2027 STATE MEDICAID AGENCY CONTRACT

STATE AGENCY (Name and Address):

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
One Commerce Plaza
99 Washington Avenue, 16th Floor
Albany, NY 12210

CONTRACTOR (Name and Address):

FEDERAL TAX IDENTIFICATION NUMBER:

IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE	STATE AGENCY SIGNATURE
By: _____	By: _____
_____ Printed Name	_____ Printed Name
Title: _____	Title: _____
Date: _____	Date: _____

State Agency Certification:
In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK)
) SS.:
County of _____)

On the _____ day of _____in the year_____, before me, the undersigned, personally appeared_____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the
individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)

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This AGREEMENT ("Agreement") is made and entered into as of the 1st day of January 2027 (the "Effective Date") by and between the New York State Department of Health ("the Department") and [PLAN NAME] ("Health Plan"). Health Plan and the Department collectively are referred to herein as the "Parties," and each individually as a "Party."

I. RECITALS

WHEREAS, Health Plan contracts with the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services ("CMS") to sponsor a Medicare Advantage ("MA") Plan under Title XVIII of the Social Security Act, including one or more Dual-Eligible Medicare Advantage Special Needs Plan(s) ("D-SNP") that arranges for the provision of Medicare services for individuals who are dually-eligible for both Medicare and at least some Medicaid benefits pursuant to Titles XVIII and XIX of the Social Security Act;

WHEREAS, Health Plan sponsors D-SNP(s) in the State of New York and enrolls residents of New York who are eligible for Medicare benefits, eligible for Medicaid pursuant to New York's Medicaid Plan as administered by the Department ("Dual Eligible Beneficiaries"), and eligible to enroll in the D-SNP;

WHEREAS, the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS require that Health Plan enter into an agreement with the Department to coordinate benefits and/or services for members of Health Plan's D-SNP(s) within the State of New York;

WHEREAS, the Bipartisan Budget Act of 2018 and its implementing regulations issued by CMS further defines a D-SNP to include Fully Integrated D-SNPs ("FIDE D-SNP") and Highly Integrated D-SNPs ("HIDE D-SNP") and impose certain rules and requirements to these plan types;

WHEREAS, Health Plan and the Department desire to enter into an arrangement regarding the provision of such benefits by Health Plan's D-SNP(s) within the State of New York in an effort to improve and expand the integration and coordination of such benefits, better educate Dual Eligible Beneficiaries into New York's D-SNP products, and thereby improve the quality of care to Dual Eligible Beneficiaries by coordinating care and reducing the costs and administrative burden.

NOW THEREFORE, in consideration of the terms and conditions set forth in this Agreement, the Parties agree as follows:

II. DEFINITIONS

A. "Applicable Integrated Plan" (AIP) means a FIDE SNP or HIDE SNP that operates with exclusively aligned enrollment limited to only Full Benefit Dually Eligible individuals who receive coverage of Medicaid benefits through the D-SNP or a Medicaid Managed Care plan owned and operated by the same parent company as the D-SNP in accordance with CMS regulations at 42 CFR §422.561.

B. "Coinsurance" means the fixed percentage of the total amount for a health care service for which an individual normally would be financially responsible pursuant to their Medicare coverage after the individual's deductible has been met.

C. "Coordination Only D-SNP" (formerly referred to as a standalone D-SNP) means a D-SNP that does not have a Medicaid managed care contract with the State to offer Medicaid benefits. The Coordination Only D-SNP does not meet a FIDE or HIDE definition in accordance with CMS regulations at 42 CFR § 422.2.

D. "Co-payment" means the fixed amount for which an individual normally would be financially responsible to pay for a covered service pursuant to their Medicare coverage.

E "Cost-Sharing" means the portion of the cost of covered services for which an individual normally would be financially responsible (including coinsurance, co-payments, and deductibles) pursuant to their Medicare coverage.

F. "Cost-Sharing Obligations" means those financial payment obligations to be paid by the Department in satisfaction of Deductibles, Coinsurance, and Co-payments for Medicare Part A and Medicare Part B services with respect to certain Dual Eligible Beneficiaries and as defined for certain Dual Eligible Beneficiaries with full Medicaid benefits, as defined in New York State's Medicaid State Plan. Such financial payment obligations shall not include premiums or Cost-Sharing relating to Medicare Part D benefits.

G. "Deductible" means the fixed amount for which an individual would normally be responsible to pay for covered services before the health plan begins to pay, pursuant to their Medicare coverage.

H. "Dual-Eligible Medicare Advantage Special Needs Plan(s)" or "D-SNP" as defined in 42 CFR § 422.2, means a specialized Medicare Advantage Plan for dually eligible individuals who are entitled to medical assistance under a State plan under title XIX of the Act that (1) coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such

services that include primary and acute care; (2) may provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services; (3) has a contract with the Department consistent with 42 CFR § 422.107 that meets the minimum requirements in paragraph (c) of such section; and (4) beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits: (i) meets the additional requirement specified in 42 CFR § 422.107(d) in its contract with the Department; (ii) is a HIDE SNP; (iii) is a FIDE SNP.

I. "Dual Eligible Beneficiary" or "Dual Eligible Beneficiaries" or "Dual Eligibles" means those categories of individuals indicated in **Attachment A** that are eligible for Medicare benefits as well as for New York State Medicaid benefits.

J. "Exclusively Aligned D-SNP" means a D-SNP enrolling only full benefit Dual-Eligible Beneficiaries who are also enrolled in an Integrated Medicaid Product offered by the Department, including but not limited to Medicaid Advantage Plus ("MAP"), that is offered by the Medicare Advantage Organization, its parent organization (directly or indirectly), or another entity owned and controlled by its parent organization.

K. "Fee-for-Service (FFS) Medicaid" is a Medicaid payment model through which the State directly reimburses Medicaid providers for each service that is provided to Medicaid recipients.

L. "Full Benefit Dual Eligible" (FBDE) means an individual who is enrolled in Medicare Part A and/or Part B and eligible for Medicaid benefits under New York State's Medicaid State Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy).

M. "Fully Integrated Dual Eligible Special Needs Plan" or "FIDE SNP" means a D-SNP (1) that provides Dual-Eligible Beneficiaries access to Medicare and Medicaid benefits under a single legal entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under Section 1903(m) of the Social Security Act with the Department; (2) whose capitated contract with the Department provides coverage, consistent with the Department policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) that for plan year 2025 and subsequent years, includes Medicare cost-sharing as defined in section 1905 (p)(3)(B), (C) and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries; (4) that for plan year 2025 and subsequent years, has exclusively aligned enrollment; (5) that for plan year 2025 and

subsequent years, has a capitated contract with the State Medicaid agency that covers the entire service area for the dual eligible special needs plan; (6) that for plan year 2025 and subsequent years, provides coverage of home health services as defined in 42 CFR §440.70; (7) that for plan year 2025 and subsequent years, provides coverage of medical supplies, equipment and appliances as described in 42 CFR §440.70(b)(3); (8) that coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; (9) that employs policies and procedures approved by CMS and the Department to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement; and (10) that has received CMS designation as a FIDE SNP.

N. "Highly Integrated Dual Eligible Special Needs Plan" or "HIDE SNP" means a D-SNP that provides coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid Managed Care plan), including coverage of long-term services and supports (LTSS), behavioral health benefits, or both, under a capitated contract with the Department. The capitated contract with the Department may be executed directly with the D-SNP, with the D-SNP's parent organization as defined in 42 CFR §422.2, or with another entity that is owned and controlled by the D-SNP's parent organization. Additionally, the HIDE SNP's capitated contract with the Department (for coverage of the required Medicaid benefits) must cover the entire service area of the D-SNP.

O. "Integrated Benefits for Dually Eligible Enrollees Program or "IB-Dual" means a program that provides Medicaid and Medicare services for Dual Eligibles enrolled in a Mainstream Managed Care Plan (MMCP) or Health and Recovery Plan (HARP), who are not required to enroll in a Managed Long Term Care Partial (MLTCP) plan or a Medicaid Advantage Plus (MAP) plan and an aligned D-SNP of the same organization.

P. "Integrated Medicaid Product" means a product offered through a CMS-approved D-SNP and a companion Medicaid Managed Care plan offered by the Health Plan or the Health Plan's parent organization that provides and/or arranges coverage of Medicare and Medicaid services for Dual Eligible Beneficiaries, including but not limited to Integrated Benefits for Dually Eligible Enrollees (IB-Dual) and Medicaid Advantage Plus.

Q. "MA Contract" means a contract between Health Plan and CMS pursuant to which Health Plan sponsors Medicare Advantage plans, including one or more D-SNPs offered in New York State.

R. "Medicaid Benefits" means those items and services that are (i) covered by New York State's Medicaid State Plan for certain individuals identified in **Attachment A,** (ii) not eligible for coverage as basic benefits under the Medicare Program, and (iii) not covered by Health Plan's D-SNP(s) as a

Supplemental Benefit.

S. "Medicaid Managed Care" means the provision of Medicaid benefits through one or all of the following health care plans certified under Article 44 of the New York State Public Health Law (PHL) and contracted by the Department for a defined group of eligible enrollees: Mainstream Managed Care Plan (MMCP), Health and Recovery Plan (HARP), Medicaid Advantage Plus (MAP), or Managed Long Term Care Partial Capitation (MLTCP).

T. "Medicare Laws" means any and all laws, rules, regulations, statutes, orders and standards, instructions and guidance applicable to the Medicare Advantage Program and Medicare Advantage Organizations, as the term is defined in 42 CFR § 422.4, including Health Plan in its capacity as the sponsor of Health Plan's D-SNP(s).

U. "Medicaid Advantage Plus Plan Integrated Appeals and Grievances Demonstration" means a Federal-State partnership established by CMS and the Department to implement a demonstration that integrates appeals and grievance processes for MAP plans and FIDE SNPs with exclusively aligned enrollment participating in the MAP program sponsored by the same offeror. The demonstration began January 1, 2020, and ended December 31, 2025.

V. "Medicare Advantage Plan Premium" means the amount Medicare Advantage plans may charge a Member for mandatory benefits and/or optional Supplemental Benefits beyond basic Medicare services.

W. "Member" means an individual eligible to enroll in, and who has enrolled in, Health Plan's D-SNP.

X. "Model of Care" means the document designed by Health Plan and approved by CMS to meet the specialized needs of a Dual Eligible population that includes (i) an appropriate network of providers and specialists available through Health Plan's D-SNP, and (ii) care management services, which include assessment, individualized plan of care and interdisciplinary team.

Y. "Partial Dual Eligible" beneficiary means those categories of individuals indicated in **Attachment A** that are eligible for Medicare benefits as well as Medicaid coverage of assistance in paying Medicare Part A and/or Part B premiums, and in some cases, Cost-Sharing Obligations for Medicare-covered services. These individuals do not receive full (comprehensive) Medicaid benefits.

Z. "Premium" means the amount the Department pays for Medicare Part A and/or Part B on behalf of certain Dual Eligible beneficiaries pursuant to Section 1905 of the Social Security Act.

AA. "Service Area" means the counties identified in **Attachment B** in which Health Plan's D-SNP(s) operate(s) pursuant to Health Plan's MA Contract and certificate of authority issued by the Department.

BB. "Subcontract" means an agreement between Health Plan and a third-party under which the third-party agrees to accept payment for providing services to Health Plan's members.

CC. "Subcontractor" means a third party with which Health Plan has an agreement.

DD. "Supplemental Benefits" means mandatory and optional Medicare Advantage D-SNP benefits defined at 42 CFR § 422.102 that are beyond basic Medicare Part A and Part B services described in 42 CFR § 422.101, including limits on out-of-pocket spending, reduction in premiums, or optional healthcare services.

III. Provisions Required by CMS

A. Coordination of Delivery of Medicaid Benefits. Health Plan shall coordinate the delivery of all benefits covered by both Medicare and New York's Medicaid Plan as administered by the Department. Health Plan is further responsible for coordinating care of all of its Members with other Medicaid managed care plans as applicable. In furtherance of these obligations, Health Plan shall specifically:

1. Identify for its Members the Medicaid benefits for which they may be eligible that are not covered by the D-SNP;

2. Assist in the coordination of and access to needed Medicaid services, and arrange for the provision of such Medicaid services to its Members by identifying participating Medicaid providers in the D-SNP's provider network; and

3. Develop and apply care coordination policies describing services Health Plan will provide or arrange, including, without limitation, care management, disease management, and discharge planning.

B. Categories and Criteria for Eligibility. The categories of Dual Eligible Beneficiaries are defined in **Attachment A.**

1. Health Plan's D-SNP(s) serving FFS Medicaid beneficiaries and/or MLTCP members (Coordination Only D-SNPs and HIDE SNPs) may enroll the following categories of Dual Eligible Beneficiaries into the D-SNP:

- QMB
- QI
- QDWI
- QMB-Plus
- Other FBDE

2. Health Plan's D-SNP(s) aligned with an MMCP or HARP operating an Integrated Benefits for Dually Eligible Enrollees (IB-Dual) plan (HIDE SNP) may enroll FFS Medicaid beneficiaries and beneficiaries enrolled in the companion MMCP or HARP. These D-SNPs may enroll the categories of Dual Eligible Beneficiaries listed above in B.1.

3. Health Plan's D-SNP that has exclusively aligned enrollment with a Medicaid Advantage Plus (MAP) product (FIDE SNP) must limit enrollment to individuals who are enrolled—or are in the process of being enrolled—in the MAP product and are in the following categories of Full Benefit Dual Eligible Beneficiaries:

   - QMB-Plus
   - Other FBDE

C. Capitated Contract with the Department. Health Plans operating a HIDE SNP or FIDE SNP must have a capitated contract with the Department that includes Medicaid payment of Medicare cost sharing. **Attachment B: Product Offerings** includes attestations that Health Plans operating FIDE SNPs and/or HIDE SNPs must complete.

D. Cost-Sharing Protections Covered Under the D-SNP. Requirements related to cost-sharing for D-SNP members are included in Section VII. Member Protections.

E. Identification and Sharing of Information on Medicaid Provider Participation.

1. Identification of Providers. Health Plan shall verify whether its contracted providers are currently registered providers under New York's Medicaid Plan before including them in its D-SNP Provider Directory. Health Plan shall identify in its provider directory those participating providers that accept both Medicare and Medicaid. Health Plan shall identify providers contracted with New York's Medicaid Plan using the electronic data file containing Medicaid Participating Providers provided annually by the Department as referenced in Section VI. State Department of Health Responsibilities, (C) Medicaid Participating Provider Electronic Data Format.

2. Network Congruency Standards. Where the D-SNP organization offers an Integrated Medicaid Product (includes FIDE SNPs and HIDE SNPs),

Health Plan shall augment the more narrow network (either Medicare or Medicaid) to develop an acceptable level of network congruency between its Medicare and Medicaid participating providers to ensure access and availability of services, such that a minimum percentage of providers in a Health Plan's participating provider network shall participate in both Medicare and Medicaid managed care. Health Plan shall not terminate network provider participation for the sole purpose of achieving network congruency.

Health Plan shall ensure that its Medicare and Medicaid participating provider networks are congruent in each service area covered by the D-SNP. Health Plan's provider networks shall maintain congruency whereby at least 85% of the Medicaid provider network overlaps with the Medicare provider network.

Health Plan shall demonstrate network congruency in a format and timeframe to be determined by the Department.

F. Verification of Enrollees' Eligibility for Medicaid. Health Plan shall verify ongoing Medicaid eligibility through the EPACES system. Health Plan shall verify the Medicare eligibility of all D-SNP Members on a monthly basis and shall also verify Medicare eligibility of individual members when requested by the Department.

G. Service Area. The service area is the geographic area in which Members or potential Members of Health Plan's D-SNP reside. Health Plan shall submit its Service Area, as approved by or pending approval from CMS to the Department by completing **Attachment B** of the Agreement. In order for Health Plan to offer benefits to Members in such Service Area, it must also be authorized by the Department. Health Plan shall notify the Department of any CMS approval of an update to its Service Area within 10 business days of CMS approval.

H. Contract Period. The contract period for the D-SNP is provided in Section IX. Term and Termination.

I. Notification of Hospital and Skilled Nursing Facility Admissions.

In accordance with 42 CFR § 422.107(d), Coordination Only D-SNPs and HIDE SNPs aligned with a MLTCP shall provide timely notification of all admissions to a hospital or skilled nursing facility ("SNF") to the Member's Medicaid Managed Care plan or the Department for FFS Medicaid beneficiaries. Such information must include, but is not limited to

- Member Name
- Subscriber ID

- Medicare Beneficiary Identifier (MBI)
- Client Identification Number (CIN)
- Date of Birth
- Facility Member admitted to
- Attending Physician
- Admission Type/Diagnosis
- Date of Admission
- Primary Care Physician (PCP)

Timely notification is defined as any real-time notification provided by Health Plan or its contracted hospitals and SNFs via secure electronic data exchange, via direct communication from Health Plan or its Subcontractor within 48 hours of becoming aware of such admission. In the event Health Plan delegates notifications to a Subcontractor, Health Plan shall retain responsibility for compliance with these requirements.

Health Plan shall enter into business associate agreements and any other agreements governing the legally compliant sharing of data in accordance with HIPAA, and/or any other applicable state and federal privacy laws, and/or pursuant to the terms of any agreements between Health Plan and the Department. Health Plan shall provide the Department with proof of documentation upon request by the Department. Where notification must be provided to the Department, Health Plan shall submit or transmit such notifications and data pursuant to instructions provided by the Department.

IV. Product Specific Requirements

A. Product Types. Pursuant to § 422.107(b), a State Medicaid Agency Contract (SMAC) is required for any Health Plan seeking to offer a D-SNP. The types of D-SNPs operating in New York State include FIDE SNPs, HIDE SNPs, and Coordination Only D-SNPs. The Product Specific Requirements section of the Agreement includes requirements specific to each of these types of D-SNPs.

B. Product Offerings. For each D-SNP offered by Health Plan and covered under this agreement, Health Plan shall complete all information required by **Attachment B**.

C. Integrated Medicaid Product Offerings.

1. To further the Department's efforts to provide integrated care and benefits for New York's Dual Eligible Beneficiaries, Health Plan shall submit a complete application to the Department to offer an Integrated Medicaid Product where Health Plan does not currently contract with the Department to provide a Medicaid Managed Care plan for Dual Eligibles.

The submission timeline shall be as follows:

- Health Plan shall send a letter of intent to the Department on or before November 1, 2026, to propose an integrated product offering effective January 1, 2028.

- Health Plan shall submit a completed application for an Integrated Medicaid Product to the Department in accordance with the Department's published submission schedule found at: https://www.health.ny.gov/health_care/managed_care/plans/

2. Plans with Pending Applications for an Integrated Medicaid Product. At the time of this Agreement's execution, if Health Plan is in the process of but has not yet executed a contract with the Department to provide coverage of the Medicaid benefits described in Appendix K of the MAP model contract or the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan model contract for the service areas specified in **Attachment B** for enrollees in the MAP or IB-Dual D-SNP (including full-benefit dually eligible enrollees), respectively, MAP, IB-Dual, or the companion D-SNPs may not enroll any new individuals until all three of the following conditions are met:

   - The Health Plan executes a Medicaid Managed Care contract with the Department to provide coverage of Medicaid benefits described in Appendix K in the service areas specified in **Attachment B**,

   - The Health Plan obtains FIDE SNP or HIDE SNP designation for MAP or IB-Dual from CMS, and

   - The Department provides express written approval to the Health Plan to enroll new individuals in MAP or IB-Dual. This approval may include an updated certificate of authority.

   The D-SNP may be deemed a Coordination-Only D-SNP until the above conditions are met, however, no new enrollment will take place until such time the D-SNP is approved for an integrated product as a FIDE SNP or HIDE SNP.

   Additionally, until all three of these conditions are met, for any Members, Health Plan shall provide timely notification of all admissions to a hospital and/or SNF to the Department for FFS Medicaid recipients or to the Member's Medicaid Managed Care plan, as appropriate. Timely notification is defined as *within 48 hours of the health plan becoming aware of the admission*. Notification shall be sent in accordance with guidance described in Section III. (I) – Notification of Hospital and SNF

Admissions of this contract and detailed instructions for file sharing between the Department and/or Medicaid Managed Care plan as provided by the Department.

2a. Service Area Expansion:

Where Health Plan has an established contract with the Department and has not received Department approval for service area expansion via a certificate of authority for counties indicated in **Attachment B** as "pending," only those pending service area expansion counties will be subject to the requirements set in (C)2 of this section, including no enrollment into the service area expansion counties until the elements above are met.

D. Coordination Only D-SNP Requirements.

1. The following section outlines requirements specific to D-SNPs that meet the definition of Coordination Only D-SNP provided in Section II. (C).

2. Applications submitted for Coordination Only D-SNP products will not be accepted by the Department, unless the Department determines in its sole discretion that extenuating circumstances exist that are based on access or preservation of choice for Dual Eligible Beneficiaries.

3. Any Health Plan currently offering a Coordination Only D-SNP may continue to provide this product type, however, the Coordination Only D-SNP may not be expanded into new service areas.

4. Such Health Plan shall comply with Plan Benefit Package (PBP) limits as outlined below.

   - Health Plan must remain in compliance with 42 CFR §422.514(h), including any updates to such regulation by CMS. A Health Plan (or the Health Plan's parent organization, or entity owned or controlled by the same parent organization) that operates an affiliated Integrated Medicaid Product in the same service area may only operate one D-SNP PBP that enrolls Full Benefit Dual Eligibles in 2027 unless one of the exceptions in 42 CFR §422.514(h) are met. Per 42 CFR §422.514(h)(3)(iii) and 42 CFR §422.107(d)(2), CO D-SNPs may enroll (1) Full Benefit Dually Eligible individuals who are in FFS Medicaid and (2) Partial Dual Eligible individuals.

   - All Coordination Only D-SNPs offered by the Health Plan must be of a single plan type (i.e., HMO, PPO, POS). Health Plans offering

multiple plan types must either non-renew or close the additional D-SNP to new enrollment beginning January 1, 2027.

- Health Plan is limited to no more than two (2) Coordination Only PBP offerings in the state per calendar year.

    - Health Plan shall complete **Attachment B** to fully describe alignment of the Health Plan's D-SNP(s) and categories of Dual Eligible Beneficiaries served for each integrated/non-integrated product type including service area and ownership/affiliation as appropriate. Health Plan shall describe any application submissions and/or service area expansion counties that may be pending Department approval at time of SMAC completion.

E. Highly Integrated D-SNP Requirements.

1. The following section outlines requirements specific to D-SNPs that meet the definition of HIDE SNP provided in Section II. (M).

2. Health Plan must remain in compliance with 42 CFR §422.514(h), including any updates to such regulation by CMS where Health Plan (or Health Plan's parent organization, or another entity owned and controlled by Health Plan's parent organization) operates a MAP, MMC or HARP plan in the counties where it operates one or more D-SNPs. In such cases, Health Plan may only operate one D-SNP PBP that enrolls Full Benefit Dual Eligibles in 2027 unless one of the exceptions in 42 CFR §422.514(h) are met. Per the exception at 42 CFR §422.514(h)(3)(i), the Health Plan (or the Health Plan's parent organization, or entity owned or controlled by the same parent organization) may operate more than one PBP if the PBPs enroll different Integrated Medicaid product enrollees (IB-Dual, MAP and MLTCP enrollees). Additionally, per the exception at §422.514(h)(3)(iii), HIDE SNPs and CO D-SNPs may enroll Full Benefit Dually Eligible individuals who are in FFS Medicaid.

3. For enrollments effective on or after January 1, 2027, IB Duals HIDE SNPs will only enroll new enrollees who are (1) already enrolled in the D-SNP's affiliated IB Duals (MMCP or HARP) managed care organization at the time of the request for D-SNP enrollment or (2) receiving Medicaid benefits through FFS Medicaid. The Health Plan will be responsible for verifying the potential enrollee's enrollment in FFS Medicaid or the HIDE SNP's affiliated MMCP or HARP enrollment prior to submitting an enrollment transaction to CMS. (The "affiliated" MMCP or HARP is the managed care plan operated by the Health Plan, the Health Plan's parent organization, or another entity owned and controlled by the Health Plan's parent organization.)

4. Requirements for D-SNPs Aligned with MLTCPs. Where Health Plan's D-SNP with an MLTCP is designated a HIDE SNP, Health Plan must comply with the following additional requirements to ensure care coordination for Dual Eligibles:

    - Health Plan must ensure that the care managers on the D-SNP's interdisciplinary care team who provide care coordination and care management services to the enrollee are the same care managers who provide such services through the MLTCP.

    - Health Plan must coordinate its D-SNP and affiliated MLTCP care plans by ensuring integrated care coordination and management, including but not limited to:

        - Assisting Members with accessing needed services identified under the care plan, including referral to and assistance with or coordination of services for the Member to obtain needed services not included in the Benefit Package of the Health Plan;

        - Ongoing care management and communication across the care teams; and

        - Complying with the elements outlined under sections III. (A) and V. (A) per this agreement.

    - Health Plan that operates a HIDE SNP aligned with an MLTCP shall continue to submit reporting for all hospital and SNF admissions.

5. Requirements for D-SNPs aligned with the IB-Dual Program. Where Health Plan offers the IB-Dual Program to MMCP/HARP enrollees and is designated as a HIDE SNP, Health Plan shall comply with the following requirements in accordance with CMS regulations:

    a. Service Area. Health Plan's capitated contract with the Department (for coverage of required Medicaid benefits) must cover the entire service area of the D-SNP.

    b. Service Area Expansion. Health Plan shall ensure any service area expansion of its D-SNP aligns with its Medicaid service area by submitting a mini-application to the Department to expand the IB-Dual Program offering. Health Plan may contact its Department plan manager to request more information on the mini-application.

    c. FFS Medicaid Transition into the IB-Dual Program. Health Plan may

enroll both IB-Dual enrollees and FFS Medicaid recipients that are Dual Eligibles into its D-SNP. Upon Department approval, Health Plan may extend MMCP enrollment into its aligned IB-Dual Program to any FFS Medicaid Members, per 42 CFR §422.514(h)(3)(iii). FFS Medicaid recipients that are Dual Eligibles may voluntarily enroll in the aligned MMCP's IB-Dual Program.

F. Fully Integrated D-SNP Requirements.

1. The following section outlines requirements specific to D-SNPs that meet the definition of FIDE SNP provided in Section II. (L).

2. Nursing Facility Services. Any Health Plan offering an aligned MAP must cover nursing facility services for at least 180 days of the plan year.

3. Ownership and/or Affiliation with Medicaid Managed Care plan. Health Plan shall demonstrate that the entity holding the capitated contract with the Department is the same legal entity as that which CMS has designated as a FIDE SNP by providing the Department with a copy of the notice from CMS attesting to such entity's status as a FIDE SNP.

   Health Plan must remain in compliance with 42 CFR §422.514(h), including any updates to such regulation by CMS. Health Plan (or the Health Plan's parent organization, or another entity owned and controlled by the Health Plan's parent organization) that operates an affiliated Integrated Medicaid Product in the same service area may only operate one D-SNP PBP that enrolls Full Benefit Dual Eligibles beginning in 2027 unless one of the exceptions in 42 CFR §422.514(h) are met. Per exception at 42 CFR §422.514(h)(3)(i), the Health Plan, the Health Plan's parent organization, or another entity owned and controlled by the Health Plan's parent organization may operate more than one PBP if the PBPs enroll different Integrated Medicaid product enrollees (IB-Dual, MAP and MLTCP enrollees).

G. Requirements for D-SNPs Designated by CMS as Applicable Integrated Plans. The following requirements are applicable only to Health Plan operation of D-SNPs with exclusively aligned enrollment.

1. Service Area. The counties within an Exclusively Aligned D-SNP's Service Area shall be aligned with the service area of its Integrated Medicaid Product.

2. Integrated Appeals and Grievances.

   a. Unified Appeals and Grievance Process. Health Plan shall implement a unified grievance and appeal system and process

grievances and appeals in compliance with the terms of 42 CFR §§ 422.629 – 422.634, 438.210, 438.400 & 438.402. This requirement includes:

- Grievances and appeals systems that meet the standards described in 42 CFR § 422.629;
- An integrated grievance process that complies with 42 CFR § 422.630;
- A process for making integrated organization determinations consistent with 42 CFR § 422.631;
- Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR § 422.632;
- A process for making integrated reconsiderations consistent with 42 CFR § 422.633; and
- A process for effectuation of decisions consistent with 42 CFR § 422.634.

Health Plan shall implement a process to ensure that Members are provided reasonable assistance in completing forms and taking other procedural steps related to integrated appeals and grievances. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

b. Integrated Appeals and Grievances Demonstration – Medicaid Advantage Plus. Health Plan shall comply with any required close out procedures following the end of the MAP Integrated Appeals and Grievances Demonstration, which was ended effective December 31, 2025.

Effective January 1, 2026, Health Plan shall implement the unified appeals and grievances process established for applicable integrated plans (AIP) in compliance with the terms of 42 CFR §§ 422.629 – 422.634, 438.210, 438.400 & 438.402.

3. Integrated Member ID Card. Health Plan shall provide each Member an integrated member ID card beginning no later than contract year 2027. Such ID card shall comply with all applicable CMS requirements.

4. Integrated Health Risk Assessment. Health Plan shall complete a single, integrated Health Risk Assessment (HRA) that satisfies both Medicare

and Medicaid requirements for each enrollee in compliance with 42 CFR § 422.101(f)(1)(v) and § 438.208 beginning no later than contract year 2027.

V. Additional Operational Requirements

A. Plan Management. Health Plan shall administer D-SNP and provide coordinated care and benefits for Dual Eligible Members per the terms as described.

1. Medicare Benefits. Health Plan shall provide to its Members the benefits set out in Health Plan's D-SNP benefit package, including basic benefits and Supplemental Benefits, pursuant to Health Plan's Medicare Advantage Contract and applicable Medicare Law.

2. Compliance with Medicare Laws. Health Plan's administration of Health Plan's D-SNP(s), including, without limitation, PBP design, provider network adequacy, provider credentialing, utilization management programs, quality improvement programs, and payment processes and procedures (collectively, "Administrative Services"), shall be subject to and in compliance with Medicare Laws.

3. Care Coordination. In accordance with the Model of Care approved by CMS, Health Plan shall develop individualized care plans that include communication and coordination with providers that render services covered under New York State's Medicaid State Plan. Health Plan will use its care management process to manage the Member's health status and assist the Member in obtaining or accessing Medicare and/or Medicaid benefits and services. Health Plan shall coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries.

   Health Plan shall employ policies and procedures to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals and quality improvement.

4. Social Determinants of Health and Special Needs Plan Health Risk Assessment. CMS requires Health Plan to complete Member HRAs at enrollment and annually. Health Plan assessment survey must also include specific standardized questions on housing stability, food security, and access to transportation that are outlined in the State-specific Accountable Health Communities assessment tool to identify any health-related social needs. Health Plan shall act on any unmet needs identified from the screening by providing referrals to services as part of care plan development for its Members. Health Plan shall include

coordination of health-related social care needs as part of its Model of Care (MOC) program development for Dual Eligibles effective January 1, 2027.

5. Summary of Benefits. Health Plan shall use the Integrated Summary of Benefits template developed by the State and CMS which is released by CMS to integrate into a single Summary of Benefits all Medicare and Medicaid benefits a Member may be eligible to receive upon enrollment in Health Plan's D-SNP(s).

6. Prompt Pay. Health Plan shall pay all claims for items and services in accordance with federal and state law and regulation, including, as applicable, Section 3224-a of the New York Insurance Law and 42 CFR § 422.520.

B. Coordination of Benefits for Medicare Advantage Supplemental Benefits. Health Plan shall adjudicate claims for services that are covered as both a Supplemental Benefit and a Medicaid Benefit with Health Plan as the primary payer, except in instances where services are not payable under Medicare Advantage.

C. Supplemental Benefits.

1. Health Plan shall ensure its Supplemental Benefits will coordinate with Medicaid Benefits covered by New York State's Medicaid State Plan during the next Medicare bid filing cycle, effective for the 2025 contract year and thereafter as outlined below.

   - Health Plan must use its rebate amount to fully cover Medicaid dental services as a Medicare Supplemental Benefit.

   - Dental care includes preventive, prophylactic and other routine dental care services and dental prosthetics required to alleviate a serious health condition. Health Plan's D-SNP benefit design will cover the full scope of Medicaid dental services. The benefit design may not include a limited allowance amount for covered services.

   D-SNPs must cover the Medicaid dental benefits available in the upcoming plan benefit package as of January 1st of the new contract year. Dental benefits added by the Department after the start of the State fiscal year (April 1st) continue to be covered by Medicaid. Health Plan's D-SNP shall cover any newly added Medicaid dental services under the Medicare supplemental benefit beginning on January 1st of the subsequent year.

- Health Plan's D-SNP supplemental dental benefit will provide coverage for all Partial and Full-Benefit Dual Eligibles.

- Health Plan shall allow enrollees to self-refer to Article 28 clinics operated by academic medical centers to obtain covered dental services.

- All D-SNP types (FIDE SNP, HIDE SNP and Coordination Only D-SNP) are subject to this Supplemental Benefit requirement.

- The Medicare appeal and grievance processes will apply to Supplemental Benefits as required.

2. Health Plan shall ensure that Supplemental Benefits (i.e., dental, vision, and hearing) offered by FIDE SNPs and HIDE SNPs coordinate with Medicaid benefits covered by New York State's Medicaid State Plan to develop an acceptable level of network congruency between its Medicare and Medicaid participating providers to ensure access and availability of supplemental services, such that a minimum percentage of providers in Health Plan's participating provider network shall participate in both Medicare and Medicaid managed care. Health Plan shall meet network congruency standards in each service area the D-SNP covers whereby at least 85% of the Medicaid provider network overlaps with the Medicare provider network beginning January 1, 2025.

    - Health Plan shall demonstrate network congruency in a format and timeframe to be determined by the Department.

3. Coordination Only D-SNPs shall ensure a level of network adequacy that complies with CMS regulations found at 42 CFR § 422.116.

D. MOOP Limit. In accordance with 42 CFR § 422.100, Health Plan shall ensure calculation of the maximum out-of-pocket limit is based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance, or remains unpaid (including when the cost-sharing is not paid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing).

E. Claims Crossover Agreement. In accordance with 42 CFR § 438.3(t), Health Plan shall enter into a signed agreement with CMS for the coordination of benefits and participate in the automated Medicare claims crossover process to receive Medicare fee-for-service claims.

F. Notifications. For each of the items listed below, Health Plan shall provide the Department with the following notifications within ten (10) business days

of their submission, unless a different time period is specified for a particular notification requirement:

1. Medicare Advantage Bid Filing. Health Plan shall provide the Department with a copy of: (i) its approved annual bid filing submitted to CMS, which shall include bid pricing tool worksheets and plan benefit package summaries; and (ii) CMS approval of its bid filing final submission.

2. Notice of Intent. Health Plan shall provide the Department with a copy of its Medicare Notice of Intent describing its proposed Medicare product offerings, service area expansions, and/or any other changes it intends to apply for to be effective in the next bid filing submission.

3. Summary of Benefits. Health Plan shall submit its annual Summary of Benefits, including Supplemental Benefits, for the counties identified in **Attachment B** for the upcoming year, to the state for review prior to distribution. Initial submissions shall be made by August 1st and a final version of the Summary of Benefits must be submitted by October 15th, and within 15 calendar days of any update or modification.

4. Model of Care. Health Plan shall submit any new CMS-approved Model of Care (MOC), or any updates to an approved MOC, to the Department at dualintegration@health.ny.gov within 30 days of approval. The MOC shall include policies and procedures incorporating care coordination and Medicaid quality of care for Dual Eligibles. Health Plan's MOC shall include a plan for any identified health related social needs as described in Section V. (A) of this contract.

5. Quality Reporting.

    1. Health Plan shall submit upon Department request copies of all quality reports, measures, and findings generated from Health Plan's D-SNP(s) quality management programs as required by and submitted to CMS.

    2. Health Plan shall notify the Department in the event Health Plan receives a less than 3.0 Medicare Star rating on either its Part C or Part D scores for any D-SNP. Health Plan shall provide the Department with a copy of any document submitted to CMS outlining the steps proposed or implemented to improve the low score.

G. Default Enrollment Process.

1. On behalf of Members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and such

Medicare eligibility results in Full Benefit Dual Eligible Beneficiary status for such Members, Health Plan shall perform the default enrollment process as provided by 42 CFR §§ 422.66 and 422.68.

2. Through this Agreement, as provided by 42 CFR § 422.66(c)(2)(i)(B) and 42 CFR § 422.107, the Department hereby approves Health Plan's implementation of the default enrollment process for its D-SNP. This approval is contingent upon Health Plan's compliance with 42 CFR §§ 422.66(c)(2)(i)(E), (F), & (G), 42 CFR § 422.66(c)(2)(ii), and other CMS-published regulatory guidance, as applicable.

3. Health Plan shall be responsible for obtaining initial default enrollment process approval from CMS in a timely manner. Health Plan shall coordinate with the Department regarding those activities necessary to obtain such CMS prior approval. Health Plan shall provide the Department a copy of its CMS default enrollment process prior approval notification or correspondence within 10 calendar days of receipt.

4. Health Plan shall be responsible for coordination and continuity of care to ensure that, for each Member enrolled in Health Plan's D-SNP through the default enrollment process (and who is thus also enrolled in a Medicaid Managed Care plan operated by the Health Plan), Health Plan shall be responsible for continuing to provide covered services authorized by the Member's Medicaid Managed Care plan, without regard to whether such services are being provided by participating or non-participating providers, for at least sixty (60) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the Health Plan's D-SNP plan or the Member's transition to a participating provider and any needed actions to mitigate potential negative consequences related to transition of providers.

5. Consistent with 42 CFR § 422.66(c)(2)(ii), Health Plan shall be responsible for coordinating those activities necessary to renew any existing default enrollment process approval(s) with CMS, such that any such subsequent CMS approval(s)/renewal(s) of Health Plan's existing default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. Health Plan shall coordinate with the Department regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. Health Plan shall forward to the Department copies of its default enrollment process renewal notification and materials, and CMS' renewal approval(s) notification or correspondence, within 10 calendar days of receipt. Failure to comply with renewal requirements in a timely manner may result in suspension of the default enrollment process.

6. Health Plan shall maintain a minimum 3.0 overall plan star rating as assigned by CMS to implement and maintain the default enrollment process.

7. Through implementation of the default enrollment process, the Department shall provide Health Plan with information necessary to prospectively identify those members eligible for default enrollment.

H. Marketing. Health Plan shall comply with all applicable State and Medicare Laws relating to marketing of its D-SNP(s). In connection therewith, Health Plan shall submit its D-SNP(s)' marketing and/or member communications materials to the Department and/or CMS (as applicable) for approval and agrees to only use approved marketing and member communication materials in New York.

I. Compliance with Applicable Laws. Health plan shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title 18 of the New York Codes, Rules and Regulations (NYCRR); Title 10 of the New York Codes, Rules and Regulations (NYCRR); Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345); for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement.

VI. State Department of Health Responsibilities

A. Financial Responsibilities. Pursuant to New York State's Medicaid State Plan, the Department will remain financially responsible for Cost-Sharing Obligations and Medicaid Benefits for certain Dual Eligible Beneficiaries, as set forth in **Attachment A**, who are enrolled in FFS Medicaid and are Members of Health Plan's D-SNP(s). The Department may have financial responsibility for Medicare Part A and/or Part B premiums for select categories of Dual Eligible Beneficiaries, as set forth in **Attachment A**. The Department is not responsible for payment of Medicare Advantage premiums for mandatory or optional Supplemental Benefits, unless

specifically prescribed in New York State's Medicaid State Plan.

The Department is not financially responsible for Cost-Sharing Obligations and Medicaid Benefits for those Dual Eligible Beneficiaries enrolled in an Integrated Medicaid Product which may include MAP, IB-Dual and certain MLTCP programs. The Department is responsible for Cost-Sharing Obligations and Medicaid Benefits for those Dual Eligible Beneficiaries enrolled in a Coordination-Only D-SNP.

B. Claims Processing. The Department shall receive, process, and adjudicate claims for Cost-Sharing Obligations and Medicaid Benefits from Health Plan providers through the FFS Medicaid payment system, in accordance with the Department's processes and procedures for claims administration. Health Plan shall receive, process and adjudicate claims for basic Medicare services and Supplemental Benefits.

C. Medicaid Participating Provider Electronic Data Format. The Department shall provide Health Plan with an electronic data file containing Medicaid participating providers in a generally accepted format on or about April 1st and October 1st of each year, or at such other time as determined by the Department.

D. Educational and Marketing Materials. The Department shall retain responsibility for developing and distributing materials and conducting educational activities relating to New York State's Medicaid State Plan and benefits and services covered under New York State's Medicaid State Plan.

VII. Member Protections

A. No Balance Billing by Providers. With respect to its Members who are eligible for Medicaid payment of Cost-Sharing, Health Plan agrees that it shall include in its contracts with Health Plan providers that they shall not bill or charge ("balance bill") such individuals the balance for any services for which such individuals are not liable in accordance with Section 1902(n)(3) of the Social Security Act.

B. Limitation on Out-of-Pocket Costs. Notwithstanding any provision in this Agreement to the contrary, for Dual Eligible Beneficiaries enrolled in Health Plan's SNP(s), Health Plan shall not impose Cost-Sharing that exceeds the amount of Cost-Sharing that would be permitted with respect to such individuals pursuant to the Medicaid State Plan if the individuals were not enrolled in Health Plan's SNP(s).

C. Member / Hold Harmless. Notwithstanding any provision in this Agreement to the contrary, Health Plan shall prohibit providers, under any circumstance including but not limited to non-payment by Health Plan or the Department,

insolvency of Health Plan or breach of Health Plan's agreement with a provider, from billing, charging, collecting a deposit from, seeking compensation or remuneration from or having any recourse against any Member for fees that are the responsibility of Health Plan or the Department.

VIII. Privacy and Security

The Parties agree that any data or other information transmitted pursuant to this Agreement shall comply with all applicable State and Federal laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA"), Sections 367b(4) and 369 of the New York Social Services Law, Article 27-F of the New York Public Health Law and its implementing regulations, and 42 USC § 1396a and its implementing regulations.

IX. Term & Termination

A. Term. This Agreement commences on the Effective Date and shall be in effect until December 31, 2027.

B. Termination. This Agreement shall automatically terminate upon the termination or expiration of (1) Health Plan's Medicare Advantage Contract with CMS to sponsor Health Plan's D-SNP(s), regardless of the reason for such termination or expiration; or (2) Health Plan's contract with the Department to provide a companion Medicaid Managed Care plan.

X. Miscellaneous

A. Survival. Any provision of this Agreement that requires or reasonably contemplates the performance or existence of obligations by either Party after termination of this Agreement shall survive such termination, regardless of the reason for termination. Additionally, upon termination of this Agreement and regardless of the reason for termination, the defined terms and the following provisions shall survive: §§ VII. (A)-(C), and § VIII.

B. Attachments.

1. The following attachments are incorporated by reference into this Agreement and attached hereto:

   a. Attachment A, "Categories of Dual-Eligible Beneficiaries"

   b. Attachment B, "Product Offerings"

ATTACHMENT A – CATEGORIES OF DUAL ELIGIBLE BENEFICIARIES

The following categories of Dual Eligible Beneficiaries are recognized within the scope of this Agreement:

A. Individuals with full Medicaid and Medicare benefits where the D-SNP is Exclusively Aligned:

1. An "Other FBDE" is an individual who is enrolled in Medicare Part A and/or Part B, and eligible for full Medicaid benefits under New York State's Medicaid State Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the eligibility criteria for Qualified Medicare Beneficiary (QMB).

2. A "QMB-Plus" is an individual who meets all of the QMB eligibility requirements and who also meets the criteria for full Medicaid benefits under New York State's Medicaid State Plan.

B. The following categories of Dual Eligible Beneficiaries and/or Partial Dual Eligible Beneficiaries are recognized within the scope of this Agreement where the D-SNP is not Exclusively Aligned and enrolls Full Benefit Dual Eligible Beneficiaries and/or Partial Dual Eligible Beneficiaries:

1. An "Other FBDE" is an individual who is enrolled in Medicare Part A and/or Part B and eligible for Medicaid benefits under New York State's Medicaid State Plan because the individual falls within a federal mandatory coverage group or an optional coverage group (such as medically needy) but who does not meet the eligibility criteria for QMB.

2. A "QMB-Plus" is an individual who meets all of the Qualified Medicare Beneficiary (QMB) eligibility requirements and who also meets the criteria for full Medicaid benefits under New York State's Medicaid State Plan.

3. Qualified Disabled and Working Individual (QDWI) is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in the purchase of Medicare Part A. The individual must meet federal income and resource criteria and may not be otherwise eligible for Medicaid. A QDWI is eligible only for Medicaid payment of Part A premiums.

4. Qualified Medicare Beneficiary (QMB) Only is an individual who is entitled to Medicare Part A and has income that does not exceed 138% of the Federal Poverty Level (FPL). A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments.

5. Qualifying Individual (QI) is an individual who is in receipt of Medicare Part

A, has income greater than 138% of the FPL but less than or equal to 186% FPL, and who is not otherwise eligible for Medicaid. A QI is eligible only for Medicaid payment of Medicare Part B premiums.

ATTACHMENT B – PRODUCT OFFERINGS

Instructions:

In accordance with the requirements outlined in the SMAC Agreement, Health Plan shall complete Attachment B for each of the D-SNP products that it offers (or proposes to offer) for the upcoming contract year. Health Plan shall review and complete Attachment B for the corresponding D-SNP product(s) that may be either integrated with a Medicaid Managed Care plan or non-integrated (i.e., Coordination Only). Instructions for parts of Attachment B are listed below.

Medicaid Benefits:

Health Plan shall attach copy of Medicaid benefits coverage as outlined in the specific appendix of the Medicaid model contract when submitting this agreement to CMS.

D-SNP Plan Name:

Where Health Plan uses a name for marketing purposes that differs from the D-SNP plan name, Health Plan shall provide both the name used for marketing purposes *and* the D-SNP plan name.

Currently Approved Service Areas:

Health Plan shall indicate all D-SNP counties currently approved by CMS for each product type.

Pending Service Areas:

Health Plan shall indicate any D-SNP counties pending Department approval for any integrated Medicaid product offerings listed below (i.e., MAP or IB-Dual).

A Health Plan that has submitted an application to CMS for a new D-SNP product or service area expansion of an existing product may only list the new counties if they are currently pending Department approval. Health Plan shall not add new counties to this Agreement that are not currently under review with the Department.

For D-SNP with Companion Partial Capitation Plan (MLTCP):

Where there is any difference between the Health Plan D-SNP approved counties and those counties approved by the Department for the aligned MLTCP, Health Plan shall identify such differences.

D-SNP WITH COMPANION MEDICAID ADVANTAGE PLUS (MAP)

Health Plan operating a FIDE SNP with a companion MAP must complete this section in full.

1. Attach a copy of Appendix K of the Medicaid Advantage Plus Model Contract (Combined Medicare Advantage and Medicaid Advantage Plus (MAP) Advantage Benefit Package for Dual Eligibles) in its entirety when submitting this agreement to CMS. See link below.

   https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/docs/2022-2026-map_model_contract.pdf

2. ☐ Check the box to attest that Health Plan operates a MAP with Exclusively Aligned enrollment into the D-SNP. *(SNP Contract Status Review Matrix Provision #1)*

3. ☐ Check the box to attest that Health Plan shall meet designation for FIDE SNP as defined in this agreement and outlined in the Appendix K link to the model contract. MAP coverage includes primary and acute care, behavioral health, and long term services and supports, including nursing facility services for a period of at least 180 days during the plan year. MAP behavioral health coverage (effective 1/1/23) is described in Appendix A at the link below. *(SNP Contract Status Review Matrix Provisions #2, 4 - 12)*

   https://health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/2022/docs/2022-08-16_mltc_22-03.pdf

4. Indicate whether Health Plan has a fully executed MAP contract with the Department: ☐ Yes ☐ No (select one)

   If the answer above is "No," Health Plan must provide the expected date of a fully executed MAP contract: _____

5. Indicate whether Health Plan has received CMS approval for default enrollment for its MAP contract: ☐ Yes ☐ No (select one)

6. Provide the following information for Health Plan D-SNP:

   CMS Contract Code (H#): _____

   CMS Contract Name: _____

   Plan Benefit Package #(s): _____

   D-SNP Plan Name: _____

D-SNP Plan Marketing Name: _____
(if different from D-SNP Plan Name)

7. Service Area: Check all counties in which the D-SNP is approved to operate. For counties awaiting Department approval, check the box for that county and write "pending" next to the county name.

   Note that a Health Plan that has submitted an application to CMS for a new plan or expansion of an existing plan may not add new counties to this SMAC that are not currently under review with the Department.

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga
☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins
☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

8. Categories of Dual Eligible Beneficiaries Enrolled: Health Plan attests that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment A**, may enroll in this D-SNP.

   Select the categories of Dual Eligible Beneficiaries that may enroll in this D-SNP.

   ☐ QMB-Plus

   ☐ Other FBDE

9. Ownership and Affiliation: Health Plan attests that the legal entity offering Health Plan is the same legal entity offering the MAP plan under which the Department provides capitated payments for provision of the services. ☐ Yes ☐ No (select one)

   Health Plan must provide the following information for each legal entity:

   Full name of legal entity offering Health Plan (D-SNP):

_____

Full name of legal entity offering MAP:

_____

(SNP Contract Status Review Matrix Provision #3)

D-SNP WITH COMPANION MANAGED LONG TERM CARE PARTIAL CAPITATION (MLTCP) PLAN

Health Plan operating a D-SNP with a companion MLTCP must complete this section in full.

1. Attach copy of Appendix G of the Managed Long Term Care Partial Capitation model contract (Covered & Non-Covered Services) in its entirety when submitting to CMS. See the link below.

   https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2023/docs/part_cap_model.pdf

2. ☐ Check the box to attest that Health Plan operates a D-SNP that meets the designation of HIDE SNP as defined in this agreement and by CMS. *(SNP Contract Status Review Matrix Provision #6)*

3. Provide the following information for Health Plan D-SNP:

   CMS Contract Code (H#): _____

   Contract Name: _____

   Plan Benefit Package #(s): _____

   D-SNP Plan Name: _____

   D-SNP Plan Marketing Name: _____
   (if different from D-SNP Plan Name)

4. Service Area: Check all counties in which the D-SNP is approved to operate. For counties awaiting Department approval, check the box for that county and write "pending" next to the county name.

   Where an MLTCP aligned D-SNP's counties and those approved by the Department for the MLTCP are not completely aligned, Health Plan should indicate any differences between the MLTCP D-SNP versus the MLTCP approved counties.

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga
☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins

☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan attests that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment A**, may enroll in this D-SNP.

Select the categories of Dual Eligible Beneficiaries that may enroll in this D-SNP.

☐ QMB

☐ QI

☐ QDWI

☐ QMB-Plus

☐ Other FBDE

5. Ownership and Affiliation: Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion partial capitation MLTC plan:

☐ The legal entity offering Health Plan is the same legal entity offering the partial capitation MLTC plan under which the Department provides capitated payments for provision of long term services and supports in Appendix A.

☐ The legal entity offering Health Plan is a separate legal entity under the same parent organization offering the partial capitation MLTC plan under which the Department provides capitated payments for the provision of long term services and supports.

Health Plan must provide the following information for each legal entity:

Full name of legal entity offering Health Plan (D-SNP):

_____

Full name of legal entity offering partial capitation MLTC plan:

_____

(SNP Contract Status Review Matrix Provision #3)

D-SNP WITH COMPANION MMC/HARP (Integrated Benefits for Dually Eligible Enrollees Program - IB-Dual)

Health Plan operating a D-SNP with a companion IB-Dual must complete this section in full.

1. Attach copy of Appendix K of the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan model contract (Prepaid Benefit Package Definitions of Covered and Non-Covered Services) in its entirety when submitting to CMS. See the link below.

   https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf

2. Check one box:

   ☐ Health Plan attests that it operates a D-SNP that enrolls both Medicaid Managed Care and FFS Medicaid Dual Eligibles.

   ☐ Health Plan attests that it operates a D-SNP that exclusively enrolls Medicaid Managed Care/Health and Recovery Plan Dual Eligibles.

   If either box is checked, Health Plan shall meet designation for HIDE SNP as defined in this agreement and outlined in the Appendix K link to the model contract. The IB-Dual coverage includes behavioral health and/or long-term services and supports. *(SNP Contract Status Review Matrix Provision #6)*

   If the second box is checked, the Health Plan shall meet requirements of an Applicable Integrated Plan (AIP) in accordance with CMS regulations at 422.561.

3. Indicate whether Health Plan has a fully executed MMC/HARP contract with the Department: ☐ Yes ☐ No (select one)

   If the answer above is “No,” Health Plan must provide the expected date of a fully executed MMC/HARP contract: _____

4. Provide the following information for the D-SNP:

   CMS Contract Code (H#): _____

   Contract Name: _____

   Plan Benefit Package #(s): _____

   D-SNP Plan Name: _____

   D-SNP Plan Marketing Name: _____

(if different from D-SNP Plan Name)

5. Indicate whether Health Plan has received Department approval to offer IB-Dual in all counties indicated below: ☐ Yes ☐ No (select one)

6. Indicate whether Health Plan has received CMS approval for default enrollment for its D-SNP aligned with an MMC/HARP (IB-Dual) contract: ☐ Yes ☐ No (select one)

7. Service Area: Check all counties in which the D-SNP is approved to operate. For counties awaiting Department approval, check the box for that county and write "pending" next to the county name.

   Note that a Health Plan that has submitted an application to CMS for a new plan or expansion of an existing plan may not add new counties to this SMAC that are not currently under review with the Department.

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga
☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins
☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

Categories of Dual Eligible Beneficiaries Enrolled: Health Plan attests that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment A**, are enrolled in this D-SNP.

Select the categories of Dual Eligible Beneficiaries enrolled in this D-SNP.

In IB-Dual:

☐ QMB-Plus

☐ Other FBDE

In FFS Medicaid:

☐ QMB

☐ QI

☐ QDWI

☐ QMB-Plus

☐ Other FBDE

8. Ownership and Affiliation: Check the applicable box to describe the ownership and affiliation between the legal entity offering Health Plan and the legal entity offering the companion IB-Dual:

   ☐ The legal entity offering Health Plan is the same legal entity offering the IB-Dual program under which the Department provides capitated payments for provision of the services in Appendix A.

   ☐ The legal entity offering Health Plan is a separate legal entity under the same parent organization from the legal entity offering the IB-Dual program under which the Department provides capitated payments for the provision of the services.

   Health Plan must provide the following information for each legal entity:

   Full name of legal entity offering Health Plan (D-SNP):

   _____

   Full name of legal entity offering IB-Dual:

   _____

   (SNP Contract Status Review Matrix Provision #3)

COORDINATION ONLY D-SNP (1) –

1. Provide the following information for the D-SNP:

   CMS Contract Code (H#): _____

   Contract Name: _____

   Plan Benefit Package #(s): _____

   Plan Name: _____

   D-SNP Plan Marketing Name: _____
   (if different from D-SNP Plan Name)

2. Service Area: Check all counties in which the D-SNP is approved to operate.

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga
☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins
☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

3. Categories of Dual Eligible Beneficiaries Enrolled: Health Plan attests that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment A**, are enrolled in this D-SNP.

   Select the categories of Dual Eligible Beneficiaries enrolled in this D-SNP.

   ☐ QMB

   ☐ QI

   ☐ QDWI

   ☐ QMB-Plus (in FFS Medicaid)

☐ Other FBDE (in FFS Medicaid)

COORDINATION ONLY D-SNP (2) –

1. Provide the following information for the D-SNP:

   CMS Contract Code (H#): _____

   Contract Name: _____

   Plan Benefit Package # (s): _____

   Plan Name: _____

   D-SNP Plan Marketing Name: _____
   (if different from D-SNP Plan Name)

2. Service Area: Check all counties in which the D-SNP is approved to operate.

☐ Albany	☐ Franklin	☐ Oneida	☐ Schuyler
☐ Allegany	☐ Fulton	☐ Onondaga	☐ Seneca
☐ Bronx	☐ Genesee	☐ Ontario	☐ Steuben
☐ Broome	☐ Greene	☐ Orange	☐ Suffolk
☐ Cattaraugus	☐ Hamilton	☐ Orleans	☐ Sullivan
☐ Cayuga	☐ Herkimer	☐ Oswego	☐ Tioga
☐ Chautauqua	☐ Jefferson	☐ Otsego	☐ Tompkins
☐ Chemung	☐ Kings	☐ Putnam	☐ Ulster
☐ Chenango	☐ Lewis	☐ Queens	☐ Warren
☐ Clinton	☐ Livingston	☐ Rensselaer	☐ Washington
☐ Columbia	☐ Madison	☐ Richmond	☐ Wayne
☐ Cortland	☐ Monroe	☐ Rockland	☐ Westchester
☐ Delaware	☐ Montgomery	☐ St. Lawrence	☐ Wyoming
☐ Dutchess	☐ Nassau	☐ Saratoga	☐ Yates
☐ Erie	☐ New York	☐ Schenectady	
☐ Essex	☐ Niagara	☐ Schoharie	

4. Categories of Dual Eligible Beneficiaries Enrolled: Health Plan attests that only Dual Eligible Beneficiaries from the following categories, as defined in **Attachment A**, are enrolled in this D-SNP. ☐ Yes ☐ No (select one)

   Select the categories of Dual Eligible Beneficiaries enrolled in this D-SNP.

   ☐ QMB

   ☐ QI

   ☐ QDWI

   ☐ QMB-Plus (in FFS Medicaid)

☐ Other FBDE (in FFS Medicaid)