

## **SPECIAL PROVISIONS RELATED TO MEDICAID AND FAMILY HEALTH PLUS MEMBERS**

All HIP Health Plan of New York and HIP Network Services IPA participating practitioner, provider and facility agreements wherein the practitioner, provider or facility will provide health care services to Medicaid and Family Health Plus members covered under a benefit program pursuant to the plan's Medicaid contracts with the New York State Department of Health and the New York City Department of Health and Mental Hygiene must include certain provisions. The most up-to-date copy of our Special Provisions Related to Medicaid and Family Health Plus Members that is part of and incorporated into all agreements is provided on the following pages for easy reference.

With respect to services rendered to the Plan's Medicaid and Family Health Plus Members (jointly referred to as "Medicaid Members"), Provider will be subject to all relevant obligations and duties imposed under Plan's Medicaid contracts with the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene ("NYC DOHMH") including the following provisions which shall apply and be binding upon the Parties. These are general guidelines and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.

A. Plan and Provider acknowledge and agree that Plan's Medicaid Members are not subject to Medicaid Utilization Thresholds or limitations on services covered by Medicaid. However, Medicaid Members may be subject to Medicaid Utilization Thresholds for outpatient pharmacy services that are billed Medicaid fee-for-service until such time as the Plan is required to manage and pay for such services (the Medicaid Pharmacy Carve-In Effective Date).

B. Plan and Provider acknowledge and agree that, with respect to Plan's Medicaid Members, Plan and Provider shall comply with the informed consent procedures for hysterectomy and sterilization, as set forth at 42 CFR, Part 441, sub-part and F, and 18 NYCRR Section 505.13, the NYSDOH C/THP Manual and all applicable public health laws and regulations including, without limitation, the reporting of communicable diseases. Provider acknowledges and agrees that compliance with this provision shall be audited by Plan in connection with its quality assurance review of Provider.

C. Plan and Provider acknowledge and agree that, with respect to the Plan's Medicaid Members, the Plan retains the right to audit Provider's claims for a six (6) year period from the date of care, services or supplies were provided or billed, whichever is later and to recoup any overpayments discovered as a result of the audit. This six (6) 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 Plan's auditing. Effective July 1, 2007, this policy also applies to recovery of overpayments to provider for Child Health Plus Members.

D. Providers treating Members enrolled in Medicaid agree and acknowledge that they must comply with the following guidelines for member-to-practitioner ratios, which are based on the assumption that the Provider's practitioners practice full-time (forty (40) hours per week). These ratios are practitioner-specific and must be prorated for practitioners practicing less than forty (40) hours per week. The ratios apply to practitioners, not to each of their practice locations.

1. Practitioners who are physicians shall have no more than 1,500 Members on their panel or 2,400 for a physician practicing in combination with a registered physician assistant or certified nurse practitioner.
2. Advanced Nurse Practitioners credentialed as Primary Caregivers shall have no more than 1,000 Members on their panel.

E. Plan and Provider acknowledge and agree that the provisions set forth in the Agreement regarding preauthorization of elective services shall not apply to Plan's Medicaid Members seeking services to which Members may self refer or to Family Planning and Reproductive Health Services, including without limitation, pre and post-test HIV counseling and blood testing.

F. Nothing contained in the Agreement shall limit or terminate Plan's obligations under its Medicaid contracts with NYSDOH or NYCDOHMH or be deemed to impair the rights of NYSDOH, NYCDOHMH, HRA, or the Department of Health and Human Services ("DHHS"), nor shall any provision contained in the Agreement be deemed to create or imply a contractual relationship between Provider, NYSDOH, NYCDOHMH, HRA or LDSSs.

G. In the event that any duty or obligation imposed on Provider in this Agreement is deemed to be inconsistent with the provisions set forth in Plan's the Medicaid contracts with NYSDOH or NYCDOHMH, the Medicaid contract duty and obligation shall govern and the duty or obligation as stated in the Agreement shall be unenforceable by Plan and shall be void and of no effect to the extent that such duty or obligation applies to Provider arranging for the provision of services to Medicaid Members.

H. Welfare Reform: If Provider has practitioners serving as a PCPs, Provider shall provide or arrange for the provision of medical documentation and health, mental health and alcohol and substance abuse assessments as follows:

1. Within ten (10) days of a request from a Medicaid Member or a former Member currently receiving public assistance or who is applying for public assistance, Provider shall provide, as appropriate, medical documentation concerning the Member's or former Member's health or mental health status to the HRA, LDSSs or to their designees. Medical documentation includes but is not limited to drug prescriptions and PCP or specialty provider reports.
2. Within ten (10) days of a request from a Member, who has already undergone, or is scheduled to undergo, an initial required mental and/or physical examination, Provider shall provide or arrange a health or mental health and/or alcohol and substance abuse assessment, mental and/or medical examination or other services as appropriate to identify or quantify the Member's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. The HRA or LDSSs may, upon written notice, specify the format and instructions for such an assessment.

I. Provider agrees to comply with the following guidelines for appointment availability:

1. For emergency care: immediately upon presentation at a service delivery site.
2. For urgent care: within twenty-four (24) hours of request.
3. Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
4. Routine appointments: within four (4) weeks of request.
5. Specialist referrals (not urgent): within four (4) to six (6) weeks of request.
6. Initial prenatal visit: within three (3) weeks during first trimester, and two (2) weeks during the second trimester and one (1) week thereafter.
7. Adult Baseline and routine physicals: within twelve (12) weeks from enrollment. (Adults over 21 years of age)
8. Well-child care: within four (4) weeks of request.
9. Initial family planning visits: within two (2) weeks of request.
10. In-plan mental health or substance abuse follow-up visits (pursuant to an emergency or hospital discharge): within five days of request, or as clinically indicated.
11. In-plan, non-urgent mental health or substance abuse visits: within two (2) weeks of request.
12. Initial PCP office visit for newborns: within two (2) weeks of Facility discharge.
13. Accommodate member visits to Provider to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a Member's ability to perform work when requested by HRA or LDSSs: within ten (10) days of request by a Member.