APPENDIX K

PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

APPENDIX K
PREPAID BENEFIT PACKAGE
DEFINITIONS OF COVERED AND NON-COVERED SERVICES

1. General

a) The categories of services in the Medicaid Managed Care and Family Health Plus Benefit Packages, including optional covered services, shall be provided by the Contractor to MMC Enrollees and FHPlus Enrollees, respectively, when medically necessary under the terms of this Agreement. The definitions of covered and non-covered services herein are in summary form; the full description and scope of each covered service as established by the New York Medical Assistance Program are set forth in the applicable NYS Medicaid Provider Manual, except for the Eye Care and Vision benefit for FHPlus Enrollees which is described in Section 19 of Appendix K.2.

b) All care provided by the Contractor, pursuant to this Agreement, must be provided, arranged, or authorized by the Contractor or its Participating Providers with the exception of emergency transportation, Family Planning and Reproductive Health services, court ordered services, and services provided by Local Public Health Agencies as described in Section 10 of this Agreement. HIV SNP and HARP covered benefits may vary.

c) This Appendix contains the following sections:

i) K.1 - "Chart of Prepaid Benefit Package" lists the services provided by the Contractor to all Medicaid Managed Care Non-SSI/Non-SSI Related Enrollees, Medicaid Managed Care SSI/SSI-related Enrollees, Medicaid fee-for-service coverage for carved out and wraparound benefits, Family Health Plus Enrollees and HARP enrollees.

K.1 HIV - "Chart of HIV Special Needs Plan Prepaid Benefit Package" lists the services provided by the Contractor to all HIV SNP Non-SSI Enrollees, HIV SNP HIV/AIDS SSI Enrollees, HIV SNP Uninfected SSI Children and Homeless Adults, and Medicaid fee-for-service coverage for carved out and wraparound benefits.

ii) K.2 - "Prepaid Benefit Package Definitions Of Covered Services" describes the covered services, as numbered in K.1. Each service description applies to both MMC and FHPlus Benefit Package unless otherwise noted.

iii) K.3 - "Medicaid Managed Care Definitions of Non-Covered Services" describes services that are not covered by the MMC Benefit Package. These services are covered by the Medicaid fee-for-service program unless otherwise noted.

iv) K.4 - "Family Health Plus Non-Covered Services" lists the services that are not covered by the FHPlus Benefit Package.

K.1

PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits
** No Medicaid fee-for-service wrap-around is available
Note: If cell is blank, there is no coverage.

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Stay covered only when admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]		Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see §6.8 of this Agreement]
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered			Covered	Covered
3.	Physician Services	Covered	Covered			Covered	Covered
4.	Nurse Practitioner Services	Covered	Covered			Covered	Covered
5.	Midwifery Services	Covered	Covered			Covered	Covered
6.	Preventive Health Services	Covered	Covered			Covered	Covered
7.	Second Medical/Surgical Opinion	Covered	Covered			Covered	Covered
8.	Laboratory Services	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered through 3/31/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing		Covered	Covered, Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing
9.	Radiology Services	Covered	Covered			Covered	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors	Hemophilia blood factors covered through MA FFS		Covered. Coverage includes prescription drugs, insulin and diabetic supplies, smoking cessation agents, select OTCs, vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formulae. Hemophilia blood factors covered through MA FFS.	Covered, Coverage excludes hemophilia blood factors.
11.	Smoking Cessation Products	Covered	Covered			Covered	Covered
12.	Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.			Covered for short term inpatient, and limited to 20 visits each per calendar year for outpatient PT, OT, and speech therapy.	Covered, Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered			Covered	
14.	Home Health Services	Covered	Covered			Covered for 40 visits in lieu of a skilled nursing facility stay or	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
						hospitalization, plus 2 post partum home visits for high risk women	
15.	Private Duty Nursing Services	Covered	Covered			Not covered	Covered
16.	Hospice	Covered	Covered			Covered	Covered
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered			Covered Covered	Covered Covered
18.	Foot Care Services	Covered	Covered			Covered	Covered
19.	Eye Care and Low Vision Services	Covered	Covered			Covered	Covered
20.	Durable Medical Equipment (DME)	Covered	Covered			Covered	Covered
21.	Audiology, Hearing Aids Services & Products	Covered	Covered			Covered	Covered
22.	Family Planning and Reproductive Health Services	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered pursuant to Appendix C of Agreement.		Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement or through the DTP Contractor.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.		Not covered, except for transportation to C/THP services for 19 and 20 year olds. Benefit to be covered by MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to phase-in schedule

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.		Covered	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.
25.	Dental and Orthodontic Services	Covered.	Covered.	For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention.		Covered, if included in Contractor's Benefit Package as per Appendix M of this Agreement, excluding orthodontia.	Covered
26.	Court-Ordered Services	Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).			Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).
27.	LDSS Mandated SUD Services	Covered, pursuant to Welfare Reform / LDSS mandate (mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)				Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)
28.	Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered			Covered, except for orthopedic shoes	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
29.	Mental Health Services	Covered	Covered on the effective date of the Behavioral Health Benefit Inclusion.	Covered		Covered subject to calendar year benefit limit of 30 days inpatient, 60 visits outpatient, combined with chemical dependency services.	Covered
30.	SUD Inpatient Detoxification Services	Covered	Covered			Covered	Covered
31.	SUD Inpatient Rehabilitation and Treatment Services	Covered	Covered on the effective date of Behavioral Health Benefit Inclusion			Covered subject to calendar year benefit limit of 30 days combined with mental health services	Covered
32.	SUD Residential Addiction Treatment Services	Covered	Covered				Covered
33.	SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Covered	Covered			Covered subject to calendar year benefit limits of 60 visits combined with mental health services	Covered
34.	SUD Medically Supervised Outpatient withdrawal	Covered	Covered				Covered
35.	Buprenorphine Prescribers	Covered	Covered				Covered
36.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis			Covered on a case by case basis	Covered on a case by case basis
37.	Renal Dialysis	Covered	Covered			Covered	Covered
38.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.			Covers only non-permanent rehabilitative stays.	
39.	Personal Care Services	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.			Not covered	Covered. When only Level I services provided, limited to 8 hours per week.

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
40.	Personal Emergency Response System (PERS)	Covered	Covered			Not covered	Covered
41.	Consumer Directed Personal Assistance Services	Covered	Covered			Not covered	Covered
42.	Observation Services	Covered	Covered			Covered	Covered
43.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP			Not covered	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP
44.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP			Not covered	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP
45.	Adult Day Health Care	Covered	Covered			Not Covered	Covered
46.	AIDS Adult Day Health Care	Covered	Covered			Not Covered	Covered
47.	Tuberculosis Directly Observed Therapy	Covered	Covered			Not Covered	Covered
48.	Crisis Intervention Services	Covered,	Covered,				Covered,
49.	Psychosocial Rehabilitation (PSR)						Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
50.	Community Psychiatric Support and Treatment (CPST)						Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
51.	Habilitation Services						Covered on a non-risk basis as directed by the State (see Appendix T of this agreement).

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
52.	Family Support and Training						Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
53.	Short-term Crisis Respite						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
54.	Intensive Crisis Respite						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
55.	Education Support Services						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
56.	Peer Supports						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
57.	Pre-vocational Services						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
58.	Transitional Employment						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
59.	Intensive Supported Employment (ISE)						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
60.	Ongoing Supported Employment						Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS		FHPlus **	HARP
61.	Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program						Covered. (see § 10.41 of this Agreement.)

K.1 HIV
HIV SNP PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits

**Benefit is only covered for HIV SNP Enrollees who also meet HARP-eligibility criteria as determined by the State.

Note: If cell is blank, there is no coverage.

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Stay covered only when admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered	
3.	Physician Services	Covered	Covered	Covered	
4.	Nurse Practitioner Services	Covered	Covered	Covered	
5.	Midwifery Services	Covered	Covered	Covered	
6.	Preventive Health Services	Covered	Covered	Covered	
7.	Second Medical/Surgical Opinion	Covered	Covered	Covered	
8.	Laboratory Services	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered through 3/31/14. HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.
9.	Radiology Services	Covered	Covered	Covered	
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors.	Hemophilia blood factors covered through MA FFS
11.	Smoking Cessation Products	Covered	Covered	Covered	

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
12.	Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered	Covered	
14.	Home Health Services	Covered	Covered	Covered	
15.	Private Duty Nursing Services	Covered	Covered	Covered	
16.	Hospice	Covered	Covered	Covered	Covered
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered	Covered Covered	
18.	Foot Care Services	Covered	Covered	Covered	
19.	Eye Care and Low Vision Services	Covered	Covered	Covered	
20.	Durable Medical Equipment (DME)	Covered	Covered	Covered	
21.	Audiology, Hearing Aids Services and Products	Covered	Covered	Covered	
22.	Family Planning and Reproductive Health Services	Covered	Covered	Covered	Covered pursuant to Appendix C of Agreement
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule
25.	Dental and Orthodontic Services	Covered.	Covered.	Covered.	For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention.
26.	Court-Ordered Services	Covered, pursuant to court order (see also § 10.9 of this Agreement).	Covered, pursuant to court order (see also § 10.9 of this Agreement).	Covered, pursuant to court order (see also § 10.9 of this Agreement).	
27.	LDSS Mandated SUD Services	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)	
28.	Prosthetic/Orthotic Services/ Orthopedic Footwear	Covered	Covered	Covered	
29.	Mental Health Services	Covered	Covered	Covered	Covered for HIV SNP uninfected SSI Enrollees
30.	SUD Inpatient Detoxification Services	Covered	Covered	Covered	
31.	SUD Inpatient Rehabilitation and Treatment Services	Covered	Covered	Covered	
32.	SUD Residential Addiction Treatment Services	Covered	Covered	Covered	
33.	SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Covered	Covered	Covered	
34.	SUD Medically Supervised Outpatient Withdrawal	Covered	Covered	Covered	
35.	Buprenorphine Prescribers	Covered	Covered	Covered	
36.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis	Covered on a case by case basis	

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
37.	Renal Dialysis	Covered	Covered	Covered	
38.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	
39.	Personal Care Services (PCS)	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.	
40.	Personal Emergency Response System (PERS)	Covered	Covered	Covered	
41.	Consumer Directed Personal Assistance Services	Covered	Covered	Covered	
42.	Observation Services	Covered	Covered	Covered	
43.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	
44.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
45.	Adult Day Health Care	Covered	Covered	Covered	Not Covered
46.	AIDS Adult Day Health Care	Covered	Covered	Covered	Not Covered
47.	Tuberculosis Directly Observed Therapy	Covered	Covered	Covered	Not Covered
48.	Crisis Intervention Services	Covered	Covered	Covered	
49.	Psychosocial Rehabilitation (PSR)**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
50.	Community Psychiatric Support and Treatment (CPST)**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
51.	Habilitation Services**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
52.	Family Support and Training**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
53.	Short-term Crisis Respite**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
54.	Intensive Crisis Respite**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
55.	Education Support Services**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
56.	Peer Supports**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
57.	Pre-vocational Services**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
58.	Transitional Employment**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
59.	Intensive Supported Employment (ISE)**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	

*	**Covered Services**	**HIV SNP Non-SSI**	**HIV SNP HIV/AIDS SSI**	**HIV SNP Uninfected SSI Children and Homeless Adults**	**MFFS**
60.	Ongoing Supported Employment**	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).	
61.	Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program	Covered. (see § 10.41 of this Agreement.)	Covered. (see § 10.41 of this Agreement.)	Covered. (see § 10.41 of this Agreement.)	
62.	HIV SNP Enhanced Services: HIV SNP Care and Benefits Coordination; HIV Treatment Adherence Services; HIV Prevention and Risk Reduction Services	Covered	Covered	Covered	

K.2

PREPAID BENEFIT PACKAGE
DEFINITIONS OF COVERED SERVICES

Service definitions in this Section pertain to both MMC and FHPlus unless otherwise indicated.

1. Inpatient Hospital Services

Inpatient hospital services, as medically necessary, shall include, except as otherwise specified, the care, treatment, maintenance and nursing services as may be required, on an inpatient hospital basis, up to 365 days per year (366 days in leap year). Contractor will not be responsible for hospital stays that commence prior to the Effective Date of Enrollment (see Section 6.8 of this Agreement), but will be responsible for stays that commence prior to the Effective Date of Disenrollment (see Section 8.5 of this Agreement). Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.

2. Inpatient Stay Pending Alternate Level of Medical Care

Inpatient stay pending alternate level of medical care, or continued care in a hospital, Article 31 mental health facility, Article 32 OASAS Program, or skilled nursing facility pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85. Continued care in an Article 31 mental health facility shall also be covered in a manner consistent with guidelines issued by the Office of Mental Health.

3. Physician Services

a) "Physicians' services," whether furnished in the office, the Enrollee's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician:

   i) within the scope of practice of medicine as defined in law by the New York State Education Department; and

   ii) by or under the personal supervision of an individual licensed and currently registered by the New York State Education Department to practice medicine.

b) Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under New York State law.

c) The following are also included in accordance with the State Medicaid Plan and Section 10.32 of this Agreement:

i) pharmaceuticals, including long-acting antipsychotic injectables and medical supplies routinely furnished or administered as part of a clinic or office visit;

ii) physical examinations, including those which are necessary for school and camp;

iii) physical and/or mental health, or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care;

iv) health and mental health assessments for the purpose of making recommendations regarding a Enrollee's disability status for Federal SSI applications;

v) annual preventive health visits for adolescents;

vi) new admission exams for school children if required by the LDSS;

vii) health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms;

viii) Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) years of age (see Section 10 of this Agreement).

d) Smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

4. Certified Nurse Practitioner Services

a) Certified nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the certified nurse practitioner's licensure and collaborative practice agreement with a licensed physician in accordance with the requirements of the NYS Education Department.

b) The following services are also included in the certified nurse practitioner's scope of services, without limitation:

i) Child/Teen Health Program(C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) (see Item 13 of this Appendix and Section 10.4 of this Agreement);

ii) Physical examinations, including those which are necessary for school and camp.

5. Midwifery Services

SSA § 1905 (a)(17), Education Law § 6951(i).

Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Enrollee's home as appropriate. The midwife must be licensed by the NYS Education Department and have a collaborative relationship with a physician or hospital that provides obstetric services, as described in Education Law § 6951.1, that provides for consultation, collaborative management and referral to address the health status and risks of patients and includes plans for emergency medical OB/GYN coverage.

6. Preventive Health Services

a) Preventive health services means care and services to avert disease/illness and/or its consequences. There are three (3) levels of preventive health services: 1) primary, such as immunizations, aimed at preventing disease; 2) secondary, such as disease screening programs aimed at early detection of disease; and 3) tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than restorative programs.

b) The Contractor must offer the following preventive health services essential for promoting health and preventing illness:

   i) General health education classes.

   ii) Pneumonia and influenza immunizations for at risk populations.

   iii) Smoking cessation counseling for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year. Effective July 1, 2014, up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner. Smoking cessation classes, with targeted outreach for adolescents and pregnant women.

   iv) Childbirth education classes.

   v) Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.

   vi) Nutrition counseling, with targeted outreach for diabetics and pregnant women.

   vii) Extended care coordination, as needed, for pregnant women.

   viii) HIV testing.

ix) Hepatitis C screening for individuals born between 1945 and 1965.

x) Asthma Self-Management Training (ASMT).

1. Enrollees, including pregnant women, with newly diagnosed asthma or with asthma and a medically complex condition (such as an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to ten (10) hours of ASMT during a continuous six-month period.

2. Enrollees with asthma who are medically stable may receive up to one (1) hour of ASMT during a continuous six-month period.

3. Asthma self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xi) Diabetes Self-Management Training

1. Enrollees, including pregnant women, with newly diagnosed diabetes or with diabetes and a medically complex condition (such as poor diabetes control [A1c>8], diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription for new equipment such as an insulin pump, etc.) will be allowed up to ten (10) hours of DSMT during a continuous six-month period.

2. Enrollees with diabetes who are medically stable may receive up to one (1) hour of DSMT during a continuous six-month period.

3. Diabetes self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xii) Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency provided in: hospital outpatient departments; free-standing diagnostic and treatment centers; physician offices (including primary care and specialist physician offices); School Based Health Centers; School Based Mental Health Centers; and OMH licensed and OASAS certified outpatient programs. SBIRT is provided in in accordance with protocols issued by the SDOH, to identify individuals with or at risk of substance use-related problems, assess the severity of substance use and the appropriate level of intervention required and provide brief intervention or brief treatment. Referrals are initiated to chemical dependence providers for evaluation and treatment, when appropriate.

xiii) All United States Preventive Services Task Force (USPSTF) grade A and B preventive services.

xiv) All approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and the administration of such vaccines.

7. Second Medical/Surgical Opinions

The Contractor will allow Enrollees to obtain second opinions for diagnosis of a condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. In the event that the Contractor determines that it does not have a Participating Provider in its network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the Contractor shall make a referral to an appropriate Non-Participating Provider. The Contractor shall pay for the cost of the services associated with obtaining a second opinion regarding medical or surgical care, including diagnostic and evaluation services, provided by the Non-Participating Provider.

8. Laboratory Services

18 NYCRR § 505.7(a)

a) Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

b) All laboratory testing sites providing services under this Agreement must have a permit issued by the New York State Department of Health and a Clinical Laboratory Improvement Act (CLIA) certificate of waiver, a physician performed microscopy procedures (PPMP) certificate, or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver or a PPMP certificate may perform only those specific tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the Physician's NYS Medicaid Provider Manual.

c) For MMC only: Until April 1, 2014, coverage for HIV phenotypic, HIV virtual phenotypic and HIV genotypic drug resistance tests and viral tropism testing are covered by Medicaid fee-for-service. Effective April 1, 2014, these tests are covered as other laboratory services.

9. Radiology Services

18 NYCRR § 505.17(c)(7)(d)

Radiology services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.

10. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas

a) For Medicaid managed care only: Medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula

are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor.

b) For Family Health Plus only: Medically necessary prescription drugs, insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets, alcohol swabs), smoking cessation agents, including over-the-counter (OTC) smoking cessation products, select OTC medications covered on the Medicaid Preferred Drug List (e.g., Prilosec OTC, Loratadine, Zyrtec and emergency contraception), vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor. Medical supplies (except for diabetic supplies and smoking cessation agents) are not covered.

c) For Medicaid Managed Care and Family Health Plus:

   i) Prescription drugs may be limited to generic medications when medically acceptable. All drug classes containing drugs used for preventive and therapeutic purposes are covered, as well as family planning and contraceptive medications and devices, if Family Planning is included in the Contractor's Benefit Package.

   ii) Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered by the Contractor. Self-administered injectable drugs (including those administered by a family member) and injectable drugs administered during a home care visit are also covered by the Contractor. Long-acting injectable medications shall be covered by the Contractor as a medical and pharmacy benefit. The Contractor's clinical criteria for coverage for long acting antipsychotic injectable medication quantity/dose/age limits shall be consistent with FDA approved labeling and Official Compendia. Hemophilia blood factors, whether furnished or administered as part of a clinic or office visit or administered during a home care visit are covered by Medicaid fee-for-service. Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™) when administered to SSI and SSI-related Enrollees in mainstream Medicaid managed care plans, are covered by Medicaid fee-for-service until the date of Behavioral Health Benefit Inclusion.

   iii) Coverage of enteral formula is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) Individuals who are fed via nasogastric, gastronomy or jejunostomy tube; 2) Individuals with inborn metabolic disorders; and, 3) Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or

metabolized. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

iv) Fluoride supplements are covered for children up to age 17.

v) Experimental and investigational drugs are generally excluded, except where included in the course of Contractor-authorized experimental/investigational treatment or ordered under the External Appeal program authorized under Article 49 of the Public Health Law.

vi) The following drugs are not covered:

1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy;

2. Drugs prescribed for cosmetic purposes;

3. Drugs prescribed for anorexia, for weight loss or weight gain;

4. Drugs prescribed to promote fertility;

5. Drugs used for the treatment of sexual or erectile dysfunction unless used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and

6. Covered outpatient drugs when the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

vii) The Contractor may establish a prescription formulary, including a therapeutic category formulary, as long as the formulary includes all categories of drugs as listed on the New York State Medicaid formulary, and as long as the Contractor has in place a brand name and therapeutic category exception process for providers to use when the provider deems medically necessary.

viii) Drugs used for the treatment of Substance Use Disorder are covered by the Contractor.

1. The Contractor's clinical criteria for coverage for all Substance Use Disorder agent's quantity/dose/duration/age limits shall be consistent with FDA labeling and Official Compendia.

2. The Contractor shall include medications for the treatment of Alcohol Use Disorder (AUD) in the Contractor's formulary, as indicated by the FDA. The Contractor shall not cover these drugs solely through a medical exception process.

3. The Contractor shall include medications for the treatment of SUD in the Contractor's formulary, including drugs for the treatment of AUD and/or opioid dependency, as indicated by Official Compendia. The Contractor shall not cover these drugs solely through a medical exception process.

4. The Contractor's formulary shall include at least one formulation of buprenorphine and buprenorphine/naloxone. The Contractor's clinical criteria shall include lengths of therapy with oral buprenorphine appropriate for Enrollees transitioning from long-acting opioids, or who are pregnant or breast feeding, consistent with the U.S. Department of Health and Human Services Center for Substance Abuse Treatment's "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Substance Abuse and Mental Health Services Administration."

5. Naloxone is available in vials/prefilled syringes, and auto-injector and/or atomizer. Naloxone vials/prefilled syringes or the auto-injector and/or atomizer shall be covered by the Contractor as a medical and pharmacy benefit.

6. Extended-release naltrexone injectable (Vivitrol®) shall be covered by the Contractor as a medical and pharmacy benefit.

11. Smoking Cessation Products

a) Smoking cessation products are covered by the Contractor. The Contractor may not require prior authorization for smoking cessation products that are included in the Contractor's formulary and ordered by a qualified provider. Except as provided in subsection (b), below the Contractor is responsible for up to two courses of smoking cessation therapy per year. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30-day supply is dispensed on any fill).

b) For Enrollees with one or more substance use disorder(s) or diagnosis of mental illness:

i) The Contractor shall cover all smoking cessation products included in the list of Medicaid reimbursable drugs;

ii) The Contractor is responsible for unlimited courses of smoking cessation therapy;

iii) The Contractor may not require prior authorization for smoking cessation products that are ordered by a qualified provider; and

iv) The Contractor must permit concomitant utilization of two (2) agents which is defined as: two (2) nicotine replacement therapies (NRTs); a NRT and bupropion substance release (SR); or a NRT and Chantix

v) Notwithstanding the provisions of this Section, the Contractor is not required to cover a brand name smoking cessation product when a generic equivalent of the product is available.

c) Contractor's age restrictions and quantity limits for smoking cessation products must comply with the U.S. Food and Drug Administration's approved labeling for use, or as supported in at least one of the Official Compendia as defined in federal law under the Social Security Act §1927(g)(1)(B)(i).

12. Rehabilitation Services
18 NYCRR § 505.11

a) Rehabilitation services are provided for the maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists. Rehabilitation services may be provided in an Article 28 inpatient or outpatient facility, an Enrollee's home, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist, or for a child in a school, pre-school or community setting, or in a Residential Health Care Facility (RHCF) as long as the Enrollee's stay is classified as a rehabilitative stay and meets the requirements for covered RHCF services as defined herein.

b) For the MMC Program, rehabilitation services provided in Residential Health Care Facilities are subject to the stop-loss provisions specified in Section 3.13 of this Agreement. Rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider. Outpatient visits for physical, occupational and speech therapy are limited to twenty (20) visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.

c) For Family Health Plus only: Outpatient visits for physical and occupational therapy are limited to twenty (20) visits each per calendar year. Coverage for speech therapy services is limited to those required for a condition amenable to significant clinical improvement within a two month period. Outpatient visits for speech therapy are also limited to twenty (20) visits each per calendar year.

d) For both Medicaid Managed Care and Family Health Plus, cardiac rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider, and rendered in physician offices, Article 28 hospital outpatient departments, freestanding diagnostic and treatment centers, and Federally Qualified Health Centers.

13. Early Periodic Screening Diagnosis and Treatment (EPSDT) Services Through the Child Teen Health Program (C/THP) and Adolescent Preventive Services
18 NYCRR § 508.8

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

14. Home Health Services
18 NYCRR § 505.23(a)(3)

a) Home health care services are provided to Enrollees in their homes by a home health agency certified under Article 36 of the PHL (Certified Home Health Agency - CHHA). Home health services mean the following services when prescribed by a Provider and provided to a Enrollee in his or her home:

   i) nursing services provided on a part-time or intermittent basis by a CHHA or, if there is no CHHA that services the county/district, by a registered professional nurse or a licensed practical nurse acting under the direction of the Enrollee's PCP;

   ii) physical therapy, occupational therapy, or speech pathology and audiology services; and

   iii) home health services provided by a person who meets the training requirements of the SDOH, is assigned by a registered professional nurse to provide home health aid services in accordance with the Enrollee's plan of care, and is supervised by a registered professional nurse from a CHHA or if the Contractor has no CHHA available, a registered nurse, or therapist.

b) Personal care tasks performed by a home health aide incidental to a certified home health care agency visit, and pursuant to an established care plan, are covered.

c) Services include care rendered directly to the Enrollee and instructions to his/her family or caretaker such as teacher or day care provider in the procedures necessary for the Enrollee's treatment or maintenance.

d) The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment,

counseling, referral, instructions or clinical monitoring. Criteria for medical necessity are as follows:

i) High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or

ii) Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or

iii) Woman otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or

iv) Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance abuse, unsafe housing and nutritional risk.

Home health service visits may be provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician.

All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above.

The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records:

i) A comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit;

ii) Timely notification to treating providers and case manager concerning significant changes in the woman or infant's condition;

iii) Referral and coordination with appropriate health, mental health and social services and other providers;

iv) Review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and

v) An appropriate discharge plan.

e) For Medicaid Managed Care only, home telehealth services are covered, pursuant to Section 3614.3-c. of the Public Health Law, when provided by agencies approved by the SDOH for Enrollees who have conditions or clinical circumstances requiring frequent monitoring and when the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admission. To be eligible for reimbursement, approved agencies must obtain any necessary prior approvals and services must be deemed medically necessary by the Contractor. Approved agencies must assess the Enrollee in person, prior to providing telehealth services, using a SDOH approved patient risk assessment tool.

f) For Family Health Plus only: coverage is limited to forty (40) home health care visits per calendar year in lieu of a skilled nursing facility stay or hospitalization, plus two post partum home visits for high risk mothers. For the purposes of this Section, visit is defined as the delivery of a discreet service (e.g. nursing, OT, PT, ST, audiology or home health aide). Four (4) hours of home health aide services equals one visit.

15. Private Duty Nursing Services – For MMC Program Only

a) Private duty nursing services shall be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services must be provided in the MMC Enrollee's home. Enrollees authorized to receive private duty nursing services in the home may also use approved hours outside the home when the Enrollee's normal life activities take him or her outside of the home. Private duty nursing services can be provided through a licensed home care agency or a private Practitioner. For a child, full time private duty nursing is also covered in a school, an approved pre-school, or a natural environment, including home and community settings, where such child would otherwise be found, pursuant to an Individualized Education Program under the School Supportive Health Services Program or an Individualized Family Services Plan under the Early Intervention Program.

b) Private duty nursing services are covered only when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and must be provided in an Enrollee's home in accordance with the ordering physician's or certified nurse practitioner's written treatment plan.

16. Hospice Services

a) Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. Hospice provides four levels of care: 1) routine home care, 2) respite care, 3) continuous care, and 4) general inpatient care. The program is available to persons with a medical prognosis of six months or less to live for FHPlus or one (1) year or less to live for MMC, if the terminal illness runs its normal course.

b) Hospice services are provided following an interdisciplinary model, and include palliative and supportive care provided to an Enrollee to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement.

c) The Hospice provider all-inclusive per diem reimbursement rate includes all services, durable medical equipment and medicine related to the hospice diagnosis.

d) For children under age 21 who are receiving Hospice services, medically necessary curative services are covered, in addition to palliative care.

e) Hospice services are provided consistent with licensure requirements, and State and Federal regulations. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by state and federal requirements. All services must be provided pursuant to a written plan of care which reflects the changing needs of the Enrollee and the Enrollee's family.

f) The Contractor's Enrollees must receive hospice services through Participating Providers.

g) Medicaid recipients in receipt of Hospice services prior to October 1, 2013, regardless of enrollment status, shall remain covered under the fee for service (FFS) Medicaid Program (per diem reimbursement) for the duration of the approved Hospice services.

h) The Contractor shall be responsible for Hospice services provided to MMC Enrollees new to Hospice care on and after October 1, 2013.

17. Emergency Services

a) Emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person are covered. Emergency services include health care procedures, treatments or services, needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs and/or alcohol. Emergency Services also include hospital emergency room observation services provide in a SDOH approved hospital emergency room observation unit that meets New York State regulatory operating standards and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Use Disorder, provided in accordance with protocols issued by the SDOH, when rendered in emergency departments. See also Appendix G of this Agreement.

b) Post Stabilization Care Services means services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition. These services are covered pursuant to Appendix G of this Agreement.

18. Foot Care Services

a) Covered services must include routine foot care provided by qualified provider types when any Enrollee's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.

b) Services provided by a podiatrist for persons under twenty-one (21) must be covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife. Services provided by a podiatrist for adults with diabetes mellitus are covered.

c) Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

19. Eye Care and Low Vision Services
18 NYCRR §505.6(b)(1-3)
SSL §369-ee (1)(e)(xii)

a) For Medicaid Managed Care only:

i) Emergency, preventive and routine eye care services are covered. Eye care includes the services of ophthalmologists, optometrists and ophthalmic dispensers, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses must duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

ii) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line

bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

iii) Examinations for diagnosis and treatment for visual defects and/or eye disease are provided only as necessary and as required by the Enrollee's particular condition. Examinations which include refraction are limited to once every twenty four (24) months unless otherwise justified as medically necessary.

iv) Eyeglasses do not require changing more frequently than once every twenty four (24) months unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.

v) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

vi) MMC Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty four (24) months, or if otherwise justified as medically necessary or if eyeglasses are lost, damaged or destroyed as described above. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.

vii) As described in Sections 10.15 and 10.28 of this Agreement, Enrollees may self-refer to Article 28 clinics affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.

b) For Family Health Plus only:

i) Covered Services include emergency vision care and the following preventive and routine vision care provided once in any twenty four (24) month period:

A) one eye examination;

B) either: one pair of prescription eyeglass lenses and a frame, or prescription contact lenses when medically necessary; and

C) one pair of medically necessary occupational eyeglasses.

ii) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

iii) FHPlus Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty-four (24) months. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.

iv) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

v) Contact lenses are covered only when medically necessary. Contact lenses shall not be covered solely because the FHPlus Enrollee selects contact lenses in lieu of receiving eyeglasses.

vi) Coverage does not include the replacement of lost, damaged or destroyed eyeglasses.

vii) The occupational vision benefit for FHPlus Enrollees covers the cost of job-related eyeglasses if that need is determined by a Participating Provider through special testing done in conjunction with a regular vision examination. Such examination shall determine whether a special pair of eyeglasses would improve the performance of job-related activities. Occupational eyeglasses can be provided in addition to regular glasses but are available only in conjunction with a regular vision benefit once in any twenty-four (24) month period. FHPlus Enrollees may purchase an upgraded frame or lenses for occupational eyeglasses by paying the entire cost of the frame or lenses as a private customer (See Section 19. b) iv) above). Sun-sensitive and polarized lens options are not available for occupational eyeglasses.

20. Durable Medical Equipment (DME)

18 NYCRR §505.5(a)(1) and Section 4.4 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

a) Durable Medical Equipment (DME) are devices and equipment, other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances, and have the following characteristics:

i) can withstand repeated use for a protracted period of time;

ii) are primarily and customarily used for medical purposes;

iii) are generally not useful to a person in the absence of illness or injury; and

iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one (1) person, it may be either custom made or customized.

b) Coverage includes equipment servicing but excludes disposable medical supplies.

21. Audiology, Hearing Aid Services and Products

18 NYCRR §505.31 (a)(1)(2) and Section 4.7 of the NYS Medicaid Hearing Aid Provider Manual

a) Hearing aid services and products are provided in compliance with Article 37-A of the General Business Law when medically necessary to alleviate disability caused by the loss or impairment of hearing. Hearing aid services include: selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluation, and hearing aid repairs.

b) Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.

c) Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts.

d) Hearing aid batteries

Hearing aid batteries are covered by the Contractor for all Enrollees as part of the prescription drug benefit.

22. Family Planning and Reproductive Health Care

a) Family Planning and Reproductive Health Care services means the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy, as specified in Appendix C of this Agreement.

b) HIV counseling and testing is included in coverage when provided as part of a Family Planning and Reproductive Health visit.

c) All medically necessary abortions are covered, as specified in Appendix C of this Agreement.

d) Fertility services are not covered.

e) If the Contractor excludes Family Planning and Reproductive Health services from its Benefit Package, as specified in Appendix M of this Agreement, the Contractor is required to comply with the requirements of Appendix C.3 of this Agreement and still provide the following services:

i) screening, related diagnosis, ambulatory treatment, and referral to Participating Provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormality/pathology;

ii) screening, related diagnosis, and referral to Participating Provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.

23. Non-Emergency Transportation

a) Transportation expenses are covered for MMC Enrollees when transportation is essential in order for a MMC Enrollee to obtain necessary medical care and services which are covered under the Medicaid program (either as part of the Contractor's Benefit Package or by Medicaid fee-for-service). The non-emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.

b) Transportation services means transportation by ambulance, ambulette (invalid coach), fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the MMC Enrollee's medical condition; and a transportation attendant to accompany the MMC Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the MMC Enrollee's family.

c) The Contractor is required to use only approved Medicaid ambulette vendors to provide transportation services to MMC Enrollees.

d) When the Contractor is capitated for non-emergency transportation, the Contractor is also responsible for providing transportation to Medicaid covered services that are not part of the Contractor's Benefit Package.

e) Non-emergency transportation is covered for FHPlus Enrollees that are nineteen (19) or twenty (20) years old and are receiving C/THP services. Subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

f) For MMC Enrollees with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.

g) For MMC plans that cover non-emergency transportation only, subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

24. Emergency Transportation

a) Emergency transportation can only be provided by an ambulance service including air ambulance service. Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an Enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of Emergency Services while the Enrollee is being transported.

b) Emergency Services means the health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.

c) Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency. Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed. When the Contractor is capitated for this benefit, emergency transportation via 911 or any other emergency call system is a covered benefit and the Contractor is responsible for payment. Contractor shall reimburse the transportation provider for all emergency ambulance services without regard for final diagnosis or prudent layperson standard.

d) The emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.

e) For MMC plans that cover emergency transportation only, according to a county-by-county phase in schedule to be determined by SDOH, and concomitantly with the assumption of the MMC non-emergency benefit by a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be removed from the Contractor's benefit package. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

25. Dental and Orthodontic Services

a) Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability.

b) For Medicaid Managed Care only:

i) As described in Sections 10.15 and 10.27 of this Agreement, Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services.

ii) The dental benefit includes up to four annual fluoride varnish treatments for children from birth until age 7 years when applied by a dentist, physician or nurse practitioner.

c) Orthodontia (for Medicaid Managed Care only)

i) Effective October 1, 2012, orthodontia is a plan-covered benefit, consistent with 18 NYCRR 506.4, for Enrollees:

A) under twenty-one (21) years of age for up to three years of active orthodontic care, plus one year of retention care, to treat a severe physically handicapping malocclusion. Part of such care could be provided after the Enrollee reaches the age of 21, provided that the treatment was approved and active therapy began prior to the Enrollee's 21st birthday.

B) 21 years and over in connection with necessary surgical treatment (e.g. approved orthognathic surgery, reconstructive surgery or cleft palate treatment).

ii) Effective October 1, 2012, for cases prior approved by the Contractor, orthodontic services are covered by the Contractor. The Contractor will be responsible for prior approval of all such cases, monitoring treatment progress and quality of care, and reimbursing orthodontists for services provided to Enrollees whose treatment was prior approved by the Contractor. The Contractor must use the same guidelines for approval of orthodontic services that are used by the Medicaid fee-for-service program.

iii) The Contractor's provider network must include a sufficient array of orthodontic providers. The Contractor will assist Enrollees in identifying participating orthodontia providers.

iv) Transitional Care: When an Enrollee changes MCOs after orthodontic appliances are in place and active treatment has begun, transitional care policies will apply if the orthodontist is not a Participating Provider in the provider network of the Enrollee's new MCO. Under the transitional care policy, the Contractor must permit a new Enrollee to continue an ongoing course of treatment with an out-of-network orthodontist during a transitional period of up to sixty (60) days. If the out-of-network orthodontist wishes to continue treating the Enrollee during the transition period, the orthodontist must agree to accept the new MCO's reimbursement as payment in full and adhere to that MCO's policies and

procedures. The Enrollee must be transferred to an orthodontist in the new MCO's provider network by the end of the transitional care period.

d) Effective July 1, 2014, dental practitioners can provide smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner within any calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

26. Court Ordered Services

Court ordered services are those services ordered by a court of competent jurisdiction which are performed by or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including treatment for mental health and/or alcohol and/or substance abuse or dependence), or other covered services. The Contractor is responsible for payment of those services included in the benefit package.

27. LDSS Mandated Services

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. LDSS Mandated services are those services mandated by an Enrollees local department of social services after a determination that such Enrollee has a mental, SUD or physical impairment that limits his/her ability to engage in work. Such services are performed by or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including treatment for mental health and/or alcohol and/or substance abuse or dependence), or other covered services. The Contractor is responsible for payment of mandated services included in the benefit package.

28. Prosthetic/Orthotic Orthopedic Footwear

Section 4.5, 4.6 and 4.7 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

a) Prosthetics are those appliances or devices which replace or perform the function of any missing part of the body. Artificial eyes are covered as part of the eye care benefit.

b) Orthotics are those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.

c) Medicaid Managed Care: Orthopedic Footwear means shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.

29. Mental Health Services

a) Inpatient Services

All inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the PHL. Inpatient mental health services also includes treatment in a Comprehensive Psychiatric Emergency Program (CPEP) licensed pursuant to Article 31 of the MHL, including Extended Observation Beds in a CPEP.

b) Outpatient Services

Outpatient services including but not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, education, symptom management, case management services, crisis intervention and outreach services, clozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). Services may be provided in-home, office or the community. Services may be provided by licensed OMH providers or by other providers of mental health services including clinical psychologists and physicians.

The Contractor must make available in an accessible manner all services required by OMH regulations 14 NYCRR Part 599. When contracting with mental health clinics licensed under Article 31 of the Mental Hygiene Law, the Contractor is required to contract for each Part 599 service at every clinic with which it has a contract.

c) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.

d) Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. A time limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR Part 587.

e) Day Treatment

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. A combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Services are expected to be of six (6) months duration. These services are certified by OMH under 14 NYCRR Part 587.

f) Continuing Day Treatment

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self- esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. These services are certified by OMH under 14 NYCRR Part 587.

g) Case Management

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. The target population consists of individuals who suffer from serious mental illness, require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system. Three case management models are currently operated pursuant to an agreement with OMH or a local governmental unit, and receive Medicaid reimbursement pursuant to 14 NYCRR Part 506.

h) Partial Hospitalization

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention. These services are certified by OMH under 14 NYCRR Part 587.

i) Assertive Community Treatment (ACT)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting. ACT programs deliver integrated services to recipients and adjust services over time to meet the recipient's goals and changing needs; are operated pursuant to approval or certification by OMH; and receive Medicaid reimbursement pursuant to 14 NYCRR Part 508.

j) Personalized Recovery Oriented Services (PROS)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. PROS, licensed and reimbursed pursuant to 14

NYCRR Part 512, are designed to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. Specific components of PROS include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation and Support and Clinical Treatment.

k) Community Mental Health/Licensed Behavioral Health Practitioner Waiver Services:

i) The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Community Mental Health/Licensed Behavioral Health Practitioner Waiver Services are community-based mental health services provided pursuant to the New York State Section 1115 Behavioral health Partnership Plan Waiver Amendment by otherwise eligible Medicaid mental health providers, including licensed behavioral health practitioners (LBHP). A LBHP is an individual who is licensed in the State of New York to prescribe, diagnose and/or treat individuals with mental illness or substance abuse operating within the scope of practice defined in State law and in any setting permissible under State practice law. A LBHP includes individuals licensed as a:

1) Licensed Psychiatrist or Advanced Nurse Practitioner;

2) Licensed Psychologist;

3) Licensed Psychoanalyst;

4) Licensed Social worker (LMSW or LCSW);

5) Licensed Marriage & Family Therapist, or

6) Licensed Mental Health Counselor.

ii) Any practitioner providing behavioral health services must operate within an agency licensed by New York State. Licensed LMSW, LCSW, PsyD, Phd and MDs may supervise unlicensed professionals in licensed agencies who have at least Bachelor's level such as a Registered Nurse or a peer with state training and certification.

iii) In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health, state law and OASAS regulations at 14 NYCRR § 853.2.

iv) The Contractor shall reimburse providers for such services at no less than the State-provided rate schedule.

30. SUD Inpatient Detoxification Services

a) Medically Managed Inpatient Detoxification

These programs provide medically directed twenty-four (24) hour care on an inpatient basis to individuals who are at risk of severe alcohol or substance abuse withdrawal, incapacitated, a risk to self or others, or diagnosed with an acute physical or mental co-morbidity. Specific services include, but are not limited to: medical management, bio-psychosocial assessments, stabilization of medical psychiatric / psychological problems, individual and group counseling, level of care determinations and referral and linkages to other services as necessary. Medically Managed Detoxification Services are provided by facilities licensed by OASAS under Title 14 NYCRR § 816.6 and the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

b) Medically Supervised Inpatient Withdrawal

These programs offer treatment for moderate withdrawal on an inpatient basis. Services must include medical supervision and direction under the care of a physician in the treatment for moderate withdrawal. Specific services must include, but are not limited to: medical assessment within twenty four (24) hours of admission; medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling and linkages to other services as necessary. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Inpatient Withdrawal services are provided by facilities licensed under Title 14 NYCRR § 816.7.

31. SUD Inpatient Rehabilitation and Treatment Services

a) Services provided include intensive management of chemical dependence symptoms and medical management of physical or mental complications from chemical dependence to clients who cannot be effectively served on an outpatient basis and who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free–standing facility. Specific services can include, but are not limited to: comprehensive admission evaluation and treatment planning; individual group, and family counseling; awareness and relapse prevention; education about self-help groups; assessment and referral services; vocational and educational assessment; medical and psychiatric consultation; food and housing; and HIV and AIDS education. These services may be provided by facilities licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to provide Chemical Dependence Inpatient Rehabilitation and Treatment Services under Title 14 NYCRR Part 818. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized.

b) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.

32. SUD Residential Addiction Services

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Residential addiction services include individual centered residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help individuals achieve changes in their substance use disorder behaviors. Services also address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. These programs are certified under 14 NYCRR Part 820.

33. SUD Outpatient Services

a) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 to deliver service to individuals who suffer from chemical abuse or dependence and/or their family members or significant others. Such services may be provided at the certified site or in the community include and provide chemical dependence outpatient treatment (including intensive outpatient services) and continuing care treatment.

b) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide outpatient rehabilitation services for individuals with more chronic SUD conditions and emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. The individual must have an adequate support system and either substantial deficits in interpersonal and functional skills or health care needs requiring attention or monitoring by health care staff. These services are provided in combination with all other clinical services provided by CD-OPs. Programs are certified by OASAS as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR § 822.

c) Outpatient Chemical Dependence for Youth Programs

Outpatient Chemical Dependence for Youth Programs (OCDY) licensed under Title 14 NYCRR Part 823, establishes programs and service regulations for OCDY programs. OCDY programs offer discrete, ambulatory clinic services to chemically-dependent youth in a treatment setting that supports abstinence from chemical dependence (including alcohol and substance abuse) services.

d) Opioid Treatment Program (OTP)

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Opioid Treatment Program (OTP) means one or more OASAS certified sites where methadone or other approved medications are administered to treat opioid dependency, following one or more medical treatment protocols as defined by 14 NYCRR Part 822. OTPs may provide patients with any or all of the following: Opioid detoxification; Opioid medical maintenance; and Opioid taper. The term "OTP" encompasses medical and support services at the certified site or in the community including counseling, educational and vocational rehabilitation. OTP also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 1301. Facilities that provide opioid treatment do so as their principal mission and are certified by OASAS under 14 NYCRR Part 822.

e) Buprenorphine and Buprenorphine Management:

i) Management of buprenorphine in all settings certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 for maintenance or detoxification of patients with Substance Use Disorders.

ii) FHPlus only: Management of buprenorphine in settings other than outpatient clinics and opioid treatment programs certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 by Primary Care Providers and Mental Health Providers for maintenance or detoxification of patients with chemical dependence. Buprenorphine is a covered benefit except when furnished and administered as part of a Part 822 outpatient clinic or opioid treatment program visit. Buprenorphine management services provided by Mental Health Providers, or in a Part 822 outpatient clinic or opioid treatment program, are subject to the combined mental health/chemical dependency benefit limit of sixty (60) outpatient visits per calendar year.

34. SUD Medically Supervised Outpatient Withdrawal

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. These programs offer treatment for moderate withdrawal on an outpatient basis. Required services include, but are not limited to: medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling; level of care determinations; discharge planning; and referrals to appropriate services. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Outpatient Withdrawal services are provided by facilities licensed under 14 NYCRR §816.7.

35. Buprenorphine Prescribers

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Management and/or Prescription of buprenorphine by Primary Care Providers and Mental Health Providers for maintenance or detoxification of patients with Substance Use Disorder.

36. Experimental or Investigational Treatment

a) Experimental and investigational treatment is covered on a case by case basis.

b) Experimental or investigational treatment for life-threatening and/or disabling illnesses may also be considered for coverage under the external appeal process pursuant to the requirements of Section 4910 of the PHL under the following conditions:

i) The Enrollee has had coverage of a health care service denied on the basis that such service is experimental and investigational, and

ii) The Enrollee's attending physician has certified that the Enrollee has a life-threatening or disabling condition or disease:

A) for which standard health services or procedures have been ineffective or would be medically inappropriate, or

B) for which there does not exist a more beneficial standard health service or procedure covered by the Contractor, or

C) for which there exists a clinical trial, and

iii) The Enrollee's provider, who must be a licensed, board-certified or board-eligible physician, qualified to practice in the area of practice appropriate to treat the Enrollee's life-threatening or disabling condition or disease, must have recommended either:

A) a health service or procedure that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the Enrollee than any covered standard health service or procedure; or

B) a clinical trial for which the Enrollee is eligible; and

iv) The specific health service or procedure recommended by the attending physician would otherwise be covered except for the Contractor's determination that the health service or procedure is experimental or investigational.

37. Renal Dialysis

Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.

38. Nursing Home Services – [Not Applicable to the HARP Program]

a) Nursing Home Services means inpatient nursing home services provided by facilities licensed under Article 28 of the New York State Public Health Law, including AIDS nursing facilities. Covered services includes the following health care services: medical supervision, twenty-four (24) hour per day nursing care, assistance with the activities of daily living, physical therapy, occupational therapy, and speech/language pathology services and other services as specified in the New York State Health Law and Regulations for residential health care facilities and AIDS nursing facilities. These services should be provided to an MMC Enrollee:

   i) Who is diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the MMC Enrollee to be so incapacitated, sick, invalid, infirm, disabled, or convalescent as to require at least medical and nursing care; and

   ii) Whose assessed health care needs, in the professional judgment of the MMC Enrollee's physician or a medical team:

      A) do not require care or active treatment of the MMC Enrollee in a general or special hospital;

      B) cannot be met satisfactorily in the MMC Enrollee's own home or home substitute through provision of such home health services, including medical and other health and health-related services as are available in or near his or her community; and

      C) cannot be met satisfactorily in the physician's office, a hospital clinic, or other ambulatory care setting because of the unavailability of medical or other health and health-related services for the MMC Enrollee in such setting in or near his or her community.

b) The Contractor is also responsible for respite days and bed hold days authorized by the Contractor.

c) The Contractor is responsible for all medically necessary and clinically appropriate inpatient nursing home services authorized by the Contractor for MMC Enrollees age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay.

39. Personal Care Services (MMC only)

a) Personal care services (PCS), as defined by 18 NYCRR §505.14(a) and as further described in the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care," are the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in his or her own home. The service must be ordered

by a physician or nurse practitioner, and there must be a medical need for the service. Enrollees receiving PCS must have a stable medical condition that is not expected to exhibit sudden deterioration or improvement; does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; is such that a physically disabled individual in need of routine supportive assistance does not need skilled professional care in the home; or the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. Enrollees receiving PCS must be self-directing, which shall mean that the Enrollee is capable of making choices about his or her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choices. Enrollees who are non self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive PCS, except under the following conditions:

i) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household;

ii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

iii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The LDSS may be the outside agency.

b) Personal care services are authorized as Level I (environmental and nutritional functions) or Level II (personal care, environmental and nutritional functions) with specific number of hours per day and days per week the PCS are to be provided. Authorization for solely Level I services may not exceed eight (8) hours per week.

40. Personal Emergency Response System (PERS)

a) Personal Emergency Response System (PERS) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.

b) Assessment of need for PERS services must be made in accordance with and in coordination with authorization procedures for home care services, including personal care services. Authorization for PERS services is based on a physician or nurse practitioner's order and a comprehensive assessment which must include an evaluation of the client's physical disability status, the degree that they would be at

risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation. PERS is not provided in the absence of personal care or home care services. Authorization of PERS is not a substitute for or in lieu of assistance with PCS tasks such as transferring, toileting or walking.

c) The Contractor will be responsible for authorizing and arranging for PERS services through network providers, as described in this Appendix and the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care."

41. Consumer Directed Personal Assistance Services (MMC Program Only)

a) Consumer Directed Personal Assistance Services (CDPAS), as defined by 18 NYCRR §§505.28(a) and (b), means the provision to a chronically ill and/or disabled Consumer of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a Consumer or the Consumer's designated representative. A Consumer must acknowledge in writing that they are willing and able to fulfill their responsibilities as provided by 10 NYCRR §505.28(g)(1)-(7).

b) For the MMC program, these terms shall have the following meanings:

   i) "Consumer" means an Enrollee who the Contractor has determined to be eligible to receive CDPAS, pursuant to a nursing and social assessment process consistent with 18 NYCRR §§505.28(c) and (d).

   ii) "Fiscal Intermediary" means an entity that has an agreement with the Contractor to provide wage and benefit processing for consumer directed personal assistants and other Fiscal Intermediary responsibilities as provided by 18 NYCRR 505.28 (i)(1)(i)-(v), (vii).

42. Observation Services

Observation Services in an Article 28 hospital are post-stabilization services covered by the Contractor for observation, short-term treatment, assessment and re-assessment of an Enrollee for whom diagnosis and a determination concerning inpatient admission, discharge, or transfer cannot be accomplished within eight hours but can reasonably be expected within forty-eight (48) hours. Observation services may be provided in distinct units approved by the Department, inpatient beds, or in the emergency department ONLY for hospitals designated as critical access hospitals or sole community hospitals. An Enrollee shall be assigned to the observation service through a hospital Emergency Department by order of a physician, nurse practitioner, or other medical professional within his/her scope of practice. Observation services may be subject to prior approval and/or notification requirements, as well as retrospective review procedures, established by the Contractor. The Enrollee must be admitted to the inpatient service, transferred to another hospital, or discharged to self-care or the care of a physician or other appropriate follow-up service within forty-eight (48) hours of assignment to the observation unit. Notwithstanding the requirements of this section, the Contractor shall provide the Observation Services benefit consistent with regulations at 10 NYCRR Part 405.32.

43. Medical Social Services

a) Medical Social Services are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Medical Social Services while in the LTHHCP. Medical Social Services is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to, home visits to the individual, family or both; visits preparatory to the transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services.

b) Medical Social Services must be provided by a qualified social worker licensed by the Education Department to practice social work in the State of New York.

44. Home Delivered Meals

Home Delivered Meals are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Home Delivered Meals while in the LTHHCP. Home Delivered Meals must be provided when the Enrollee's needs cannot be met by existing support services, including family and approved personal care aides. The Home Delivered Meals benefit includes up to two meals per day on week days and/or weekends.

45. Adult Day Health Care

a) Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the Adult Day Health Care program in accordance with a comprehensive assessment of care needs and the PCSP, ongoing implementation and coordination of the PCSP, and transportation.

b) Registrant means a person who is a nonresident of the Residential Health Care Facility who is functionally impaired and not homebound and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided by a general hospital, or Residential Health Care Facility; and whose assessed social and health care needs, in the professional judgment of the physician of record, nursing staff, Social Services and other professional personnel of the Adult Day Health Care program can be met in whole or in part satisfactorily by delivery of appropriate services in such program.

46. AIDS Adult Day Health Care

AIDS Adult Day Health Care Programs (AIDS ADHCP) are programs designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services. Registrants in AIDS ADHCP require a greater range of comprehensive health care services than can be provided in any single setting, but do not require the level of services provided in a residential health care setting. Regulations require that a person enrolled in an AIDS ADHCP must require at least three (3) hours of health care delivered on the basis of at least one (1) visit per week. While health care services are broadly defined in this setting to include general medical care, nursing care, medication management, nutritional services, rehabilitative services, and substance abuse and mental health services, the latter two (2) cannot be the sole reason for admission to the program. Admission criteria must include, at a minimum, the need for general medical care and nursing services.

47. Directly Observed Therapy (DOT) of Tuberculosis Disease

Tuberculosis Directly Observed Therapy (TB/DOT) is the direct observation of oral ingestion, or the administration of injectable/infused medication, to assure patient compliance with the physician's prescribed medication regimen. DOT is the standard of care for every individual with active TB. Clinical management of TB, including TB/DOT and all TB medications, is included in the benefit package.

48. Crisis Intervention Services

The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Crisis Intervention Services are provided to an Enrollee who is experiencing or is at imminent risk of having a psychiatric crisis. Such services are designed to interrupt and/or ameliorate a crisis, and include preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the Enrollee as connected as possible with the person's environment and activities. The goals of Crisis Intervention Services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

49. Psychosocial Rehabilitation (PSR) [Applicable to HARP and HIV SNP Programs Only]

Psychosocial Rehabilitation (PSR) is a face-to-face intervention designed to assist the Enrollee with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with a behavioral health condition. PSR may be provided in any setting best suited for desired outcomes and may include rehabilitation counseling, recovery activities, interventions and support with skills necessary for the individual to improve self-management of and reduce relapse to substance use or the negative effects of psychiatric or emotional symptoms. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

50. Community Psychiatric Support and Treatment (CPST) – [Applicable to HARP and HIV SNP Programs]

Community Psychiatric Support and Treatment (CPST) is a face-to-face intervention with the Enrollee, family or other collaterals designed to help Enrollees with serious mental illness achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST includes time-limited goal-**directed supports** and solution-focused interventions intended to achieve identified person-centered goals or objectives. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

51. Habilitation Services– [Applicable to HARP and HIV SNP Programs Only]

Habilitation Services are typically provided on a 1:1 basis and are designed to assist Enrollees with a behavioral health diagnosis in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist Enrollees with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable Enrollees to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the Enrollee.

52. Family Support and Training– [Applicable to HARP and HIV SNP Programs Only]

Family Support and Training is available only at the request of the Enrollee. Family Support and Training is designed to facilitate engagement and active participation of the Enrollee's family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Family Support and Training involves partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder or mental illness. For purposes of this service, "family" is defined as the persons who live with or provide care to an Enrollee served and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the Enrollee.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual

Recovery **Plan and** shall include updates, as necessary, to safely maintain the Enrollee at home and in the community.

53. Short-Term Crisis Respite– [Applicable to HARP and HIV SNP Programs Only]

Short-term Crisis Respite is a short-term, site-based care and intervention strategy for Enrollees who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports. Components offered may include peer support, either on-site or as a wrap-around service during the respite stay, health and wellness coaching, WRAP (Wellness Recovery Action Plan) planning, wellness activities, family support, conflict resolution, and other services as needed.

Referrals to Short-Term Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

54. Intensive Crisis Respite–[Applicable to HARP and HIV SNP Programs Only]

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms and cannot be managed in a short-term crisis respite. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

55. Education Support Services– [Applicable to HARP and HIV SNP Programs Only]

Education Support Services are provided to assist Enrollees with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 codified at 20 U.S.C. § 1401 et seq. to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career & Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the Enrollee to participate in an apprenticeship program. Ongoing Supported Education is conducted after a participant is successfully admitted to an educational program. Ongoing follow-

along is support available for an indefinite period as needed by the Enrollee to maintain their status as a registered student.

56. Peer Supports– [Applicable to HARP and HIV SNP Programs Only]

Peer Support services are peer-delivered rehabilitation and recovery services designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer supports may be provided in a variety of settings, including inpatient, outpatient, community, and respite programs. Peer support providers must be certified as either an OMH-established Certified Peer Specialist or a OASAS-established Peer Advocate. Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from behavioral health issues. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

57. Pre-Vocational Services– [Applicable to HARP and HIV SNP Programs Only]

Pre-vocational services are time-limited, face-to-face services that prepare an Enrollee for participation in competitive employment. The services provide learning and work experiences in order to develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environments or a self-employment arrangement. Service components include teaching concepts such as work compliance, attendance, task completion, problem solving, safety, and, if applicable, how to identify obstacles to or accommodations needed for employment, how to obtain paperwork necessary for employment applications and interpersonal skills. Services may also include providing scheduled activities outside of an individual's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, socialization, daily living skills, communication, community living, social and cognitive skills, including opening and maintaining a bank account.

Pre-vocational services may only be provided by State-designated HCBS providers. Pre-vocational Services may be provided at the program site, in the community or at a work location where the individual may acquire work-related experience.

58. Transitional Employment– [Applicable to HARP and HIV SNP Programs Only]

Transitional Employment is a time-limited, face to face intervention designed to strengthen the Enrollee's work record and work skills toward the goal of achieving assisted or unassisted competitive employment. Transitional Employment provides Enrollees with on-the-job training in an integrated employment setting in order to develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environments. This service is provided instead of Intensive Supported Employment and only when the Enrollee specifically chooses this service.

Transitional Employment Services may only be provided by State-designated HCBS providers. Settings where this service may be provided include State-designated Clubhouses, psychosocial clubs and OASAS Recovery Centers.

59. Intensive Supported Employment– [Applicable to HARP and HIV SNP Programs Only]

Intensive Supported Employment services are individualized, person-centered services providing supports to Enrollees in order to obtain and/or maintain competitive employment or self-employment. Intensive Supported Employment services provide job placement, systematic job development, job coaching, negotiation with prospective employers, including regarding appropriate behavioral health accommodations, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by a supported individual), benefits counseling support, training and planning transportation navigation, asset development, career advancement services, and other workforce support services such as Employee Assistance Program services.

Intensive Supported Employment may only be provided by State-designated HCBS providers, including providers designated for Individualized Employment Support services. This service may be provided in any community location, including the program site or the workplace.

60. Ongoing Supported Employment– [Applicable to HARP and HIV SNP Programs Only]

Ongoing Supported Employment services are provided to Enrollees who have successfully obtained and are oriented to competitive and integrated employment. The services include assistance identifying reasonable accommodations necessary to manage mental health symptoms that may emerge after obtaining employment, assistance in establishing positive workplace relationships, interactions with supervisors and co-workers. Support services also include job retention training and ongoing follow-along support as needed by the Enrollee to maintain their paid position.

Ongoing Supported Employment may only be provided by State-designated HCBS providers and may be provided in any community location, including the program site or the workplace.

61. Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program – Applicable to the HARP and HIV SNP Program Only

The HARP Benefit package includes enhanced services that are essential for promoting wellness and recovery. HARP Care Coordination includes arranging for the provision of Behavioral Health Home and Community Based Services through ensuring eligible Enrollees receive appropriate assessments, developing and approving plans of care, and providing comprehensive care management services through State-designated Health Homes or other entities, pursuant to Section 10.41 of this Agreement.

62. HIV SNP Enhanced Services - Applicable to HIV SNP Program Only

The HIV SNP Benefit package includes enhanced services that are essential for promoting wellness and preventing illness. HIV SNP Enhanced Services include the following:

a) HIV SNP Care and Benefits Coordination Services

HIV SNP Care and Benefits Coordination Services include medical case management/care coordination services in consultation with the PCP; assessment and service plan development that identifies and addresses the Enrollee's medical and psychosocial needs; service utilization monitoring and care advocacy services that promote Enrollee access to needed care and services; case manager provider participation in quality assurance and quality improvement activities.

b) HIV Treatment Adherence Services

HIV treatment adherence services include treatment education policies and programs to promote adherence to prescribed treatment regimens for all Enrollees, facilitate access to treatment adherence services including treatment readiness and supportive services integrated into the continuum of HIV care services, and the development of a structural network among providers that facilitates the coordination of treatment adherence services as well as promotes, reinforces and supports adherence services for Enrollees while ensuring collaboration between the provider and Enrollee. Treatment adherence services include development and regular reassessment of an individualized treatment adherence plan for each Enrollee consistent with guidelines as developed by the AIDS Institute and assessment of the overall health and psychosocial needs of the Enrollee in order to identify potential barriers that may impact upon the level of adherence and the overall treatment plan.

c) HIV Primary and Secondary Prevention and Risk-Reduction Services

HIV primary and secondary prevention and risk-reduction services include HIV primary and secondary prevention and risk- reduction education and counseling; education and counseling regarding reduction of perinatal transmission; harm reduction education and services; education to Enrollees regarding STDs and services available for STD treatment and prevention; counseling and supportive services for partner/spousal notification (pursuant to Chapter 163 of the Laws of 1998); and HIV community education, outreach and health promotion activities.

K.3

Medicaid Managed Care Prepaid Benefit Package
Definitions of Non-Covered Services

The following services are excluded from the Contractor's Benefit Package, but are covered, in most instances, by Medicaid fee-for-service:

1. Medical Non-Covered Services

a) Nursing Home Services

Services provided in a nursing home to an Enrollee under age 21 who is determined by the LDSS to be in Long Term Placement Status are not covered for Medicaid Managed Care (MMC) or Family Health Plus Enrollees. Family Health Plus covers only non-permanent rehabilitation stays in nursing homes. Enrollees under age 21 in Long Term Placement Status in nursing home are excluded from MMC and must be disenrolled. Once disenrolled, the beneficiary will receive these services through Medicaid fee-for-service.

b) Emergency and Non-Emergency Transportation (MMC only)

According to a county-by-county phase-in schedule to be determined by SDOH, and subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be covered under Medicaid fee-for-service.

c) Orthodontic Services

i) All existing orthodontic cases that have begun treatment or have been reviewed and approved for treatment prior to October 1, 2012 through Medicaid fee-for-service and issued an eMedNY prior approval number will continue being paid through Medicaid fee-for-service until the completion of the approved course of treatment. Monitoring of such cases will be conducted by SDOH as needed.

ii) If an Enrollee loses eligibility for Medicaid services after appliances are in place and active treatment has begun, the Enrollee will be disenrolled from Medicaid managed care and will be entitled to a maximum of six (6) months of treatment reimbursed by Medicaid fee-for-service.

2. Non-Covered Behavioral Health Services

a) Mental Health Services

i) Day Treatment Programs Serving Children

Day treatment programs are characterized by a blend of mental health and special education services provided in a fully integrated program. Typically these programs include: special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, support and education, crisis intervention, interpersonal skill development, behavior modification, art and music therapy.

ii) Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children

This waiver is in select counties for children and adolescents who would otherwise be admitted to an institutional setting if waiver services were not provided. The services include individualized care coordination, respite, family support, intensive in-home skill building, and crisis response.

iii) Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)

Services provided by designated OMH clinics to children and adolescents through age eighteen (18) with a clinical diagnosis of SED are covered by Medicaid fee-for-service.

b) Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs, as follows:

i) OMH Licensed CRs*

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior defects associated with the person's mental illness.

ii) Family-Based Treatment*

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

*These services are certified by OMH under 14 NYCRR § 586.3, Part 594 and Part 595.

c) Office for People With Developmental Disabilities (OPWDD) Services

i) Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities

These services are provided to persons with developmental disabilities including medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in or move to, the least restrictive residential and/or day setting. These services are certified by OPWDD under 14 NYCRR Part 679 (or they are provided by Article 28 Diagnostic and Treatment Centers that are explicitly designated by the SDOH as serving primarily persons with developmental disabilities). If care of this nature is provided in facilities other than Article 28 or Article 16 centers, it is a covered service.

ii) Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive twenty-four (24) hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation, self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in ICF or a comparable setting. These services are certified by OPWDD under 14 NYCRR Part 690.

iii) Medicaid Service Coordination (MSC)

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OPWDD which assists persons with developmental disabilities and mental retardation to gain access to necessary services and supports appropriate to the needs of the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities and mental retardation. MSC promotes the concepts of a choice, individualized services and consumer satisfaction. MSC is provided by authorized vendors who have a contract with OPWDD, and who are paid monthly pursuant to such contract. Persons who receive MSC must not permanently reside in an ICF for persons with developmental disabilities, a developmental center, a skilled nursing facility or any other hospital or Medical Assistance institutional setting that provides service coordination. They must also not concurrently be enrolled in any other comprehensive Medicaid long term service coordination program/service including the Care at Home Waiver. Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under Item 3 “Other Non-Covered Services.”

iv) Home And Community Based Services Waivers (HCBS)

The Home and Community-Based Services Waiver serves persons with developmental disabilities who would otherwise be admitted to an ICF/MR if waiver services were not provided. HCBS waivers services include residential habilitation, day habilitation, prevocational, supported work, respite, adaptive devices, consolidated supports and services, environmental modifications, family education and training, live-in caregiver, and plan of care support services. These services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

v) Services Provided Through the Care At Home Program (OPWDD)

The OPWDD Care at Home III, Care at Home IV, and Care at Home VI waivers, serve children who would otherwise not be eligible for Medicaid because of their parents' income and resources, and who would otherwise be eligible for an ICF/MR level of care. Care at Home waiver services include service coordination, respite and assistive technologies. Care at Home waiver services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

d) Non-Medical Transportation – [Applicable to HARP and HIV SNP Programs Only]

This benefit is covered under Medicaid fee-for-service. Non-medical Transportation services are offered, in addition to any medical transportation furnished pursuant to 42 CFR 440.17(a) and incorporated in the State Plan. Non-Medical Transportation will only be available for non-routine, time-limited services, not for ongoing treatment or services and all other options for transportation, such as informal supports and community services must be explored and utilized prior to requesting waiver transportation. Non-medical Transportation services are necessary, as specified by the plan of care, to enable participants to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the Enrollee. Transportation may consist of either private or public modes of transportation.

3. Other Non-Covered Services

a) The Early Intervention Program (EIP) – Children Birth to Two (2) Years of Age

i) This program provides early intervention services to certain children, from birth through two (2) years of age, who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. All managed care providers **must** refer infants and toddlers suspected of having a delay to the local designated Early Intervention agency in their area. (In most municipalities, the County Health Department is the designated agency, except: New York City - the Department of Health and Mental Hygiene; Erie County - The Department of Youth Services; Jefferson County - the Office of Community Services; and Ulster County - the Department of Social Services).

ii) Early intervention services provided to this eligible population are categorized as Non-Covered. These services, which are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, will be identified on eMedNY by unique rate codes by which only the designated early intervention agency can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor. Consequently, the Contractor, through its Participating Providers, will be expected to refer any enrolled child suspected of having a developmental delay to the locally designated early intervention agency in their area and participate in the development of the Child's Individualized Family Services Plan (IFSP). Contractor's participation in the development of the IFSP is necessary in order to coordinate the provision of early intervention services and services covered by the Contractor.

iii) SDOH will instruct the locally designated early intervention agencies on how to identify an Enrollee and the need to contact the Contractor or the Participating Provider to coordinate service provision.

b) Preschool Supportive Health Services–Children Three (3) Through Four (4) Years of Age

i) The Preschool Supportive Health Services Program (PSHSP) enables counties and New York City to obtain Medicaid reimbursement for certain educationally related medical services provided by approved preschool special education programs for young children with disabilities. The Committee on Preschool Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related health services.

ii) PSHSP services rendered to children three (3) through four (4) years of age in conjunction with an approved IEP are categorized as Non-Covered.

iii) The PSHSP services will be identified on eMedNY by unique rate codes through which only counties and New York City can claim reimbursement. In addition, a limited number of Article 28 clinics associated with approved pre-school programs are allowed to directly bill Medicaid fee-for-service for these services. Contractor covered and authorized services will continue to be provided by the Contractor.

c) School Supportive Health Services–Children Five (5) Through Twenty-One (21) Years of Age

i) The School Supportive Health Services Program (SSHSP) enables school districts to obtain Medicaid reimbursement for certain educationally related medical services provided by approved special education programs for children with disabilities. The Committee on Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related services.

ii) SSHSP services rendered to children five (5) through twenty-one (21) years of age in conjunction with an approved IEP are categorized as Non-Covered.

iii) The SSHSP services are identified on eMedNY by unique rate codes through which only school districts can claim Medicaid reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.

d) Comprehensive Medicaid Case Management (CMCM)

A program which provides "social work" case management referral services to a targeted population (e.g.: pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but refer to a wide range of service Providers. Some of these services are: medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical providers. Consequently, if an Enrollee of the Contractor is participating in a CMCM program, the Contractor must work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care Enrollee on EMEVS and informed on the need to contact the Contractor to coordinate service provision.

e) School-Based Health Centers

A School-Based Health Center (SBHC) is an Article 28 extension clinic that is located in a school and provides students with primary and preventive physical and mental health care services, acute or first contact care, chronic care, and referral as needed. SBHC services include comprehensive physical and mental health histories and assessments, diagnosis and treatment of acute and chronic illnesses, screenings (e.g., vision, hearing, dental, nutrition, TB), routine management of chronic diseases (e.g., asthma, diabetes), health education, mental health counseling and/or referral, immunizations and physicals for working papers and sports.

f) Conversion or Reparative Therapy

Conversion Therapy is any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to

prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

K.4

Family Health Plus
Non-Covered Services

1. Non-emergency Transportation Services (except for 19 and 20 year olds receiving C/THP Services per K.2, Section 23. e) of this Appendix, in counties that have not implemented the Medicaid Managed Care transportation carve-out)
2. Personal Care Services
3. Private Duty Nursing Services
4. Long Term Care – Residential Health Care Facility Services
5. Medical Supplies
6. Alcohol and Substance Abuse (ASA) Services Ordered by the LDSS
7. Office of Mental Health/ Office for People With Developmental Disabilities
8. School Supportive Health Services
9. Comprehensive Medicaid Case Management (CMCM)
10. Directly Observed Therapy for Tuberculosis Disease
11. AIDS Adult Day Health Care
12. Home and Community Based Services Waiver
13. Opioid Treatment Program (OTP)
14. Day Treatment
15. IPRT
16. Infertility Services
17. Adult Day Health Care
18. School Based Health Care Services
19. Personal Emergency Response System
20. Consumer Directed Personal Assistance Services
21. Orthodontia