Eddy SeniorCare Provider Manual

TABLE OF CONTENTS

Definitions	2
Participant Bill of Rights	4
Patient Referrals/Service Authorization	8
Billing	8
Prohibition on Use of Federal Funds for Lobbying	10
Monitoring and Evaluation	10
Physician Orders	11
Record Keeping and Medical Records	11
Recovery of Overpayments	
Utilization Management	14
Coordination of Benefits	14
Civil Rights	14
Provider Complaints	18
Quality Assessment and Performance Review	19
Cultural Competance	
Grievances	21
Appeals	23

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 lay person, 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, 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, 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 program director, director of participant services, medical director and other clinical and non-clinical professional staff as deemed appropriate by ESC**.**

PARTICIPANT BILL OF RIGHTS

Right #1 Respect and nondiscrimination

Each participant has the right to considerate, respectful care from all PACE employees and contractors at all times and under all circumstances. Each participant has the right not to be discriminated against in the delivery of required PACE Services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment. Specifically, each participant has the right to the following:

1. To receive comprehensive health care 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. Not to be required to perform services for the PACE organization.

4. To have reasonable access to a telephone.

5. To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the participant's medical symptoms.

6. To be encouraged and assisted to exercise rights as a participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights.

7. To be encouraged and assisted to recommend changes in policies and services to PACE staff.

Right #2 Information disclosure

Each PACE participant has the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, each participant has the following rights:

1. 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 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.

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

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

Right #3 Choice of providers

Each participant has the right to a choice of health care providers, within the PACE organization's network, that is sufficient to ensure access to appropriate high-quality health care. Specifically, each participant has the right to the following:

1. To choose his or her primary care physician 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 disenroll from the program at any time.

Right #4 Access to emergency services

Each participant has the right to access emergency health care services when and where the need arises without prior authorization by the PACE interdisciplinary team.

Right #5 Participation in treatment decisions

Each participant has the right to participate fully in all decisions related to his or her treatment. A participant who is unable to participate fully in treatment decisions has the right to a designated representative. Specifically, each participant has the following rights:

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 the participant so desires.

3. To be fully informed of his or 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 the participant's welfare, or that of other participants). The PACE organization must document the justification in the participant's medical record.

Right # 6 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. Each participant also has the right to review and copy his or her individual 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.

Right #7 Complaints and appeals

Each participant has the right to a fair and 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. Specifically, each participant has the following rights:

1 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.

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

The following responsibilities apply to a participant enrolled in Eddy SeniorCare:

1. Accept help from Eddy SeniorCare staff without regard to race, religion, age, sex or national origin of the person providing care or services.

2. Keep appointments or notify Eddy SeniorCare if an appointment cannot be kept.

3. Provide to the best of your knowledge information that is accurate and complete with regard to past illness, present complaints and all other health related matters.

4. Authorize Eddy SeniorCare to obtain and use records and information from hospitals, nursing facilities, home health agencies, physicians and other providers who have treated you.

5. Actively participate in the development and updating of your Plan of Care.

6. Cooperate fully in providing relevant medical and financial information to Eddy SeniorCare.

7. Ask questions and request further information regarding anything you do not understand.

8. Cooperate with Eddy SeniorCare in billing for and collecting applicable fees from third party payors.

9. Be respectful of the safety of all personnel involved in your care, and assist in developing and maintaining a safe environment for you, your family and your caregivers.

10. Use Eddy SeniorCare's contracted Provider Network for services included in the benefit package.

11. Notify Eddy SeniorCare when you receive health services without authorization from Eddy SeniorCare's interdisciplinary team.

12. Assume the risks of the results should you refuse treatment, or do not follow the care plan and related instructions.

13. Notify Eddy SeniorCare promptly of any change in address. Notice should be mailed to Eddy SeniorCare at 504 State Street, Schenectady, NY 12305.

14. Comply with all policies of the program as noted in the Member Handbook

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

Referrals are forwarded to Provider on a "Patient Referral/Service Authorization" form, signed by Eddy SeniorCare staff. The original and second copies of the form are sent to the Provider. The original copy should be returned as appropriate with the Provider's consultant report, date and time of service and provider signature. A section on the referral form provides instructions regarding where to send bills for services rendered.

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.

Providers must only provide services as authorized by the Eddy SeniorCare multidisciplinary team, on the "Patient Referral/Service Authorization" form. Any services that may be necessary need to be authorized by Eddy SeniorCare's medical director/ multidisciplinary team. 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 120 days of 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.

The following information should appear on the bill or be sent as backup, to ensure timely and accurate payment of services:

Member: Name, Address, Phone
Provider Information: Name of Provider, Address, Phone, Dates of Service, Description of Service(s), When the service is billable to Medicaid/Medicare Number

of Units or Visits x Rate, Total Amount Due, Eddy SeniorCare Authorization, Person Authorizing Service, Authorization Date

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 or from any Member, DOH, or DHHS.

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 pay the claim. 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 Vice President/Director 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: vice president/ program director, medical director/ primary care physician, and controller. These individuals can be contacted by phone at 382-3290 or fax 382-3398.

PRE-ENROLLMENT SERVICES

Members may be served by Providers and Eddy SeniorCare for a period of time prior to formal Medicare and/ or Medicaid capitation. During this period, services continue to be reimbursed on a traditional fee-for-service basis. Provider shall make best efforts to bill Medicaid and/or Medicare directly during (i) that period in which the participant being cared for by Provider and (ii) ESC is not yet subject to capitation. ESC will promptly notify Provider when the direct billing process should cease and billing to ESC, shall commence in writing.

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.

PHYSICIAN ORDERS

1. Provider shall recognize written physician orders which, for each Member, shall 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 orders are received by Provider within 48 hours of the time service is requested to be initiated.

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 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;

(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 ~~access and audit of records~~ 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. ~~the record retention period~~.

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.

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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, 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 vice president/ program director and/or the medical director immediately. Appeals relating to specific billing and claims processing should be directed to the Eddy SeniorCare controller. The Provider may be asked to submit the complaint in writing.

Eddy SeniorCare will provide a written response within 3 days to confirm receipt of complaints, and ESC will seek to resolve the appeal within 30 days 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; including include contracted service providers, MDS reports, 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 COMPETANCIES

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.

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.

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MEMBER GRIEVANCE AND APPEAL PROCEDURES

Eddy SeniorCare promotes open communication with its participants, and is committed to addressing any complaints, either written or verbal regarding dissatisfaction with service delivery, quality of care, and non-coverage or nonpayment of services being provided by Eddy SeniorCare. A participant or designated representative may make a grievance or appeal at any time. It is policy that Eddy SeniorCare continues to provide care to the participant during the grievance or appeal process without fear of any reprisal. A grievance or appeal will be kept confidential and in no way will the grievance or appeal adversely affect a person's care or services. Eddy SeniorCare investigates grievances and appeals, and informs participants of their Bill of Rights when voicing grievances and appeals. We hope that grievances and appeals are addressed to one's satisfaction in a prompt and courteous manner.

The right to file a grievance or appeal is made known to the participant in writing upon enrollment and annually thereafter. Contractors receive a copy of Eddy SeniorCare's Member Handbook outlining the Grievance and Appeal Procedures, and must agree to participate in the process.

For persons who do not speak English, a bilingual staff member, or translation service are available to help with the grievance and appeal processes.

GRIEVANCE PROCEDURES:

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

Each time there is an expression of dissatisfaction with service delivery or quality of care. The participant will be provided with and have discussed, a written explanation of the specific steps that will be taken or already have been taken to resolve the grievance. Participants or designated representatives may make grievances with a social worker, home care coordinator, nurse, PACE Center manager and coordinator of home care, on-call registered nurse, contractor, home health aide, or any other staff. Participants are encouraged to give complete information so appropriate staff can resolve grievances in a timely manner. Participants may designate a representative to file a grievance on their behalf. Contractors receiving complaints from participants report them to the vice president/ program director.

When making a grievance you may contact Eddy SeniorCare's staff in person or by phone by calling one of the following numbers; (518) 382-3290, Toll free 1-855-376-7888, TYY 1-800-662-1220, Monday through Friday between the hours of 8:00 to 4:30.

An on-call staff member can be reached by calling the same number after hours and on weekends or holidays.

An Eddy SeniorCare employee who receives a grievance informs their supervisor for necessary action and follow up. Grievances are reviewed by personnel who are not involved in the grievance or issue in question. The director of participant services or designee, coordinates grievances. Clinical grievances and are reviewed by qualified clinical personnel not involved in the decision.

Whenever a grievance is received the documentation on the grievance includes:

- Date grievance received
- Name of person making grievance
- Address and phone number
- Nature of grievance
- Staff assigned regarding the investigation and date
- Findings of investigation
- Action taken resolution and date

If a solution is found regarding a grievance and agreed to by the participant (or designated representative), the grievance is considered resolved. A written response to all grievances is provided to the participant or designated representative after the grievance has been resolved.

Participants or designated representatives may upgrade their grievance if they find the resolution unsatisfactory by using the internal Grievance Petition process. An internal Grievance Petition must be sent in writing to the Vice President/ Program Director, Eddy SeniorCare, 504 State Street, Schenectady, NY 12305 within 30 days of the initial grievance.

The vice president/ program director or designee conducts an investigation, establishes solutions and takes appropriate action in conjunction with relevant staff. Additional information may also be requested by the director of participant services, medical director, or vice president/ program director, as necessary.

The internal Grievance Petition must be resolved within 15 calendar days from the day the Grievance Petition was received by the vice president/ program director.
The vice president/ program director notifies the participant or designated representative in writing of the findings describing the resolution to the Grievance Petition including the basis for the resolution. The decision is final.

Grievances that are deemed by the director of participant services or vice president/ program director to involve a significant life or health risk to the participant must be resolved within 48 hours. Notification of the resolution will be shared with the participant (or designated representative) immediately upon resolution.

APPEAL PROCEDURES:

Definition: *An appeal is a participant's action taken with respect to noncoverage of or nonpayment for a service including denials, reduction or termination of services. A participant has up to 45 days to request an appeal from the date of notification of noncoverage.*

Participants or designated representatives may make an appeal with a social worker, home care coordinator, nurse, PACE Center manager and coordinator of home care, on-call registered nurse, contractors, home health aide, or any other staff member. Employees involved in processing an appeal are required to maintain confidentiality of the participant's appeal. Participants are encouraged to give complete information so following up on an appeal can be completed in a timely manner. Participants may designate a representative to file an appeal on their behalf. Contractors receiving complaints must report them to the vice president/ program director.

When making an appeal you may contact Eddy SeniorCare's staff in person or by calling one of the following numbers; (518) 382-3290, Toll free 1-855-376-7888, TYY 1-800-662-1220, Monday through Friday between the hours of 8:00 to 4:30. An on-call staff member can be reached by calling the numbers above after hours and during a weekend or holiday.

The staff member who receives an appeal informs their supervisor of necessary action and follow up. Appeals are reviewed by personnel who are not involved in the appeal or issue in question. The director of participant services or designee, coordinates appeals. Clinical aspects of appeals are reviewed by qualified clinical personnel not involved in the decision.

Whenever an appeal is received the documentation regarding the appeal includes:

- Date when the appeal was received
- Name of person making an appeal
- Address and phone number
- Nature of appeal
- Staff assigned regarding the investigation and date
- Findings of investigation
- Resolution and date

The director of participant services or the vice president/ program director must respond to and resolve the participant's appeal as quickly as the health condition requires, but no later than thirty (30) calendar days after receiving the appeal.

During the appeals process, Eddy SeniorCare may not reduce or terminate disputed services while appeal is pending. If the decision is not in your favor, you may be held liable for the cost of services.

When a determination is wholly or partially adverse to a participant, Eddy SeniorCare will notify CMS, the State administering agency and the participant at the same time the decision is made. The appeals information will be maintained, aggregated, analyzed and utilized for Eddy SeniorCare's internal quality assessment and performance improvement program.

EXPEDITED APPEALS PROCESS:

An expedited appeal may be requested should a participant believe that his or life, health, or ability to regain or maintain maximum function could be seriously jeopardizing absent the provision of a service. An expedited appeal must be resolved within 72 hours. Notification of the resolution will be shared with the participant (or designated representative) in writing immediately upon resolution. Care will continue until notification of this resolution. The Director of Participant Services or the Vice President/ Program director will respond in writing to confirm receipt of appeal within 24 hours of receipt. This notification acknowledges with timeline for reply and your right to an expedited appeal process.

The expedited appeals process involving the 72 hours time frame may be extended by up to 14 calendar days if the participant requests an extension, or Eddy SeniorCare justifies to the NYSDOH's Bureau of Continuing Care Initiatives the need for additional information, and how the delay would benefit the participant.

ADDITIONAL APPEAL RIGHTS UNDER MEDICARE AND MEDICAID:
The appeal processes are reviewed with participants upon enrollment and annually thereafter by the social worker. The social worker is responsible for informing participants or designated representatives of their additional appeal rights under Medicare or Medicaid managed care, or both, and a right to having a Fair Hearing. The social worker may assist the participant in choosing which to pursue if both are applicable. In the event that Medicaid is applicable, Eddy SeniorCare's social worker can offer a Fair Hearing notice to the participant to exercise an external appeal to the New York State Office of Hearing and Appeals. When Medicare is involved**,** an external appeal, if elected, will be forwarded to the Center for Health Dispute Resolution.

State and Federal Complaint Options:

A participant or designated representative may file a complaint at any time. To pursue complaints with the New York State Department of Health

Nursing Home Hotline
New York State Department of Health
At 1**-888-201-4563**
and identify the complaint as a managed long term care concern

New York State Managed Care Hotline
1-866-712-7197