SECTION 2 - Provider Networks

2.1- Description of the Networks

VNSNY CHOICE serves the healthcare needs of its members through comprehensive provider networks for each of its various programs (Total, MLTC, and SelectHealth). While each network is separate and unique, most VNSNY CHOICE providers participate in one or more of these networks. Each network includes the clinical practitioners necessary to offer the full spectrum of covered healthcare services.

2.2- Provider Rights & Responsibilities (All Plans)

Provider Rights

VNSNY CHOICE will not discriminate against any healthcare professional acting within the scope his/her license or certification under state law regarding participation in the network, reimbursement, or indemnification solely on the basis of the practitioner's license or certification. Nor will VNSNY CHOICE discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions. Consistent with this policy, VNSNY CHOICE may differentiate among providers based on the following:

- VNSNY CHOICE may refuse to grant participation status to healthcare professionals whom VNSNY CHOICE, at its sole discretion, deems not necessary nor appropriate to provide and manage its provider network.

- VNSNY CHOICE may use different reimbursement methodologies for different clinical specialties or for different hospital affiliations.

- VNSNY CHOICE may implement measures designed to maintain quality and control costs consistent with its responsibilities.

- VNSNY CHOICE providers will be given written notice of material changes in participation rules and requirements at least 30 days before the changes are implemented. These communications will generally be circulated in special mailings.

- VNSNY CHOICE will not prohibit or otherwise restrict a healthcare professional, acting within the lawful scope of practice, from advising or advocating on behalf of a VNSNY CHOICE member regarding the following:

    - The member's health status, medical care, or treatment options, as well as any

alternative treatments that may be self-administered (This includes providing sufficient information to the individual so that there is an opportunity to decide among all relevant treatment options

- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Provider Responsibilities

VNSNY CHOICE maintains provider agreements that incorporate provider and health plan responsibilities consistent with industry standards in compliance with New York State Managed Care Legislation and requirements for individuals and organizations receiving federal funds. The following requirements are applicable to VNSNY CHOICE participating providers.

Nondiscrimination

Providers must provide care to all VNSNY CHOICE members and must not discriminate on the basis of the following:

- Age
- National Origin
- Race
- Disability
- Sex
- Economic, social, or religious background
- Sexual orientation
- Health Status
- Claims Experience
- Source of Payment
- Legally Defined Disability
- Veteran Status
- Marital Status

In addition, providers are required to be in compliance with Title VI of the Civil Rights Act of 1975, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), and other laws applicable to recipients of federal funds. The New York State Department of Health (NYSDOH) has adopted specific guidelines for ADA compliance by managed care organizations, including their affiliated provider networks. VNSNY CHOICE has developed a plan for achieving full compliance with these regulations and may request information from your practice as part of this program. The scope of the guidelines includes ensuring appropriate access to services through physical access to the site of care (wheelchair accessibility), access within the site (exam rooms, tables, and

medical equipment), and access to appropriate assessment and communication tools that enable disabled individuals to receive needed services and to understand and participate in their care.

Cultural Competence

Providers must ensure that services and information about treatment are provided in a manner consistent with the member's ability to understand what is being communicated. Members of different racial, ethnic, and religious backgrounds, as well as individuals with disabilities, should receive information in a comprehensive manner that is responsive to their specific needs. If language barriers exist, a family member, friend, or healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator. In addition, the VNSNY CHOICE Member Services department can provide assistance for members who do not speak English, either through their multilingual staff or by facilitating a connection with a telephone-based language interpretation service. It is essential that all efforts be made to ensure that the member understands diagnostic information and treatment options, and that language, cultural differences, or disabilities do not pose a barrier to communication.

Program Participation and Compliance

VNSNY CHOICE has developed Quality Improvement, Medical Management, and other programs to identify opportunities for improving the delivery of health services and their related outcomes.

In addition, VNSNY CHOICE has operating agreements with Federal, State, and County governments that govern the terms of its participation in the Medicaid managed care, Medicaid Advantage Plus, and SelectHealth programs. Regulatory authorities periodically review VNSNY CHOICE operations and data reporting (i.e., complaints, enrollment, and financial information). Pursuant to their provider agreements with VNSNY CHOICE, participating providers are required to cooperate with VNSNY CHOICE to meet its regulatory responsibilities as well as comply with its internal programs to ensure compliance with contractual obligations. This applies to the policies set forth in this Provider Manual as well as to any new programs developed by VNSNY CHOICE.

In addition, VNSNY CHOICE providers are responsible for supporting the member care components of the Member Rights and Responsibilities document found in Section 3.4 of this Provider Manual. It outlines member rights related to access to care, complete treatment information, privacy and confidentiality, nondiscrimination, refusal of medical treatment, and other fundamental elements of the member's relationship with VNSNY CHOICE. It is expected that providers inform members under their care about specific healthcare needs requiring follow-up and will teach members appropriate self-care and other measures to promote their own health.

Further, providers must discuss potential treatment options, side effects, and management of symptoms (without regard to plan coverage). The member has the final say in the course of action they will take about their health.

Release of Member Information
Medical information about VNSNY CHOICE members must be released to VNSNY CHOICE upon request and in compliance with the Confidentiality Policy detailed in Section 4.3 of this Provider Manual. VNSNY CHOICE will only release medical information to persons authorized by VNSNY CHOICE to receive such information for medical management, claims processing, or quality and regulatory reviews. Providers must also adhere to the appeals and expedited appeals procedures for Medicare members, including gathering and forwarding information on appeals to VNSNY CHOICE as necessary.

Billing
Providers must submit claims for reimbursement of services provided. These claims also serve as encounter data for services rendered under a capitation arrangement. Claims must be accurate and be submitted according to the guidelines described in Section 11.3. Failure to comply with VNSNY CHOICE policies in this regard may result in nonpayment for services or termination from the VNSNY CHOICE provider network. Providers should never bill VNSNY CHOICE members for covered services.

Provider Information
Providers are responsible for contacting VNSNY CHOICE to report any changes in their practice. It is essential that VNSNY CHOICE maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Changes and updates should be submitted at least two weeks prior to the effective date. Any changes to the following list of items should be reported to VNSNY CHOICE using our electronic Demographic Change Form found on the VNSNY CHOICE website (www.vnsnychoice.org), or changes can be emailed to VNSNY CHOICE at choicepdm@vnsny.org/Attn: Demographic Update Request.

The Demographic Change form should be submitted with a fax cover sheet that includes full contact information, and a comprehensive request on the provider or group letterhead that includes the provider's license number and identifies the practice record for update. Any supporting documentation (such as a W9 form or a Board Certificate) should be faxed with these requests.

- Update in the Provider or Group name and Tax ID number (W-9 Formrequired)
- Update in provider/group practice address, zip code, telephone or fax number (full practice information required)
- Update in provider/group billing address (W-9 Formrequired)
- Update in NY license, such as a new number, revocation or suspension (new certificate or information on action required, if applicable)

- Closure of a provider panel (reason for panel closure)
- Update in hospital affiliation (copy of current and active hospitalprivileges)
- Update or addition of specialty (copy of board certificate or appropriate education information)
- Update in practice's office hours
- Update in Provider's board eligibility/board certificationstatus
- Update in participation status
- Update in NY Medicaid Number (if applicable)
- Update in National Provider Identification Number (ifapplicable)
- Update in wheelchair accessibility
- Update in covering provider
- Update in languages spoken in the provider's office

The Role of the Primary Care Provider / Selecting a Provider

All members of VNSNY CHOICE Total and SelectHealth must choose a participating Primary Care Provider (PCP). Upon enrollment, every member selects a PCP from the VNSNY CHOICE Provider Directory. For members of the SelectHealth, every participating primary care provider (PCP) that follows HIV-infected members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies: (a) The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, (b) HIV-Specialist status accorded by the American Academy of HIV Medicine or (c) Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

If a member does not choose a PCP within 30 days of notification of enrollment, Member Services will assign a PCP to the member.

Enrollees in VNSNY CHOICE MLTC are not required to select a PCP, however, their physician or Nurse Practitioner must be willing to work with the plan. Members may change their designated PCP at any time by contacting Member Services at the telephone number listed in Section 1 of this provider manual. Members will receive a new ID card with updated PCP information.

As a Primary Care Provider (PCP), you are the manager of your patients' total healthcare needs. PCPs provide routine and preventive medical services, authorize covered services for members, and coordinate all care that is given by VNSNY CHOICE specialists, VNSNY CHOICE participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

Providers may contact the plan to request a standing referral to a specialist provider.

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

One of the cornerstones of VNSNY CHOICE's healthcare philosophy is the availability of services. All PCPs must arrange to have coverage available to provide medical services to their members, 24 hours a day, seven days a week.

In becoming a VNSNY CHOICE PCP, you and your staff agree to follow and comply with VNSNY CHOICE's administrative, medical management, quality assurance, and reimbursement policies and procedures.

2.3- Provider Rights & Responsibilities (SelectHealth Specifically)

The following four sections apply to providers of members of SelectHealth from VNSNY CHOICE.

Specialist Services Provided by PCPs

HIV Specialist Criteria

One of the distinguishing characteristics of the SelectHealth network is that every participating primary care provider (PCP) that follows HIV-infected members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider.
- HIV-Specialist status accorded by the American Academy of HIV Medicine. Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB). Eligibility requirements include:

    - Current and valid MD, DO, PA or NP state license year.

- Provision of direct, ongoing care to at least 20 HIV patients over the 24 months preceding the date of application.

- Completing a minimum of 30 credits of HIV-related Category 1 CME/CEU/CE within the 24 months preceding the date of application.

For Homeless Enrollees in SelectHealth

Homeless enrollees may select any participating PCP that the plan contracts with to provide PCP services to enrolled "homeless" members.

A. If a homeless enrollee is seeking care from a non-participating provider due to the proximity to the shelter, the provider will need to request authorization from the Plan to conduct an Evaluation and Management or provide urgent care to the member. SelectHealth will approve the initial visit when a homeless enrollee presents at a non-participating shelter provider or non-participating community provider, but participates in the Medicaid fee-for-service program. Requests for prior authorization are approved.

B. For an assessment, the plan will reimburse the non-participating provider at the fee-for service non-facility global fee for E&M (evaluation and management) code 99203 (currently $56.93).

C. Urgent care needs identified during the initial assessment may be treated by a non-par provider with reimbursement by the plans at the FFS rate. Any follow-up and/or specialty care needed must be prior authorized by the plan or referred by the PCP to a participating provider. If urgent care is needed, the MCO must consider whether any delay in seeking treatment may result in the member not accessing care, and should, in that case, be authorized. The provider must seek authorization on the next business day if care was provided during non-business hours.

D. SelectHealth will allow a member (or her/his designee) to change PCPs, upon request:

- To the participating shelter provider;

- To a PCP closer to shelter location

- SelectHealth will coordinate with the homeless member, their designee (if any), the shelter program staff (if any), and with Medicaid CHOICE to disenroll and enroll transfer) the member into another Plan in order to continue the relationship with a provider, if the provider does not participate in SelectHealth.

E. Providers at homeless shelters may function as PCPs for the homeless population if their total hours worked, at all locations, is a minimum of 16 hours weekly. This provision is only for the homeless population who wish to use the providers at a

shelter site. These providers will not be listed in the provider directory unless they meet all credentialing requirements. SelectHealth will inform members that providers affiliated to shelters are available as PCPs even though they are not listed in the directory.

PCP Teams

Teams of physicians/nurse practitioners may serve as PCPs for members of SelectHealth. Such teams may include no more than four (4) physicians/nurse practitioners and, when a member chooses or is assigned to a team, one of the practitioners must be designated as "lead provider" for that member. All such team practitioners must meet HIV Specialist PCP criteria.

In the case of teams comprised of medical residents under the supervision of an attending physician, the attending physician must be designated as the lead physician and must meet HIV Specialist PCP criteria.

Member to Provider Ratios

PCPs agree to adhere to the member-to-PCP ratios referenced in the Provider Agreement that governs their relationship with SelectHealth (Individual Provider or Hospital). These ratios are for Medicaid enrollees only, are CHOICE-specific and assume that the PCP is a full-time equivalent (FTE) defined as a provider practicing 40 hours per week for the SelectHealth. These ratios will be prorated for PCPs that represent less than an FTE to CHOICE.

Minimum Office Hours

A SelectHealth PCP must practice a minimum of 16 hours a week at each primary care site.* Providers must promptly notify VNSNY CHOICE of changes in office hours and location as soon as this information becomes available, but no later than three business days after the change takes effect.

The minimum office hour requirement may be reduced under certain circumstances. Please contact the VNSNY CHOICE Provider Relations Department at the telephone number listed in Section 1 of this provider manual for further information.

Responsibility to Your Patients

The PCP coordinates all aspects of a member's care covered under the plan. As a SelectHealth PCP, you agree to provide the following, where applicable.

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

a. Treatment of routine illness

b. Health consultations and advice

c. Injections

d. Conducting baseline and periodic physical exams, including any tests and any ancillary services required to make your appraisal. (Members of a SelectHealth are to be assessed by the PCP within 4 weeks of the effective date of enrollment.)

e. Diagnosing and treating conditions not requiring the services of a specialist.

f. Initiating referrals from non-primary care service as required by the specific plan in which the member is enrolled

g. Arranging inpatient care

h. Consulting with specialists, behavioral health providers, laboratory and radiological services when medically necessary.

i. Coordinating the findings of consultations and laboratories

j. Interpreting such findings for the member and his/her family, subject to regulatory requirements regarding confidentiality.

k. Coordinating dental care as part of the overall health care management of SelectHealth members.

l. Assessing the member's need for mental health and/or alcohol/substance abuse services during initial, subsequent and annual visits.

l. Providing documentation of member HIV and AIDS status to VNSNY CHOICE. (For further information, see Section 2 Verifying Eligibility for Covered Services.)

m. Assisting the plan in securing laboratory results (CD4 measurements/viral loads) and prescription information

n. Maintains a current medical record for the member

o. Appropriate coverage for your patients who may be in a hospital or skilled nursing facility

p. Educational services including:
   a. Information to assist members in using healthcare services appropriately

   b. Information on personal health behavior and lifestyle

   c. Information on achieving and maintaining physical and mental health

q. Maintenance of certain standards for your office, service, and medical records.

q. C/THP screening for children and adolescents

r. SelectHealth requires HIV pre-test counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.

s. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

t. Conspires with others to get a false or fraudulent claim paid by the federal government.

u. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

2.4- Appointment Availability and 24-Hour Access Standards (SelectHealth)

Office Hours
Each PCP must practice at least two days per week and maintain a minimum of 16 office hours per week at each primary care site. HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement. Medicare and commercial providers must maintain a minimum of 10 office hours per week at each primary care site. Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

Participating providers must be accessible 24 hours a day, 7 days a week throughout the year, either directly or through back-up coverage arrangements with other VNSNY CHOICE participating providers. Each provider must have an on-call coverage plan acceptable to VNSNY CHOICE that outlines the following information:

- Regular office hours, including days, times, and locations
- After-hours telephone number and type of service covering the telephone line (e.g., answering service)
- Providers who will be taking after-hours calls

Facilities as well as individual practitioners must conform to the following requirements:

- Members will be provided with a telephone number to use for contacting providers after regular business hours. Telephone operators receiving after-hours calls will be familiar with VNSNY CHOICE and its emergency care policies and procedures and will have key VNSNY CHOICE telephone numbers available at all times.

- The VNSNY CHOICE provider will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member as soon as possible, but in no case to exceed 30 minutes.

- It is expected that VNSNY CHOICE providers will be familiar with VNSNY CHOICE and will be able to act in accordance with VNSNY CHOICE emergency policies and procedures, such as notifying Medical Management of emergency care or admissions. These policies are further discussed in Section 8. Please be aware that hospital-based providers may have their own particular on-call group relationships.

  If the covering provider is not located at the usual site of care for the member, the covering provider must provide clinical information to the member's PCP by the close of business that day, or, if on a weekend, by the next business day, so that it can be entered into the member's medical record.

VNSNY CHOICE members must be able to locate a VNSNY CHOICE participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs members to the emergency room in lieu of appropriate

contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

Waiting Time Standards

In addition to access and scheduling standards, VNSNY CHOICE providers are expected to adhere to site-of-care waiting time standards. They are as follows:

Emergency Visits: Members are to be seen immediately upon presentation at the service delivery site.

Urgent Care and Urgent Walk-in Visits: Members should be seen within one hour of arrival. Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment with prescribed pharmaceuticals.

Scheduled Appointments: Members should not be kept waiting for longer than one hour.

Non-Urgent Walk-in Visits: Members with non-urgent care needs should be seen within two hours of arrival or scheduled for an appointment in a time frame consistent with the VNSNY CHOICE scheduling guidelines

Missed Appointments

VNSNY CHOICE expects providers to follow up with members who miss scheduled appointments.

When there is a missed appointment, providers should follow these guidelines to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained.

At the time an appointment is scheduled, confirm a contact telephone number with the member. If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone.

To encourage member compliance and minimize the occurrence of "no shows," provide a return appointment card to each member for the next scheduled appointment.

SelectHealth Providers

- Emergency Care: Immediately upon presentation at a service delivery site.
- Urgent medical or behavioral problem: Within 24 hours of request
- Non-urgent "sick" visits: Within 48 – 72 hours of request, as clinically indicated
- Routine non-urgent, preventive appointment: Within four weeks of request.
- Specialist referral (non-urgent): Within four to six weeks of request.
- Initial prenatal visit: Within three weeks during first trimester, within two (2) weeks during second trimester, within one (1) week during third trimester, within four (4) to six (6) weeks of request.
- Adult baseline and routine physical: Within four (4) weeks of enrollment (Adults >21).
- Initial visit for members with ongoing treatment needs: Within seven (7) days of enrollment if medically necessary.
- Wellness child care: Within four weeks of request.
- Initial family planning visit: Within two weeks of request.
- In-plan mental health follow-up visit (pursuant to an emergency or hospital discharge): Within five days of request, or as clinically indicated.
- In-plan, non-urgent mental health visits: Within two weeks of request.
- Initial PCP office visit for newborn: Within 48 hours of hospital discharge.

Provider visit to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding member's ability to perform work when requested by Local Department of Social Services: Within 10 days of request.

Children´s behavioral health services, including all six home and community based service (HCBS) waivers currently operated by OMH, DOH, OPWDD and the Office of Children and Family Services (OCFS), will be included in the Medicaid Managed Care benefit package. These expanded Behavioral Health services for Foster Care children and/or medically fragile children will be coordinated between SelectHealth and its Behavioral Health Vendor, Beacon Health Options.

2.4- Fraud, Waste & Abuse (All Plans)

It is the policy of VNSNY CHOICE to comply with all federal and state laws regarding fraud, waste, and abuse. VNSNY CHOICE will implement and enforce procedures to detect and prevent fraud, waste, and abuse regarding claims submitted to federal and state healthcare programs, and to provide protection for those who report in good faith actual or suspected wrongdoing.

VNSNY CHOICE is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the NY state-funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

The Compliance Policy

VNSNY CHOICE maintains a strict policy of ***zero tolerance*** toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action, up to and including termination.

As part of our commitment to this zero-tolerance policy, VNSNY CHOICE provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

In general, VNSNY CHOICE has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or VNSNY CHOICE from

paying more for a service than it is obligated to pay.

Definitions

Fraud—An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste—The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

Abuse—Provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost or in the reimbursement for services that are not medically necessary
or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Relevant Statutes and Regulations:

Stark Law

The Stark law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation

Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship—unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of Stark and Physician Self-Referral are to be reported to the Centers for Medicare and Medicaid Services through an established self-disclosure process.

False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the

government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, "knowing and/or knowingly" means that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government.
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

Reporting of Fraudulent, Wasteful, and Abusive Activities
VNSNY CHOICE wants to make sure that our providers understand that we expect members, vendors, providers, interns (volunteers), consultants, board members, and First Tier, Downstream and Related Entities (FDRs) as well as others associated with the business of VNSNY CHOICE to bring any alleged inappropriate activity which involves VNSNY CHOICE to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

VNSNY CHOICE Compliance Officer at:
220 East 42nd Street 3rd Floor New York, NY 10017
By phone – 1-212-946-9100
Email – complianceadministrator@vnsny.org

Providers may also report fraud, waste, and abuse anonymously to Ethics Point, Inc., a contracted vendor, by using the VNSNY CHOICE Hotline at 1-888-634-1558 or online at www.vnsny.ethicspoint.com. This service is available 24/7.

2.5 Credentialing, Recredentialing Requirements, and Provisional Credentialing

The VNSNY CHOICE Credentialing/Recredentialing processes are components of the organization's Quality Improvement Program. These processes were designed to protect

members and provide continued assurance that potential and/or current participating providers meet the requirements necessary for the provision of quality care and service.

The objectives of the VNSNY CHOICE Credentialing Program are to ensure that:

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

Credentialing is required for all practitioners who provide services to VNSNY CHOICE members and all other health professionals and facilities who are permitted to practice independently under State law and who provide services to VNSNY CHOICE members, with the exception of hospital-based health care professionals.

Hospitals and freestanding facilities are required by law to credential providers exclusively operating within their setting. As such, VNSNY CHOICE does not credential providers that practice exclusively within the inpatient hospital or a freestanding facility setting but instead relies on the hospital's credentialing program/appointment process for these providers. Providers in this category include, but are not limited to, providers employed by or contracted with the hospital who do not practice outside of the hospital.

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

VNSNY CHOICE does not discriminate in terms of participation or reimbursement against any physician or health care professional that is acting within the scope of his or her license. Providers are obligated to submit their credentialing applications (and supporting documents) for initial and recredentialing in a timely manner.

VNSNY CHOICE credentialing documents are available for download through the Provider Toolkit, found on our website.

Delegation of Credentialing

VNSNY CHOICE may choose to delegate provider credentialing and recredentialing in accordance with established policies. However, VNSNY CHOICE is ultimately responsible for credentialing and recredentialing of providers and maintains the responsibility for ensuring that the delegated functions are being performed according to VNSNY standards.

Application Process

VNSNY CHOICE completes credentialing activities and notifies providers within sixty (60) days of receipt of a completed application. The notification to the provider includes whether they are credentialed, whether additional time is needed for review or that VNSNY CHOICE is not in need of additional providers. If additional information is required, VNSNY CHOICE will notify the provider within 30 days of receipt of the application.

Initial Credentialing

The applicant is responsible for supplying all requested documentation in a form that is satisfactory to the Credentialing Subcommittee. A fully executed provider agreement, or relevant facility contract is required to initiate the credentialing process. Providers are required to submit an initial credentialing request through our webform; which is provided by our contracting and/or provider relations representatives.

VNSNY CHOICE requires all practitioner applicants to complete the Council for Affordable Quality Healthcare (CAQH) ProView® credentialing application form. If you do not have a CAQH number, register with CAQH Proview (proview.caqh.org/Login/Index) If you have any questions about how to obtain a CAQH number, call CAQH at **1-888-599-1771**.

In addition to the CAQH Provider Application, supplemental credentialing documents and certifications are requested and reviewed. Examples of requested information includes:

- New York State License and Registration
- Valid and Current DEA certification (physicians only)
- Board Certification
- Insurance Coverage (Participating providers are required to carry insurance coverage amounts as specified in their contract, as required by VNSNY CHOICE policy or as required by law or regulation.
- Malpractice History
- Federal and/State Sanctions
- Medicaid/Medicare Participation Status
- Curriculum Vitae (CV)
- Hospital Privileges (Physicians only)
- HIV Specialist PCP Addendum
- Disclosure of Ownership and Control Interest Statement

- IRS-W9 Form

- Collaborative Physician Agreement (Physician Assistants and Nurse Practitioners only)

The Credentialing Subcommittee will consider all information gathered on the Credentialing Application and evaluate it in light of the criteria.

The Credentialing Subcommittee will then make a determination to recommend either approval or disapproval of the provider's application. VNSNY CHOICE will provide written notice to a provider whom VNSNY CHOICE declines to include in the network, setting forth the reason(s) for its decision.

Credentialing Requirement for HIV PCP/HIV Specialists (SelectHealth)

HIV PCPS/HIV Specialists must meet the following criteria:

- Completed 10 hours within the last 12 months of HIV-related CME that includes information on the use of antiretroviral therapy in the ambulatory care setting and provided direct, ongoing care to at least 20 HIV positive patients during the past year.

- Has recertification in the subspecialty of Infectious Disease in previous 12 months or has maintained a current HIV Specialist status by the American Academy of HIV Medicine (AAHIVM) or meets the definition of an HIV-experienced provider by the HIV Medicine Association (HIVMA) or is credentialed as an Advanced AIDS Certified Registered Nurse (ACRN) by the HIV/AIDS Nursing Certification Board (HANCB).

Note: HIV PCP Specialists must meet all of the following criteria:

- See patients at least 16 hours per week over at least two days at each primary care site.

- Participate in a practice that provides 24 hours/7 day telephone coverage.

- Have completed 10 hours of HIV-related CME within the last 12 months that includes information on the use of antiretroviral therapy in the ambulatory caresetting.

- Have provided direct, ongoing care to at least 20 HIV infected patients within the last 12 months

Providers agree to notify VNSNY CHOICE promptly in the event of any material change in the status of their licensure, Medicare provider status, hospital medical staff appointments or privileges, physical or mental impairment or any other credentialing criteria that would affect their ability to practice.

All HIV PCPs must complete an annual assessment to confirm that they still meet the requirements to be an HIV PCP.

Credentialing Requirements for Organizational Providers

- Completed and signed Provider Application
- All regulatory licenses, registrations, and certifications
- Liability Insurance to include General/Commercial, Professional, Worker's Compensation Policy, as applicable
- Proof of Medicaid and Medicare (if applicable)
- Copy of Accreditation Certification
- Most recent federal or state regulatory body site visit report (with an approval letter of acceptance of corrective action plan)

Recredentialing

Participating Providers must be recredentialed every three years. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance indicators.

The recredentialing process requires that providers submit updated applications to VNSNY CHOICE or its designated agent. VNSNY CHOICE will contact the provider at least three months prior to the provider's recredentialing due date. In addition to the provider's recredentialing application, VNSNY CHOICE may consider the following as part of its recredentialing process:

- Member complaints
- Quality of services
- Utilization management (compliance with protocols, standards, and procedures)
- Member satisfaction (access, availability, and waitingtime)
- Medical record reviews

VNSNY CHOICE will make available on a periodic basis, and upon the request of the provider, the information, profiling data and analysis used to evaluate provider performance. Upon receipt of profiling data, providers are afforded the opportunity to discuss the unique nature of their patient population that may have bearing on the data and to work cooperatively with VNSNY CHOICE to improve performance.

VNSNY CHOICE conducts medical record audits and measures performance using commonly accepted standards of care. HIV PCP are also evaluated using HIVQUAL standards.

Confidentiality
At all times, information relating to a provider obtained in the credentialing/re- credentialing process is considered confidential.

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

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

2.6- Termination of Provider Agreements

Provider Termination and Disciplinary Action/Discipline of Providers
The Credentialing Subcommittee has responsibility for recommending suspension or termination of a participating provider for substandard performance or failure to comply with the requirements outlined in the VNSNY CHOICE Provider Agreement.

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

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

- Requiring the provider to submit and adhere to a corrective activeplan
- Monitoring the provider for a specified period of time, followed by a Peer Review or Credentialing Subcommittee determination as to whether substandard performance or noncompliance is continuing
- Requiring the provider to use medical or surgical consultation for specific types of care
- Requiring the provider to obtain training in specific types ofcare
- Ceasing enrollment of new VNSNY CHOICE members under the care of theprovider

- Temporarily suspending the provider's participationstatus

- Terminating the provider's participation status with VNSNYCHOICE

The Medical Director of VNSNY CHOICE may determine at his/her sole discretion that the health of any VNSNY CHOICE member is in imminent danger because of the actions or inactions of a participating provider, or that the provider is committing fraud or has received a final disciplinary action by a state licensing or governmental agency that impairs the provider's ability to practice ("Immediate Action Events") and in such case the Medical Director may immediately suspend or restrict the provider's participation status, during which time the Credentialing Subcommittee will investigate to determine if further action is required.

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

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

VNSNY CHOICE's initial and ongoing credentialing process consists of a review of all federal and state sanctions including medical license or practice privilege probation, revocation, restriction, sanction or reprimands. VNSNY CHOICE's review of sanctions also includes Medicare and Medicaid reprimands, censure, disqualification, suspension or fines, as well as conviction of or indictment for a felony.

Additionally, VNSNY CHOICE checks the following lists of excluded providers for parties which are excluded from receiving Federal contracts and subcontracts, and certain Federal financial and nonfinancial assistance and benefits:

- U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) Exclusions Database (LEIE)

- New York State Office of the Medicaid Inspector General(OMIG)

- U.S. Government's System for Award Management(SAM)

- New York State Office of Professional Misconduct (OPMC)

- Social Security Administration's Death Master File(DMF)

- CMS Preclusion List

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

Procedure for Provider Termination

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

- The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in the VNSNY CHOICE Credentialing program.

- The provider rendered(s) care to a member in a harmful, potentially harmful, personally offensive, or unnecessary or inefficient manner; or fails to provide access to care to an extent that continuity of care is provided to enrolled patients is adequate.

- The provider engaged(s) in abusive or fraudulent billing practices, including but not limited to submitting claims for payment that were false, incorrect or duplicated.

- The provider fails to comply with VNSNY CHOICE's policies and procedures, including thosefor utilization management, quality management or billing.

- The provider's privileges at a network institution, or any other institution, are lost or restricted for anyreason

  The provider's license or DEA certification are limited, suspended or revoked by any agency authorized to disciplineproviders.

- The provider is censured, suspended, debarred, excluded or terminated as a Medicaid or Medicare provider.

- The provider is indicted or convicted of afelony.

- The provider fails to comply with the application, selection or recredentialing process, or

- Submits false, incomplete or misleading information with respect to credentials orfails to comply with any provision of the Program Agreement.

- The provider renders professional services outside the scope of his/her license or beyond the bounds of appropriate authorization.

- The provider fails to maintain malpractice insurance that meets approved guidelines.

- The provider experiences physical or mental impairment, including chemical dependency, which affects his/her ability to provide care to patients or fails to meet the criteria of the plan's

- Provider Impairment Policy or the relevant policies of networkinstitutions.

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

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

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

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

In the event that the Subcommittee's recommendation is to impose any disciplinary action, including, but not limited to, termination of the provider, the Subcommittee shall provide to the provider a written explanation of the reasons therefore and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action unless the reasons therefore involve imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice, in which cases the Credentialing Subcommittee may immediately suspend or restrict the provider's participation in the VNSNY CHOICE provider network.

Subject to the provider's rights to appeal, the Credentialing Subcommittee's recommendations will be forwarded to the Board of VNSNY CHOICE for final approval.

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

The Credentialing Subcommittee shall notify the provider that he or she has a right to request a hearing or review, at the provider's discretion, of said recommendation.

VNSNY CHOICE shall include in the termination notice:

- The reason for the proposed action
- Notice that the provider has the right to request a hearing or review, at his or her discretion, before a panel appointed by the Medical Director
- The provider has 30 days within which the provider may submit to the Medical Director a written request for a hearing and/or review
- A time limit for a hearing date, which must be held within 30 days after the date of the Credentialing Subcommittee receipt of a request for ahearing.

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

Upon receipt of a request for hearing or review, the Medical Director shall inform the Credentialing Subcommittee members and shall select a review panel consisting of three persons (the "Review Panel"), at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Subcommittee.

The Medical Director may appoint more than three persons to the Review Panel; provided that for appeals by providers in VNSNY CHOICE Long Term Care plans (MLTC and Total) or SelectHealth, at least one-third of the Review Panel must be clinical peers of the provider under review and for appeals by providers in the plan, the majority of the Review Panel must be clinical peers of the provider under review. The Board shall appoint one of the Review Panel members as chairperson ("Review Panel Chairperson").

Within 14 days of receipt of a provider's written request for hearing, the Medical Director will notify the provider of the time and place of the hearing, which shall be no more than 30 days after receipt by the Medical Director of the request for hearing, unless the parties mutually agree upon a later date. In addition, said notice shall include the witnesses, if any, to be called

by the Credentialing Subcommittee in support of its recommendation, and a list of the members of the Review Panel.

The Hearing

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

- Chairman's Statement of the Procedure: Before evidence or testimony is presented the Chairman of the Review Panel will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.

- Presentation of Evidence by Credentialing Subcommittee: The Credentialing Subcommittee may present any oral testimony or written evidence it wants the Review Panel to consider. The provider or the provider's representative will have the opportunity to cross- examine any witness testifying on the Credentialing Subcommittee's behalf.

- Presentation of Evidence by Provider: After the Credentialing Subcommittee submits evidence, the provider may present oral testimony or written evidence to rebut or explain the situation or events described by the Credentialing Subcommittee. The Credentialing Subcommittee will have the opportunity to cross-examine any witnesses testifying on the provider's behalf.

- Credentialing Subcommittee Rebuttal: The Credentialing Subcommittee may present additional written evidence to rebut the provider's evidence. The provider will have the opportunity to cross- examine any additional witnesses testifying on the Credentialing Subcommittee's behalf.

- Summary Statements: After the parties have submitted their evidence, first the Credentialing Subcommittee and then the provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the Review Panel. The Review Panel will establish a reasonable time frame for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.

- Examination by Review Panel: Throughout the hearing, the Review Panel may question any witness who testifies.

Evidentiary Standards

The evidence must reasonably relate to the specific issues or matters involved in the recommended action. The Review Panel has the right to refuse to consider evidence that it

deems irrelevant or otherwise unnecessary to consider. An individual who objects to the presentation of any evidence must state the grounds for the objection and the Review Panel has the sole discretion to determine whether the evidence will be admitted.

Review Panel Determination
The Review Panel may, at its sole discretion, uphold, reject or modify the recommendation of the Credentialing Subcommittee. The decision of the Review Panel will be made in a timely manner and based upon the affirmative vote of a majority of the Review Panel members. The Review Panel's decision may include (i) reinstatement of the provider; (ii) provisional reinstatement subject to conditions set forth by the Review Panel; or (iii) termination of some or all privileges of participation in the plan. The provider will be notified in writing by the Review Panel Chairperson of the decision and the basis therefore. If a provider is terminated or his or her privileges are curtailed, the Credentialing Subcommittee will ensure that patients or clients of the plan who have or are currently obtaining services from the provider are notified and that access to alternative providers within the plan is made available to them. Decisions of termination will be effective not less than thirty (30) days after receipt by the provider of the hearing panel's decision.

Provider Terminations and Continuity of Care
In the case of any provider termination, VNSNY CHOICE will provide for continuity of care for members. Providers who terminate participation with VNSNY CHOICE are obligated to the continuation of treatment and hold harmless provisions specified in their contracts.

Termination of hospital contracts will comply with Section 4406-c (5-c) of the NYS Public Health Law, which requires that the contracted hospital and VNSNY CHOICE, continue to cover all services covered under the contract and abide by the terms of the contract, including reimbursement rates, for a period of two months from the effective date of termination or non-renewal. The exception to this requirement applies when both parties agree to the effective date of the scheduled termination or non-renewal, or when either the contracted hospital or VNSNY CHOICE, requests a waiver of the "cooling off" period from DOH. The hospital will collaborate with VNSNY CHOICE, so that an impact/ disruption analysis with regard to enrollee access to care is submitted to the NYS Department of Health within the Department's required timeframes.

Duty to Report
VNSNY CHOICE MLTC and SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 30 days of the following:

- Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare.

- The voluntary/involuntary termination of a contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures.

- The termination of a health care provider contract in the case of a determination of fraud or in the case of imminent harm to patient health.

VNSNY CHOICE MLTC and Total and SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 60 days of the following:

- The date VNSNY CHOICE obtains knowledge of any information that reasonably appears to show that a health care professional is guilty of professional misconduct as defined in Education Law.

Medical records are monitored for appropriate documentation of administrative and clinical requirements. The criteria for this review are based on requirements and standards from the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health, including those of the Department of Health AIDS Institute.