling
  **Toll Free at 1-(855)-376-7888**
  **Schenectady: 518-382-3290**
  **Latham: 518-213-7526 or toll free: 1-855-376-7888**
  **8:00 a.m. to 4:00 p.m. Monday through Friday**
  or after hours by using the above phone number and asking to speak with the administrator on-call.

- A participant may also send a written request for an appeal to the following addresses:
  Executive DirectorExecutive Director
  Eddy SeniorCare PACEEddy SeniorCare PACE
  385 Watervliet Shaker Road1938 Curry Road
  Latham, NY 12110Schenectady, NY 12303

- For a Medicaid participant, Eddy SeniorCare will continue to furnish the disputed services until issuance of the final determination if the following conditions are met:
  - Eddy SeniorCare is proposing to terminate or reduce services currently being furnished to you

- A participant requests continuation with the understanding he/she may be held liable for the cost of these services if the determination is not resolved in his/her favor.

**Documenting an appeal**

- The participant will have the opportunity to present information to support his/her appeal either in person or in writing.

- All information will be documented, filed and forwarded to the Director of Operations who will review the information. If the Director of Operations does not rule in favor of the participant, an impartial third party reviewer/committee will be consulted. A decision about the appeal will be made by a qualified health professional not involved in the original action and who does not have a stake in the outcome of the appeal.

**Responding to an appeal**

A decision about the participant's appeal will be made within 30 days of receipt of the appeal.

Eddy SeniorCare will give all parties involved in the appeal appropriate written notification of the decision to approve or deny/partially deny the appeal.

- Notice of a **favorable** decision will explain the conditions of the approval in understandable language.

  - **Action following a favorable decision:** Eddy SeniorCare will furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant's appeal.

- Notice of a **partially or fully adverse decisions**:

- Notice of any **denial** will:
  - State the specific reason(s) for the denial
  - Explain the reason(s) why the service would not improve or maintain the participant's overall health status
  - Inform the participant of his/her right to appeal the decision
  - Describe the additional external appeal rights under Medicare or Medicaid

**Expedited Appeal Process**

- An expedited appeal process is available for situations in which a participant believes that his/her life, health or ability to regain or maintain maximum function could be seriously jeopardized, absent the provision of the service(s) in dispute.

- Eddy SeniorCare will respond to the expedited appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after the appeal is received. The 72-hour time frame may be extended up to 14 calendar days if the participant requests the extension or if Eddy SeniorCare justifies to the New York State Department of Health the need for additional information and how the delay is in the participant's interest.

**External Appeal Options**

- Medicaid participants have the right to request a State Fair Hearing if they are unsatisfied with the outcome of the Eddy SeniorCare appeal process. Eddy SeniorCare staff will help the participant in accessing State Fair Hearing rights. These appeals are conducted by the New York State Office of Hearing and Appeals.

- If a participant is a Medicare recipient who is unsatisfied with the outcome of the Eddy SeniorCare appeal process, the participant may choose to appeal to Medicare. Eddy SeniorCare staff will help the participant in accessing the Medicare appeal process. The appeal will be sent to The Centers for Medicare and Medicaid Services' (CMS) Independent Review Entity (IRE).

- If the participant has both Medicaid and Medicare, Eddy SeniorCare staff will assist the participant in choosing which agency to appeal to and accessing the chosen agency. **Both agencies cannot review the appeal.**

**Voicing concerns to the New York State Department of Health**

Participants can contact the New York State Department of Health at any time to voice a complaint. Participants may voice concerns regarding Eddy SeniorCare by calling the NYS Department of Health Managed Care Complaint Line at 1-800-206-8125. Participants can also call the NYS Home Care Hot Line at: 1-800-628-5972 to voice concerns about the homecare services received through Eddy SeniorCare, or the participant may write to the NYS Department of Health regarding Home Care services by writing to: Division of Home and Community Based Services, 875 Central Avenue, Albany, NY 12206.