Molina Healthcare of New York, Inc. Provider Manual

Medicaid Managed Care, Molina Healthcare PLUS and Child Health Plus Programs

Effective November 2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at www.MolinaHealthcare.com.

Last Updated: 09/2022

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Molina Healthcare of New York, Inc. Provider Manual Addendum – September 2022

Required Update: **New language will be added**

Section Title: **Risk Adjustment Management Program**

Subsection Title: **Interoperability**

The following new language will be added:

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider, will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

CONTENTS

INTRODUCTION

Welcome to the Molina Healthcare of New York, Inc. (Molina or MHNY) Provider Network!

This manual will provide the necessary information to you about the Molina managed Medicaid and Child Health Plus products as well as Skilled Nursing Facility and the Health and Recovery Program products.

We currently offer the following to eligible individuals:

- A NYS Managed Medicaid product in Allegany, Bronx, Broome, Cattaraugus, Chautauqua, Chenango, Cortland, Erie, Genesee, Kings, Livingston, Monroe, Nassau, New York, Onondaga, Ontario, Orange, Orleans, Queens, Richmond, Rockland, Seneca, Suffolk, Tioga, Tompkins, Wayne, Westchester, and Wyoming counties.
- A Child Health Plus program in Allegany, Bronx, Cattaraugus, Chautauqua, Cortland, Erie, Genesee, Kings, Livingston, Monroe, Nassau, New York, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Richmond, Rockland, Seneca, Suffolk, Tompkins, Wayne, Westchester, and Wyoming counties.
- Molina Healthcare PLUS (formerly HARP) in Allegany, Bronx, Broome, Cattaraugus, Chautauqua, Chenango, Cortland, Erie, Genesee, Kings, Livingston, Monroe, Nassau, New York, Onondaga, Ontario, Orange, Orleans, Queens, Richmond, Rockland, Seneca, Suffolk, Tioga, Tompkins, Wayne, Westchester, and Wyoming counties.

We understand the importance of the Provider-patient relationship and the administrative requirements of managing your patients' health care needs. This manual was designed to assist you and your office staff in understanding the requirements that govern the management of Molina Members while serving as a resource for any questions you have about our programs. Molina will update this manual as our operational policies change. If Molina updates any of the information in this manual, we will provide bulletins, as necessary, and post the changes on our website, www.MolinaHealthcare.com. You can also find a copy of this manual on our website.

We are proud of the relationship we have with our Participating Providers and are committed to working with you to provide the support and assistance necessary to meet the needs of your patients.

We encourage you to carefully read this manual and to contact your Provider Relations Representative with any questions or comments regarding this manual, or to discuss any aspects of being a Molina Participating Provider.

SECTION 1. CONTACT INFORMATION FOR PROVIDERS

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. Your Provider Representative can assist you with any questions, issues or training that is needed by contacting them at the following.

Provider Services	
Phone:	(877) 872-4716 An answering service will be available after business hours.
Fax:	(844) 879-4509
Email:	MHNYProviderServices@MolinaHealthCare.com

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 a.m. – 6:00 p.m. Monday through Friday, excluding State holidays.

Member Services	
Address:	Molina Healthcare of New York, Inc. 1776 Eastchester Road, Bronx, NY 10461
Phone:	(800) 223-7242
Fax:	(844) 879-4509
TTY/TDD:	711

Claims Department

Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal).

- Access the Provider Portal (www.availity.com/molinahealthcare)
- EDI Payer ID **16146**.

To verify the status of your claims and/or to dispute a claim, please use Molina's Provider Portal. For other claims questions contact Provider Services at the number listed below.

If necessary, paper claims can be submitted to the following address:

Claims	
Address	Molina Healthcare of New York, Inc. PO Box 22615, Long Beach, CA 90801
Phone:	(877) 872-4716

Claims Recovery Department

The Claims Recovery Department manages recovery for Overpayment and incorrect payment of Claims.

Claims Recovery	
Address	Molina Healthcare of New York, Inc. Attn: Claims Recovery 200 Oceangate Suite 100 Long Beach, CA 90802
Phone:	(866) 642-8999

Compliance and Fraud Alert Line

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina Healthcare Alert Line or submit an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance Section of this Manual.

Molina Healthcare Alert Line	
Address:	Attn: Compliance Officer 5232 Witz Drive North Syracuse, NY 13212
Phone:	(866) 606-3889
Website:	https://molinahealthcare.alertline.com

Credentialing Department

The Credentialing Department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Credentialing	
Address:	Molina Healthcare of New York, Inc. 5232 Witz Drive North Syracuse, NY 13212
Phone:	(877) 872-4716
Fax:	(844) 879-4509
Email:	MHNYNetworkOperations @MolinaHealthCare.com

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are

available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

Nurse Advice Line **24 hours per day, 365 days per year**
Phone: 1-844-819-5977
TTY/TDD: 711

Healthcare Services (HCS) Department

The Healthcare Services (formerly Utilization Management) Department conducts inpatient review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) Department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically using Molina's Provider Web Portal.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces cost associated with fax and telephonic interactions

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina Healthcare of New York via the Provider Portal. See our Provider Web Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of our website for guidance.

Healthcare Services (UM) **Authorizations & Inpatient Census and Behavioral Health**
Provider Portal: www.availity.com/molinahealthcare
Address: Molina Healthcare of New York, Inc. 1776 Eastchester Road Bronx, NY 10461
Phone: 1-877-872-4716 An answering service will be available after business hours.
Fax: (866) 879-4742

Behavioral Health

Molina Healthcare manages all components of our covered services for behavioral health for Medicaid Managed Care, Child Health Plus and Molina Healthcare PLUS (formerly HARP) members. For Member behavioral health needs, please contact:

Molina Healthcare	
Website:	https://www.MolinaHealthcare.com
Address:	Molina Healthcare of New York, Inc. 1776 Eastchester Road Bronx, NY 10461
Phone:	1-877-872-4716
Crisis Line: Twenty-Four (24) Hours per day, Three-Hundred-Sixty-Five (365) day per year: (800) 223-7242	

Pharmacy Department

Prescription drugs are covered by Molina Healthcare. The drug formulary and a list of in-network pharmacies is available on the www.MolinaHealthcare.com website, or by contacting Molina at (877) 872-4716.

Molina Healthcare	
Prior Authorization Assistance, Inquiries (J Codes and Home Infusion)	
Phone:	1-877-872-4716
CVS/Caremark:	1-800-364-6331
Prior Authorization Fax:	(844) 823-5479

Dental Services

Dental services are covered by Molina, via our Dental Vendor, DentaQuest®.

DentaQuest®	
Address:	Claims/ Utilization Management/Appeals: DentaQuest IPA of New York LLC PO Box 2906 Milwaukee, WI 53201-2906
Phone:	1-888-308-2508
Fax:	Claims/payment issues: 1-262-241-7379 Claims to be processed: 1-262-834-3589
Electronic Claims:	www.dentaquest.com
Email: Claims Questions: Eligibility/Benefit Questions:	 denclaims@dentaquest.com denelig.benefits@dentaquest.com

Vision

Versant Health	
Address:	Versant Health Complaints & Appeals Department PO Box 791 Latham NY 12110 Paper Claims Att Claims Dept PO Box 967 Rancho Cordova CA 95741
Phone:	(866) 819-4298

Quality Department

Molina maintains a Quality Department to work with Members and Providers in administering Molina's Quality Programs.

Quality Department	
Email:	MHNYQuality@MolinaHealthCare.Com

Service Area

Molina Healthcare of New York, Inc. operates in the following New York State counties:

Allegany	Livingston	Richmond
Bronx	Monroe	Rockland
Broome	Nassau	Seneca
Cattaraugus	New York	Suffolk
Chautauqua	Onondaga	Tioga
Chenango	Ontario	Tompkins
Cortland	Orange	Wayne
Erie	Orleans	Westchester
Genesee	Oswego	Wyoming
Kings	Queens	

SECTION 2. PROVIDER RESPONSIBILITIES

Participation Guidelines and Standards of Care

Provider Guidelines:

All Participating Providers are expected to:

- Perform duties in their area of specialty.
- Provide preventive care services, including well child, adolescent, and adult preventive services (e.g., pap smears, HIV counseling, immunizations). Provide complete current information concerning a diagnosis, treatment, treatment options and prognosis from a physician or other Provider in terms the patient can be reasonably expected to understand. When it is not advisable to give such information to the patient, the information will be made available to an appropriate person on the patient's behalf.
- Provide information from a physician or other Provider necessary to give informed consent prior to the start of any procedure or treatment. Afford the patient the opportunity to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Be responsible for the supervision of patient care if a mid-level practitioner or resident renders care.
- Be responsible for patient care twenty-four hours a day or make arrangements with an alternate Participating Provider who must be available by telephone and can be available for coverage. If you use an answering machine, the message must direct the Member to a live voice.
- Promptly report to the referring primary care physician with any significant findings or urgent changes in therapy resulting from the consultation.
- Work closely with the Molina Quality and Healthcare Services Departments to assure patient compliance with follow-up.
- Comply with Molina's credentialing criteria and policies.
- Primary Care Providers (PCP) will coordinate care when the patient is referred to a specialist.
- Comply with Molina's procedures on referrals and preauthorization.
- Refer patients to the Molina Healthcare Services Department who require Case Management Services.
- Maintain confidentiality of medical information. For patients who have AIDS or who have been tested for the HIV virus, please see NYS Public Health Law Article 27.F, Section 2782.
- Comply with New York State Department of Health Communicable Disease Reporting Requirements (e.g. HIV, Tuberculosis, Hepatitis C etc.). These requirements are found at http://www.health.ny.gov/professionals/diseases/reporting/communicable/
- Communicate with patients regarding areas of needs, and concerns requiring immediate attention.
- Comply with Federal and state requirements for informed consent for hysterectomies and sterilization. Requirements are found on http://www.health.state.ny.us.

- Utilize formal Mental Health and Substance Use Assessment Tools.
- Adhere to the Molina Pharmacy Formulary. See our website at www.MolinaHealthcare.com for detailed information.
- Refer patients needing urgent evaluation or emergency care to a Participating emergency department or urgent care site whenever possible.
- Adhere to Molina's Appointment Access & Availability Guidelines. Ensure that Members with appointments are not routinely made to wait longer than one (1) hour.
- Adhere to Child/Teen Health Guidelines.
- Comply with the Adult Preventive Care Guidelines.
- Following Medicaid requirements for screening for children and adolescents and Medicaid/FHP
- Allow the member to select a lead provider to be a PCP if the member is using a behavioral health clinic that also provides primary care services
- Make available records and medical information for Quality Improvement/Utilization Review activities.
- Follow Molina's standards for Medical Records.
- Receive signed acknowledgment from the Member prior to rendering non-covered services. Signed acknowledgments confirm the Member's knowledge of non-covered services under their Benefit Plan.
- Participate in Molina Health Advisory Committees if possible.
- Treat all patients equally;
- Not discriminate because of race, sex, marital status, sexual orientation, religion, ancestry, national origin, place of residence, disability, source of payment, utilization of medical, mental health services or supplies, health status, or status as a Medicare or Medicaid recipient, or other unlawful basis; and,
- Agree to observe, protect, and promote the rights of Molina's Members as patients.

For your reference, we have included the Molina's Member Rights and Responsibilities as a Section in this Provider Manual.

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

Standards of Care

Molina Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered evidence-based services in a manner consistent with standards, including nationally recognized clinical protocols and guidelines, related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating Providers must also comply with Molina's standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control Prevention (or any successor entity)

- New York State Department of AIDS Institute
- All federal, state, and local laws regarding the conduct of their profession
- Participation on committees and clinical task forces to improve the quality and cost of care
- Referral Policies
- Preauthorization and notification requirements and timeframes
- Participating Provider credentialing requirements
- Care Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of Member medical record information to fulfill the business and clinical needs of Molina
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with Molina personnel and fellow Participating Providers, and
- Providing equal access and treatment to all Members

Role of Primary Care Provider (PCP)

PCP's are required to:

a) Delivery primary care services.

b) Supervise and coordinate medically necessary health care of the enrollee, including 24/7 coverage.

c) Follow Molina's standards of care, which are reflective of professional and generally accepted standards of medical practice.

d) Follow Medicaid requirements for screening for children and adolescents and Medicaid behavioral health screening by PCP for all members, as appropriate.

e) Allow the member to select a lead provider to be a PCP, if the member is using a behavioral health clinic that also provides primary care services.

Each Molina Member is encouraged to select a PCP from Molina's Provider Directory. 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, a credential given by the HIV/AIDS Nursing Certification Board (HANCB).

If a Provider has a closed panel, there will be a "notation indicating that the Provider is not currently accepting new patients in the Provider Directory. If a Member does not select a PCP, the Molina Member Service Department contacts the Member to assist them with selecting (A Primary Care Provider is a Pediatrician, Family Practitioner or Internist). If all attempts to contact the Member are unsuccessful, the Member is notified by mail of a selection made by Molina. At this time, the Member is again afforded the opportunity to select his or her own PCP.

As a Primary Care Provider (PCP), you are the manager of your patients' total health care needs. PCPs provide routine and preventive medical services, authorize covered services for Members, and coordinate all care that is given by Molina's specialists and 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.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Pediatricians, Geriatrics, OB/GYNs, and physicians that specialize in Infectious Disease, and Nurse Practitioners. Members may select the lead physician in a Mental Health Clinics as a primary care physician.

Specialist or Specialty Center as PCP

For Members with a degenerative and disabling condition or disease, the Member or Members' Representative or a PCP may request a specialist or specialty center as PCP. The Molina Medical Director will, in consultation with the Primary Care Provider and the specialist or specialty center, review the Member's medical record and determine whether, based on existing clinical standards, the Member's disease or condition is degenerative and disabling.

A Member cannot elect to use a non-participating specialist or center as PCP unless the Molina network does not include an appropriate Provider. Molina must approve requests for Members to receive primary care services from Non-Participating Providers. Once approved, if a non-participating specialist or specialty center is chosen, services will be provided at no additional cost to the Member. The specialist/specialty center must be willing to comply with the requirements of PCPs as outlined in this manual.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Healthcare of New York website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against Members based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

Section 1557 Investigations

All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Toll Free: (866) 606-3889
TTY/TDD: 711

On Line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA© required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Any other information that may impact Member access to care

Please visit our Provider Online Directory at https://providersearch.molinahealthcare.com to validate and correct most of your information. A convenient Provider web form van be found on the POD and additionally on the Provider Portal at www.availity.com/molinahealthcare. Or notify your Provider Services Representative or contact our Provider Services Department at (877) 872-4716 if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the Credentialing section of this Provider Manual.

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of Molina's Provider Web Portal (Provider Portal).

Molina strongly encourages the submission of electronic claims, which includes claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by registering for Molina's Provider Web Portal. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers) (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at www.MolinaHealthcare.com

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Web Portal

Molina Mobile App

Molina encourages providers to engage and assist members in using our health plan's customized Mobile App. There are several features and capabilities that can provide a more convenient and simplified experience such as:

- Improved virtual ID cards with sharing and printing options
- Improved bill pay for Marketplace

- Members
- Urgent Care Finder
- Pharmacy Finder
- Symptom Checker
- Favorite Doctor Option
- Face ID Recognition

For more information on how to use the app or to request educational materials, please contact the Provider Relations Team at (877) 872-4716.

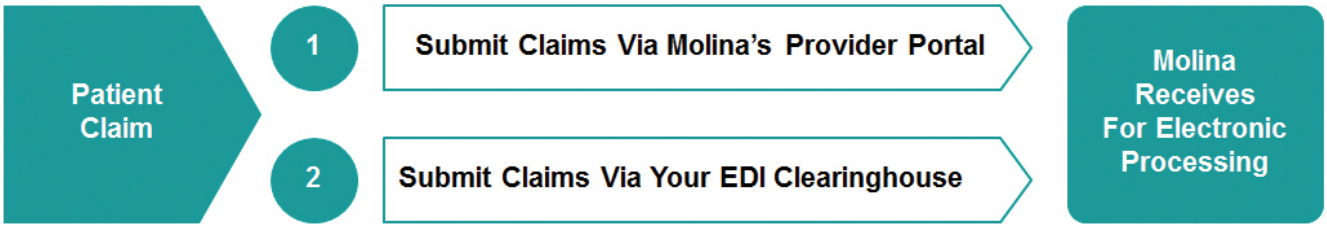
Electronic Claims Submission

Molina strongly encourages Participating Providers to submit claims electronically. Electronic claims submission provides significant benefits to the Provider including:

- Promotes HIPAA compliance
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of New York via the Provider Portal. See our Provider Web Portal Quick Reference Guide www.availity.com/molinahealthcare or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 16146; refer to our website www.MolinaHealthcare.com for additional information.



While both options are embraced by Molina, Providers submitting claims via Molina's Provider Portal (available to all Providers at no cost) offer a number of claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Electronic Claims submitting benefits include:

- Ability to add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status

- Receive timely notification of a change in status for a claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claims Templates

For more information on EDI Claims submission, see the Claims and Compensation Section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com. Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or (877) 389-1160.

Provider Web Portal

Providers are required to register for Molina's Availity Provider Portal. The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print Member eligibility – As well as view benefits, covered services and Member Health Record
- Member Roster – View as list assigned membership for PCP(s)
- Claims Functions
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
    - Create and Manage Claims Templates
    - Open Saved Claims
    - Appeal Claims
- Prior Authorizations/Service Requests
    - Create and submit Service/Prior Authorization Requests
    - Check status of Service/Authorization Requests

    - Receive notification of change in status of Service/Authorization Requests
    - Create Service Request/Authorization Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
    - Create and submit a Claim Appeal
    - Add Appeal attachments to Appeal
    - Receive Email Confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

Balance Billing

Providers contracted with Molina cannot bill the Member for any Covered Services. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments, deductibles or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the member website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: https://www.molinahealthcare.com/providers/ny/medicaid/policies/Pages/member_rights.aspx

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document.

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Molina Healthcare at (800) 223-7242, Monday- Friday, 8:00 a.m. – 6:00 p.m. TTY users, please call 711.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use. Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Possession of a Molina Healthcare of New York ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options is available in the Eligibility, Enrollment and Disenrollment and Grace Period section of this Manual.

Member Cost Share

Providers should verify the Molina Member's Cost Share status prior to requiring the Molina Member to pay co-pay, co-insurance, deductible or other Cost Share that may be applicable to the Member's specific Benefit Plan. Some plans have a total maximum Cost Share that frees the Member from any further out of pocket charges once reached (during that calendar year).

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at www.MolinaHealthcare.com.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.MolinaHealthcare.com). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient service centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on Molina's list of allowed in-office laboratory tests will be denied.

Referrals

When a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Healthcare Services section of this Manual). Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made. Molina does not require a referral to an in-network specialist. All requests for referrals to a non-participating provider require a referral.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Providers will assess for and promptly refer members experiencing first episode psychosis to specialty programs or program utilizing evidence-based practices for this condition, such as:

OnTrackNY Providers, trained by The Center for Practice Innovations (CPI) at Columbia Psychiatry/ NYS Psychiatric Institute, deliver coordinated, specialty care, for those experiencing FEP, including: "psychiatric treatment, including medication; cognitive-behavioral approaches, including skills training; individual placement and support approach to employment and educational services; integrated treatment for mental health and substance use problems; and family education and support" (CPI website). Each site has the ability to care for up to 35 individuals. Requirements:

1. Ages 16-30
2. Began experiencing psychotic symptoms for more than a week, but, less than two
3. Years prior to referral Borderline IQ or above, such that individual is able to benefit from services offered. Providers who need to refer members for further behavioral health care should contact Molina Healthcare

Admissions

Providers are required to comply with Molina's facility admission, prior authorization, and Medical Necessity review determination procedures.

Participation in Utilization Review and Care Management Programs

Providers are required to participate in and comply with Molina's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

Continuity and Coordination of Provider Communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings. Each year, we review feedback received from PCPs and specialists and facilities to determine if the level of satisfaction with the information provided across settings or between Providers is sufficient.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at www.MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for health care services. The form should be faxed to Molina at (844) 879-4471.

Newborn Process

Notification to Molina is based on the receipt of the daily newborn reports, monthly rosters and daily transaction reports.

Notify of birth via phone at (800) 223-7242 or via e-mail to the following:
MHNYEnrollment@MolinaHealthCare.Com

The following elements are necessary to process enrollment. We will respond within two (2) business days with an eligibility update.

Mother:

- First Name
- Last Name
- DOB (date of birth)
- CIN #

Child:

- First Name
- Last Name
- DOB (date of birth)
- CIN # if available
- Gender
- Primary Care Physician (*optional)

Prescriptions

Providers are required to adhere to Molina's drug formularies and prescription policies.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Healthcare Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers.

Additional information regarding Quality Programs is available in the Quality section of this Manual.

Member to Provider Ratios

PCPs agree to adhere to the Member-to-PCP ratios of 1500 Members per 1 PCP. These ratios assume that the PCP is a full-time equivalent (FTE) defined as a Provider practicing forty (40) hours per week.

Minimum Office Hours

A Molina PCP must practice a minimum of sixteen (16) hours a week at each primary care site. Providers must promptly notify Molina 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.

Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are

provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Manual.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

Appointment Availability Guidelines

- All Providers in the Molina network will comply with the following appointment availability guidelines.
- **Emergency Care:** Immediately upon presentation at a service delivery site.
- **For CPEP:** inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services; immediately upon presentation at a service delivery site.
- **Urgent Care:** Within twenty-four (24) hours of request.
- **Non-Urgent "Sick" Visit:** Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- **Routine, non urgent, preventative appointments except as otherwise provided in this Section:** Within four (4) weeks of request.
- **Specialist Referrals (not urgent), preventative appointments, except as otherwise provided in this Section:** Within four (4) to six (6) weeks of request.
- **Initial Prenatal Visit:** Within three (3) weeks during first trimester, two weeks during the second trimester, and one week during the third trimester.
- **Adult Baseline and Routine Physicals:** Within twelve (12) weeks from enrollment. (Adults > 21 years) [Applicable to HIV SNP Program only]:Adult baseline and routine physicals: within four (4) weeks from enrollment (Adults > 21 years)
- **Well Child Care:** Within four (4) weeks of request.
- **Initial Family Planning Visits:** Within two weeks of request.

- **In-Plan Mental Health or Substance Use Follow-Up:** Pursuant to an emergency hospital discharge or release from incarceration, where the Plan is informed of such release, mental health or Substance Abuse Disorder follow up visits with a participating provider: within five (5) days of request, or a clinically indicated.
- **In-Plan, Non-Urgent Mental Health or Substance Use and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic Visits** with a Participating Provider**:** Within one (1) week of request.
- **Initial PCP Office Visit for Newborns:** Within two (2) weeks of hospital discharge. [Applicable to HIV SNP Program} Initial PCP office visit for newborns within forty-eight (48) hours of hospital discharge or the following Monday if the discharge occurs on a Friday. `
- **Provider Visits to Perform Health, Mental Health and Substance Use Assessments:** for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a Local Department of Social Services (LDSS) Provider: within ten (10) days of request by a Member, in accordance with Benefit Agreement.

For Behavioral Health/Substance Use Disorders the following appointment availability guidelines will be followed:

- Behavioral Health Specialist referrals (non-urgent):
    - For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Abuse Disorder treatment services: within two (2) to four (4) weeks; and
    - For PROS programs other than clinic services: within two (2) weeks of request.
- Urgent care – within 24 hours.
- Emergency Services/CPEP – immediately; 24 hours a day/7 days per week
- For urgent needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT) , Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs: within twenty-four hours of request.
- OASAS Residential Treatment – immediately for inpatient substance use detoxification and within twenty-four (24) hours for inpatient rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.
- Non-24-hour Diversionary Psychopharmacology Services – within two (2) calendar days.
- Medication Management – within 14 calendar days
- Outpatient mental health office and clinic services – within two (2) to four (4) weeks of request.
- Psychological or neuropsychological testing – non-urgent within two (2) to (4) weeks
- Personalized Recovery Oriented Services (PROS) pre-admission status – begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted. Pre-Admission is open-ended with no time limits. Appointment should be given within 24-hours of request.
- Personalized Recovery Oriented Services (PROS) Admission – begins IRP is approved by the plan. Appointment should be given within weeks of request.

- Mental Health Continuing Day Treatment (CDT) – Appointment should be offered within two (2) to four (4) weeks of request.
- Mental Health Intensive Outpatient – Appointment should be offered within one (1) week of request.
- Assertive Community Treatment (ACT) – new referrals made within 24 hours and should be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determination of eligibility and appropriateness of ACT
- Outpatient office and clinic treatment provided by OASAS certified agencies – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request.
- Medically Supervised Outpatient Substance withdrawal – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request.
- Opioid Treatment Program (OTP) services – LOCADTR tool to inform level of care determinations. Appointments within 24 hours of request.
- Substance Use Disorder Intensive Outpatient – LOCADTR tool to inform level of care determinations. Appointments should be offered within one week of request.
- Substance Use Disorder Day Rehabilitation – LOCADTR tool to inform level of care determinations. Appointments should be offered within two (2) to four (4) weeks of request.
- Stabilization and Rehabilitation services for residential SUD treatment – LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

For Foster Care, a comprehensive initial assessment needs to be done. These series of assessments will provide a complete understanding of the foster care child's health needs and should be used to develop a comprehensive treatment plan for the enrollees.

Molina Healthcare of New York ("MHNY") will ensure the required Foster Care Initial Health Assessments are completed by the Mental Health Providers/Facilities in a timely manner. In a collaboration between Provider Network and Healthcare Service departments will conduct random audit to ensure the assessments are being done accurately within the timeframe established by OMH.

VFCA / Article 29-I Health Facilities into Medicaid Managed Care

Beginning July 1, 2021, children/youth placed in foster care, will be directly enrolled in Managed Care Plans and receive Medicaid benefits unless otherwise exempt or excluded beginning on a date to be determined by NYS. VFCAs may opt to become a licensed health care facility provider through New York State Public Health Law (PHL) Article 29-I, which provides for the provision of Core Limited Health-Related Services (CLHRS) and Other Limited Health-Related Services (OLHRS)5 , and enter into agreements with Medicaid Managed Care Plans. The requirements of the licenses, including procedures for obtaining that licensure and the requirements of the licensure are described and can be found on the NYS website. Not all VFCAs have elected to become Article 29-I providers. VFCAs who have opt out of Article 29-I licensure are not authorized to provide health services and will not be reimbursed for Article 29-I health services through Medicaid FFS or the Medicaid Managed Care

Plan. However, children/youth placed in the care of these VFCAs and are eligible for Medicaid will be enrolled in a Managed Care Plan unless otherwise exempted or excluded from enrollment.

The following are the services the Molina Health Plan must cover under a 29-I Health Facility or for enrollees who are eligible to be served by a 29-I Health Facility, in accordance with the 29-I Billing Guidance:

1. Core Limited Health-Related Services (CLHRS) on a per diem basis, inclusive of:
    a. Nursing Services
    b. Skill Building Licensed Behavioral Health Practitioner (LBHP)
    c. Medicaid Treatment Planning and Discharge Planning
    d. Clinical Consultation/Supervision Services e. VFCA Managed Care Liaison/Administration
2. Medically necessary Other Limited Health-Related Services (OLHRS) that the 29-I Health Facility is authorized by the State to provide may include:
    a. Children and Family Treatment Supports and Services (CFTSS)
        i. Other Licensed Practitioners (OLP)
        ii. Community Psychiatric Supports and Treatment (CPST)
        iii. Psychosocial Rehabilitation (PSR) iv. Family Peer Supports and Services (FPSS) v. Youth Peer Support and Training (YPST)
        vi. Crisis Intervention (CI)
    b. Children's Waiver HCBS
        i. Caregiver Family Supports and Services
        ii. Community Advocacy and Support
        iii. Respite (Planned and Crisis)
        iv. Prevocational Services
        v. Supported Employment
        vi. Day Habilitation
        vii. Community Habilitation
        viii. Palliative Care: Bereavement Therapy
        ix. Palliative Care: Expressive Therapy
        x. Palliative Care: Massage Therapy
        xi. Palliative Care: Pain and Symptom Management

xii. Environmental Modifications xiii. Vehicle Modifications

xiv. Adaptive and Assistive Equipment

xv. Non-Medical Transportation c. Medicaid State Plan services

i. Screening, diagnosis and treatment services related to physical health, including but not limited to:

- Ongoing treatment of chronic conditions as specified in treatment plans
- Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
- Primary pediatric/adolescent care
- Immunizations in accordance with NYS recommended childhood immunization schedule
- Reproductive health care

ii. Screening, diagnosis and treatment services related to developmental and behavioral health. This includes the following:

- Psychiatric consultation, assessment, and treatment
- Psychotropic medication treatment
- Developmental screening, testing, and treatment
- Psychological screening, testing and treatment
- Smoking/tobacco cessation treatment
- Alcohol and/or drug screening and intervention
- Laboratory tests

29-I Health Facilities will also provide CLHRS and OLHRS to children/youth as described in the Article 29-I VFCA Health Facilities License Guidelines and the 29-I Billing Guidance. Child/youth populations served by 29-I Health Facilities and covered by the MMCP for CLHRS and/or OLHRS are described and defined in the 29-I Billing Guidance, including: 1. Children/youth placed in foster care; 2. Babies residing with their parent who are placed in a 29-I Health Facility and in foster care (8D Babies); 3. Children/youth placed in a 29-I Health Facility by Committee on Special Education (CSE); 4. Pre-dispositional placed youth; and 5. Children/youth and adults who are discharged from a 29i Facility.

Foster Care Initial Health Services

Initial Health Services Time Frames				
Time Frame	**Activity**	**Mandated Activity**	**Mandated Time Frame**	**Who Performs**
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child Welfare Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X	X	Mental health practitioner
30 Days	Family Planning Education and Counseling and follow	X	X	Health Practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Child Welfare Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent &	X	X	Child Welfare Caseworker or health staff
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation	X	X	Health practitioner
60 Days	Arrange HIV testing for child determined infollow up assessment to be	X	X	Child Welfare Caseworker or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in	X	X	Child Welfare Caseworker or health staff

These guidelines are based on New York State Department of Health requirements and may be changed by the Department of Health. Molina will annually complete appointment availability and accessibility surveys of Providers. The Molina Chief Medical Officer will communicate outcomes of those surveys to the Provider.

When an enrolled child in foster care is placed in another county and the Plan he/she is enrolled in operates in the new county, the Plan must allow the child to transition to a new primary care provider as well as any/all other healthcare providers without affecting the care plan already in place. When an enrolled child in foster care is placed outside of the Plan's service area, the Plan must allow the child to access providers with expertise treating foster care children. This is critical in order to ensure continuity of care and the provision of all medically necessary benefit package services. In the situations when there is a long-term foster care placement outside of the Plan's service area, and solely at the discretion of the Local Department of Social Services (LDSS) or Voluntary Foster Care Agency (VFCA), the Plan will coordinate with the LDSS or VFCA to facilitate a smooth enrollment transition.

Molina provides access to medical services to its Members twenty-four (24) hours a day, seven days a week through the network of Primary Care Providers who supervise and coordinate their care.

Molina's contracts with Primary Care Providers require that each PCP assure the availability of covered health services to Molina Members on a twenty-four (24) hour a day, 365 days per year basis, including periods after normal business hours, on weekends, or at any other time. The PCP must arrange for complete back up coverage from other Participating Providers in the event the PCP is unable to be available.

Coverage and availability must allow a Member to reach a live voice with one phone call. In the event the Molina Member is calling from a pay phone, or cannot receive a return call, adequate arrangements must be in place to connect the Member to his/her Provider.

In the event the PCP is temporarily unavailable or unable to provide patient care or referral services to Molina Members, the PCP must arrange for another Molina Participating physician to provide such services. In the rare event a PCP has a non-contracted physician covering, the PCP must have prior approval of Molina. The covering Provider must sign an agreement to accept the PCP's negotiated rate and agree not to balance bill Molina Members.

Medical Record Review

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

As part of Molina's Quality Improvement Plan, a review of medical records and clinical documentation is completed to assess Provider compliance with New York State and Health Plan specific requirements including compliance with the Medicaid Prenatal Care Standards, EPSDT/CTHP standards, infectious disease reporting and compliance with clinical practice guidelines and medical record standards. All Molina Participating Providers shall comply with this review.

Additional details regarding medical record review standards and procedures are available in the Quality section of this manual.

Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay co-pay, co-insurance, deductible or other cost share that may be applicable to the Member's specific benefit plan.

Healthcare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Healthcare Services section of this Provider Manual

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at www.MolinaHealthcare.com.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at https://appointment.questdiagnostics.com/patient/confirmation and https://www.labcorp.com/labs-and-appointments.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this Provider Manual

Delivery of Patient Care Information

Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

Compliance

Providers must comply with all State and Federal Laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that its Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Please refer to the Compliance section of this Provider Manual for additional information.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member appeals, the Provider will participate by providing medical records and/or statement as needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

Please refer to the Adverse Determinations, Appeals and Complaints (Grievances) section of this Manual for additional information regarding this program.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation. State and Federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

More information about Molina's Credentialing program, including Policies and Procedures is available in the Provider Credentialing and Termination section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

SECTION 3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at (877) 872-4716.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

Provider Training

Molina conducts training for both new and existing providers. This can be done both in-person and virtually, depending on circumstances and the needs of the provider.

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with Limited English Proficiency.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on www.MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including Appeals and Grievance forms, are also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within plan's membership
    - Revalidate data at least annually
    - Contracted Providers to assess gaps in network demographics
- Local geographic population demographics and trends derived from publicly available sources (Community Health Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2020

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (800) 223-7242. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember, it is never permissible to ask a family member, friend or minor to interpret.

All eligible members who are Limited English Proficient (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make available assistive listening devices for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the member.

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly at 1-844-819-5977 (TTY:711) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

SECTION 4. MEMBER RIGHTS AND RESPONSIBILITIES

This section explains the rights and responsibilities of Molina Healthcare Members as written in the Molina Member Handbook. New York Law requires that health care Providers or health care facilities recognize Member rights while they are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of patients.

Below are the Member Rights and Responsibilities, as they appear in the Member Handbooks:

Molina Healthcare Member Rights & Responsibilities Statement

Your Rights:

As a Molina Managed Care or Molina Healthcare PLUS Member you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from Molina
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Refuse enrollment into a Health Home and be told how to receive your physical and behavioral health care needs without having an assigned Health Home Care Manager. *
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use Molina Healthcare complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

*Applies only to Molina Healthcare PLUS Members

Your Responsibilities:

As a Member of Molina Healthcare, you agree to:

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

Second opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

SECTION 5. ENROLLMENT, ELIGIBILITY AND DISENROLLMENT

Enrollment

Enrollment in Medicaid Programs

The New York Medicaid programs are administered by the Department of Health. Eligibility is determined by the New York Department of Health. Membership is effective on the date determined by the Department of Health.

No eligible Member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

Effective Date of Enrollment

(a) For MMC Members, Molina, NYSoH and the LDSS are responsible for notifying the Member of the expected Effective Date of Enrollment.

(b) Notification may be accomplished through a "Welcome Letter." To the extent practicable, such notification must precede the Effective Date of Enrollment.

(c) In the event that the actual Effective Date of Enrollment changes, Molina, and for MMC Members the LDSS or NYSoH, must notify the Member of the change.

(d) As of the Effective Date of Enrollment, and until the Effective Date of Disenrollment, Molina shall be responsible for the provision and cost of all care and services covered by the Benefit Package and provided to Members whose names appear on the Prepaid Capitation Plan Roster, except as hereinafter provided.

Newborn Enrollment

All newborn children not Excluded from Enrollment in the MMC Program pursuant to Appendix H of the State of New York Medicaid Contract, shall be enrolled in the MCO in which the newborn's mother is an Member, effective from the first day of the child's month of birth, unless the MCO in which the mother is enrolled does not offer a MMC product in the mother's county of fiscal responsibility.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is no longer confined to an acute care hospital.

Eligibility Verification

Medicaid Programs

The State of New York, through Medicaid Enrollment Operations determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina Healthcare places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid Programs

Providers who contract with Molina Healthcare may verify a Member's eligibility and/or confirm PCP assignment by checking the following:

- Molina Healthcare Provider Services at (877) 872-4716
- Eligibility can also be verified through the ePACES system of New York
- Molina Healthcare, Inc. Web Portal www.availity.com/molinahealthcare

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards

Molina Healthcare of New York, Inc. Sample Member ID cards

Molina Heallthcare of New York, Inc.

Card Front

MOLINA HEALTHCARE

Member: <Member_Name_1>
CIN #: <Member_ID_1>
Date of Birth: <Date_of_Birth_1>
Effective Date: <Member_Effective_Date_1>
PCP Name: <PCP_Name_1>
PCP Phone: <PCP_Phone_Number_1

RxBIN: <Bin_number_1>
RxPCN: <RXPCN_1>
RxGRP: <RXGroup_1>

PRESCRIPTION DRUGS

Non-Preferred Brand Name Drugs: <Rx_Non_Formulary_fee_1>
Preferred Brand Name Drugs: <Rx_Formulary_fee_1>
Generic Drugs: <Missed_Appointment_fee_1>
Over the Counter Drugs (OTC): <Financial_Class_1>

MyMolina.com

Card Back

Members:

Emergency Care:	**Call 911** or go to the nearest Emergency Room.
Behavioral Health Benefit:	**(800) 223-7242**
Dental Benefit (DentaQuest®):	**(855) 208-6768**
Pharmacy Benefit (CVS):	**(800) 223-7242**
Teladoc® Virtual Services:	**(800) 835-2362** connect with a board-certified doctor 24/7
Vision Benefit (Superior Vision®):	**(800) 879-6901**

Providers:

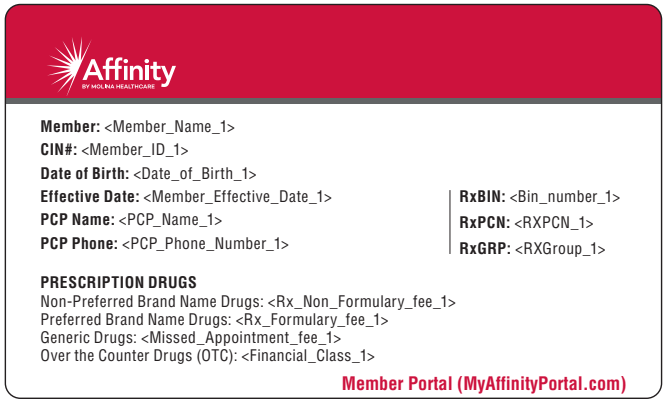
Remit claims to: Molina Healthcare, PO Box 22615, Long Beach, CA 90801
Pharmacists: Contact Caremark Pharmacy Helpdesk at **(800) 364-6331**

*This card does not guarantee coverage. To confirm eligibility or obtain specific benefit information, call Molina Healthcare of New York Member Services at **(800) 223-7242/ TTY:711.** To speak to a nurse 24/7, call our Nursing Advice Line at **(844) 819-5977.***

MolinaHealthcare.com

Affinity by Molina Healthcare

Card Front



Card Back

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members wishing to disenroll from Molina should contact the Managed Care staff at the local Department of Social Services.

Voluntary disenrollment does not preclude Members from filing a grievance with Molina Healthcare for incidents occurring during the time they were covered.

Involuntary Disenrollment

Molina may initiate an involuntary disenrollment if an enrollee engages in conduct or behavior that seriously impairs Molina's ability to furnish services to either the enrollee or other enrollees, provided that Molina has made and documented reasonable efforts to resolve the problems presented by the enrollee. These efforts will include health plan-initiated restriction where the enrollee's actions meet the criteria for such restriction as specified in the restricted recipient section of the Medicaid Managed Care Model Contract. Molina will submit the request for disenrollment in writing to the LDSS, SDOH or NYSoH and shall include the documentation of reasonable efforts.

PCP Dismissal

In the event that a PCP should need to dismiss a member from their panel for any reason, the PCP must submit a PCP change form, located on the Molina Healthcare of New York website, located here. This Section does not apply if the Member's behavior is attributable to a physical or behavioral condition.

Missed Appointments

Molina Healthcare requires that all primary care physicians follow up with members who have missed their appointment. Depending on the situation, providers are required to ensure that members are aware of the various services available to them. This includes, but is not limited to, medical transportation and translation services.

PCP Assignment

Members are given the opportunity to select a PCP within the first thirty (30) days of enrollment. If a PCP is not selected by the Member, Molina will assign a PCP to the Member.

PCP Changes

A Member can change their PCP at any time by calling the Molina Member Services Department at 1-800-223-7242. The effective date of the change will be the first of the month *following* the month of the request unless there are special circumstances.

SECTION 6. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare of New York Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina Healthcare at (877) 872-4716 (Monday through Friday, 8:00 a.m. to 6:00 p.m.).

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina plan.

There are no copayments for Child Health Plus (CHP). For Medicaid Managed Care (MMC) and Molina Healthcare PLUS (formerly HARP) Members copayments may apply for pharmacy services only.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copayment and other Cost Sharing will be deducted from the Molina payment for all Claims involving Cost Sharing.

Service Covered by Molina

Starting June 1, 2021, Adult Behavioral Health Home and Community Based Services (BH HCBS) will be changing to Community Oriented Recovery and Empowerment (CORE) services. Molina Healthcare of New York, Inc. will cover CORE services. Members can use their Molina Healthcare of New York, Inc. plan card to get these CORE services.

New York State is making this change because CORE services are easier to get than BH HCBS. Eligible members can get CORE services through a recommendation from a qualified provider.

CORE services include:

Psychosocial Rehabilitation (PSR)

This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.

Community Psychiatric Support and Treatment

This service helps members manage symptoms through counseling and clinical treatment.

Empowerment Services – Peer Supports

This service connects members to peer specialists who have gone through recovery. Members will get support and assistance with learning how to:

- live with health challenges and be independent,
- help make decisions about their own recovery, and
- find natural supports and resources.

Family Support and Training

This service gives the members family and friends the information and skills to help and support you.

BH HCBS and CORE are almost the same. There are 3 changes.

1. Members can now work with a PSR provider to help them:
    - get a job or go to school while managing mental health or addiction struggles;
    - live independently and manage your household; and
    - build or strengthen healthy relationships.

    This means if a member is getting any of the following BH HCBS now, their provider may change to a CORE PSR provider.
    - Habilitation
    - Education Support Services
    - Pre-Vocational Services
    - Transitional Employment
    - Intensive Supported Employment
    - Ongoing Supported Employment
2. Short-term Crisis Respite and Intensive Crisis Respite are now called Crisis Residential Services and are still available.
3. Non-Medical Transportation is no longer available.

Some services require prior authorization. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina Healthcare at (877) 872-4716. (Monday-Friday 8:00 a.m. to 6:00 p.m.)

Summary of Benefits

Molina benefits are comprehensive in nature and include all medically necessary services as included in the general New York Medicaid fee-for-service program.

This section provides an overview of the medical benefits and covered services for Molina Medicaid Managed Care (MMC), Molina Healthcare PLUS (formerly HARP), and Child Health Plus (CHP) Members.

Benefits may require prior authorization. For complete prior authorization requirements see the MHNY Prior Authorization Guide on our website: www.MolinaHealthcare.com, or at the end of the Healthcare Services section of this manual.

The following benefits are covered for Medicaid Managed Care Members (MMC), Molina Healthcare PLUS, Members and Child Health Plus (CHP) Members:

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Abortion (medical or surgical)	Only covered when medically-necessary, elective abortions are not covered	Only covered when medically-necessary, elective abortions are not covered	Only covered when medically-necessary, elective abortions are not covered	
Acupuncture	Not Covered	Not Covered	Not covered	
Adult Day Health Care	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS) for more details.
AIDS Adult Day Health Care	Covered	Covered	Not Covered	See section 13 (Home and Community Based) Services (HCBS) for more details.
Anesthesia	Covered	Covered	Covered	Modifiers 47 is no longer payable when billing for dates of service on and after November 18, 2010.
Audiology Services	Covered	Covered	Covered	Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations.
Biofeedback	Not covered	Not covered	Not covered	
Birth Control	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Blood Clotting Factors (Outpatient)	Not Covered by MHNY (covered FFS)	Not Covered by MHNY (covered FFS)	Covered	
Blood Products	Covered	Covered	Covered	Autologous blood donation and storage are not covered.
Breast Implants	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	
Cardiac Rehabilitation	Coverage is limited to 36 visits per calendar year and (1) one session per day.	Coverage is limited to 36 visits per calendar year and (1) one session per day.	Coverage is limited to 36 visits per calendar year and (1) one session per day.	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Children and Family Treatment and Support Services (CFTSS)	Covered CFTSS are for children under age 21 with behavioral health needs. These services may be provided at home or in the community.	Covered	Covered	Starting January 1, 2020, Medicaid Managed Care Plans will cover more Children and Family Treatment and Support Services (CFTSS). These services help children and their families improve their health, well-being, and quality of life. The additional CFTSS services available on January 1, 2020 includes: Youth Peer Support and Training. This benefit is provided by a credentialed Youth Peer Advocate, or Certified Recovery Peer Advocate with a youth focus who has similar experiences. Get support and assistance with: • Developing skills to manage health challenges and be independent. • Feeling empowered to make decisions • Making connections to natural supports and resources • Transitioning to the adult health system when the time is right.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				Crisis Intervention. Professional help at home or in the community when a child or youth is and other supports. Including support and help with using crisis plans to de-escalate the crisis and prevent or reduce future crises.
Chemical Dependency	Covered inpatient and/or outpatient. For individuals younger than 21, OASAS outpatient clinic, OASAS OTP, OASAS outpatient rehabilitation programs, Outpatient Chemical Dependence for Youth Programs are currently excluded from the MMC benefit package but are covered fee for service	Covered inpatient and/or outpatient.	Covered inpatient and/or outpatient.	Members can self-refer for one (1) one chemical dependence assessment from a Detoxification or Chemical Dependence Participating Provider in any calendar year period without requiring preauthorization or referral from the Member's Primary Care Provider. There are no limitations for the diagnosis or treatment of alcoholism and substance abuse.
Chemotherapy	Covered	Covered	Covered	
Children's Crisis Residence	Not covered	Not covered	Covered	This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Chiropractic Care	Not covered	Not covered	Not covered	
Contact Lenses	Covered when medically necessary and for ocular pathology	Covered when medically necessary and for ocular pathology.	Covered when medically necessary.	Contact lenses may be replaced when lost or damaged.
Court Ordered Treatment	Covered for services included in the benefit package	Covered for services included in the benefit package.	Covered for services included in the benefit package.	
Dental Services	Up to (4) four annual fluoride varnish treatments for children from birth to age 7 years when applied by a dentist, physician or nurse practitioner. Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability	Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability.	Prophylaxis at 6-month intervals. Topical fluoride at 6-month intervals where local water supply is not fluoridated. Dental examinations, visits, and consultations covered (1) once within 6 months consecutive period. X-rays, full mouth x-rays or panoramic at 36-month intervals. Bitewing –rays at 6-12-month intervals	Non-medical dental services will be covered by our dental vendor, DentaQuest .

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
			Prosthodontics **Fixed bridges are not covered unless:** Required for replacement of a single upper anterior (central/ lateral incisor or cuspid) in a Member with an otherwise full complement of natural, functional and/ or restored teeth. Required for cleft-palate treatment or stabilization. Required as demonstration by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removal prosthesis.	
Detoxification Services	Covered	Covered	Covered	There are no limitations for the diagnosis or treatment of alcoholism and substance abuse

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Diabetes Self-Management Training	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus.	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus.	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus.	Effective **February 1, 2020,** Medicaid Managed Care will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months. Eligibility Patients may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and are: • At least 18 years old, • Not currently pregnant, • Overweight, and • Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				And, have met one of the following criteria: • Had a blood test result in the prediabetes range within the past year, or • Have been previously diagnosed with gestational diabetes, or • Scored 5 or higher on the CDC/ American Diabetes Association (ADA) Prediabetes Risk Test.
Diabetic Supplies	Covered	Covered	Covered	Pharmacy Benefit
Dialysis	Covered	Covered	Covered	
Durable Medical Equipment (DME)	Covered subject to limitations	Covered subject to limitations	Covered subject to limitations	Coverage includes durable medical equipment, prosthetics and orthotics, prescription footwear, medical supplies, enteral therapy products, and hearing aid batteries and is subject to limitations. Contact the health plan for authorization requirements and/or limitations

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Emergency Medical Services	Covered	Covered	Covered	
Emergency Transportation	Covered Fee for Service not through MHNY	Covered Fee for Service not through MHNY	Covered, ground or air	
Enteral Products	Covered Standard milk-based infant formulas are not covered. Enteral therapy is not covered as a convenient food substitute.	Covered Standard milk-based infant formulas are not covered. Enteral therapy is not covered as a convenient food substitute.	Covered	
Experimental Treatment or Devices	Covered on a case by case basis	Covered on a case by case basis	Not covered	These services require prior authorization, see the prior authorization guide above for more information
Family Planning and Reproductive Health Services	Covered	Covered	Covered	
Fertility Drugs	Covered	Not covered	Not covered	**Effective 10/1/2019:** Some fertility drugs will be covered, limited to 3 cycles of treatment per lifetime. **Eligibility:** 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.
Gender Transition Services	Covered	Covered	Covered	Contact the health plan for coverage criteria.
Genetic Testing	Covered	Covered	Covered	A laboratory must hold a permit in Genetic Testing in order to bill for molecular diagnostic procedures (procedure codes 83890 – 83912).
Hearing Aids and Hearing Aid Accessories	Covered	Covered	Covered	
Hearing Screening/Exam	Covered.	Covered.	Covered.	
	Hearing screening and testing can be provided by any licensed practicing Provider who may administer hearing services within their	Hearing screening and testing can be provided by any licensed practicing Provider who may administer hearing services within their	Hearing examinations are covered to determine the need for corrective action and speech therapy performed by an	
	scope of practice using accepted standards and practices for screening, medical clearance, testing, and evaluation	scope of practice using accepted standards and practices for screening, medical clearance, testing, and evaluation.	audiologist, language pathologist, a speech therapist and/or otolaryngologist	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Health Education	Covered	Covered	Covered	Contact the health plan for more information
Adult Home and Community Based Services (HCBS)	Not Covered	Coverage includes:	Not Covered	HCBS services will be subject to utilization caps at the recipient level that apply on a rolling basis (any 12-month period). These limits will fall into three categories:
		Psychosocial Rehabilitation (PSR); Community Psychiatric Support and Treatment (CPST); Habilitation/ Residential Support Services; Family support and training; Short-term crisis respite; Intensive crisis respite; Family support and training, Education support services; Peer support services (Empowerment Services); Pre-vocational services;		1. Tier 1 HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor on this threshold that will allow plans to go up to $10,000 without a disallowance. 2. There will also be an overall cap of $16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to $20,000 without a disallowance.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
		Transitional employment; Intensive supported employment; On-going supported employment; and staff transportation for select services Staff Transportation for only for these selected HCBS services: • Psychosocial Rehabilitation (PSR) (Individual per diem) • Community Psychiatric Support and Treatment (CPST) • Habilitation/ Residential Support Services • Family Support and Training (FST) • Education Support Services • Empowerment Services – Peer Supports (OMH)		3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crises respite services are limited within their own individual caps (7 days per episode, 21 days per year).

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
		• Pre-Vocational Services • Transitional Employment • Intensive Supported Employment (ISE) • Ongoing Supported Employment		
Home Health Care	Covered	Covered	Limited to 40 visits in a calendar year. Private Duty Nursing is not covered.	Covered services include skilled nursing (MMC and Molina Healthcare PLUS only), Therapy (Physical, Occupational and Speech/Audiology), Home Health Aide, Pregnant/Postpartum Visits, Telehealth Services, Personal Care Services
Home Health Services for Mom and Baby after Delivery	Covered	Covered	Covered	The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				Postpartum home visits are also covered. **All women enrolled are presumed eligible for (1) one medically necessary postpartum home health care visit** which may include assessment f the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed.
				Other than the initial postpartum visit, additional home health visits must meet medical necessity criteria.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Hospice Care	Covered for Members with a life expectancy of one (1) year or less For child Members aged 20 and under who are receiving Hospice services curative services are also covered in addition to palliative care.	Covered for Members with a life expectancy of one (1) year or less	Covered for Members with a life expectancy of six (6) months or less Up to 5 visits of bereavement counseling are covered for family Members	Routine Home Care, Respite Care, Continuous Care, General Inpatient Care, Palliative and supportive Care, Room and Board. The following programs are not allowed in combination with the hospice benefit: Private Duty Nursing, Long Term Home Health Care Program/Lombardi Program, Certified Home Health Agency Services, Adult Day Health Services
Hospitalization	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Hysterectomy	Covered except when performed for the purpose of sterilization.	Covered except when performed for the purpose of sterilization.	Covered except when performed for the purpose of sterilization.	When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262,58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58570, 58571,58572, 58573, 58951, 58953, 58954, 58956, 59135, or 59525 are billed, a properly completed "Hysterectomy Receipt of Information Form" must be attached to the bill f or payment. No bill will be processed without a properly completed "Hysterectomy Receipt of Information Form", (DSS-3113).
Immunizations	Covered	Covered	Covered	Vaccine purchase costs associated with childhood immunizations that may be obtained free of charge from the Vaccine for Children Program are not reimbursable.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Infertility Services	Covered	Not covered	Not covered	**Effective 10/1/2019:** **Fertility services covered related to prescribing and monitoring the use of approved fertility drugs including:** **Office Visits** **X-ray of the uterus and fallopian tubes** **Pelvis Ultrasound** **Blood Testing.** **Eligibility:** **21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.** **35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.**
Intensive Crisis Residence	Covered	Covered	Covered	This is a treatment program for people who are age 18 or older who are having severe emotional distress.
Laboratory Services	Covered	Covered	Covered	In-home phlebotomy services are limited to 24 visits per calendar year.
Mammogram	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Massage Therapy	Not covered	Not covered	Not covered	
Mental Health Services	Covered	Covered	Covered	Members can self-refer for one (1) mental health assessment from a Participating Provider in any calendar year period without requiring preauthorization or referral from the Member's Primary Care Provider. (MMC and Molina Medicare Plus)
Midwifery Services	Covered	Covered	Covered	Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Member's home as appropriate.
Newborn Hearing Screening	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Non-Emergent Transportation	Covered by Fee for Service, not by MHNY	Covered by Fee for Service, not by MHNY	Not Covered	
Nursing Homes (Long Term Care)	Inpatient nursing home services authorized by the Contractor for MMC Members age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay	Inpatient nursing home services authorized by the Contractor for MMC Members age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay	Not Covered	Leave of absences are limited to a combination of 18 days in a calendar year.
Certified Nurse Practitioner Services	Covered	Covered	Covered	Certified nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the certified nurse practitioner's licensure and collaborative practice agreement with a licensed physician

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				The following services are also included in the certified nurse practitioner's scope of services, without limitation: Child/Teen Health Program(C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21). Physical examinations, including those which are necessary for school and camp.
Observation Services	Covered	Covered	Covered	The Member must be admitted to the inpatient service, transferred to another hospital, or discharged to self-care or the care of a physician or other appropriate follow-up service within forty-eight (48) hours of assignment to the observation unit.
OB/GYN Services	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Outpatient Therapies (Speech, Physical, and Occupational)	Covered	Covered	Covered	
Organ Transplants	Covered	Covered	Covered	Contact the health plan for further information
Orthodontics	Coverage is limited to:	Not covered except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts.	Coverage includes Rapid Palatal Expansion (RPE); Placement of component parts (e.g. brackets, bands); Interceptive orthodontic treatment; Comprehensive orthodontic treatment; Removable appliance therapy; Orthodontic retention	Transitional care for a Member that changes MCOs for orthodontic appliances that are in place and active treatment has begun transitional care policies will apply if the orthodontist is not in the Provider network for a sixty-day period.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	Members aged 20 years or under up to (3) three years of active orthodontic care, plus (1) one year of retention care, to treat a service physically handicapping malocclusion. Part of such care can be provided after the Member reaches the age of 21; provided that the treatment was approved, and active therapy began prior to the Members 21st birthday. Members aged 21 years and over in connection with necessary surgical treatment.			Non-medical dental services will be covered by our dental vendor, DentaQuest
Out-of-Area Care (Emergent)	Covered	Covered	Covered	Limited to the 50 states in the United States and US territories only
Outpatient Surgery	Covered	Covered	Covered	
Pap Smears	Covered	Covered	Covered	
Physical Exams	Covered	Covered	Covered	
Personal Care Services	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS) for more details

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Consumer Directed Personal Assistance Services	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS) for more details
Personal Emergency Response System (PERS)	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS) for more details
Private Duty Nursing	Covered	Covered	Not covered	
Pregnancy and Delivery	Covered	Covered	Covered	
Prenatal Care	Covered	Covered	Covered	
Prescription Drugs/Pharmacy	Covered	Covered	Covered	Contact the health plan for most current formulary list for specific coverage.
Preventive Health Services	Covered	Covered	Covered	
Physician Services	Covered	Covered	Covered	Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice. The following are also included without limitations: -Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				Note: All physician administered drugs (including drugs administered by nurse practitioners, licensed midwives and drugs administered in an ordered ambulatory setting) require the 11-digit NDC, the NDC dispensing quantity, and the NDC unit of measure, in addition to the CPT/HCPCS code and units to be billed or the claim will deny. -Physical examinations, including those which are necessary for school and camp; -Physical and/or mental health, or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care; -Health and mental health assessments for the purpose of making recommendations regarding a Member's disability status for Federal SSI applications;

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				-Annual preventive health visits for adolescents; -New admission exams for school children if required by the LDSS; -Health screening, assessment and treatment of refugees, including completing SDOH/ LDSS required forms; -Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) years of age in the MMC program
Podiatry Services	Covered for all Members.	Covered for all Members.	Services of a podiatrist are not covered for CHP	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	Covered services include routine foot care provided by qualified Provider types **other than podiatrists** when any Member's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.	Covered services include routine foot care provided by qualified Provider types **other than podiatrists** when any Member's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.	Routine foot care is not covered when done by any type of Provider for CHP	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Radiology	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	DXA scans are covered at a maximum of once (1) every two (2) years for women over the age of 65 and men over the age of 70. Medically necessary DXA scans to women younger than 65 and men younger than 70 who present with significant risk factors for developing osteoporosis will also be reimbursed at a maximum of once (1) every two (2) years .
Reconstructive Surgery	Covered when medically necessary	Covered when medically necessary	Covered when medically necessary	
Residential Crisis Support	Covered	Covered	Covered	This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
Respite Care	Covered	Covered	Covered	
Second Opinions Surgical Care	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Second Opinions Medical Care	Covered	Covered	Covered in the event of a positive or negative diagnosis of cancer, recurrence of cancer, or a recommendation of a course of treatment for cancer.	
Skilled Nursing Facilities	Covered	Covered	Not Covered	
Smoking Cessation	Covered	Covered	Covered	
Sterilization	Covered for Members over the age of 21 unless medically necessary	Covered	Not covered unless medically necessary	Reversals of sterilizations are not covered

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				Codes 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58670 and 58671 require the sterilization consent form (DSS-3134) to be signed not less than 30 days nor more than 180 days prior to the performance of the procedure.
				In cases of premature delivery and emergency abdominal surgery, consent must have been given at least 72 hours prior to sterilization. The consent form must be submitted with the claim for reimbursement.
Tuberculosis Directly Observed Therapy	Covered	Covered	Covered	
Urgent Care	Covered	Covered	Covered	
Vehicle & In Home Modification	Not Covered	Not Covered	Covered	This service provides physical adaptations to the primary vehicle of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence.

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Vision	Coverage includes: -Emergency, preventive and routine eyes care services; -Eyeglasses (frames and lenses);	Coverage includes: -Emergency, preventive and routine eye care services; -Eyeglasses (frames and lenses);	Coverage is limited to: -Emergency, preventive and routine vision services; -Exams to determine the need for corrective lenses and/or to provide a prescription;	
	-Contact lenses when medically necessary and for ocular pathology;	-Contact lenses when medically necessary and for ocular pathology;	-Eyeglasses (frames and lenses), limited to once in 12 months unless appropriate documentation supports the need to exceed this limit	
	-Polycarbonate lenses (monofocal, bifocal, or multifocal/ trifocal) -Artificial eyes (stock or custom-made); -Low vision services (including rehab) and low vision aids; -Replacement and/or repair of lost or destroyed eyeglasses (frames and lenses);	-Polycarbonate lenses (monofocal, bifocal, or multifocal/ trifocal) -Artificial eyes (stock or custom-made); -Low vision services (including rehab) and low vision aids; -Replacement and/or repair of lost or destroyed eyeglasses (frames and lenses);	-Contact lenses when medically necessary	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	-Orthoptic training; -Specialist referrals for eye diseases or defects	-Orthoptic training; -Specialist referrals for eye diseases or defects		
	The vision benefit is subject to the limits below: -Complete Routine Optometric Eye Exams are limited to one (1) every two (2) calendar years -Non-diabetic Members may self-refer for complete routine optometric exams once (1) every two (2) calendar years - Members diagnosed with diabetes may self-refer to any participating provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than (1) once in any twelve (12) month period	The vision benefit is subject to the limits below: -Complete Routine Optometric Eye Exams are limited to one (1) every two (2) calendar years - Non-diabetic Members may self-refer for complete routine optometric exams once (1) every two (2) calendar years -Members diagnosed with diabetes may self-refer to any participating provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than (1) once in any twelve (12) month period		

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	- Eyeglass lenses/frames are limited to once every two (2) calendar years	- Eyeglass lenses/frames are limited to once every two (2) calendar years		
	- Polycarbonate lenses are covered for children and adolescents up to 21 years of age if needed for safety reasons and for adults age 21 and over when the Member is essentially monocular with functional vision in only one eye or has a history of auto-aggressive behavior with a history of breaking glasses.	- Polycarbonate lenses are covered for children and adolescents up to 21 years of age if needed for safety reasons and for adults age 21 and over when the Member is essentially monocular with functional vision in only one eye or has a history of auto-aggressive behavior with a history of breaking glasses.		

Obtaining Access to Certain Covered Services
Self-Referral

There are some services that a Member can choose where to get the care. The Member can get these by using their Personal Care Services Membership Card. The Member may also go to Providers who will take their Medicaid Benefit Card. Members may self-refer for specialist services without a referral from their PCP for the following services:

- One mental health and one substance use visit with a Participating Provider per year for evaluation
- Vision services with a Participating Provider
- Diagnosis and Treatment of TB by public health facilities
- Family planning or reproductive health services from a Participating Provider or a Medicaid Provider
- HIV Testing and Counseling
- OB/GYN Services including prenatal care, two routine office visits per year and any follow up care for an acute gynecological condition

For Behavioral Health, a member may self-refer for specialist services. There are unlimited behavioral health and substance use assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization and HCBS services.

Prescription drugs

Prescription drugs are covered by Molina, via our pharmacy vendor. A list of in-network pharmacies is available on the MolinaHealthcare.com website, or by contacting Molina at (877) 872-4716.

Molina Healthcare	
Pharmacy Provider Service	(877) 872-4716
Pharmacist Caremark Helpdesk (CVS)	(800) 364-6331
Prior Auth Fax:	(844) 823-5479

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina at (877) 872-4716 or at www.MolinaHealthcare.com.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Healthcare Services section of this Provider Manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Note: All physician administered drugs (including drugs administered by nurse practitioners, licensed midwives and drugs administered in an ordered ambulatory setting) require the 11-digit NDC, the NDC dispensing quantity, and the NDC unit of measure, in addition to the CPT/HCPCS code and units to be billed or the claim will deny.

Access to Dental Benefits

Molina Dental Benefits are administered through DentaQuest:

DentaQuest Phone: 1-888-308-2508
DentaQuest Fax Number:
Claims Issues: 1-262-241-7379
Claims to be Processed: 1-262-834-3589
All other: (262) 834-3450

Claims Questions: denclaims@dentaquest.com
Eligibility or Benefit Questions: denelig.benefits@dentaquest.com

Access to Behavioral Health Services

Mental Health and Substance Use

Molina provides all required behavioral health benefits to its Medicaid Managed Care, Child Health Plus and Molina Healthcare PLUS members. All members are managed through the policies and procedures outlined in this manual.

All members will see Providers in Molina's network for most behavioral health, mental health and substance use disorder services. Behavioral Health Providers in Molina's network should contact Molina or refer to Molina's Provider Manual for details including billing guidance, prior authorization requirements, eligibility, and claims inquiries.

Provider Relations: 1-877-872-4716

Member Services: 1-800-223-7242 (TTY: 711)

Prior Authorizations: 1-877-223-7242

Clinical Appeals Coordinator: 1-800-223-7242

Crisis Option thru Carenet: 1-210-572-9014

Hours of Operation: Monday through Friday, 8:00 a.m.-6:00 p.m. EST. Emergency coverage available 24/7.

Behavioral Health Claims Submissions

Payer ID: 16146

Claims Mailing Address:

Molina Healthcare of New York, Inc.
P.O. Box 22615
Long Beach, CA 90801

For further detail, please visit https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

Out of Network "Health Home" Policy for Children:

To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. Molina Healthcare of New York, (The Plan) will be paying on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with The Plan.

Molina Healthcare of New York's Healthcare Services Department will authorize services to a non-participating provider if the services are not available within the network. A SCA will be negotiated with the non–participating entity.

The Healthcare Services Department, the MHIL Medical Director, or the Utilization Department will initiate the SCA process. The Provider Contract Manager will negotiate the terms and conditions of the SCA based on the healthcare needs of the enrollee. The Plan will ensure the reimbursement rate will not be lower than New York State published Medicaid FFS Fee Schedule.

Provider Payment Policy:

Molina will execute Single Case Agreements (SCA) with non-participating providers to meet clinical needs of children when in-network services are not available. Molina will pay at least the State published fee-for-service fee schedule for 24 months for all the Single Case Agreements.

Molina will also pay at least the Medicaid fee-for-service fee schedule for 24 months or as long as New York State mandates for the following services/providers:

- New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
- OASAS Clinics (Article 32 Certified Programs)
- All OMH Licensed Ambulatory Programs (Article 31 Licensed Programs)
- Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

Molina will reimburse providers who have historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide Care Management services that are being transitioned to Health Home and may receive a transitional rate for no more than 24 months. The transitional rates will be financially equivalent as practical to the interim rates established under the former waivers and in place immediately prior to their transition to Health Home.

Molina will contract with OASAS Residential Programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

Molina will also ensure that all HCBS (Home & Community Based Services) are paid according to the NYS fee schedule as long as the Plan is not at risk for the service costs.

Transfer of Mental Health and Substance Use Information

It is the policy of Molina to promote continuity of care and ensure adequate communication of all services received by a Member to the Plan PCP. Mental Health and Substance Use Specialists

will obtain signed patient release of information forms at initial visits to ensure consistent communication between Mental Health and Substance Use Specialists and the Plan PCP.

Emergency Mental Health or Substance Abuse Services

Members are directed to call "911" or go to the nearest emergency room if they need Emergency mental health or substance abuse services. Examples of Emergency mental health or substance abuse problems are:

- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm
- Should a member in crisis call Molina, the member will be connected with a clinician to address the crisis and ensure connection to crisis services. Following the intervention, Molina will outreach to the provider to follow-up with the member and refer the member

Out of Area Emergencies

Members having a behavioral health Emergency who cannot get to a Molina approved Providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
- Call Member's PCP and follow-up within (24) to (48) hours

For out-of-area Emergency care, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Note: Emergency transportation is covered by MHNY for Child Health Plus (CHP) Members only. Emergency transportation services to Medicaid Managed Care (MMC) and Molina Healthcare PLUS (formerly HARP) Members are covered through fee for service by the State.

Non-Emergency Medical Transportation

Non-Emergency transportation is covered through the state on a fee for service basis for Medicaid Managed Care (MMC) and Molina Healthcare PLUS Members. Non-Emergency Medical transportation is not covered for Child Health Plus (CHP) Members.

To access non-emergency transportation, the Member or the Member's Provider must call either Medical Answering Service (MAS) or ModivCare, depending on which county the member resides in.

Medical Answering Services (MAS) is the contracted Transportation Manager for all of New York State with the exception of Nassau and Suffolk counties.

ModivCare (formerly LogistiCare) is the contracted Transportation Manager for the Long Island Region (Nassau and Suffolk counties).

Telephone numbers listed by County are available below:
https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_PA_Guidelines_Contact_List.pdf

Preventive Care

Clinical Practice Guidelines

Molina Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered evidence-based services in a manner consistent with standards, including nationally recognized clinical protocols and guidelines, related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment.

Participating Providers must also comply with Molina's adopted clinical practice guidelines, which include the following:

- Adults ages 19 and older – U.S. Preventive Services Task Force Clinical Practice Guidelines
  - http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/
- Healthy Children to age 19 – American Academy of Pediatrics and Bright Futures
  - https://brightfutures.aap.org/clinical-practice/Pages/default.aspx
  - https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx
- Diabetes – American Diabetes Association
  - http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf
- Asthma – NYS Asthma Practice Guidelines
- https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2011-6_ifa_report.pdf
- ADHD – American Academy of Pediatrics – ADHD Practice Guidelines
  - http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/14/peds.2011-2654.full.pdf
  - http://pediatrics.aappublications.org/content/pediatrics/suppl/2011/10/11/peds.2011-2654.DC1/zpe611117822p.pdf
- Depression – Institute for Clinical Systems Improvement, Inc. (ICSI) Health Care Guideline "Adult Depression in Primary Care Sixteenth Edition, September 2013"
- https://www.icsi.org/guidelines/about-icsi-guidelines/

- HIV/AIDS – New York State Department of Health AIDS Institute practice guidelines. In addition to the clinical practice guidelines, the health plan has adopted NYS guideline on HIV testing, HIV and pregnancy and a resource to order publications.
    - http://www.hivguidelines.org/
    - http://www.health.ny.gov/diseases/aids/providers/testing/index.htm#publichealthlaw
    - http://www.hivguidelines.org/clinical-guidelines/perinatal-transmission/
    - https://www.hivguidelines.org/home/guideline-slides-and-pocket-guides/

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP.

All Providers administering vaccines to children under age nineteen (19) must participate in the New York State Vaccines for Children (VAC) Program. The VFC program provides the vaccines free of charge. For more information about the VFC and how to obtain vaccines, Providers should contact VFC directly. More information on the program can be found at: https://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm

Molina is responsible for all costs associated with vaccine administration associated with childhood immunizations. Molina Healthcare covers immunizations not covered through Vaccines for Children (VFC).

Well Child Visits and EPSDT Guidelines

The federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams.

New York State's Medicaid program for children and adolescents, implements EPSDT via the Child Teen Health Program (CTHP). In line with the federal EPSDT mandate, CTHP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or mental health problems identified during these exams. The CTHP care standards and periodicity schedule generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics. They also emphasize recommendations such as those described in *Bright Futures* in order to guide your practice and improve health outcomes for your Child Health Plus a (Medicaid) population.

Molina Providers must comply with the EPSDT/CTHP standards. The EPSDT/CTHP Provider Manual can be found on eMedNY.

https://www.emedny.org/ProviderManuals/EPSDTCTHP/index.aspx

The screening services include (but are not limited to):

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current New York Recommended (or Centers for Disease Control and Prevention Advisory Committee on Immunization Practices) Childhood Immunization Schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet the targeted state standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our Health Education line at (877) 872-4716.

Medical Complications	
Severe Anemias associated with chronic disease	Thrombocytopenias
Sickle Cell Anemia	Hemoglobin C Disease
Thalassemia	Hemophilia
Von Willebrand's Disease	Cardiovascular Disease
History of Valvular Replacement	Pulmonary Hypertension
History of Cardiomyopathy	Peripartum Cardiomyopathy
Endocarditis	Pulmonary Edema
History of Pulmonary Embolism	Renal Failure (acute or chronic)
Glomerulonephritis	Polycystic Disease
Previous Nephrectomy	Insulin Dependent Diabetes
Collagen Vascular Disease	Hyperthyroidism
Pre-eclampsia	Eclampsia

Pregnancy Related Issues	
Pregnancy Induced or Chronic Hypertension	Seizure Disorder
Active Syphilis	AIDS
Pregnancy Related Issues	
Previous Infant Fetus with Congenital Abnormality	Recurrent abortion
Isoimmunization	Previous Neural Tube Defect
Stillbirths	Abnormal Alpha Fetal Protein
Multiple Gestation with Growth Discrepancy	Placenta Previa
Amniocentesis	Fetal Abnormality Noted on Ultrasound
Maternal Age Over 35 for Genetic Counseling	Breech (36 weeks) for Possible Version
Polyhydramnios/Oligohydramnios	Intrauterine Growth Retardation
Any Acute or Chronic Material Illness Which Will Increase the Risk to the Mother or Infant	Positive Material Blood Antibody Screen or Evidence of Isoimmunization/Fetal Hydrops

Prenatal Care

In February 2010, the DOH revised the NYS Medicaid Prenatal Standards. The standards incorporate evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of Provider or delivery system. They integrated updated standards and guidance from the American College of Obstetrics (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low income, high-risk women.

Molina has adopted the NYSDOH Prenatal Care standards. The standards provide a comprehensive model of care that integrates the psychosocial and medical needs and reflects the special needs of the Medicaid population. The standards of care include:

- Prenatal Care Provider requirements
- Access to care standards
- Prenatal risk assessment, screening and referral for care
- Psychosocial risk assessment, screening, counseling, and referral for care
- Nutritional screening, counseling, and referral for care
- Health education
- Development of a care plan and care coordination
- Prenatal care services
- Postpartum services

The NYS DOH Prenatal Care Standards can be found on the NYS DOH web site at http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

Referrals for High Risk Pregnancies

Prenatal risk assessment should be an ongoing process. Assessment should be performed and documented at initial visit and reviewed at each subsequent visit. Appropriate consultation should be obtained based on the risk factors listed below. Continued patient care should be in collaboration with the consulting Provider, or in some instances, by transfer of care to an OB/GYN or Perinatologist.

Behavioral Health Clinical Practice Guidelines

Molina Healthcare supports the use of nationally-recognized and validated Clinical Practice Guidelines (CPGs) and other evidence-based practice (EBPs) to ensure the highest quality care for members through use of acceptable standards of care, and to reduce undesirable variance in diagnosis and treatment by ensuring compliance with established guidelines.

The selection of particular guidelines and standards of practice allows Molina Healthcare to provide its network of practitioners and providers with:

- Widely accepted established methods of treatment with proven efficacy Scientifically based materials that reflect current national trends and updated research in treatment
- A mechanism to provide input into decisions regarding the content of clinical practice guidelines

Molina Healthcare expects providers to be aware of CPGs when making treatment referrals to in-network services to ensure members are accessing appropriate levels of care to best meet their clinical needs.

Emergency Services

Emergency Services means: health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

Emergency Medical Condition or Emergency Condition means: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
(b) Serious impairment to such person's bodily functions;
(c) Serious dysfunction of any bodily organ or part of such person; or
(d) Serious disfigurement of such person.

Emergent and urgent care services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Emergency Prescription Supply

For prescribers, a 72-hour emergency supply of a prescribed drug will be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

A seven-day emergency supply of supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization is also available.

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

Nurse Advice Line (24 Hours)	
Phone:	1-844-819-597 (TTY:711)

Molina is committed to helping our Members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room (ER)

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Case Management

Molina recognizes that its Members have unique needs that may interfere with their compliance with services recommended by their Primary Care Providers.

The Molina Case Management Program is available to assist Providers with Case Management services when these individuals are identified. For more information on Case Management see the Healthcare Services section of this manual.

Health Management Programs

Molina Healthcare of New York Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Licensed Vocational Nurse, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. He/she will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit

from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma
- Diabetes

For more info about our programs, please call:

Provider Services Department at (877) 872-4716

TTY at 711

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;

- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina Healthcare Services Department **toll free at 1-877-872-4716**.

SECTION 7. HEALTHCARE SERVICES (HCS)

Introduction

Molina provides care management services to Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department toll free at (877) 872-4716. The UM Department fax number is (866) 879-4742.

Utilization Management (UM)

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Case Management team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by managing benefits effectively and efficiently to ensure appropriate use of health care services through the following processes:

- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services.
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization.
- Authorizing services in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM/CM processes.
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions.
- Identifying and assessing the need for Care Management through early identification of high or low service utilization, and high cost-chronic diseases.
- Promoting health care in accordance with local, state and national standards.
- Processing authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services:

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and Referral Management	Satisfaction evaluation of the UM program using Member and practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensuring authorized care correlates to Member's medical necessity need(s) & benefit plan	Retrospective Review	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/ hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA©, state and health plan UM standards

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or by calling the UM Department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to McKesson InterQual®, other third-party guidelines, CMS guidelines, state guidelines, LOCADTR 3.0, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent inpatient review, or retrospectively.

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all Medical Necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly but may be updated more frequently as appropriate. To ensure the most current information is being utilized, Providers are encouraged to access the guide posted on the Molina website at www.MolinaHealthcare.com.

Molina has a PA LookUp tool here. Requests for prior authorizations to the UM Department may be sent by fax or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section.

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes
- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Crisis intervention and OMH/OASAS specific non-urgent ambulatory services are not subject to prior authorization

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon Member eligibility at the time of service.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (877) 872-4716.

Upon receipt of necessary information for a Utilization Management (UM) decision to be made, the following timeframes and methods will be followed by Molina:

Pre-authorization: Molina must make decision and notify Member/Member's Representative and Provider, by phone and in writing, within three (3) business days of receipt of necessary information. For Medicaid, Molina's decision must be made as fast as the Member requires or within three (3) business days of receipt of necessary information but no more than fourteen (14) days of the request. Expedited and standard review timeframes for pre-authorization and concurrent inpatient review may be extended by an additional fourteen (14) days if the Member, Member's Representative or Provider requests an extension or Molina demonstrates there is a need for more information and the extension is in the Member's interest. (Extensions are not applicable to Child Health Plus). A notice of the extension to Member required.

Concurrent: Molina must make decision and notify Member/Member's Representative and Provider by phone and writing within one (1) business day of receipt of necessary information [this requirement may be satisfied by notice to the Provider, by telephone and in writing, within one (1) business day of necessary information]. For Medicaid/FHP, Molina must make a decision as fast as the Member's condition requires and within one (1) business day of receipt of necessary information, but no more than three (3) business days of an expedited authorization request or, two (2) in all other cases, within one (1) business days of receipt of necessary information but no more than fourteen (14) days of the request. (Note: this requirement may be satisfied by notice to the Provider, by telephone and in writing, within one (1) business day of receipt of necessary information)

Expedited: An expedited review may be requested when a delay would seriously jeopardize the Member's life, health, or ability to maintain or regain maximum functions. Expedited reviews must be completed within seventy-two (72) hours of receipt of expedited request. Expedited Concurrent reviews must be completed within one (1) business day after all information received; no more than 72 hours. (Expedited reviews are not applicable to Child Health Plus). Molina can deny an expedited request and process within standard timeframes. If all necessary information is not received, Molina has up to fourteen (14) days to make a determination.

Retrospective: Molina must make decisions within thirty (30) days of receipt of necessary information. A notice will be mailed to Member on the date of a payment denial, in whole or in part.

Molina may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of the Public Health Law when:

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and the information existed at the time of the pre-authorization review but was withheld or not made available; and

- Molina was not aware of the existence of the information at the time of the pre-authorization review; and had Molina been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Requesting Prior Authorization

Provider Portal: Participating Providers are required to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization form can be faxed to Molina at: (866) 879-4742. If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Member or could jeopardize the Member's ability to regain maximum function. Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being processed as expeditiously as possible.

Phone: Providers can inquire about Prior Authorizations by contacting Molina Healthcare's Services Department at (877-872-4716). It will be necessary to submit additional documentation before the authorization can be processed, as prior authorizations cannot be completed by phone.

Affirmative Statement about Incentives

Molina requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to Providers, Members, and staff, that Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

Molina HCS staff is accessible (877) 872-4716 during normal business hours, Monday through Friday from 8:00 a.m. to 6:00 p.m. (except for Holidays) for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (877) 872-4716. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

During business hours staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

Levels of Administrative and Clinical Review

Molina reviews and approves or denies plan coverage for various services—inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or Participating Provider, covered services) and
- Clinical (e.g., Medically Necessary)

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All UM requests that may lead to denial are reviewed by a heath professional at Molina (medical director, pharmacy director, or appropriately health professional).

All staff involved in the review process has an updated list of services and procedures that require Pre-Service Organization Decision/Authorization.

The timelines and procedures are published in the Provider Manual and are available on the www.MolinaHealthcare.com website.

In addition, Molina's Provider training includes information on the UM processes and Authorization requirements.

Hospitals

Emergency Services

Emergency Services means: An emergency means a medical or behavioral condition that comes on all of a sudden and has pain or other symptoms. This condition would make a person with an average knowledge of health (prudent layperson) fear that someone would suffer serious harm to body parts or function or serious disfigurement without care right away.

Emergency Medical Condition or Emergency Condition means: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
(b) Serious impairment to such person's bodily functions;
(c) Serious dysfunction of any bodily organ or part of such person; or
(d) Serious disfigurement of such person.

A medical screening exam performed by licensed medical personnel in the emergency department, including CPEP and subsequent Emergency Services rendered to the Member do not require prior authorization from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services.

Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina within one business day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within the next business day. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, the duration of the inpatient stay will be covered for as long as it is deemed medically necessary or until there is a change in level of care, however, all services received after their termination of eligibility are not covered services.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;
- The service is not experimental or investigation in nature;
- The service meets Medical Necessity criteria (according to accepted, nationally recognized resources);
- All covered services, e.g. test, procedure, are within the Provider's scope of practice;
- The requested Provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;

- The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina performs prior authorization for inpatient review in order to ensure patient safety, and Medical Necessity for all in-network facilities. Molina performs concurrent inpatient review in order to ensure patient safety, and Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plan for all out of area Providers. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body Member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Inpatient Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The inpatient review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation and guidance and evidence-based criteria sets.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Readmissions

Hospital readmissions less than thirty-one (31) calendar days from the date of discharge have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as Federal and State regulations.

Molina will conduct readmission reviews for applicable participating hospitals if both admissions occur at the same facility. If it is determined that the subsequent admission is related to the first admission (Readmission), the first payment may be considered as payment in full for both the first and second hospital admissions.

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission.
2. The readmission is part of a Medically Necessary, prior authorized or staged treatment plan.
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.
4. Certain diagnoses are excluded from a readmission review including cancer, maintenance chemotherapy, behavioral health, transplants, pregnancy and delivery, elective admissions and planned procedures.
5. Please see the following link for the complete list: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf

Non-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations. Non participating providers will receive NYS Medicaid rates unless a Single Case Agreement is executed.

"Emergency Services" means an emergency medical or behavioral condition that comes on all of a sudden and has pain or other symptoms. This condition would make a person with an average knowledge of health (prudent layperson) fear that someone would suffer serious harm to body parts or function or serious disfigurement without care right away.

Access to Out of Network Specialty

The following guidelines outline Member access to Specialty Provider or Specialty Center outside of the Molina Network

- The Member will not be allowed to elect a non-participating specialist, unless the Molina network does not include an appropriate Provider.
- If the Molina Network does not have a health care Provider with appropriate training and experience to meet the needs of the Members, an authorization can be made to an appropriate accredited specialty center or to an appropriate Provider outside of the Network if medically necessary services are not available through network Providers.
- If a Member with a life threatening or degenerative and disabling condition or disease requires specialized medical care over a prolonged period of time, a Member may receive a referral to an accredited or designated specialty care center with expertise in the field.
- The referral will be made pursuant to a treatment plan approved by Molina in consultation with the PCP, Non-Participating Provider, specialty center and Member or Member's Designee.
- The services from a Non-Participating specialist will add no additional cost beyond what Members pay for in network services.
- In addition to the requirements in the Medicaid Managed Care Model Contract, the Plan shall expand its network to meet the needs of special populations including but not limited to Transition Age Youth (TAY) with behavioral health needs; children in foster care; children deemed medically fragile; children with intellectual/developmental disability (I/DD); children with complex trauma etc. The Plan must contract with providers with expertise in working with medically fragile children including those with co-occurring developmental disabilities to ensure services are being provided appropriately. It is expected that network providers will refer to the appropriate community and facility providers or request authorization from the Plan for out-of-network providers when in-network providers cannot meet the child's

needs. The Plan must authorize services in accordance with the established timeframes in the Medicaid Managed Care Model Contract; Office of Health Insurance Programs Principles for Medically Fragile Children and under EPSDT, HCBS and CFCO rules and with consideration for extended discharge planning.

Avoiding Conflict of Interest

The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Molina's Health Care Services (HCS) includes Utilization Management, and Care Management. HCS works with Providers to assist with coordinating services and benefits for Members with complex needs. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Members:

1. The first occurs when a new Member enrolls in Molina and needs to transition medical care to Molina contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc.
   (a) If a new Member has an existing relationship with a health care Provider who is not a Member of the Molina Provider network, Molina shall permit the Member to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the effective date of enrollment if the Member has a life-threatening disease or condition or a degenerative and disabling disease or condition.
   (b) If a Member has entered into their second trimester of pregnancy with a Non-Participating Provider at the effective date of enrollment, the transitional period would include covered care until the post-partum visit.

All requests for transition of care referrals must be submitted either orally or in writing by Member or Member representative to review for criteria. The Utilization Review Department will then follow the appropriate steps and use utilization management criteria to make a determination and authorize care. Medical services will be authorized for the transition period. Molina will support the transition of the Member to a Participating Provider by assisting the Member locating a new Provider and coordinating activities through the transition period. Molina will not deny coverage of an ongoing course of care unless an appropriate Provider of alternate level of care is approved for such care.

Members may receive care from appropriate Non-Participating Providers during the applicable transitional care time period only if the Non-Participating Provider agrees to:

(a) Accept Molina rates as payment in full, which rates will be no more than the level of reimbursement applicable to similar Providers within the network.

(b) Adhere to Molina quality assurance requirements and agrees to provide necessary medical information related to the care.

(c) Otherwise adhere to Molina policies and procedures including, but not limited to procedures regarding referrals and prior

2. The second coordination of care process occurs when a Molina Member's benefits will be ending and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

Continuity of Care when Provider Leaves Network

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Molina shall permit Member for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with the Member's current health care provider during a transitional period. The transitional period shall continue up to ninety (90) days from the date the provider's contractual obligation to provide services to the Molina Member terminates; or, if the Member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery through sixty (60) days postpartum. If the Member elects to continue to receive care from a non-participating provider, such care shall be authorized by Molina for the transitional period only if the non-participating provider agrees to the following:

- Accept reimbursement from Molina at rates established by Molina as payment in full, which shall be no more than the level of reimbursement applicable to similar providers within the Molina network for such services;
- Adhere to Molina's quality assurance requirements and agrees to provide to Molina necessary medical information related to such care; and

- Otherwise adhere to Molina's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by Molina.
- In no event shall this requirement be construed to require Molina to provide coverage for benefits not otherwise covered Molina shall notify impacted Members whose healthcare provider has left Molina's provider network.

Transition of Care of New Member

If a new Member has an existing relationship with a health care Provider who is not a Member of the Molina Provider network, Molina shall permit the Member to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the effective date of enrollment if the Member has a life-threatening disease or condition or a degenerative and disabling disease or condition. If a Member has entered into their second trimester of pregnancy with a Non-Participating Provider at the effective date of enrollment, the transitional period would include covered care until the post-partum visit.

All requests for transition of care referrals must be submitted either orally or in writing by Member or Member representative to review for criteria. The Healthcare Services will then follow the appropriate steps and use utilization management criteria to make a determination and authorize care. Medical services will be authorized for the transition period. Molina will support the transition of the Member to a Participating Provider by assisting the Member locating a new Provider and coordinating activities through the transition period. Molina will not deny coverage of an ongoing course of care unless an appropriate Provider of alternate level of care is approved for such care.

Members may receive care from appropriate Non-Participating Providers during the applicable transitional care time period only if the Non-Participating Provider agrees to:

- Accept Molina rates as payment in full, which rates will be no more than the level of reimbursement applicable to similar Providers within the network.
- Adhere to Molina quality assurance requirements and agrees to provide necessary medical information related to the care.
- Otherwise adhere to Molina policies and procedures including, but not limited to procedures regarding referrals and prior

For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 223-7242.

UM Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services;
- Payment for Emergency Services, post stabilization care or urgently needed services.

All Medical Necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating Providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria does not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members. Molina covers all services and items required by State.

Requests for authorization not meeting criteria must be reviewed by a designated Provider or presented to the appropriate committee for discussion and a determination. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of medical necessity.

Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA© standards.

Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected in State must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

Report to: New York Statewide Central Register of Child Abuse and Maltreatment (SCR) 24 hours a day/ 7 days a week

Mandated Reporter: (800) 635-1522
Public Hotline: (800) 342-3720
For Abuse by Institutional Staff: (855) 373-2122

Oral reports to the SCR from a mandated reporter must be followed within 48 hours by a written report to the local department of social services' CPS unit on Form LDSS-2221A. Visit ocfs.ny.gov and select "Forms." Enter the form number in the keyword search field.

Adult Abuse:

To report adult abuse, call (844) 697-3505 between 8:30 a.m. and 8:00 p.m. or contact the local, county social services department's Adult Protective Service bureau. A listing by county can be found here.

Molina's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper State agency.

Emergency Services

Emergency Services means: An emergency means a medical or behavioral condition that comes on all of a sudden and has pain or other symptoms. This condition would make a person with an average knowledge of health (prudent layperson) fear that someone would suffer serious harm to body parts or function or serious disfigurement without care right away.

Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina Healthcare of New York accomplishes this service by providing a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina Healthcare of New York, Inc. contracts with vendors that provide (24) hour Emergency Services for ambulance and hospitals. An out of network Emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in a Non-Participating Provider facility are not covered, and Member will be responsible for payment.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member including the health of a pregnant woman and/or her unborn child in serious jeopardy;

- Serious impairment to bodily functions;
- Serious dysfunction of any body part; and/or,
- Serious disfigurement.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative. Failure to review and render a decision on the post-stabilization pre-approval request within one (1) hour of receipt of the call shall be deemed an authorization of the request.

Molina or its delegated entity is financially responsible for these services until Molina or its delegated entity becomes involved with managing or directing the Member's care.

Molina and its delegated entity provides urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two (2) days of onset of symptoms, as judged by a prudent layperson.

Continuity and Coordination of Provider Communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Care Management

Molina Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with reports, updates, and information regarding the Member's progress through the Care Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The case manager collaborates with the Member and all resources involved in the Member's care to develop an individualized plan of care which includes recommended interventions from Member's interdisciplinary care team. Individualized care plan interventions include links to appropriate institutional and community resources, to address medical and psych-social needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager, Providers, and the Member are responsible for implementing the plan of care. Additionally the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team Members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation, weight management and wellness, Motherhood Matters, and disease-specific health management programs. Refer to "Benefits and Covered Services" section for detailed information regarding these services.

Health Management's primary focus is on Asthma and Depression; however it also manages other conditions such as: Diabetes, CVD and COPD.

- Weight Management – For information about the telephonic Molina Weight Management Program or to enroll Members, please contact our Member Assessment Unit.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll Members, please contact our Health Management Unit
- Motherhood Matters Program - For information about Pregnancy Program or to enroll Members, please contact our OB Prenatal service Unit

Member Newsletters

Member Newsletters are posted on the www.MolinaHealthcare.com website at least (two) 2 times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina HCS Department toll free at (877) 872-4716.

Medical Case Management (CM)

Molina provides a comprehensive Case Management (CM) program to all Members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by Members with complex needs through a continuum of care. Molina adheres

to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina case managers are licensed professionals and are educated, trained and experienced in the Care Management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The CM program is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Care Management: Members with high-risk medical conditions may be referred by their PCP or specialty care Provider to the CM program. The case manager works collaboratively with all Members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.

Criteria for Referral

Members with the following conditions should be referred to our Case Management Department:

- Hospitalizations (Primary Diagnoses):
  - Psychiatric
  - Substance Use
  - Admissions for Controllable Diseases, for example—diabetes, asthma, hypertension
- Social Issues:
  - Medical Child Neglect
- Life Threatening Chronic Diseases:
  - HIV/AIDS
  - Cancer
  - Tuberculosis
- Members with Three or More Consecutive Missed Appointments.
- Members with Significant Impairments.
  - Hearing Impaired
  - Vision Impaired
  - Mobility Impaired
  - Cognitively/Mentally Impaired
- Pregnant Patients
- Members That Failed To Meet the following Health Prevention Guidelines:
  - Delayed Immunizations Three (3) Months Or More. (Ages 0-18 Years)
  - Absence or Delayed Lead Screening of More Than Six (6) Months. (Ages 1-6 Years)

    - Mammograms Delayed For Two (2) Years. (40 Years And Older)
    - Pap Smears Delayed Two (2) Years. (From Onset Sexual Activity Or 18 Years And Older)
    - Inability to have Member patient return for follow-up of an abnormal lab or condition which may result in significant morbidity or mortality, for example—TB test, suspected cancer, etc.
- Newly Diagnosed Patients With:
    - Asthma
    - Diabetes
    - HIV/AIDS
    - Mental Illness
    - Substance Use
    - Failure to Thrive
    - Low Birth Weight Infants
    - Critically Ill Newborn
    - Newborns with NICU stay greater than 24 hours
- Identify through claims data high risk populations that would benefit from Case Management Services. High risk populations will include Members who meet the following criteria:
    - Members with at least one (1) ER/hospitalization for diabetes
    - Members with inpatient admission for asthma
    - Members with more than one admission for mental health/chemical dependency within 6 months
    - Members with inpatient admissions for acute MI, Coronary Artery Bypass Graft (CABQ), or Percutaneous Transluminal Coronary Angioplasty (PTCA)
- Cases Identified By:
    - Primary Care Provider
    - Quality Improvement Program
    - Complaint or Grievance Procedure
    - Molina Medical Director
    - Member
    - Hospital Discharge Planner
    - Quarterly Administrative Claims Review
    - New York State Department of Health

High risk populations will be discussed quarterly at the QM Committee meetings. Categories for review may be modified depending on the needs of the membership.

Referrals to the CM program may be made by contacting Molina at:

Phone: (877) 872-4716
Fax: (866) 879-4742

Behavioral Health Case Management

Molina Healthcare of New York's Behavioral Health Case Management program is designed to ensure the coordination of care for children and adults at significant clinical risk due to behavioral health conditions and psychosocial factors. The program includes assessment, care planning, advocacy and linkage to necessary support and services. Individualized care plans are developed in collaboration with the members and their healthcare teams aimed at improving a member's overall functioning. Molina Healthcare case management is provided by licensed behavioral health clinicians.

Referrals for case management are taken from inpatient facilities, outpatient providers, health plan representatives, PCPs, state agencies, members and their families.

Molina Case Management staff are trained to assess and monitor member's needs for case management, including defined triggers for referrals to health home. These triggers include New York State's Health Home eligibility criteria is as follows: 1) Medicaid eligible/active Medicaid, 2) Two or more chronic conditions and 3) One single qualifying condition of either HIV/AIDS or a Serious Mental Illness (SMI). Other triggers that Molina Case Management staff are trained to assess and monitor the member's needs for case management above and beyond the eligibility criteria for health home are as follows:

- Member has a prior history of acute psychiatric, or substance use admissions authorized by Molina with a readmission within 60-day period;
- First inpatient hospitalization following serious suicide attempt, or treatment for first psychotic episode
- Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family or social support along with an inadequate outpatient treatment relationship, which places the member at risk of requiring acute behavioral health services
- Presence of a co-morbid medical condition that, when combined with psychiatric and/or substance use issues, could result in exacerbation of fragile medical status
- Adolescent or adult who is currently pregnant, or within a 90-day postpartum period that is actively using substances, or requires acute behavioral health treatment services
- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services who requires support to link family, providers and state agencies,, which places the member at risk of requiring acute behavioral health services
- Multiple family members who are receiving acute behavioral health and/or substance use treatment services at the same time
- Other complex, extenuating circumstances where the case management team determines the benefit of inclusion beyond standard criteria

NYS DOH Requirements for HIV Counseling, Testing and Care of HIV Positive Individuals

HIV Confidentiality

All Providers must comply with the HIV confidentiality provisions of Section 2782 of the New York Public Health Law to assure the confidentiality of HIV related information. Compliance requires:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access to HIV related information and the limits of access
- Procedure to limit access to trained staff, including contractors
- Protocol for secure storage, including electronic storage
- Procedures for handling requests for HIV related information
- Protocols to protect from discrimination persons with or suspected of having HIV infection

For complete details, please see the following websites:

http://www.health.ny.gov/diseases/aids/providers/regulations/

http://public.leginfo.state.ny.us

Role of the Primary Care Provider (PCP)

The PCPs' roles are critical in the early identification of Members at risk for HIV infection or disease. A person of any age, sex, race, ethnic group, religion, economic background, or sexual orientation can get HIV.

HIV Provider Access

HIV qualified Providers are listed in the Provider Directory as HIV Specialty Care Centers and HIV/AIDS specialists. If services are not available in network or geographically convenient for the Member, the Member can request services outside the Molina Provider network. If the Member prefers to have the HIV Provider act as their PCP, the Member can request such.

The HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information allows individuals to use a single form to authorize release of general medical information, as well as HIV-related information, to more than one Provider and to authorize designated Providers to share information between and among them. This form can be found on the DOH website at: http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

At Risk Members

The following partial factors heighten the possibility that a Member may be at risk for HIV:

- Injection drug users (IDU) – Injected drugs or steroids with others, piercing, tattooing, or used shared equipment (e.g. syringes, needles, works) currently or any time in the past;
- Member has been diagnosed with or been treated for hepatitis, tuberculosis (TB), or a sexually transmitted disease such as gonorrhea, Chlamydia or syphilis;
- Unprotected anal, vaginal and oral sex – Had unprotected vaginal, anal, or oral sex with multiple partners, anonymous partners, or men who have sex with men;

- Sexual partner with known HIV infection;
- Had sex with a partner they located on the Internet;
- Infants born to HIV infected mothers - Babies can potentially become infected during their mother's pregnancy, during delivery, or after birth in the immediate postpartum period. They can also become infected through breastfeeding.
- Health care and maintenance workers who may be exposed to blood and/or body fluids at work sometimes are infected through on-the-job exposures like needle-stick injuries.
- Individuals who received a transfusion of blood or blood products before screening of the blood supply for HIV antibody was initiated in 1985.

Symptoms

The PCP should consider the possibility of HIV infection when minimally the following signs or symptoms are noted:

- Persistent fevers
- Night sweats
- Weight loss
- Lymphadenopathy
- Chronic diarrhea

Counseling, Screening

Members may seek HIV counseling and testing services outside of the plan network Providers. Members also should be advised that such services are obtainable anonymously through the New York State Anonymous Counseling and Testing Programs. This is available at various clinics in each NYS county in addition to free testing for sexually transmitted diseases. Hours and locations can be accessed at https://www.health.ny.gov/diseases/communicable/std/clinics/ and the AIDS Hotline: 1-800-541-AIDS.

The Provider must counsel, screen, manage and/or refer patients consistent with the guidelines established by the AIDS Institute of the New York State Department of Health.

Every individual ages of 13 and over (if there is evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in Subdivision 10 of Section 2801 of the Public Health Law or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under Article 28 of the Public Health Law or from a physician, physician assistant, nurse practitioner, or midwife providing primary care in any office, clinic, facility or other setting shall be offered an HIV-related test unless the health care practitioner providing such services reasonably believes that:

- the individual is being treated for a life threatening emergency; or
- the individual has previously been offered or has been the subject of an HIV-related test (except that a test shall be offered if otherwise indicated); or
- the individual lacks capacity to consent to an HIV-related test.

Qualified OB/GYN Providers are required to provide 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.

Consent for Testing

Performing an HIV test as part of routine medical care requires at a minimum advising that an HIV-related test is being performed prior to ordering an HIV-related test.

When a provider orders an HIV test, the provider must give the patient information related to HIV as required by the Public Health Law. Prior to performing, the certain key points must be reviewed with the patient. The key points may be delivered orally, in writing or via electronic means. The key points are found at the following website: http://www.health.ny.gov/publications/9678/index.htm. The key points are listed below:

- HIV is the virus that causes AIDS. It can be spread through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with HIV-infected blood by sharing needles (piercing, tattooing, drug equipment, including needles); by HIV-infected pregnant women to their infants during pregnancy or delivery, or by breast feeding.
- There are treatments for HIV/AIDS that can help a person stay healthy.
- People with HIV/AIDS can use safe practices to protect others from becoming infected. Safe practices also protect people with HIV/AIDS from being infected with different strains of HIV.
- Testing is voluntary and can be done at a public testing center without giving your name (anonymous testing).
- By law, HIV test results and other related information are kept confidential (private).
- Discrimination based on a person's HIV status is illegal. People who are discriminated against can get help.
- The law requires that an individual be advised before an HIV-related test is performed and that no test shall be performed over his or her objection.
- Health care and other HIV test Providers authorizing HIV testing must arrange, with the consent of the patient, an appointment for medical care for those confirmed as positive.
- Anonymous HIV testing of source patients in occupational exposure situations who are unable to provide consent is allowed in certain circumstances, though results cannot be shared with the source patients or included in their medical record.
- The capacity to consent to an HIV test (either confidential or anonymous) is determined without regard to age. If a practitioner determines a person does not have the capacity to consent, the offer of testing should be made to a person(s) authorized to consent to health care for such individual.
- If a Member is tested, pre- and post-test counseling must be completed and documented in the medical record. Advisement and objection of individual or authorized person to perform HIV-related testing must be noted in the individual's medical record.

- Member Educational materials related to HIV are available through the New York State Department of Health AIDS Institute – consumer Educational Materials Order Form can be found at: http://www.health.ny.gov/forms/order_forms/hiv_educational_materials.pdf

Reporting

The PCP is responsible to report all Members testing HIV positive to the New York State Department of Health consistent with the communicable disease reporting requirements. This would apply to new HIV disease as well as any change in HIV status.

Positive Results

All determinations or diagnoses of Human Immunodeficiency Virus (HIV) infection, HIV-related illness and Acquired Immune Deficiency Syndrome (AIDS) shall be reported to the commissioner by physicians and other persons authorized to order diagnostic tests or make medical diagnoses or their agents as soon as possible after post-test counseling but no later than fourteen (14) days after the Provider's receipt of a positive laboratory result or after diagnosis, whichever is sooner. (Source: Effective Date: 02/22/2012, Title: Section 63.3 - HIV-related testing (http://w3.health.state.ny.us/dbspace/NYCRR10nsf/11fb5c7998a73bcc852565a1004e9f87/8525652c00680c3e8525652c004f3d82?OpenDocument)

The testing Provider must provide test results (directly or through a representative) to a person who test is HIV positive. The testing Provider also must, with the consent of the patient, help arrange an appointment for medical care for those Members confirmed as positive as soon as possible. Provider must provide the following education for Member's who test positive:

- coping emotionally with the test results;
- discrimination issues relating to employment, housing, public accommodations, health care and social services;
- authorizing the release and revoking the release of confidential HIV-related information;
- preventing high risk sexual or needle-sharing behavior; the availability of medical treatment;
- HIV reporting requirements for the purposes of monitoring of the HIV/AIDS epidemic;
- the advisability of contacts being notified to prevent transmission, and to allow early access of exposed persons to HIV testing, health care, and prevention services, and a description of notification options and assistance available to the protected individual;
- the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner pursuant to law;
- the fact that known contacts, including a known spouse, will be reported and that protected persons will also be requested to cooperate in contact notification efforts of known contacts and may name additional contacts they wish to have notified with the assistance of the Provider or authorized public health officials;
- protection of names and other information about HIV-infected persons during the contact notification process;

- the right to have an appointment made for HIV follow-up medical care, the use of HIV chemotherapeutics for prophylaxis and treatment, and the availability of peer group support.
- the risk of perinatal transmission

Negative Results

A person who tests HIV negative must be provided with the result and information concerning risks of participation in sexual and needle-sharing activities that can result in infection. This information may be in the form of written materials such as those available on the Department's website. The negative test result and required information do not need to be provided in person. Other mechanisms such as email, mail, and phone may be used as long as you have taken steps to ensure the patient's confidentiality Patients who are consented orally and given a rapid test should be provided their results during the same clinic visit or the same day. In addition, it is not appropriate to tell patients that if they are not contacted, they may assume their tests were negative. However, it is acceptable to provide patients with the required information and a phone number or other means of confirming their negative result if they so choose.

Pregnant Women

Identifying Acute HIV Infection (AHI) During Pregnancy:

- Immediate testing is recommended for any pregnant woman who presents with a clinical syndrome compatible with Acute HIV Infection (AHI) without a known cause, even if she tested HIV-negative earlier in pregnancy. General information on AHI may be found at http://www.hivguidelines.org.
- In suspected cases of AHI during pregnancy:
    - Immediate testing using an HIV antibody test and an HIV RNA test should be performed. If either is positive or there is strong clinical suspicion:
    - Immediate consultation with an HIV specialist regarding diagnosis and treatment;
    - Confirmatory antibody testing 3-6 weeks later if the HIV RNA test is positive and the initial antibody test is negative or indeterminate.
- Testing for AHI in pregnancy may be accessed by contacting:
    - In New York City: New York City Department of Health & Mental Hygiene, HIV Surveillance and Epidemiology Program, Provider Line 1-212-442-3388;
    - Outside New York City: New York State Department of Health, Wadsworth Center, Diagnostic HIV Laboratory 1-518-474-2163.

HIV Testing in the Third Trimester:

- In concert with the Centers for Disease Control and Prevention (CDC), the New York Department of Health recommends that prenatal Providers routinely recommend repeat HIV testing, preferably at 34-36 weeks, for all women who test negative early in prenatal care.

- The second test ideally should be at least three months after the initial test. Repeat testing will identify women who become infected with HIV during pregnancy, a group that accounts for an increasing proportion of Mother-to-Child Transmission (MTCT).

Point-of-Care Rapid HIV Testing in Delivery Settings:

Implementing point-of-care (rapid) testing facilitates timely administration of prophylaxis to HIV-positive women and their exposed newborns. For women diagnosed with HIV during labor, HIV antiretroviral (ARV) regimens to prevent mother-to-child HIV transmission (MTCT) are most effective if initiated during labor, HIV antiretroviral (ARV) regimens to prevent MTCT are most effective if initiated during labor or, if intrapartum ARV is not possible, to the newborn within 12 hours of birth.

The New York Department of Health recommends:

- All birth facilities adopt point-of-care rapid HIV testing in labor and delivery settings.
- Expedited HIV test results should be available within an hour to facilitate effective administration of ARV prophylaxis.
- For information on rapid testing, see: http://www.health.ny.gov/diseases/aids/providers/testing/rapid/workbook.htm

Assuring Access to Care and Supportive Services:

To facilitate linkages to care and to provide the support many women need it is considered standard of care to link HIV-positive pregnant and postpartum women, including those who deliver without prenatal care, to HIV-specific case management and supportive services.

Resources

- Consultation and technical assistance for prenatal care Providers and hospital obstetrical departments is available from:
    - HIV Clinical Education Initiative (CEI): call 1-866-637-2342 or visit
    - HIVAIDS Regional Training Centers: These centers offer training on reducing MTCT and expedited and rapid testing in obstetrical settings. See https://www.health.ny.gov/diseases/aids/general/about/education.htm.
- NYSDOH AIDS Institute has a resource directory intended for use by individuals seeking services and as a referral tool for Providers. The directory can be found at http://www.health.ny.gov/diseases/aids/general/resources/resource_directory/
- Resources specific to case management of HIV patients are available at: https://www.health.ny.gov/diseases/aids/general/resources/index.htm

Tuberculosis Screening, Diagnosis and Treatment

Tuberculosis screening, diagnosis and treatment is a covered benefit for Molina Members.

Screening

Providers are responsible to appropriately screen Molina Members in accordance with the following:

- Children: American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care
- Adults: Adult Preventive Care Guidelines as defined by the US Preventive Services Health Task Force (http://www.uspreventiveservicestaskforce.org/)
- Symptomatic considerations: skin test or chest x-ray for the following
    - Productive and/or prolonged cough;
    - Chest pain;
    - Hemoptysis;
    - Fever, chills, night sweats, fatigue;
    - Weight loss.
- High Risk Populations: skin test or chest x-ray should be considered for the following:
    - Positive HIV status;
    - Foreign born persons where tuberculosis is common;
    - Exposed to persons with tuberculosis;
    - Unreliable histories;
    - Suspected or known elicit injectable drug use;
    - Residence of long-term facilities;
    - Socio-economic - homeless or low income;
    - Persons with certain medical conditions in addition to +HIV status;
    - Children four years of age and under.

Diagnosis and Testing

- The Mantoux skin testing is the preferable skin testing method consisting of .1 ML of 5 TU PPD intradermally. The Provider is responsible to ensure that the interpretation and documentation of the results are conducted by trained staff (i.e., licensed nurse, P.A., N.P., or physician).
- A skin test is considered positive as below:
    - Equal or greater than 15MM induration (no known risk factors)
    - Equal or greater than 10MM induration (symptomatic or at-risk groups).
    - Equal or greater than 5MM induration for patients that are immunocompromised, IV drug users, or having had contact with known infectious cases, people that have chest radiograph, suggestive of previous tuberculosis
- Patients with a positive skin test should have a chest x-ray obtained to rule out pulmonary tuberculosis
- Molina has agreements with the County Health Department for consultation and referral for Members with diagnosed or suspected tuberculosis. Molina Network Providers must

notify Molina Case Management with the names of diagnosed patients for referral and coordination and any necessary authorizations.

Treatment

- Treatment guidelines can be found at: http://www.cdc.gov/tb/publications/guidelines/default.htm
- Molina Participating Providers must engage infection control procedures to isolate suspected and known patients with tuberculosis in order to minimize the transmission of disease. The suspected patient should not wait in general waiting areas. The Provider will need to assure appropriate room ventilation for the performance of procedures. The Provider must demonstrate that support staff is educated on the appropriate infection control procedures including the use of personal respiratory masks.
- The Primary Care Provider is responsible to promptly report all suspected and positive TB cases to the County Health Department. The County Health Department will assist Providers on infection control procedures.

Directly Observed Therapy for Tuberculosis Disease (TB/DOT)

- TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the prescribed medication regimen
- TB/DOT is the standard of care for all patients with active TB
- Molina Case Management is responsible for the coordination, communication and cooperation of the Clinical Management of the TB/DOT Provider but where applicable, services may be billed directly to eMedNY by an SDOH approved Medicaid Fee-for-Service TB/DOT Provider
- The service may be provided in the community at the local health department (LDH), in the patient's home, or on an inpatient basis.
- Outpatient TB/DOT involves the observation of dispensing of medication, assessing any adverse reactions to the medications and case follow up.
- Inpatient long-term treatment may be indicated where the LHD has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.
- Molina is contracted with four local Department of Health agencies that provide this service. For more information, please visit the New York State Department of Health's website here where you can find a listing by county.
- Clinical protocols followed by the LDH agencies above are established by the Centers for Disease Control and can be found at: http://www.cdc.gov/tb/publications/guidelines/default.htm

Medical Record Standards

The Provider is responsible for maintaining an electronic or paper medical record for each individual Member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all Providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard Member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable Federal and State regulations. The Provider must ensure his/her staff receives periodic training regarding the confidentiality of Member information.

The Provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the Member was referred to the Provider.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in the Quality section of this Provider Manual. Medical records shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.

Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals/Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including the PA request form, is available on our website: www.MolinaHealthcare.com.

Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

SECTION 8. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina Healthcare of New York, Inc. maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality Department **toll free at (877) 872-4716 or fax (844) 879-4471**.

This Provider Manual contains excerpts from the Molina Healthcare of New York Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of New York's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory and accreditation guidelines. The QIP provides structure and outlines specific activities designed to improve the care, service and health of our Members.

Molina does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process; and during potential Quality of Care and/or Critical Incident investigations; and
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their Primary Care Providers. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part.
- Surgery on the wrong patient.
- Wrong surgery on a patient.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Molina conducts a medical record review of all Primary Care Providers (PCPs) that have a fifty (50) or more Member's on their panel that includes the following components:

- Medical record confidentiality and release of medical records including behavioral health care records;
- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record
- The record verifies that PCP coordinates and manages care
- Medical record retention period of six years after date of service rendered to Members and for a minor, three years after majority or six years after the date of the service, whichever is later
- (Prenatal care only): centralized medical record for the provision of prenatal care and all other services
- Medical records are stored away from patient areas and preferably locked
- Medical records are available at each visit and archived records are available within twenty-four (24) hours
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for Quality and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

Providers must remain consistent in their practices with Molina Healthcare of New York's medical record documentation guidelines. Medical records are maintained and should and include the following information:

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact
- Legible signatures and credentials of provider and other staff members within a paper chart;
- All providers who participate in the member's care;
- Information about services delivered by these providers;
- A problem list that describes the member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;

- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and,
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped, or attached to the file;
- Chart sections are easily recognized for retrieval of information; and
- A release document for each Member authorizing Molina to release medial information for facilitation of medical care.
- (Prenatal care only): centralized medical record for the provision of prenatal care and all other services.

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality;
- The medical record is available to Molina Healthcare of New York Quality Department and the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request.
- A storage system for inactive member medical records which allows retrieval within twenty four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 (ten) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member protected health information, including information specific to behavioral health and substance use, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State low in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information;
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department **toll free at** (877) 872-4716. See also the Compliance Section of this Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 100% availability for Emergency Services and 75% or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Medical Appointment Types	Standard
Routine, asymptomatic	Within 28 calendar days
Routine, symptomatic	Within 2-3 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 28 – 42 calendar days
Specialty Care (High Impact)	Within 28 - 42 calendar days
Urgent Specialty Care	Within 24 hours
Obstetrical Care	Within 21 calendar days in the first trimester, within 14 calendar days in the second trimester and within 7 days thereafter

Behavioral Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-Life-threatening Emergency	Within 6 hours
Urgent Care	Within 24 hours
Routine Care	Within 14 calendar days
Follow-up Routine Care	Within 7 calendar days

Additional information on appointment access standards is available from your local Molina Quality Department **toll free at (877) 872-4716.**

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed sixty (60) minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. For PCPs and OB/GYNs, if a recorded message is used, it must provide an option to direct the Member to a live person. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services Department at (877) 872-4716 or TTY/TDD 711;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;

5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. Provider's office cannot require a Member to come to the office to complete a medical record request prior to Member's appointment. An appointment must be provided at the time of the call requesting an appointment, any forms required, including medical record requests, should be completed at the time of the first visit. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of New York as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina Quality Department **toll free at (877) 872-4716**.

Monitoring Access Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and afterhours access.
2. Member complaint data – assessment of Member complaints related to access to care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for

identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on access to care is available under the Resources tab at www.MolinaHealthcare.com or is available from your local Molina Quality Department **toll free at (877) 872-4716.**

Quality of Provider Office Sites

Molina has established guidelines to ensure that the offices of all Providers meet office-site and medical record keeping practices standards. Molina continually monitors Member complaints for all office sites to determine the need of an office site visit and will conduct office site visit if it is determined that such review is necessary. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under "Medical Record Keeping Practices") and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping

Physical accessibility

Molina evaluates office sites to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for physically disabled patients.

Physical appearance

The site visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of waiting and examining room space

During the site visit, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one (1) medical/treatment record for the areas described in the Medical Record Keeping Practices section above. To ensure Member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Monitoring Office Site Review Guidelines and Compliance Standards

Provider office sites must demonstrate an overall eighty percent 80% compliance with the Office Site Review Guidelines listed above. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Improvement Plans/Corrective Action Plans

If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:

- Send a letter to the Provider that identifies the compliance issues.
- Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
- Request the Provider to submit a written corrective action plan to Molina within thirty (30) calendar days.
- Send notification that another review will be conducted of the office in six (6) months.

When compliance is not achieved, the Provider will be required to submit a written corrective action plan (CAP) to Molina within thirty (30) calendar days of notification by Molina. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or Provider and must include the expected time frame for completion of activities.

Additional reviews are conducted at the office at six-month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the Provider is included in the Provider's permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Fair Hearing Plan policy.

Molina Healthcare of New York will report to OMH and OASAS, at least quarterly, regarding provider performance deficiencies and corrective actions related to performance issues. In addition, Molina Healthcare of New York reports serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directives requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents**.**

Advance Directives are a written choice for health care. There are three types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment**: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members (18 years old and up) of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative, and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Molina will notify the Provider via fax of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form.

Advance Directives forms are State specific to meet State regulations.

Molina will look for documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

EPSDT Services to Members Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services to Members under twenty-one (21) years are timely according to required preventive guidelines. All Members under twenty-one (21) years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905® of the Social Security Act. Molina's Improvement Department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well child / adolescent visits

Visits consist of age appropriate components including but not limited to:

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services;
- health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention);
- adolescent preventive care assessments (depression, sexual activity, alcohol/drug abuse and tobacco use).

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within thirty (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a corrective action plan (CAP) with a request the Provider submit a written corrective action plan to Molina within thirty (30) calendar days. Follow-up to ensure resolution is conducted

at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

The Molina Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Provider Manual.

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina's Healthcare Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Clinical Practice Guidelines include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure

- Hypertension
- Obesity
- Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease
- New York State Department of Health, AIDS Institute
- New York State Prenatal Care Standards

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality Department **toll free at (877) 872-4716**.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old
- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®);

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Upon request by the SDOH, Molina Healthcare of New York shall prepare and submit other operational data reports. SDOH usually provides a thirty (30) to ninety (90) day-notice to receive that report. As a result, the contracted providers/facilities with Molina Healthcare of New York are also required to submit HARP related reports along with Medicaid and Essential Plan Product related reports that Molina may require to submit to the NYSDOH.

Molina's most recent results can be obtained from your local Molina Quality staff toll free at (877) 872-4716 or fax (844) 879-4471 or by visiting our website: www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS)®

Molina utilizes the NCQA® HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including preventive care, immunizations, women's health screening, obstetrical care, diabetes care, well check-up, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina's clinical Quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member Satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually to randomly selected Members by an NCQA©-Certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Experience of Care and Health Outcomes (ECHO)® Survey

Molina obtains feedback from Members about their experience, needs, and perceptions of Members with behavioral health care. This feedback is collected at least annually to understand how our members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, and perceived improvement, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods we use to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as on requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what they need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® and CAHPS® Star Ratings measures.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance© (NCQA).

Provider Performance

Molina collects and maintains Provider performance data from results of Quality Assurance Reporting Requirements (QARR)/Healthcare Effectiveness Data and Information Set (HEDIS) rates, Gap in Care reports, Performance Quality Indicators (PQI)/PDI, annual Medical record review (MRR) for PCPs and OB/GYNs (including Members who are in Foster Care), and CAHPS results. These data sets are used by the health plan to evaluate the performance/practice of health care professionals.

Provider performance evaluations are an ongoing process. Monthly paid claims data for Members' medical, pharmacy, dental and behavioral health services are provided to a Molina vendor for analysis and reporting. The reports generated from this data are referred to as gap in care reports and measure rate analyses. Reports are created at a large network level down to an individual Provider level. These reports are distributed to the Providers on a regular basis.

QARR/HEDIS is an annual evaluation process that measures the performance of health plans and their Providers on preventive, acute and chronic health care aspects. HEDIS is utilized by 90 percent of health plans for comparison.

Molina also completes annual medical record reviews (MRR) for both PCP's and OB/GYN's during the third quarter. A random sample is drawn for both primary care and OB/GYN physicians. Medical records are obtained from the Provider offices and reviewed for standards adopted from Clinical Practice Guidelines promoted from recognized agencies such as U.S. Preventive Services Task Force Clinical Practice Guidelines, American Academy of Pediatrics and Bright Futures, American Diabetes Association, NYS Asthma Practice Guidelines, Institute for Clinical Systems Improvement, Inc., and NYS Department of Health. If a Provider's MRR falls below eighty-five (85) percent, Molina collaborates with the Provider to develop and implement a corrective action plan.

Molina Providers receive feedback from the data results on a periodic basis and Providers may request the gap in care reports, network rates, profiling data and MRR analysis used to evaluate their performance.

Meetings are scheduled between Providers and both Quality Assurance and Provider Relations staff to discuss the Provider's performance and to work collaboratively on improving each Provider's performance.

Provider Performance Evaluations

Molina will perform Provider performance evaluations including:

- The information maintained by the health plan to evaluate the performance/practice of health care professionals
- The criteria against which the performance of health professionals will be evaluated
- The process used to perform the evaluation that the plan is required to provide Providers with any information and profiling data used to evaluate the Providers performance

- The plan shall make available on a periodic basis and upon the request of the health care professional the information, profiling data and analysis used to evaluate the Provider's performance
- Each Provider shall be given the opportunity to discuss the unique nature of the Provider's professional patient population which may have bearing on the Provider's profile and to work cooperatively with the plan to improve performance

Provider Specific Reviews

Random Provider specific reviews will be conducted in regard to:

- General chart documentation
- Preventive Health
- Specific diagnosis
- Prenatal Care

Any patient issues of concern will be referred to the Chief Medical Officer. The plan will contact the patient and the Provider when missing services are identified, for example, need for pap smear, immunization delay, etc. Information on the quality improvement reports and expected actions will be provided to the applicable Provider(s).

Quality Management Committee

Molina maintains committees such as the Medicaid Behavioral Health Quality Management Subcommittee that provides oversight and guidance and ongoing performance monitor for the QMP products. The committee meets on a quarterly basis and includes participation of members, peers, peer specialists and provider representative in an advisory capacity to inform the design and implementation of key quality, UM and clinical initiatives.

Member Incentives

Molina Healthcare of New York, Inc.'s member incentive program aims to boost member participation in services for preventive care and condition management. Molina providers play an important role in helping qualified members complete these needed services and earning incentives. We are currently updating our program and will be sending out a communication to all providers once complete. All questions can be directed to our Quality team at MHNYquality@molinahealthcare.com

Committee Structure

In addition, Molina maintains committees, such as the Behavioral Health Quality Management Subcommittee (BHQM) and the Behavioral Heath Utilization Management Subcommittee (BHUM) that provide oversight, guidance, and ongoing performance monitoring related to the populations, benefits and services under the Children's Standards. The committees meet on a quarterly basis and includes participation of members, family members, youth and family peer support and child serving providers in an advisory capacity, to inform the design and implementation of key quality, UM, and clinical initiatives.

The BHQM committee is accountable to and reports regularly to the governing board or its designee concerning behavioral health QM activities. It is responsible for carrying out the planned quality activities within the Children's Standards related to individuals with behavioral health conditions who access behavioral health benefits and/or HCBS. The committee is led by the BHQM Director, who also maintains records documenting attendance by members, as well as committee findings, recommendations, and actions.

The BHQM committee documents committee activities (focused discussions, tracking, trending, analysis and follow-up) related to services for medically fragile children/complex conditions, and related to behavioral health services and HCBS for children.

The BH Medical Director for Children's Services participates on the BHUM subcommittee, which examines service utilization and outcomes for children including medically fragile children. It reviews and analyzes data in the following areas: Under- and over-utilization of behavioral health services and cost data; admission and readmission rates/trends; average length of stay; follow-up after discharge; inpatient and outpatient civil commitments; emergency department utilization and crisis services use; behavioral health prior authorizations/denials/notices of action; substance use disorder initiation and engagement rates; FEP initiation and engagement rates; psychotropic medication utilization (with separate analysis for children in foster care); addiction medication utilization; transitional issues for youth ages 18 to 23 years, focusing on the continuity of care and service utilization; and other metrics as determined by the State.

For HCBS eligible children, the UM BH subcommittee shall separately report, monitor and recommend appropriate action on: use of crisis diversion and crisis intervention services; prior authorizations/denials/notices of action; HCBS utilization; HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and enrollment in Health Home.

Molina will ensure interventions have measurable outcomes and are included in BH UM committee meeting minutes. Analyses will be conducted separately for individuals under 21 years of age.

For questions on how to join and participate in our committees, please contact Molina.

SECTION 9. COMPLIANCE

Fraud Waste & Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate employees, vendors, Providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Molina regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act ("DRA") aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state Laws pertaining to submitting false claims;
- How Providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

The Federal False Claims Act and State Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

Waste: Health care spending that can be eliminated without reducing the quality of care. Quality waste includes, overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to the Medicaid program.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the physician has a financial relationship. (Stark Law)
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.

- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that he/she does not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed

and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Provider Education

When Molina identifies through an audit or other means a situation with a Provider (e.g. coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education visit is appropriate.

The Molina Provider Services Representative will inform the Provider's office that an on-site meeting is required in order to educate the Provider on certain issues identified as inappropriate or deficient.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty (365) days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at **1-866-606-3889** or you may use the service's website to make a report at any time at https://MolinaHealthcare.alertline.com

You may also report cases of fraud, waste or abuse to Molina's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of New York
Attn: Compliance
5232 Witz Drive
North Syracuse, NY 13212

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the State at:

NYS Medicaid Inspector General
Toll Free Phone: 1-877-87FRAUD (1-877-873-7283)

HIPAA Requirements and Information
HIPAA (The Health Insurance Portability and Accountability Act)
Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. Federal Laws and Regulations

- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH)
- 42 C.F.R. Part 2
- Medicare and Medicaid Laws
- The Affordable Care Act

2. State Medical Privacy Laws and Regulations.

Providers should be aware that HIPAA provides a floor for patient privacy but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and

health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement;
    - Disease management;
    - Case management and care coordination;
    - Training Programs;
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**

   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft –

both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

Molina requires the use of electronic transactions to streamline health care administrative activities. Molina Providers must submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions " or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management;
- Care Coordination and/or Complex Medical Care Management Services;
- Claims Review;
- Resolution of an Appeal and/Grievance;
- Anti-Fraud Program Review;
- Quality of Care Issues;
- Regulatory Audits;
- Risk Adjustment;
- Treatment, Payment and/or Operation Purposes; and
- Collection of HEDIS® medical records.

Information Security

1. Network Security.

Provider agrees at all times to maintain network security that—at a minimum—includes: network firewall provisioning, intrusion and threat detection, and regular (three [3] or more annually) third party vulnerability assessments. Provider agrees to maintain network security that conforms to generally recognized industry standards and best practices that Provider shall apply to its own network (refer to "12. Industry Standards").

2. Application Security.

Provider agrees at all times to provide, maintain, and support its software and subsequent updates, upgrades, and bug fixes such that the software is, and remains, secure from those vulnerabilities in accordance with industry practices or standards.

3. Data Security.

Provider agrees to preserve the confidentiality, integrity and accessibility of Molina data with administrative, technical and physical measures that conform to generally recognized industry standards and best practices that Provider then applies to its own processing environment (refer to "12. Industry Standards"). Maintenance of a secure processing environment includes but is not limited to the timely application of patches, fixes and updates to operating systems and applications as provided by Provider or open source support.

4. Data Storage.

Provider agrees that any and all Molina data will be stored, processed, and maintained solely on designated target servers and that no Molina data at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and encrypted (refer to "6. Data Encryption").

5. Data Transmission.

Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2") and Section 7. Data Re-Use.

6. Data Encryption.

Provider agrees to store all Molina backup data as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina data defined as personally identifiable information under current legislation or regulations stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and FIPS PIB 140-2.

7. Data Re-Use.

Provider agrees that any and all data exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement. Data shall not be distributed, repurposed or shared across other applications, environments, or business units of the Provider. Provider further agrees that no Molina data of any kind shall be transmitted, exchanged or otherwise passed to other Providers or interested parties except on a case-by-case basis as specifically agreed to in writing by Molina.

8. End of Provider Agreement Data Handling.

Provider agrees that upon termination of the Provider Agreement and upon Molina's written approval it shall erase, destroy, and render unrecoverable all Molina data and certify in writing that these actions have been completed within thirty (30) days of the termination of the Provider Agreement or within seven (7) days of the request of an agent of Molina, whichever shall come first. At a minimum, a "Clear" media sanitization is to be performed according to the standards enumerated by the National Institute of Standards and Technology ("NIST") Guidelines for Media Sanitization (SP800-88, Appendix A).

9. Security Breach Notification.

Provider agrees to comply with all applicable laws that require the notification of Molina, in the event of an unauthorized disclosure or breach of information or other events requiring notification. Molina will then decide on further action including, but not limited to, notification to effected individuals or government entities. In the event of a breach of any of Provider's security obligations, or other events requiring notification under applicable law, Provider agrees to:

(a) Notify the Molina Chief Information Security Officer by telephone and email of such an event within twenty-four (24) hours of discovery;

(b) Upon Molina's prior written request, assume responsibility for informing all such individuals in accordance with applicable law; and

(c) Indemnify, hold harmless and defend Molina and its trustees, officers, and employees from and against any claims, damages, or other harm related to such event.

10. Right to Audit.

Molina or a Molina-appointed audit firm ("Auditors") has the right to audit the Provider and the Provider's sub-Providers or affiliates that provide a service for the processing, transport or storage of Molina's data. Molina will announce their intent to audit the Provider by providing at a minimum of ten (10) business days' notice to the Provider. This notice will go to the Provider that the Provider Agreement is executed with. A scope document along with a request for deliverables will be provided at the time of notification of an audit. If the documentation requested cannot be removed from the Provider's premises, the Provider will allow Molina or Auditors access to their site or share on the desktop screen in an audio-video conference. Where necessary, the Provider will provide a personal site guide for Molina or Auditors while on site. If site visit is necessary, the Provider will provide a private workspace on site with electrical and internet connectivity for data review, analysis and meetings. The Provider will make necessary employees or Providers available for interviews in person or on the phone during the time frame of the audit.

In lieu of Molina or its appointed audit firm performing their own audit, if the Provider has an external, independent audit firm that performs a certified SOC or HITRUST review, Molina has the right to review the controls tested as well as the results, and has the right to request additional controls to be added to the certified SOC or HITRUST review for testing the controls that have an impact on Molina data. Audits will be at Molina's sole expense, except where the audit reveals material noncompliance with contract specifications, in which case the cost will be borne by the Provider.

11. Provider Warranty.

Provider (i) warrants that the services provided in the Provider Agreement will be in substantial conformity with the information provided in Provider's response to Molina's Due Diligence/Security Assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from that reflected in the Provider's response to Molina's Due Diligence/Security Assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's Response to Molina's Due Diligence/Security Assessment questionnaire will be deemed a material breach of the Provider Agreement.

12. Industry Standards.

Generally recognized industry standards include but are not limited to the current standards and benchmarks set forth and maintained by the:

(a) Center for Internet Security - http://www.cisecurity.org

(b) Payment Card Industry/Data Security Standards ("PCI/DSS") - http://www.pcisecuritystandards.org/

(c) National Institute for Standards and Technology (NIST 800-53) - http://csrc.nist.gov

(d) Federal Information Security Management Act ("FISMA") - http://csrc.nist.gov

(e) ISO/IEC 27000-series - http://www.iso27001security.com/

(f) HIPAA and HITECH

(g) Federal Risk and Authorization Management Program ("FedRamp")

13. Business Continuity ("BC") and Disaster Recovery ("DR").

As part of its Business Continuity Management Program, Molina requires Providers to have documented procedures in place to ensure continuity of the Providers' business operations during an Incident that may otherwise disrupt the Provider's delivery of services to Molina.

For the purposes of this Section 13, an "Incident" is defined as a situation that might be, or could lead to, a disruption, loss, emergency or crisis (Source: *ISO 22300:2012 - Societal security – Terminology*).

A. Resilience Questionnaire

i Providers shall complete a questionnaire provided by Molina to establish the resilience capabilities of the Provider.

B. BC and DR Plans

i The Provider's procedures addressing continuity of business operations shall be collected and/or summarized in a documented business continuity plan ("BCP").

ii Included within the BCP's content shall be identification of the service level agreement(s) established between the Provider and Molina.

iii The BCP shall also indicate where Molina ranks among the Provider's other customers in recovery priority.

iv Providers shall develop information technology disaster recovery or systems contingency plans consistent with the guidelines set forth in the National Institute of Standards and Technology ("NIST") Special Publication 800-34 Revision 1 ("*Contingency Planning Guide for Federal Information Systems*"), or a similar standard.

v The BC and DR plans may be separate documents, or may be consolidated into a single document.

vi The Provider's operating practices and BC and DR plan(s) must ensure compliance with the Security Rule of the Health Insurance Portability and Accountability Act ("HIPAA"), i.e., Title 45 of the Code of Federal Regulations, Parts 160, 162, and 164.

vii The Provider's operating practices, BC, and DR plan(s) shall also comply with the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Subtitles A, B, and D.

C. BC and DR Plan Submission and Modification

i Upon written request, Provider shall promptly, but no later than five (5) business days after such request, provide Molina an electronic copy of its current BC and DR plan(s).

ii In the event Provider makes a material change to its BC and DR plan(s), Provider shall give Molina at least a fifteen (15) day notice prior to implementation of the change.

D. Provider shall notify Molina as soon as practicable but not to exceed twenty-four (24) hours of Provider's discovery of any BC or DR incident such as interruption of business operations that

may interfere with the delivery of services to Molina or detrimentally effects Molina's Information Systems or Nonpublic Information (as those terms are defined by 23 NYCRR 500).

i BC and DR Testing

E. Provider shall exercise its BC and DR plan(s) at least once each calendar year, and shall provide Molina a written report in electronic format upon request.

F. At a minimum, the test report shall include the date of the test, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

i. Preferred standards/guidelines for BC and DR include, but are not limited to:

(a) International Organization for Standardization (ISO) 22301 – "*Societal security – Business continuity management systems – Requirements*"
(b) Disaster Recovery Institute International (DRI) Professional Practices
(c) National Institute of Standards and Technology (NIST) Special Publication 800-34 Revision 1 – "*Contingency Planning Guide for Federal Information Systems*"

Cybersecurity

1. Molina is required by law to implement a Cybersecurity Program that, among other things:
   (A) protects the confidentiality, integrity, and availability of its Information Systems;
   (B) identifies and assesses internal and external cybersecurity risks that may threaten its Nonpublic Information stored on its Information Systems;
   (C) uses defensive infrastructure and implements policies and procedures to protect its Information Systems and Nonpublic Information from unauthorized access, use or malicious acts;
   (D) detects Cybersecurity Events;
   (E) responds to identified or detected Cybersecurity Events;
   (F) recovers and restores normal operations; and
   (G) fulfills applicable regulatory reporting obligations.
2. As part of its Cybersecurity Program, Molina is also required by law to ensure the security of its Information Systems and Nonpublic Information accessible to or held by Third Party Service Providers ("TPSPs") such as Provider. Therefore, TPSPs must have, and permit Molina to audit via written request, the cybersecurity measures, safeguards and standards used by such TPSPs including, but not limited to, the policies, procedures and practices:
   (A) Delineating access controls, including Multi-Factor Authentication, to limit access to Molina's Information Systems and Nonpublic Information accessible to or held by the TPSP;
   (B) Using encryption to protect Molina's Nonpublic Information, in transit and at rest, accessible to or held by the TPSP;
   (C) Requiring notice to be provided to Molina if a Cybersecurity Event threatens or affects Molina's Information Systems or Nonpublic Information accessible to or held by the

TPSP. Such notice must be provided to Molina within seventy-two (72) hours from a determination that a Cybersecurity Event has occurred that is either of the following:

(i) Cybersecurity Events impacting Molina of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body; or,

(ii) Cybersecurity Events that have a reasonable likelihood of materially harming any material part of the normal operation(s) of Molina; and

(D) Ensuring the security of Molina's Information Systems and Nonpublic Information accessible to or held by the TPSP.

Definitions

"Affiliate" means any Person that controls, is controlled by or is under common control with another Person. For purposes of this subsection, control means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of stock of such Person or otherwise.

"Cybersecurity Program" means a program designed to protect the confidentiality, integrity and availability of the Covered Entity's Information Systems.

"Cybersecurity Event" means any act or attempt, successful or unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or information stored on such Information System.

"Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) Knowledge factors, such as a password; (2) Possession factors, such as a token or text message on a mobile phone; or (3) Inherence factors, such as a biometric characteristic.

"Nonpublic Information" means all electronic information that is not publicly available information and is:

(1) Business related information of Molina the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of Molina;

(2) Any information concerning an individual which because of name, number, personal mark, or other identifier can be used to identify such individual, in combination with any one or more of the following data elements: (i) social security number, (ii) drivers' license number or non-driver identification card number, (iii) account number, credit or debit card number, (iv) any security code, access code or password that would permit access to an individual's financial account; or (v) biometric records;

(3) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or an individual and that relates to (i) the past, present or future physical, mental or behavioral health or condition of any individual or a member of the individual's family, (ii) the provision of health care to any individual, or (iii) payment for the provision of health care to any individual.

"Information System" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system.

"Third Party Service Provider" ("TPSP") means an entity that (i) is not an affiliate of Molina, (ii) provides services to Molina, and (iii) maintains, processes or otherwise is permitted access to Nonpublic Information through its provision of services to Molina.

All other provisions of the Provider Agreement shall remain unchanged and in full force and effect.

MOLINA HEALTHCARE

Your Extended Family

Health Insurance Portability and Accountability Act (HIPAA) Authorization Form

I, _____, authorize Molina Healthcare of New York, Inc. (Molina) to release and/or discuss my Protected Health Information (PHI) with the following individual(s) for the purposes of care coordination, diagnosis, services and/or treatment:

Name	Relationship to Beneficiary

Section 1: Acknowledgment of Release of Protected Health Information

I acknowledge that the PHI released and/or discussed may include, but is not limited to:

- Claims related information
- Treatment and/or diagnosis related information received from a physician or treatment facility (ex: hospital)
- Medications that I am taking or have been prescribed to me
- Appointment times and locations

I acknowledge that the individual(s) listed is/are only authorized to discuss PHI. The form does **not** give the individual(s) listed the right to make healthcare decisions for me, without my permission and consent, and this form does **not** remove any of the rights, privileges, and/or abilities of the beneficiary to make decisions for his/her own healthcare.

Section 2: Time Frame and Notice of Right to Revoke Authorization (circle 1 or 2)

This authorization is valid up to (1) _____ (period of time or specific date) or (2) until the member deems the authorization unnecessary or unwanted. Further, this authorization may be revoked **at any time** by completing the HIPAA Authorization Revocation Form and returning it to at Molina. This form can be provided by Molina.

Section 3: Acknowledgement and Signature

By signing this form, I acknowledge that:

- I am not required to sign this authorization in order to receive services from Molina, and any refusal will not affect my ability to receive, or the quality of, my services.
- The above named individual(s) is/are authorized to discuss my PHI and does **not** have the right to make healthcare decisions for me without my permission and consent.
- The above named individual(s) may not be covered by any privacy laws and once my PHI is disclosed to them, the individual(s) may redisclose my information.
- I may revoke this authorization in writing at any time and for any reason by completing the HIPAA Authorization Revocation Form, with or without the consent of the individual(s) listed above.

Beneficiary Signature	**Enrollee ID Number**	**Date**

Please return this form and any accompanying documentation securely via one of the following methods:

Mail (Tracked and/or Certified)
Attn: Service Fulfillment Press Telegram
Molina Healthcare Inc.
604 Pine Ave.
Long Beach, CA 90802-9877

Fax:
(844) 834-2155

If you have questions regarding this letter, call Member Services at (800) 223-7242 (TTY: 711), Monday – Friday, 8:00 a.m. to 6:00 p.m.

SECTION 10. CLAIMS AND COMPENSATION

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:

- Hospital-Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Editing Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayments and Incorrect Payments
- Claims Disputes
- Billing the Member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would reduce reimbursement for certain conditions that occur as a direct result of a hospital stay. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA). The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

Hospital Acquired Conditions include the following events occurring during a hospital stay. The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers

5. Falls and Trauma
    (a) Fractures
    (b) Dislocations
    (c) Intracranial Injuries
    (d) Crushing Injuries
    (e) Burn
    (f) Other Injuries
6. Manifestations of Poor Glycemic Control
    (a) Hypoglycemic Coma
    (b) Diabetic Ketoacidosis
    (c) Non-K etotic Hyperosmolar Coma
    (d) Secondary Diabetes with Ketoacidosis
    (e) Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    (a) Spine
    (b) Neck
    (c) Shoulder
    (d) Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    (a) Laparoscopic Gastric Restrictive Surgery
    (b) Laparoscopic gastric bypass
    (c) Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    (a) Total Knee Replacement
    (b) Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: http://www.cms.hhs.gov/HospitalAcqCond/

Claim Submission

Participating Providers are strongly encouraged to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers are strongly encouraged to utilize electronic billing through a clearinghouse or Molina's Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 16146**.** For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

Providers must use good faith effort to bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed within thirty (30) calendar days from the change.

Electronic Claims Submission

Molina strongly encourages Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of New York via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 16146

Provider Portal:

Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available 24 hours per day, 7 days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse:

Molina is affiliated with Claimsnet, an electronic claims clearinghouse. Claimsnet has relationships with many other clearinghouses. Typically, Providers can continue to submit Claims to Molina through their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the most current version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed electronically:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Paper Claim Submissions

If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of New York, Inc.
PO Box 22615
Long Beach, CA 90801

Coordination of Benefits (COB) and Third Party Liability (TPL)

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal.

TPL

Molina is the payer of last resort and will make every effort to determine the appropriate third party payer for services rendered. Molina may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third party benefits are not available to pay a Claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and

all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within ninety (90) calendar days after the discharge for inpatient services or the Date of Service for outpatient services, unless otherwise noted in your Contract. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within ninety (90) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - CMS Physician Fee Schedule Relative Value File (RVU) indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.

- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

For specific details regarding billing and coding of Behavioral Health Services such as HARP, please visit https://www.omh.ny.gov.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Providers must submit corrected claims within sixty (60) days of receiving the remittance advice. Molina's Provider

Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - "1" –ORIGINAL (initial claim)
    - "7"–REPLACEMENT (replacement of prior claim)
    - "8" --VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number – ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1," "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number – ICN/DCN).

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within forty-five (45) days after receipt of Clean Paper Claims, and within thirty (30) days of receipt of electronic claims. All hard copy claims received by Molina will be clearly stamped with date of receipt. Claim payment will be made to contract Providers in accordance with the timeliness standards set forth by the Provider Agreement.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at www.MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Molina will not reduce payment to that Provider for other services unless the Provider agrees to the reduction or fails to respond to Molina's Claim as required in this subsection.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest owithin the specified number of days on the refund request letter mailed to the Provider.

If a provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the Overpayment amount(s) against future payments made to the provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Claim Disputes

Providers disputing a Claim previously adjudicated must request such action within ninety (90) days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all written Claim disputes must be submitted on the Molina Provider Appeal Form found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed.*

Additionally, the item(s) being resubmitted should be clearly marked as a Claim Payment Dispute and must include the following:

- Any documentation to support the dispute
- The Claim number clearly marked on all supporting documents
- Copy of Authorization form (if applicable)

Submission Process

- Provider Portal
- Fax: 315-234-9812
- Mail: Molina Healthcare of New York, Inc. Attention: Appeals and Grievances Department 1776 Eastchester Road Bronx NY 10461

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within thirty (90) calendardays of receipt of the Claims Dispute/Adjustment request and all necessary supporting information.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
    - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data

Each capitated Provider/organization delegated for Claims administration is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted twice per month, and within 30 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial. Molina will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

Billing Instructions for Ancillary Service Providers

Molina follows the instructions of eMedNY in the submission of ancillary service claims. The billing form listed in the eMedNY instructions is the form Molina will accept to process claims. Please use the appropriate claim form for the services provided to Molina Members.

SECTION 11. ADVERSE DETERMINATIONS, APPEALS AND COMPLAINTS (GRIEVANCES)

Background

Molina will maintain an efficient complaint process that seeks to resolve Member or Member Designee complaints regarding the dissatisfaction with any aspect of Molina's operations, benefits, employees, vendors or Providers, within the timeframes defined by the contract with the State of New York and any other related Medicaid policies. The Member Services department has primary oversight for the accurate classification, review and timely resolution of all complaints.

Molina will work with the New York State Department of Health (SDOH) and the Local Department of Social Services (LDSS) on the investigation of any complaint filed with SDOH or the LDSS.

Molina will provide Members and Member Designees with reasonable assistance in filing a complaint, complaint appeals or action appeals, completing forms and other procedural steps including, but not limited to providing interpreter services, and toll-free numbers with TTY/TDD capability.

Molina will not retaliate or take any discriminatory action against a Member because a complaint or complaint appeal has been filed.

Molina subcontracts dental utilization management functions for Molina members. The subcontractor will collaborate with the Member Services and Utilization Management Team on any Actions, Action Appeals, Complaints or Complaint Appeals related to dental benefits. Molina keeps all complaints and complaint appeals strictly confidential.

Molina must provide written Notice of Action to Members/Member Designee and Providers including, but not limited to, the following circumstances:

- Molina makes a coverage determination or denies a request for a referral, regardless of whether the Member has received the benefit;
- Molina determines that a service does not have appropriate authorization;
- Molina denies a claim for services provided by a Non-Participating Provider for any reason;
- Molina denies a claim or service due to medical necessity;
- Molina rejects a claim or denies payment due to a late claim submission;
- Molina denies a claim because it has determined that the Member was not eligible for Managed Medicaid coverage on the date of service;
- Molina denies a claim for service rendered by a Participating Provider due to lack of a referral;
- Molina denies a claim because it has determined it is not the appropriate payer; or
- Molina denies a claim due to a Participating Provider billing for Benefit Package services not included in the Provider Agreement between the Contract and the Participating Provider.

Molina is not required to provide written Notice of Action to Members in the following circumstances:

- When there is a prepaid capitation arrangement with a Participating Provider and the Participating Provider submits a fee-for-service claim to Molina for a service that falls within the capitation payment;
- If a Participating Provider of Molina itemizes or "unbundles" a claim for services encompassed by a previously negotiated global free arrangement:
- If a duplicate claim is submitted by the Member or a Participating Provider, no notice is required, provided an initial notice has been issued;
- If the claim is for a service that is carved-out of the MMC Benefit Package and is provided to a MMC Member through Medicaid fee-for-service, however, Molina should notify the Provider to submit the claim to Medicaid;
- If Molina makes a coding adjustment to a claim (up-coding or down-coding) and its Provider Agreement with the Participating Provider includes a provision allowing Molina to make such adjustments;
- If Molina has paid the negotiated amount reflected in the Provider Agreement with a Participating Provider for the services provided to the Member and denies the Participating Provider's request for additional payment; or
- If Molina has not yet adjudicated the claim. If Molina has pended the claim while requesting additional information, a notice is not required until the coverage determination has been made.

Adverse Determination

Adverse Determination: A clinical peer reviewer who is different from the one making the initial determination will review the appeal and render a final determination.

Behavioral Health - all denial, grievance, and appeal decisions will be peer-to-peer and are subject to the following requirements:

- A physician board certified in general psychiatry will review all inpatient level of care denials for psychiatric treatment
- A physician certified in addiction treatment will review all inpatient level of care denials for SUD treatment
    - Any appeal of a denied Behavioral Health medication for a child should be reviewed by a board-certified child psychiatrist
    - A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family and caregiver

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, LOCATOR2 and other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. The criteria is updated as new treatments, applications, and technologies are adopted

as generally accepted professional medical practice. The UM criteria is applied in a manner that considers the individual health care needs of the Member and characteristics of the local delivery system.

At least annually, the determination process is evaluated for the consistency with which those involved in the Utilization Review process apply the criteria in the determination of coverage. Individual circumstances and needs will be considered in the development, adoption, and application of clinical UM criteria.

The following factors may be considered:

- Age
- Co-morbidities and complications
- Progress of treatment
- Treatment goals
- Psychosocial situation
- Home environment

Characteristics of the local health care delivery system, including but not limited to Member access and Member circumstances are considered in the development, adoption, and application of clinical UM criteria.

A written notice of an adverse determination (initial adverse determination) will be sent to the Member and Provider and will include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals and
- Notice of the availability, upon request of the Member or the Member's Designee of the clinical review criteria relied upon to make such determination.
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained by Molina in order to render a decision on the appeal.

For Medicaid the notice will also include:

- Description of Action to be taken
- Statement that Molina will not retaliate or take discriminatory action if appeal is filed
- Process and timeframe for filing/reviewing appeals, including Member right to request expedited review
- Member right to contact DOH, with toll-free number, regarding their complaint
- Fair Hearing notice including aid to continue rights
- Statement that notice is available in other languages and formats for special needs. as well as how to access

The adverse determination notice will also include a description of action to be taken and a statement that Molina will not retaliate or take discriminatory action if an appeal is filed.

Molina may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and
- The information existed at the time of the pre-authorization review but was withheld or not made available; and
- Molina was not aware of the existence of the information at the time of the pre-authorization review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

The failure of Molina to make a UR determination within the time periods prescribed in this section is deemed to be an adverse determination subject to appeal. If the timeframes allotted for the appeal expire, Molina will send a notice of denial on the date review timeframes expire.

Appeal of Adverse Determinations

Members may appeal an adverse determination on an expedited or standard appeal within sixty (60) days of the initial adverse determination notice. The appeal process will begin upon receipt of the appeal either by mail or by telephone.

Appeals can be mailed to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
1776 Eastchester Road | Bronx, NY 10461

or Members may call 1-800-223-7242 (TTY: 711)

Expedited Appeal

An expedited appeal may be filed for the following:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

Molina will provide reasonable access to a clinical peer reviewer within one (1) business day of receiving an expedited appeal request.

An expedited appeal must be decided within:

- Two (2) business days of receipt of necessary information but no more than 72 hours from receipt of request.
- This time may be extended for up to fourteen (14) days upon Member or Provider request; or if MCO demonstrates more information is needed and delay is in best interest of Member and so notices Member

Written and oral notice of final adverse determination concerning an expedited UR appeal shall be transmitted to Member and Provider within two (2) business days of receipt of necessary information but no more than 72 hours of receipt of appeal request.

Standard Appeal

These appeals may be filed by a Member or a Member's Designee. A Provider may file a UR appeal for a retrospective denial. Appeals may be filed in writing or by phone. Any appeal received by phone must be followed up with a written appeal. The acknowledgement of the appeal and request for additional information required to review the appeal will be provided in writing within fifteen (15) days of receipt of appeal. If the information provided is incomplete, Molina will request the missing information in writing within five (5) business days of receipt of information. During appeal review period, the Member or their Designee may see their case file and the Member may present evidence to support their appeal in person or in writing. Molina will make a determination no later than thirty (30) days from receipt of the appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request; or if Molina demonstrates more information is needed and delay is in best interest of the Member and notifies the Member in writing. Molina will notify the Member or the Member's Designee within two (2) business days of the appeal decision in writing.

Each notice of final adverse determination will be in writing, dated, and include:

- The basis and clinical rationale for the determination
- The words "final adverse determination"
- Molina contact person and phone number
- Member coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/Provider and developer/manufacturer of service as available
- Statement that Member may be eligible for external appeal and timeframes for appeal
- Must include clear statement in bold that Member has 4 months from the final adverse determination to request an external appeal. .
- Standard description of external appeals process. .
- Summary of appeal and date filed
- Date appeal process was completed
- Description of Member's fair hearing rights
- Right of Member to complain to the Department of Health at any time via a toll-free number

- Statement that notice available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer; provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. In the case of Behavioral Health, a physician board certified in general psychiatry, will review all inpatient level of care denials for psychiatric treatments. A physician certified in addiction treatment will review all inpatient level of care denials for SUD treatment. If Molina fails to make a determination with the applicable time periods it would be considered a reversal of the adverse determination.

External Review

Members have the right to an external appeal of a final adverse determination. The external appeal must be submitted within four (4) months of the receipt of the final adverse determination of the first level appeal.

The Member or the Member's Designee in connection with retrospective adverse determinations, and the Molina Provider have the right to request an external appeal.

The circumstances when an external appeal may be filed are:

1. When the Member has had coverage of a health care service, which would otherwise be a covered benefit under the health benefit plan and the benefit is denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and Molina has rendered a final adverse determination with respect to such health care service or if Molina and the Member have jointly agreed to waive any internal appeal.
    - Member has had coverage of a health care service denied on the basis that such service is experimental or investigational, and
    - the denial has been upheld on appeal or both the MCO and the Member have jointly agreed to waive any internal appeal, and
    - the Member's attending physician has certified that the Member has a life-threatening or disabling condition or disease
    - for which standard health services or procedures have been ineffective or would be medically inappropriate or
    - for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or
    - for which there exists a clinical trial, and
    - the Member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member's life-threatening or disabling condition or disease, must have recommended either
    - a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Member than any covered standard health service or procedure; or

- a clinical trial for which the Member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and
- the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

Complaints, Grievance and Appeals Process

Definitions

Complaint: Any expression of a Member's dissatisfaction with any aspect of Molina operations, his or her care other than an action (See TC OPS.001 Actions). This includes written or verbal contact to Molina, SDOH or the LDSS, in which the Member, or the Member's Designee, describes dissatisfaction with any aspect of Molina's operations, benefits, and employees, vendors or Providers. A complaint is the same as a Grievance.

Complaint Appeal: a request for a review of a complaint determination.

Complaint Determination: Any decision made by or on behalf of Molina regarding a complaint whereas a Member is dissatisfied.

Grievance System: Molina's complaint and appeal process including a complaint and a complaint appeal process, a process to appeal actions and access to the State's fair hearing system.

Inquiry: Any oral or written request to Molina, a Provider, or facility, without an expression of dissatisfaction, e.g., a request for information. Inquiries are routine questions about benefits (i.e. inquiries are not complaints) and do not automatically invoke the grievance or appeals or request for Service Authorization process.

Complaint Process

Complaints will be accepted either orally or in writing. Written complaints will be responded to in writing. Verbal complaints may be responded to verbally or in writing, unless the Member or a Member representative requests a written response, which will be responded to in writing.

Complaints and/or complaint appeals will be accepted during call center hours. Molina staff are available to assist with filing of complaints, complaint appeals, and action appeals.

If any other departments or staff at Molina receives a complaint from a Member, the Member Services Department will be notified, and the complaint will funnel through the process identified in this policy. Any complaints involving Marketplace Facilitated Enroller or Marketing Representatives will be forwarded to the Marketing Manager. Molina recognizes that a Member has the right to designate an authorized legal representative (Member Designee) to act on his/her behalf at any time during the complaint process. The designated representative may be anyone to whom the Member designates, in writing, the authority to speak for him/her and may include a health care Provider or attorney and will follow any State specific requirements.

Written Complaints

All written complaints will be reviewed by one or more qualified personnel who were not involved in previous decision-making roles. Complaints pertaining to clinical matters, complaints that are an action appeal denial based on lack of medical necessity, or a complaint regarding the denial of expedited resolution of an action appeal will be reviewed by one or more licensed, certified or registered health care professionals in addition to non-clinical personnel.

If an Member files a complaint regarding difficulty accessing a needed service or referral from a Participating Provider, and, as part of or in addition to the complaint, requests the service or referral directly from Molina, Molina will accept and review the service authorization request and make a determination in accordance with Plan Policy and Procedure.

For all written complaints an acknowledgement of the complaint and a notice of the determination will be sent to the Member or Member Designee.

If a determination was unable to be made because insufficient information was presented or available to reach a determination, Molina will send a written statement that a determination could not be made to the complainant on the date the allowable time to resolve the complaint has expired. All interactions regarding the complaint including, but not limited to, Provider inquiries and interactions, interactions with Members, interactions with other Molina staff, letters, etc. will be documented.

Complaint Appeals

A Complaint Appeal may be filed within sixty (60) business days after the receipt of the notice of complaint determination. Complaint Appeals may be submitted in writing by letter or by completion of the complaint appeal form after a complaint determination is received. A Member may also call and specifically request a complaint appeal based on the receipt of a complaint determination. Within fifteen (15) business days of the receipt of the Complaint Appeal, Molina will provide a notice of Complaint Appeal Acknowledgement. Complaint Appeals of clinical matters will be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL §4900(2)(a).

Complaint Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original complaint determination.

Members and Providers will be notified of the process to request an Appeal of a Complaint Determination in the Complaint Determination notification and in Member and Provider Handbooks.

Expedited complaint

If a delay in processing a complaint would significantly increase the risk to a Member's health, complaints will be resolved within 48 hours from the receipt of necessary information and no more than seven (7) calendar days from the receipt of the complaint.

Standard Complaint

Complaints will be resolved within forty-five (45) calendar days after the receipt of necessary information and no more than sixty (60) calendar days from the receipt of the complaint.

Complaint appeals will be decided and notification provided within two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health.

Complaint appeals will be decided and notification provided within thirty (30) business days after the receipt of all necessary information when Member health is not at risk.

Complaint Acknowledgement

Molina will provide written acknowledgement of any complaint within fifteen (15) business days of the receipt of the complaint. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the complaint.
- Identification of any additional information required from any source to make a determination.
- If a complaint determination is made before the written acknowledgement is sent, Molina may include the acknowledgement with the notice of determination (one notice).

Complaint Determination

A complaint determination will be made in writing to the Member, and/or the Member Designee and will include:

- Detailed reasons for the determination.
- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- The procedure and form for filing an appeal of the complaint determination within sixty (60) business days.
- Notice of the right for the Member or Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number 1.800.206.8125.
- For Medicaid Members only – the right to complain to their local Department of Social Services.

In cases where delay would significantly increase the risk to a Member's health, Molina will provide notice of a determination by telephone directly to the Member or to the Member's Designee, or when no phone is available, some other method of communication, with written notice to follow within three (3) business days.

When a Member's complaint is related to dissatisfaction with a Provider, the notice of determination will include the names and addresses and telephone numbers of three alternative Providers within the Molina network.

When a Member is required to meet certain criteria to achieve a goal related to their care and the Member did not meet the criteria, Molina will include recommendations to the Member in how to reach the goal.

Complaint Appeal Acknowledgement

Molina will provide written acknowledgement of any Complaint Appeal within fifteen (15) business days of the receipt. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the Complaint Appeal.
- Identification of any additional information required from any source to make a determination.

Complaint Appeal Determination

Complaint appeal determination notifications will be sent within thirty (30) business days of the receipt of the complaint appeal. The complaint determination will be made in writing to the Member, the Member Designee and may include:

- A detailed reason for the determination.
- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- A Notice of the right for the Member, Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number.
- Instructions for any further appeal, if applicable.

Important Telephone Numbers and Addresses

Members/Member Designees and Providers may contact the following agencies at any time with a grievance:

The Molina Member Service Department

Members may call toll free at 1-800-233-7242 or submit their appeal or grievance in writing to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
1776 Eastchester Road
Bronx, NY 10461

Members may also contact their Local Department of Social Services. They can do this by calling New York State Department of Health Toll free (800) 206-8125 or viisit their website at: https://www.health.ny.gov/health_care/medicaid/ldss.htm for a complete listing by county.

They can also write to:

New York State Department of Health
Bureau of Certification and Surveillance
Corning Tower
Albany, New York 12237

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

SECTION 12. CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee of Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Definitions

A Rental/Leased Network - a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Provider (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Unprofessional conduct - refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct, which is reasonably likely to be detrimental to Patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina plan.

Telemedicine - the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional encounter in person between a practitioner and a patient.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. These practitioners must be licensed, certified or registered by the state to practice independently.

Providers that are licensed as organizations or facilities will be credentialed as an Organizational Provider (please refer to the policy titled Assessment of Organizational Providers).

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons.
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists

- Psychiatrists and other physicians
- Psychologist
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Providers for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application -** Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **License, Certification or Registration -** Provider must hold an active, valid and unrestricted license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members.
- **DEA or CDS Certificate -** Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members.
- **Education and Training -** Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
    - **Residency Training -** Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
    - **Fellowship Training -** If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.

- **Board Certification -** Board certification in the specialty in which the Provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History -** Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional.
- **Malpractice History -** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance –** Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the provider's activities on Molina's behalf.
- **Hospital Privileges -** Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI -** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).
- **SSA Death Master File -** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

Credentialing Requirement for State-Designated Provider

To credential a State-Designated Provider, Molina will confirm the State-Designation of the Provider. Contracting with NYS-Designated Providers, Molina may not separately credential individual staff members in their capacity as employees of these programs.

However, Molina will conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. Molina will still collect and accept program integrity related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Professional Review Committee's review must be re-verified. The Professional Review Committee's or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

If Molina is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the Provider remains in place, Molina will recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider's file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the re-credentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. The application must include, unless State law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and,
- The correctness and completeness of the application.

Non-Discriminatory Credentialing and Re-credentialing

Molina does not make credentialing and re-credentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation or the types of procedures

(e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude Molina from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Notification of Discrepancies in Credentialing Information

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the receipt of the application.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. A copy of the Provider Manual is also sent to the Provider at the time of initial contracting.

The Provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Provider has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Provider are documents which the Provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or re-credentialing application is received.

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license or malpractice claims history. Molina is not

required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

The notification sent to the Provider will detail the information in question and will include instructions to the Provider indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Provider's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the Provider, Molina will document receipt of the information in the Provider's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', the Credentialing Department will notify the Provider. The Provider may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the Provider does not respond within ten (10) calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application.

The Provider can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the Provider where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither

it nor its Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina monitors the following agencies for Provider sanctions and exclusions between re-credentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** - Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** - Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **National Practitioner Database** - Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

SECTION 13. PROVIDER TERMINATION

Molina will immediately remove any Provider from the network who is unable to provide health care services due to a final disciplinary action. Providers that are sanctioned by the DOH's Medicaid Program will be excluded from participation in Molina's Medicaid panel.

To afford a health care professional the opportunity for review or hearing, Molina will provide a written explanation of reasons for a proposed termination with the health care professional. However, written notification will not be required in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency such as sanctioning by NYS DOH Medicaid Program that impairs the health care professional's ability to practice, nor are they eligible for hearing or review.

The notification of the proposed termination by Molina to the health care professional will include:

- The reasons for the proposed action;
- Notice that the Provider has the right to request a hearing or review before a panel appointed by Molina;
- A time limit of not less than thirty (30) days within which a health care professional may request a hearing, and
- A time limit for a hearing date that will be held within thirty (30) days after the date of receipt of a request for a hearing.

Molina will not terminate a contract or employment, or refuse to renew a contract, solely because a health care Provider has:

- Advocated on behalf of a Member;
- Filed a complaint against Molina;
- Appealed a Molina decision;
- Provided information or filed a report pursuant to PHL §4406-c regarding prohibitions by plans, or
- Requested a hearing or review pursuant to PHL §4406-d and the following sections.

Except as provided above, no contract or agreement between Molina and a health care professional will contain any provision, which will supersede or impair a Provider's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination.

Right to Hearing

A health care professional that has been notified of his or her proposed termination will be allowed a hearing. The health care professional must request a hearing within thirty (30) days of notification by Molina. A hearing will be held within thirty (30) days after the date of receipt of a request for a hearing. The procedures for this hearing must meet the following standards:

- The hearing panel will be comprised of three (3) persons appointed by Molina. At least one (1) person on such panel will be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of

more than three (3) persons, provided however that the number of clinical peers on such panel will constitute one-third or more of the total membership of the panel.

- The hearing panel will render a decision on the proposed action in a timely manner. Such decision will include reinstatement of the health care professional by Molina, provisional reinstatement subject to conditions set forth by Molina or termination of the health care professional. Such decision will be provided in writing to the health care professional.
- A decision by the hearing panel to terminate a health care professional will be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision. Notwithstanding the termination of a health care professional for cause or pursuant to a hearing, Molina will permit a Member to continue an on-going course of treatment for a transition period of up to ninety (90) days, and post-partum care, subject to Provider agreement, pursuant to §4406(6)(e).
- In no event will termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

Termination and Continuity of Care

If a Member's health care Provider leaves the managed care organization's network of Providers for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, the managed care organization will permit the Member to continue an ongoing course of treatment with the Member's current health care Provider during a transitional period.

The transitional period date begins the date the Provider's contractual obligation to provide services to Molina terminates and ends no later than ninety (90) days, or if health care professional is providing obstetric care and the Member has entered her second trimester of pregnancy at the time of the Provider's termination, the transitional period includes post-partum care directly related to the delivery.

The care will be authorized by Molina for the transitional period only if the health care Provider agrees to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full; to adhere to quality assurance requirements and to provide medical information related to such care; and to adhere to the organization's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the organization.

In no event will this paragraph be construed to require Molina to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the Member's benefit plan.

Duty to Report

Molina is obligated under New York State Public Health Law (Article 4405-b) to make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Article One Hundred Thirty-One Section 6530.

Molina will report the following to the Office of Medical Misconduct:

- The termination of a health care Provider contract pursuant to New York State Public Health Law (4406-d) for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare;
- The voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures; or
- The termination of a health care Provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

Molina will submit the information, in writing to:

Director, Central Intake Operations
Office of Professional Medical Conduct
New York State Department of Health
433 River Street, Suite 303
Troy, New York 12180-2299

The report will include the Provider's full name, license number, address, account/date of event/incident, of actions taken by the health plan (including date of termination of contract or withdrawal), and contact persons at the managed care organization (MCO). Molina will seek an "advisory opinion" if Molina is reasonably unable to determine whether a report must be made. These advisory opinions will be sought by written request to the Director of OPMC at the address listed above.

Any report or information furnished to an appropriate professional discipline agency in accordance with the provisions of Section 4405-b will be deemed a confidential communication and will not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issue in a pending action or proceeding.

Non-Renewal

Either party to a contract may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one (1) year, upon sixty (60) days' notice to the other party; provided, however, that any non-renewal will not constitute a termination for purposes of this section. PHL §4403(6) (e), concerning continuation of course of treatment and post-partum care, also applied to disaffiliations based upon non-renewal. Notification of non-renewal will contain explanation of the right of non-renewal, time frames and language that non-renewal does not constitute termination.

SECTION 14. HOME AND COMMUNITY BASED SERVICES (HCBS)

HCBS Overview

HCBS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community.

Molina Healthcare of New York understands the importance of working with our Providers and Community Based Organizations (CBO's) in your area to ensure our Members receive HCBS services that maintain their independence and ability to remain in the community.

Molina's HCBS Provider network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our HCBS Provider network and achieve a successful partnership in serving those in need.

HCBS Benefits and Approved Services

These include the following services:

Adults:

- Adults Day Care Services
- AIDS Day Care Services
- Consumer Directed Personal Services
- Agency based Personal Care Services

Children

Under Age 19

- Office of Mental Health Designated Serious Emotional Disturbance Clinics

Under Age 21

- Family Peer Support Services
- Personal Emergency Response (PERS) Services
- Alcohol and Substance Abuse Services (Outpatient – Clinical (hospital-based)
- Opioid Treatment Program Services
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS)

For All Eligible Children Under Age 21 Receiving Supplemental Security Income (SSI), Federal Social Security Disability Insurance (SSDI), or Who Have Been Determined Certified Disabled by a New York State Medical Disability Review:

- OASAS Chemical Dependence Inpatient Rehabilitative Services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Inpatient Psychiatric Services
- OMH Outpatient Services
- Children and Family Treatment and Support Services (CFTSS), including:
    - Other Licensed Practitioner (OLP)
    - Psychosocial Rehabilitation (PSR)
    - Community Psychiatric Treatment and Supports (CPST)
- Psychiatric Services
- Psychological Services
- Second generation long acting injectable antipsychotics and naltrexone extended release suspension under both the Pharmacy and Medical benefit.

Member Eligibility

The Plan adheres to NY State criteria for the determination of eligibility for HCBS services for children and youth under the age of 21. Aligned services are available based on need to all who are HCBS eligible and include members of the 1915 (c) waivers (OMH SED, DOH Care at Home, OPWDD-CAH, OCFS B2H/SED, OCFS B2H DD and OCFS B2H Medically Fragile) which are transitioning to the 1115 waiver.

Children who are currently receiving HCBS as part of 1915(c) Medicaid waiver will still have access to HCBS as long as they continue to meet eligibility criteria. Children eligible for HCBS may be eligible for Medicaid under special rules - "family of one." Children who are eligible for HCBS are also eligible for Health Home. Members who opt out of a Health Home will be referred to a State I Independent Entity. There are 4 levels of care categories for HCBS/LOC eligibility determination: SED, Medically Fragile, DD/Foster Care, DD and Medically Fragile. Each of these categories has its respective diagnoses, conditions and/or requirements which must be documented before being able to move to the HCBS eligibility determination process. Once found eligible (and Medicaid enrolled) HCBS eligibility lasts for one year beginning on the date the HCBS/LOC determination is signed and finalized within the UAS. Three factors must be met: target population, risk factors and functional criteria. The Plan of Care can then be developed.

Molina will accept referrals for HCBS for Children from providers to include those individuals who are part of the 1915c Children's Waivers (OMH SED, DOH CAH 1/11, OCFS B2H). These services are aligned with HCBS benefits.

Children and Family Treatment and Support Services (CFTSS)

Starting January 1, 2020, Medicaid Managed Care Plans will cover more Children and Family Treatment and Support Services (CFTSS). These services help children and their families improve their health, well-being, and quality of life.

CFTSS are for children under age 21 with behavioral health needs. These services may be provided at home or in the community. The additional CFTSS services available on January 1, 2020 includes:

Youth Peer Support and Training: This benefit is provided by a credentialed Youth Peer Advocate, or Certified Recovery Peer Advocate with a youth focus who has similar experiences.

Get support and assistance with:

- **Developing skills to manage health challenges and be independent.**
- **Feeling empowered to make decisions**
- **Making connections to natural supports and resources**
- **Transitioning to the adult health system when the time is right.**

Crisis Intervention. Professional help at home or in the community when a child or youth is distressed and can't be helped by family, friends and other supports. Including support and help with using crisis plans to de-escalate the crisis and prevent or reduce future crises.

Getting Care, Getting Started

Molina Healthcare of New York Case Manager will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and HCBS services. Specifically, along with providing the fully integrated Person-Centered Services Plan (PCSP), Case Managers provide verbal, written and/or alternate format information on:

- After-hours assistance for urgent situations
- Access to timely appointments
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication
- Advocacy, engagement of family members and informal supports

Each Member will be assigned a Case manager no later than 30 days after enrollment. At a minimum, the Case Managers name and their contact information and hours of availability are included in, which is shared with all Person-Centered Services Plan (PCSP) (also known as the Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Case Managers are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Members:

- HCBS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Service Management
- Medicaid Resolution
- Assessment of LTSS Need
- Member Education

Molina Healthcare of New York will work closely with the various Community Based Organizations (CBO's) for home and community-based services (HCBS) to ensure that the Member is getting the care that they need.

Once a Provider of service has been located, billing for services will be the responsibility of the Provider. Please see the billing section of this manual for additional information.

Person Centered Services Plan (PCSP) Team (also known as Care Management Team or Interdisciplinary Care Team)

All Members will receive care management and be assigned a Case Manager from the Molina Plan.

Person Centered Services Plan (PCSP) Team will include at minimum the Member and/or their authorized representative, Medical Case Manager, the Member's PCP, a registered nurse, social worker, service Providers, family members, and others chosen by the Member to be involved with the service planning and delivery. PCSP team members may also include HCBS Providers (e.g. Adult Day Health Care Center staff Nursing Facility staff, etc.), PCP, specialist(s), behavioral health clinician, and pharmacist. The PCSP can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required Members.

Transition of HCBS and LTSS Authorizations for Children in Receipt of HCBS

The Plan intends to facilitate a smooth transition of HCBS and LTSS authorizations for children who are already in receipt of HCBS and will, therefore, begin accepting Plans of Care on the following dates:

(a) May 1, 2018 for the Plan's enrolled population and for a child for whom the Health Home or Independent Entity has obtained consent to share the POC with the Plan and the family has indicated that the Plan selection process has been completed; and

(b) February 1, 2020 for a child in the care of a LDSS (Local Department of Social Services)/licensed VFCA (Voluntary Foster Care Agency) and when the LDSS/VFCA has confirmed Plan election.

(c) The Plan will continue to accept POCs for children in receipt of HCBS in advance of the enrollment effective date when notified by another Plan; a Health Home or the Independent Entity that there is consent to share the POC with the Plan and when the family has indicated that the Plan selection process has been completed; or for a child in the care of a LDSS/licensed VFCA the Plan selection process has been confirmed by the LDSS/VFCA.

HCBS services to be covered by Molina Healthcare of New York will require coordination and approval.

The Person-Centered Services Plan (PCSP) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The PCSP includes informal care, such as family and community support. Molina Healthcare will ensure that a person-centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A Person-Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community-based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301),

The Person-Centered Services Plan (PCSP) will be developed under Member's direction and implemented by assigned Members of the PCSP team no later than the end date of any existing SA or within the state specific timeframes for initial and reassessments. All services and changes to services must be documented in the PCSP and be under the direction of the Member in conjunction with the care manager. Reassessment and update of the PCSP will be done at least once every six (6) months.

The Person-Centered Services Plan (PCSP) Team under Member's or Member's representative's direction, is responsible for developing the PCSP, and is driven by and customizable according to the needs and preferences of the Member. As a Provider you may be asked to be a part of the PCSP Team.

Additional services can be requested through the Member's Case Manager anytime including during the assessment process and through the PCSP process. Additional service need must be at the Members' direction and can be brought forward by the Member, the care manger, and/or the PCSP team as necessary. Once an additional need is established, the PCSP will be updated with the Member's consent and additional services approved. For additional information regarding HCBS service coordination and approvals in the Member's PCSP, please contact Molina Healthcare of New York at (877) 872-4716.

Transition of Care Programs

For continuity of care purposes, the plan will allow children to continue with their care providers, including medical, behavioral health and HCBS, for a continuous episode of care. This requirement will be in place for the first 24 months of the transition and applies only to episodes of care that were ongoing during the transition period from FFS to Managed Care.

Molina has goals, processes and systems in place to ensure smooth transitions between Member's setting of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

All Case Managers are trained on the transitions of care approach that Molina follows for transitions between care settings. The case managers can use tablet technology to facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

HCBS Transitional Care Policy and Requirements

For 24 months from the date of transition (January 1, 2019) of the children's specialty services carve-in, for FFS children in receipt of HCBS at the time of enrollment, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing

providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the Plan) for no less than 180 days, during which time, a new POC is to be developed.

For children transitioning from a 1915(c) waiver, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the Plan) for no less than 180 days, during which time, a new POC is to be developed. During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review.

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, and Providers for ninety (90) days from the effective date of enrollment or until the Member's PCSP is in place, whichever is later. Ongoing Provider support and technical assistance will be provided especially to community behavioral health, LTSS Providers, and out of network Providers during the continuity of care period. All existing Person-Centered Services Plan (PCSP) and Service Authorizations (SAs) will be honored during the transition period.

A Member's existing Provider may be changed during the ninety (90) days transition period only in the following circumstances: (1) the Member requests a change; (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or New York State Department of Health (SDOH) identify Provider performance issues that affect a Member's health or welfare; or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network Providers. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the ninety (90) days, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility (NF) at the time of Molina HCBS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their families or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or SDOH identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider is excluded under state or federal exclusion requirements.

Molina will perform the initial health risk assessment within the first thirty (30) days of enrollment to determine type of case management. Reassessment will be performed everyone hundred eighty (180) days.

For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at (877) 872-4716.

Members have the choice of how their services are delivered through various models, which may include consumer-direction.

In a consumer-directed model, the state requires Molina to maintain a contract with state Fiscal Intermediary (FI) agencies. Currently, Molina contracts with the following three FI agencies: ARISE, AccessCNY, and Finger Lakes Independent Center (FLIC).

Consumer Directed Personal Assistance Services (CDPAS) is available for the MMC program. CDPAS Authorizations will not exceed six (6) months. A copy of the authorization will be sent to the Fiscal Intermediary (FI) selected by the Member or Members' representative.

Molina will be providing each Member with the name, address, and phone number of at least two (2) Fiscal Intermediaries. The Member will arrange through the Fiscal Intermediary for the wage and benefit processing of the Members consumer directed personal assistant.

Claims for HCBS Services

Providers are required to bill Molina Healthcare of New York for all HCBS services through EDI submission, or through the Web Portal. After registering on the Molina Web Portal, a Provider will be able to check eligibility, claim status and create/submit claims to Molina Healthcare. To register please visit: www.availity.com/molinahealthcare

Atypical Providers

Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although, they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina Healthcare of New York.

Atypical Providers are required to use their Medicaid Identification Number (given to them by the state of New York to take the place of the NPI).

Vehicle Modifications

This service provides physical adaptations to the primary vehicle of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence.

The Care Manager (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost- effective approach to fulfill the child's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified, and that State required bidding procedures have been followed. For Vehicle Modifications, the LDSS or MCO is the provider of record for billing purposes. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value.

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent and ongoing transportation for the child. All equipment and technology used for entertainment is prohibited. Costs may not exceed current market value of vehicle. Other exclusions include the purchase, installation or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments, insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of modification: In most instances a specific type of Vehicle Modification is a onetime benefit to motor vehicles used by the child. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Routine Maintenance of the Vehicle: Routine maintenance and/or maintenance/service contracts are not reimbursable under this benefit.

Contracts for Environmental modifications and Vehicle modifications may not exceed $15,000 per year.

Allowable Vehicle Modifications under the HCBS Waiver are limited to only those services that are not reimbursable under the Community First Choice Option (CFCO) Medicaid State Plan benefit, Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams.

Member Responsibility

Molina Healthcare of New York will be responsible to deduct the Net Available Monthly Income (NAMI) from claims where Members reside in a nursing home when applicable.

Nursing Facility Billing Guidance

Providers must bill with the following codes:

- Bill Type: 021X
- Revenue Codes
    - 0001 – Totals Charges
    - 0100 - All-inclusive Room and Board-Custodial Care & Respite
    - 0101 - All-inclusive Room and Board-Vent
    - 0120 - All-inclusive Room and Board-AIDS
    - 0199 - All-inclusive Room and Board-Head Injury

- 0183 - Therapeutic leave
- 0185 - Hospital leave
- 0189 - Therapeutic leave when authorized by medical professional

Note: A separate claim must be completed if the period of service includes therapeutic or hospital leave days. Leave of absences are limited to a combination of 18 days in a calendar year.

SECTION 15. DELEGATION

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass Molina's credentialing pre-assessment, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG and SAM, exclusion lists a minimum of every thirty days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: If the Provider is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include

review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the entity's ability to meet Molina, State and Federal requirements for delegation.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

Molina Healthcare of New York, Inc.

Behavioral Health Policy and Procedure Manual

Molina Healthcare PLUS (Health and Recovery Plan)

SECTION 16. OVERVIEW OF THE HARP PROGRAM

About the HARP Program

A Health and Recovery Plan (HARP) is a special needs plan that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. In addition to the State Plan Medicaid services offered by mainstream MCOs, the HARP offers access to an enhanced benefit package comprised of 1915(i)-like Home and Community Based services designed to provide the individual with a specialized scope of support services. Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005.

1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS services to develop a range of community-based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don't allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

HARP Model of Care

The HARP model of care is a recovery model. This model emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well -being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self - direction, social inclusion, and coping skills.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by SAMHSA, patients, health-care professionals, researchers and others agreed on 10 core principles undergirding a recovery orientation. Providers working with HARP eligible members, and especially those providing HCBS Services, must implement processes to ensure clinical work adheres to recovery-based principles including but not limited to:

- Self-direction: Consumers determine their own path to recovery.
- Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds.
- Empowerment: Consumers can choose among options and participate in all decisions that affect them.

- Holistic: Recovery focuses on people's entire lives, including mind, body, spirit and community.
- Nonlinear: Recovery isn't a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience.
- Strengths-based: Recovery builds on people's strengths.
- Peer support: Mutual support plays an invaluable role in recovery.
- Respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery
- Responsibility: Consumers are responsible for their own self-care and journeys of recovery.
- Hope: Recovery's central, motivating message is a better future – that people can and do overcome obstacles.

Molina will evaluate the use of Recovery Principles in care during both utilization management activities, quality evaluations and chart review processes.

HARP Enrollment and Eligibility Process

Unlike other Medicaid Redesign initiatives, enrollment in a HARP plan is not "mandatory". This initiative offers potentially eligible individuals the chance to enroll in a qualified plan that offers enhanced benefits. Individuals are then screened for eligibility and a personalized recovery plan is developed that specifies the scope, type and duration of services the member is eligible to receive. Individuals will initially be identified by New York State as potentially needing HARP services on the basis of historical service use. Once a member is identified as HARP eligible, they can enroll in a HARP at any point.

A key goal in this managed care design is to avoid disrupting access to physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. This will ensure that Plan members will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan, choose another HARP or opt out of the HARP plan. Individuals will have 30 days to opt out or switch to a new HARP plan. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream before they are locked into the HARP for 9 additional months (after which they are free to change Plans at any time). HARP eligible individuals in an HIV SNP will be able to receive HCBS services through the HIV SNP.

They will also be given the opportunity to enroll in another HARP. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.

Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will be notified by their Plan of their HARP eligibility and referred to an enrollment broker to help them decide which Plan is right for them. Individuals enrolled in an MCO without a HARP are not required to dis -enroll from their current plan to join a HARP plan but plan without a HARP are not required to offer 1915(i) like services.

Eligibility and Assessment – HARP and Home and Community-Based Services

Medicaid members are identified by New York State as a member with a serious condition who may benefit from additional coordination of care and Medicaid Waiver Services (HCBS). Health Plans are notified by NYS of a member's eligibility for HARP and eligibility for a Community Mental Health Assessment. It must be in compliance with conflict free case management requirements and will determine the level of need, or eligibility, to have additional services (HCBS) available to them. The assigned Health Homes must develop a Plan of Care indicating the need, as defined by the assessment, of the HCBS services. Only qualified Health Home Care Coordinators or State designated entities may conduct the NYS Eligibility Assessment for HCBS services.

All HARP eligible members and/or those members identified as in need of additional support, will receive plan-based case management. Specific triggers that may result in a referral for case management include Molina case management can aid in the assessment, identification of providers, timely access to services and the development of their person-centered Plan of Care. Additionally, consenting HARP members will be connected to Health Home Care Coordination. Molina Healthcare refers to HARP members as Molina Healthcare PLUS members.

For full details on QMP and HARP, including OMH and OASAS specific guidance, please go to http://www.omh.ny.gov/omhweb/bho/ or the OMH Guidance memo in Attachment 1 at the end of this document.

Quality Improvement Efforts Focus on Integrated Care

Molina Healthcare (Molina) has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services. A special focus of these activities is the improvement of physical health outcomes resulting from the integration of behavioral health into the member's overall care. Molina will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization and target those areas where opportunities to promote efficient services exist.

Behavioral Health Services

Definition of Behavioral Health

Molina defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders DSM and/or ICD of the American Psychiatric Association.

Accessible Intervention and Treatment

Molina promotes health screening for identification of behavioral health problems and patient education. Providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem.

- Primary care providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using DSM and/or ICD codes.
- Inform members how and where to obtain behavioral health services.
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider.

This can be achieved by providing members with access to a full continuum of mental health and substance use disorder services through Molina's network of contracted providers.

Molina Healthcare PLUS Covered Benefits and Services

Behavioral Health Benefits for All Medicaid Populations 21 and Over*

- Medically supervised outpatient withdrawal (OASAS services)
- Outpatient clinic and opioid treatment program (OTP) services (OASAS services)
- Outpatient clinic services (OMH services)
- Comprehensive psychiatric emergency program
- Continuing day treatment
- Partial hospitalization
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment (ACT)
- Intensive case management/ supportive case management
- Home Care Coordination and Management
- Inpatient hospital detoxification (OASAS service)
- Inpatient medically supervised inpatient detoxification (OASAS Service)
- Inpatient treatment (OASAS service)
- Rehabilitation services for residential SUD treatment supports (OASAS service)
- Inpatient psychiatric services (OMH service)
- Rehabilitation services for residents of community residences

Services are available through Mainstream, HIV SNP, and HARP Plans in NYC on 10/1/18 and the rest of New York State on 7/1/16.

Additional HCBS Services for Adults Meeting Targeting and Functional Needs

- Rehabilitation
    - Psychosocial Rehabilitation
    - Community Psychiatric Support and Treatment (CPST)
    - Crisis Intervention
- Peer Supports
- Habilitation
    - Habilitation
    - Residential Supports in Community Settings

- Respite
    - Short-term Crisis Respite
    - Intensive Crisis Respite
- Non-medical transportation
- Family Support and Training
- Employment Supports
    - Pre-vocational
    - Transitional Employment
    - Intensive Supported Employment (ISE)
    - Ongoing Supported Employment
- Education Support Services
- Supports for self-directed care
    - Information and Assistance in Support of Participation Direction
    - Financial Management Services

For additional information on HCBS services please refer to the HCBS Manual, available on the OMH website: https://omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf.

Primary Care Provider Requirements for Behavioral Health

Primary care providers (PCPs) may be able to provide behavioral health services within the scope of their practice. If an enrollee is using a behavioral health clinic that also provides primary care services, the enrollee may select his or her lead provider to be a PCP.

PCP's are required to:

(a) Delivery primary care services.
(b) Supervise and coordinate medically necessary health care of the enrollee, including 24/7 coverage.
(c) Follow Molina's standards of care, which are reflective of professional and generally accepted standards of medical practice.
(d) Follow Medicaid requirements for screening for children and adolescents and Medicaid behavioral health screening by PCP for all members, as appropriate.
(e) Allow the member to select a lead provider to be a PCP, if the member is using a behavioral health clinic that also provides primary care services.

Appointment Availability Guidelines

All Providers in the Molina network will comply with the following appointment availability guidelines.

For Behavioral Health/Substance Use Disorders the following appointment availability guidelines will be followed:

- Routine/non-urgent – within 14 calendar days

- Urgent care – within 24 hours
- Emergency Services/CPEP – immediately; 24 hours a day/7 days per week
- OASAS Residential Treatment – immediately for inpatient substance use detoxification and within twenty-four (24) hours for inpatient rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.
- Non-24-hour Diversionary Psychopharmacology Services – within two (2) calendar days
- Medication Management – within 14 calendar days
- Outpatient mental health office and clinic services – within two (2) to four (4) weeks of request
- Psychological or neuropsychological testing – non-urgent within two (2) to (4) weeks
- Personalized Recovery Oriented Services (PROS) pre-admission status – begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted. Pre-Admission is open-ended with no time limits. Appointment should be given within 24-hours of request
- Personalized Recovery Oriented Services (PROS) Admission – begins IRP is approved by the plan. Appointment should be given within weeks of request
- Mental Health Continuing Day Treatment (CDT) – Appointment should be offered within two (2) to four (4) weeks of request
- Mental Health Intensive Outpatient – Appointment should be offered within one (1) week of request
- Assertive Community Treatment (ACT) – new referrals made within 24 hours and should be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determination of eligibility and appropriateness of ACT
- Outpatient office and clinic treatment provided by OASAS certified agencies – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request
- Medically Supervised Outpatient Substance withdrawal – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request
- Opioid Treatment Program (OTP) services – LOCADTR tool to inform level of care determinations. Appointments within 24 hours of request
- Substance Use Disorder Intensive Outpatient – LOCADTR tool to inform level of care determinations. Appointments should be offered within one week of request
- Substance Use Disorder Day Rehabilitation – LOCADTR tool to inform level of care determinations. Appointments should be offered within two (2) to four (4) weeks of request
- Stabilization and Rehabilitation services for residential SUD treatment – LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

HCBS specific appointment and availability standards:

- For Short Term and Intensive Crisis Respite: within 24 hours of request
- For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training: within 2 weeks of request (unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is 5 days of request)
- Educational and Employment Support Services: within 2 weeks of request Peer Support Services: within 1 week of request (unless appointment is pursuant to emergency or hospital discharge, in which care the standard is 5 days; or if PSS are needed urgently for symptom management, in which case standard is 24 hours)

Unscheduled Non-Urgent Care Visit:

Members with non-urgent care needs should be seen within 2 hours of arrival or scheduled for an appointment in a time frame consistent with the State's Access & Availability Guidelines. Any non-urgent visit must be scheduled within 48-72 hours of request as indicated by the nature of the clinical problem.

Molina Healthcare of New York expects providers to work with the members who are present for unscheduled non-urgent care visits to educate them on how to obtain an appointment and provide access to care. At the time of appointment scheduling, the provider should provide a return appointment card or schedule a return appointment date to encourage member compliance and minimize the occurrence of "no shows".

SECTION 17. HCBS SERVICE DESCRIPTIONS AND LEVEL OF CARE CRITERIA

1915i Home and Community Based Services Review Guidelines and Criteria

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in Molina Healthcare PLUS to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

All Molina Healthcare PLUS eligible members that consent will be linked to a local Health Home (HH) for care coordination. In addition, any Medicaid member with a serious mental illness, HIV/AIDS or two chronic medical conditions can also receive Health Home support. Health Home care management is provided by the assigned community mental health agency. The Molina Healthcare PLUS plan, in partnership with the Health Homes (HHs) and Home and Community-Based Service (HCBS) providers, ensures medical and behavioral health care coordination and service provision for its members. Molina will oversee and support the Health Homes and HCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by New York State established criteria Molina utilizes a provider profiling tool that delivers programmatic data to both HHs and HCBS providers. This tool includes outcomes and compliance with HCBS assurances and sub -assurances. The Molina Healthcare PLUS program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for HARP enrollees.

Molina Healthcare PLUS eligible members will additionally be assigned a Molina care manager who will serve at the contact with the Health Home, will review clinical information and collaborate on coordination of care as appropriate.

These review guidelines provide a framework for discussion between HCBS provider s and Molina. The review process is a collaboration between all pertinent participants including but not limited to the Health Home care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member's chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

The medical necessity criteria related to HCBS services is as follows:

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
All of the following criteria 1 – 7 must be met:	**All of the following criteria 1 – 5 must be met:**	**Any one of the following: Criteria 1, 2, 3, 4, or 5; criteria #6 is recommended, but optional:**
1) The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.	1) Member continues to meet admission criteria and an alternative service would not better serve the member.	1) Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive.
2) Where the member has been deemed eligible to receive services, a Level of Service Determination is made to ensure recommended HCBS are appropriate for meeting the member's identified goals, and appropriate HCBS provider(s) are identified in a conflict-free manner.	2) Interventions are timely, need based as per the CMHA (Full Assessment), consistent with evidence based/best practice, and provided by a designated HCBS provider.	2) Member or parent/guardian withdraws consent for treatment.
3) Upon receipt of notification from the HCBS provider(s), up to 3 visits over 14 days is authorized for intake and evaluation.	3) One of the following is present: (a) Member is making measurable progress towards a set of clearly defined goals; Or (b) There is evidence that the service plan is modified to address the barriers in treatment progression; Or (c) Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration	3) Member does not appear to be participating.

4) The BH Prior and/or Continuing Authorization Request Form is submitted by the HCBS provider(s) for Prior Authorization and includes service scope, duration and frequency.	4) There is care coordination with physical and behavioral health providers, State, and other community agencies.	4) Member's needs have changed, and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge, alternative services are being explored in collaboration with the member, the member's family members (if applicable), Health Home, HCBS provider, and MCO.
5) The service request must support the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.	5) Family/guardian/caregiver is participating in treatment where appropriate.	5) Member's goals have been met.
6) The member must be willing to receive home and community-based services.	6) In addition, determination of progress and modifications to goals/objectives are made by reviewing the BH HCBS Prior and/or Continuing Authorization Request Form and/ or with a telephonic review with the provider.	6) Member's support system is in agreement with the aftercare service plan
7) There is no alternative level of care or co-occurring service that would better address the member's clinical needs.		

Health Home care managers facilitate administration of the assessment to determine eligibility for HCBS services.

1. The HH care manager will conduct a brief screening for HCBS eligibility with the member.
2. If the member is eligible for HCBS, the HH care manager will complete a full assessment that includes documentation of the member's needs, strengths, goals and preferences.
3. In collaboration, the member and HH care manager will develop a comprehensive and person-centered Plan of Care. The Plan of Care will reflect the member's assessed and self-reported needs as well as those identified through review claims and case conference with providers when appropriate.

4. The Health Home care manager will share results of the HCBS assessment and Plan of Care with the Plan for review and feedback.
5. If the member is enrolled with the Health Home, the Health Home will link the member with an HCBS provider; if the member is not enrolled with the Health Home, Molina will link the member to the HCBS provider. Members will be offered a choice of HCBS providers from within the Molina network.
6. HCBS provider(s) will conduct service specific assessment(s) and forward additional information to HH Care Manager regarding intensity and duration of services. The HH Care Manager will update Molina with HCBS provider specific information and present it to Molina for review and approval.
7. HCBS providers will be required to submit a notification to Molina when a member has been accepted. The notification must be made before the member begins to receive HCBS. The HCBS provider will present the member's Plan of Care to the Molina for review. Notification will allow for authorization of specific HCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. Molina Utilization Management will ensure the member's Plan of Care reflects the member's individual, assessed and self -reported needs and is aligned with concurrent review protocols.

HH outcome data and analytics included member's level of care, adequacy of service plans, provider qualifications, member health and safety, financial accountability and compliance will be collected by Molina.

The following is a description of the various HCBS services. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible.

Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are designated as a cluster. An appointment to any of the Community Rehabilitation Services should be offered within two weeks of the request:

(a) Psychosocial Rehabilitation (PSR): PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

(b) Community Psychiatric Support and Treatment (CPST): CPST includes time-limited goal- directed supports and solution-focused interventions intended to achieve identified person- centered goals or objectives as set forth in the individual's Plan of Care and CPST

Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily y living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment. An appointment with Educational/Vocational or Employment Services should be offered to a member within two weeks of the request.

Pre-vocational Services: Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task- specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre -vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Transitional Employment (TE): This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Intensive Supported Employment (ISE): This service assists individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that

enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) mode l which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

Ongoing Supported Employment: This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wag e and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual e employment support.

Crisis Respite Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Crisis Services- Intensive Crisis Respite and Short-term Crisis Respite are designated as a cluster. These crisis services are part of the HCBS benefit but members will not be required to complete the HCBS Eligibility Evaluation and meet Tier 1 or Tier 2 criteria before receiving the service. HARP members who have not already been screened for HCBS eligibility and who are experiencing a crisis should be offered immediate crisis services as clinically indicated. Connectivity to Crisis Respite Services should be made within 24 hours of the request. For these members, the plan will work with the provider and Health Home care manager to complete an HCBS Eligibility Evaluation within 30 days of discharge from the crisis service, to ensure that the member has access to adequate and appropriate follow-up supports and services.

(a) Short-term Crisis Respite: This is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self -referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

(b) Intensive Crisis Respite: This is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service.

Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college -level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship

program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college -level courses or classes. An appointment should be offered within two weeks of request.

Empowerment Services — Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery -oriented principles (e.g. hope and self- efficacy, and community living skills). Peer support uses trauma -informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery. An appointment should be offered within one week of request unless appointment is pursuant to emergency or hospital discharge, in which case the standard is five days. Or if Peer Support Services are needed urgently for symptom management then standard is 24 hours.

Habilitation/Residential Support Services

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

Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use

disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in -laws. "Family" does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include update s, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual's recovery plan and for the benefit of the Medicaid covered participant. Appointments should be offered within two weeks of the request.

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
All the following criteria must be met:	**All of the following criteria must be met:**	**Criteria #1, 2, 3, 4, or 8 are suitable; criteria #6. is recommended, but optional:**
1. The member must be deemed eligible to receive HCBS or HCBS like services, using the HCBS Eligibility Assessment tool.	1) Member continues to meet admission criteria and an alternative service would not better serve the member.	1) Member no longer meets admission criteria and/ or meets criteria for another more appropriate service, either more or less intensive.
2) Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual.	2) Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider.	2) Member or parent/ guardian withdraws consent for treatment.
3) An Individual Care Plan (ISP) has been developed, informed and signed by the member, Health Home coordinator, and others responsible for implementation. The POC has been approved by the Plan.	3) Member is making measurable progress towards a set of clearly defined goals; (or) There is evidence that the service plan is modified to address the barriers in treatment progression	3) Member does not appear to be participating in the ISP.

4) The HCBS provider develops an (ICP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation.	4) There is care coordination with physical and behavioral health providers, State, and other community agencies.	4) Member's needs have changed, and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member's Health Home and HCBS provider and MCO.
5) The ISP and subsequent service request supports the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.	5) Family/guardian/ caregiver is participating in treatment where appropriate.	5) Member's goals have been met.
6) The member must have the desire and willingness to receive rehabilitation and recovery services as part of their ISP.	6) In addition, determination of progress and modifications to goals/ objectives are made by reviewing the BH HCBS Prior and/or Continuing Authorization Request Form and/ or with a telephonic review with the provider.	6) Member's support system is in agreement with the aftercare service plan
7) There is no alternative level of care or co-occurring service that would better address the member's clinical needs as shown in POC and ISP.		

SECTION 18. PROVIDER PARTICIPATION

Network Development and Network Operations

Molina Provider Relation & Health Plan Operation Departments are responsible for procurement and administrative management of Molina's behavioral health provider network, which includes contracting and credentialing functions. Representatives are easily reached by email or by phone between 8:00 a.m. and 6:00 p.m., Eastern Standard Time (EST), Monday through Friday.

Contracting and Maintaining Network Participation

A "Participating Provider" is an individual practitioner, private group practice, licensed outpatient agency, New York State designated HCBS provider or facility that has been credentialed by and has signed a Provider Service Agreement (PSA) with Molina. Participating providers agree to provide mental health and/or substance use services and/ or Home and Community Based Services to members; have a procedure for monitoring HCBS utilization for each enrollee; accept reimbursement directly from Molina according to the rates set forth in the fee schedule attached to each provider's PSA; and adhere to all other terms in the PSA, including this provider manual. Note that New York State law currently requires that effective 10/1/18 in New York City and 7/1/18 in the rest of New York State, Plans must pay 100% of the Medicaid fee-for-service (FFS) rate (aka, "government rates") for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement remains in place for at least two full years. While alternative payment arrangements, in lieu of the FFS rates, may be allowed they require prior approval from OMH and OASAS.

Home and Community Based Provider Designation

In order to provide HCBS to Molina Healthcare PLUS eligible individuals, a program must be designated by New York State to provide a specific service and contracted by Molina to provide that service.

Molina will follow the special procedures that are developed by the State to ensure credentialing is consistent with approved HCBS provider qualifications. Molina will contract with State-designated Behavioral Health (BH) HCBS providers and such designation will suffice for Molina's credentialing process. Molina's Professional Review Committee shall adhere to these procedures, established credentialing timeframes and criteria set by New York State.

The Credentialing Department will follow its policy of auditing and reporting that are aligned with New York State's rules and regulations.

Criteria for Participation in the Molina Network

Organizational providers must meet the following additional criteria to be eligible to participate in the Molina network. If the organizational provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Organizational providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

Molina requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Training Program Overview

To prepare our providers for the program, we are developing materials and a training curriculum specific to this program. Many of the materials will be developed in collaboration with NYS OMH and the RPCs. This program will offer providers the skills, and expertise to comply with the requirements under managed care. This program will transition as a foundation for ongoing new provider credentialing and re-credentialing.

Training Notifications

Molina Healthcare will publish a training schedule on its website and make providers aware of the training sessions when engaged either by telephone or during an in-person office visit. All trainings will be either in-person training or done through Web-Ex conducted by the Health Plan.

For physicians who cannot attend the training during the scheduled session, a separate training will be provided for those physicians on an ad-hoc basis upon requested by the Provider within 5 (five) business days. The training materials will also be posted on our website, for Physicians who would prefer self-paced training.

Training Registrations

Registration will not be required for training sessions.

Training Times

Training sessions will be offered on a regular schedule and/ or at the request of the provider(s). Training materials posted to our website are available 24/7 for all the provider's availability.

Timing

Go Live:	For go live, training will occur, at the earliest between 4-6 weeks prior to go live and up through six (6) weeks post-go live. For more guidelines on specific courses, see the attached detailed agenda.
New Providers:	After go-live, as part of the credentialing process, new providers will be directed to our training schedule and requested to complete the trainings housed on our website.
Orientation:	In-person orientation training will occur on a pre-scheduled monthly basis after going live.
Annual training:	Providers will receive notification from Molina Healthcare when annual training is deployed.
Re-credentialing:	As part of the re-credentialing process, providers will receive their re-credentialing packet and re-credentialing training schedule approximately three (3) months prior to their re-credentialing date.

Training Materials

Training materials are prepared by the Medical Management and Provider Relation Department of the Health Plan. The training materials will be available on our website for physicians who prefers self-paced training. For in-person training, Health Plan will provide the training materials to the Provider.

Cultural Competency

Molina Healthcare understands that we serve diverse communities and that a key underpinning of serving members is based on cultural competency and the understanding of how it affects treatment outcomes. Therefore, we ensure that all of our training programs reflect these concepts to ensure that the approach to service includes these concepts. We will continue to ensure that this training remains up-to-date as population demographics change.

Training Attestations

All required trainings will have an accompanying attestation for providers to complete. These attestations will be used to certify that the provider has completed the training and uses the content to train their own downstream employees.

If Providers have completed the training with another health plan and can provide proof of the completion, we will allow them to attest to the training providing the date, topic and associated plan that they completed the training with.

Trainer Qualifications

Non-Clinical and Clinical subject matter experts will be used for the implementation of this program.

Non-Clinical Trainers:	Subject matter experts will work with the training department to design and develop training that supports the non-clinical topics such as: billing, claims, and administrative tasks. Experienced provider trainers will be available to host the live trainings.
Clinical Trainers:	Licensed clinical subject matter experts will work with the training department to develop the clinical training topics. Licensed clinicians will provide the live trainings based on their areas of expertise. These clinicians will be supported by a professional trainer to ensure that there is an approach aligned with adult learning theories and that the training applies instructional design techniques.

Collaboration with the NYS DOH Regional Planning Consortiums (RPCs)

Molina Healthcare will work with the NYS and the RPCs to coordinate the provider initial training and annual training programs where appropriate.

Ongoing Technical Assistance Support for Providers

Once training is completed, providers will still be provided support from a number of areas:

Provider Relations: Assigned Provider Relation Representative from the Provider Relation Department will continue to offer the standard orientation and updates to content on a monthly basis. Ad-hoc visit can also be requested by the Provider based on need/request.

Claims Customer Service: If a provider has a question on completing, submitting, or any other aspect of the claims process, they can contact the Provider Relations Department. Provider Relations will work with the Health Plan's Claims Customer Service team to assist with the Provider's request. Provider Relation Representative or Trainer will also make themselves available to meet with the provider to provide an in-person 1:1 assistance.

Standard Training Timeline

New Providers:

Timeline	Topic	Notes
4-6 weeks prior to credentialing	Credentialing	Once a provider starts the credentialing process, they will be provided with a schedule of offered credentialing trainings that they can attend. This training is designed to provide an overview of the process and assist with any paperwork questions the provider may have. This training also outlines the required trainings that they need to complete.
Within 30 days of provider go live	Provider Orientation	Providers are offered multiple session which the can attend.
Within 30 days of provider go live	New Provider Curric-ulum	Providers can obtain the training curriculum from the provider manual and ad-hoc training will be provided within 5 business days upon request.

Annual Trainings

90 days prior to the annual training date, the Molina Healthcare website will be updated with a reminder to the physicians of their requirements and topics of the training.

Member Advisory Council

The member advisory council, which includes members and family members, is a subcommittee of the quality improvement committee. This committee will provide input to Molina Healthcare on suggested topics for ongoing provider trainings. Where appropriate members and family members will be involved in trainings.

Scheduled Required Training

Molina Healthcare of New York's Provider Relation Department in collaboration with the Behavioral Health Team has prepared a comprehensive training program for all contracted providers on common medical conditions and medical challenges with HARP population. The training program is developed in collaboration with NYS OMH and the RPCs. The training program will offer providers the skills, and expertise to comply with the requirements under managed care. The training program will transition as a foundation for ongoing new provider credentialing and re-credentialing.

The training program document will be available for our provider into Molina Healthcare of New York's Provider Portal, for physicians who would prefer self-paced web-based training. The training sessions will be provided on an ad-hoc basis upon requested by the Provider within 5 (five) business days.

Molina Healthcare of New York will be updating the Training program over time to follow the requirement sets by NYS and OMH and will notify the providers in the network along with provide updated training.

SECTION 19. UTILIZATION AND CARE MANAGEMENT

Utilization Management (UM)

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Care Management team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by managing benefits effectively and efficiently to ensure appropriate use of health care services.

- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services.
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while providing timely responses to Member appeals and grievances.
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions.
- Identifying and assessing the need for Care Management through early identification of high or low service utilization, and high cost-chronic diseases.
- Promoting health care in accordance with local, state and national standards;
- Processing authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and referral management	Satisfaction evaluation of the UM program using Member and Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis

Ensure authorized care correlates to Member's medical necessity need(s) & benefit plan	Post service/post claim audits	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/ hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA©, State and health plan UM standards

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or by calling the UM Department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually. Delegated entities utilization review/ actions process is available for review, either upon request or available via the delegated entities public website.

- DentaQuest: www.dentaquest.com
- Claims Questions: denclaims@dentaquest.com
- Eligibility/Benefit Questions: denelig.benefits@dentaquest.com

Utilization Management Molina's Utilization Management (UM) program is administered by licensed, experienced clinicians, who are specifically trained in UM techniques and in Molina's standards and protocols. All Molina employees with responsibility for making UM decisions have been made aware that:

- All UM decisions are based on medical necessity
- Financial incentives based on an individual UM clinician's number of adverse determinations/adverse actions or denials of payment are prohibited
- UM decision makers do not receive financial incentives for decisions that result in under utilization
- UM cannot deny coverage or ongoing course of care unless an appropriate alternate level of care can be identified and approved

Note that the information in this chapter, including definitions, procedures, and determination and notification may vary for different lines of business. Such differences are indicated where applicable.

Medical Necessity and Level of Care Criteria

Molina shall perform utilization review (UR) for the determination of clinical appropriateness, level of care (LOC) and/or medical necessity to authorize payment for behavioral health services in the areas of mental health and substance use disorders. Molina defines medically necessary services as those which are:

(a) Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM-,) that threatens life, causes pain
or suffering,
or results in illness or infirmity.

(b) Expected to improve an individual's condition or level of functioning.

(c) Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.

(d) Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.

(e) Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.

(f) Not primarily intended for the convenience of the recipient, caretaker, or provider.

(g) No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.

(h) Not a substitute for non-treatment services addressing environmental factors.

Molina's application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of, and1or evaluate the medical necessity, appropriateness, efficacy, and efficiency of, behavioral health care services.

Molina's mental health LOC criteria were developed from the compassion of national, scientific and evidence-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACP). Molina's substance use disorder LOC criterion is determined by the Level of Care for Alcohol and Drug Treatment Referral, (LOCADTR). Home and Community Based Services LOC is approved by the New York State Office of Mental Health.

Molina's mental health LOC criteria are reviewed annually, or more frequently, as necessary by the Quality Improvement Committee (which contains licensed behavioral health practitioners) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice. The criteria sets are reviewed by Molina's behavioral health medical director. New treatment applications and technologies are reviewed by the Quality Improvement Committee. After review and approval of any new or changed LOC criteria, they are updated on participating provider webpage, as appropriate. Molina's LOC criteria are available to all providers upon request.

Unless otherwise mandated by state or contractual requirement, all medical necessity behavioral health mental health determinations are based on the application of Molina's LOC criteria. SUD determinations are made based on medical necessity and LOCADTR and Home and Community Based Services LOC determinations are based on an InterRAI assessment and approved Health Home Plan of Care. Molina's process for conducting UR typically is based on chart review and1or direct communications from the evaluating/requesting provider (designee). Molina's behavioral health authorization and UM activities comply with federal mental health parity law.

To ensure that members receive the care that best meets their individual behavioral health needs in the most appropriate treatment setting, members' needs are assessed and matched with the capabilities, locations and competencies of the provider network when authorizing services. All decisions regarding authorization are made as expeditiously as the case require s, but no longer than required timeliness standards.

A member, authorized representative or treating health care provider may request an expedited authorization decision. If the request is made by a treating health care provider, the request will be granted unless the request is unrelated to the member's health condition. All other requests will be reviewed and decided upon by a Molina behavioral health medical director.

Molina does not require a primary care physician (PCP) referral to obtain authorization for behavioral health services. A member may self-refer for specialist services except for ACT, inpatient psychiatric treatment, partial hospitalization and HCBS services. A member may initiate outpatient behavioral health services for a predetermined number of visits, without prior authorization from Molina, as determined by New York State Offices of Mental Health and Alcoholism and Substance Abuse Services. Authorization is required for ongoing outpatient services after members exceed the predetermined number of visits allowed by their health plan/State.

Molina will cover emergency services for all members whether the emergency services are provided by an affiliated or non-affiliated provider. Molina does not impose any requirements for prior emergency services for all members whether the emergency services are provided by an affiliated or non-affiliated provider. Molina does not impose any requirements for prior emergency services. CPEP, crisis intervention and OMH/OASAS specific non-urgent ambulatory services. Unless otherwise specified, all admissions to impatient mental health and substance use disorder facilities and some diversionary services require prior authorization. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Molina to make a medical necessity determination, Molina will make a determination based on the information received within the specified time frames, which may result in an adverse determination1action. LOCATDR 3 tool with be used for level of care determination for OASAS services.

Adverse determinations (denials) are never decided on the basis of pre -review or initial screening and are always made by a Molina behavioral health medical director. All adverse determinations are rendered by board-certified psychiatrists or a psychologist of the same or similar specialty as the services being denied. All inpatient substance use disorder adverse determinations are made by a physician certified in addiction psychiatry. Molina behavioral health medical directors hold current and valid unrestricted licenses. Treating providers may request reconsideration of an adverse determination from a clinical peer reviewer, which will be completed within one business day of request.

A written notice of an adverse determination will be sent to the member and provider and include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals, and

- Notice of the availability, upon request of the enrollee or the enrollee's designee of the clinical criteria relied upon to make such determination.
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained by Molina, in order to render a decision for the appeal.

For Medicaid, the notice will also include:

- Description of Action to be taken;
- Statement that Molina will not retaliate or take discriminatory action if appeal is filed;
- Process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review;
- Member right to contact the Department of Health (DOH), with 1-800 number, regarding their complaint;
- Fair Hearing notice including aid to continue rights;
- Statement that notice is available in other languages and formats for special needs and how to access these formats.

Please contact Molina's Member Services Department if you have any questions regarding court-ordered treatment and adverse determination rules. Medical necessity determinations are not affected by whether a member is mandated involuntarily to treatment or is voluntarily requesting services. Unless an HP1MCO contract specifies payment for court-ordered treatment, authorization requests for members who are mandated involuntarily to services must meet LOC criteria to be authorized for the treatment. The requested service must also be covered by the member's benefit plan.

Molina's behavioral health medical directors are available at any time during the UM process, to discuss by telephone, adverse determinations based on medical necessity with attending physicians and other licensed practitioners. Molina offers and provides a mechanism for direct communication between a Molina behavioral health medical director and an attending provider (or provider designated by attending physician) concerning medical necessity determinations. Such equivalent two-way (peer-to-peer) direct communication shall include a telephone conversation and1or facsimile or electronic transmission, if mutually agreed upon. If the attending provider is not reasonably available or does not want to participate in a peer -to-peer review, an adverse determination can be made based on the information available.

Molina does not terminate, suspend or reduce previously authorized services. Molina will not retrospectively deny coverage for behavioral health services when prior approval has been issued, unless such approval was based upon inaccurate information material to the review, or the healthcare services were not consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval.

Terms and Definitions

Utilization Management (UM)

UM includes review of pre-service, concurrent and post-service requests for authorization of services. Molina UR clinicians gather the necessary clinical information from a reliable clinical source to assist in the certification process and then applies Molina's LOC criteria to authorize the most appropriate medically necessary treatment for the member. Molina uses its LOC criteria and LOCADTR as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, treatment history in determining the best placement for a member. Authorizations are based on the clinical information gathered at the time of the review.

All concurrent reviews are based on the severity and complexity of the member's condition. A clinical evaluation for medical necessity is conducted at each concurrent review to determine when the next review will be due. For those reviews that do not appear to meet Molina's LOC criteria a referral is made to a Molina behavioral health medical director. Molina

UM also includes reviewing utilization data resulting from medical necessity decisions. This data is compared to national, local and organizational benchmarks (e.g., average length of stay and readmissions rates) to identify trends. Based on the analysis of the utilization data, specific interventions may be created to increase standardization and decrease fluctuations.

The definitions below describe utilization review, including the types of the authorization requests and UM determinations that are used to guide Molina's UM reviews and decision-making. All determinations are based upon review of the information provided and available to Molina at the time.

Adverse Action/Determination

The following are actions or inactions by the organization:

1. Failure to provide covered services in a timely manner in accordance with the waiting time standards
2. Denial or limited authorization of a requested service, including the determination that a requested service is not a covered service
3. Reduction, suspension, or termination of a previous authorization for a service
4. Denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to, denials based on the following:
    - Failure to follow prior authorization procedures
    - Failure to follow referral rules
    - Failure to file a timely claim
    - Failure to act within the time frames for making authorization decisions
    - Failure to act within the time frames for making appeal decisions
5. Failure to act within the timeframes for making authorization decisions
6. Failure to act within the timeframes for making appeal decisions

Emergency Services

Emergency Medical Condition or Emergency Condition means: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
(b) Serious impairment to such person's bodily functions;
(c) Serious dysfunction of any bodily organ or part of such person; or
(d) Serious disfigurement of such person.

Emergent and urgent care services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Non-Urgent (Standard) Concurrent Review Decisions

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, Molina will respond to the request within the time frame of a non-urgent, pre-service decision as defined below.

Non-Urgent (Standard) Pre-Service Decisions

Any case or service that must be approved in advance of a member obtaining care or services. A non- urgent pre-service decision would include treatment over a period of time or a number of days or treatments in a non-acute treatment setting. Requests for continued treatment (concurrent) that are n on- urgent are considered, for the purposes of this policy, as new pre -service requests.

Post-Service Review and Decisions

Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre -service decision was not rendered, based on the information that would have been available at the time of a pre service review and treatment stay, also known as retrospective decisions. **Retrospective decisions are made within 30 days of receipt of necessary information.**

Molina may reverse a pre-authorized treatment, service or procedure based on a retrospective review pursuant to section 4908 (8) of PHL when:

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and
- The information existed at the time of the pre-authorization review but was withheld or not made available; and
- Molina was not aware of the existence of the information at the time of the pre-authorization review; and;

- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Urgent Care Requests

Expedited and standard review timeframes for pre -authorization and concurrent review may be extended by an additional 14 days if any request for medical care or treatment concerning application of the time period for making a non-urgent care decision:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is requested.
- Expedited review must be conducted when Molina or requesting provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum functions. Member have the right to request expedited review, but Molina may deny and notice will process under standard timeframes.

Urgent (Expedited) Concurrent Review Decisions

Any reviews for an extension of a previously approved ongoing course of treatment over a period or a number of days or treatment in an acute treatment setting or for members whose condition meets the definition of urgent care.

Urgent (Expedited) Pre-Service Decisions

Any case or service that must be approved in advance of a member obtaining care or services or for members whose condition meets the definition of urgent care. An urgent pre -service decision would include treatment over a period of time or a number of days or treatments in an acute treatment setting, also known as pre-certification or prospective decision.

Molina does not require prior authorization for either urgent or non -urgent ambulatory services delivered by OASAS certified Part 822 outpatient clinics (including intensive outpatient services), outpatient rehabilitation and opioid treatment programs, OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs.

Accessibility Standards

See Molina Healthcare's Provider Manual Section 8 for General Accessibility Standards.
HCBS Specific Standards

TYPE OF APPOINTMENT	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
Short-term and Intensive Crisis	Within 24 hours of request
Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training	Within 2 weeks of request (unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is 8 days of request)
Educational and Employment	Within 2 weeks of request
Peer Support Services	Within 1 week of request (unless appointment is pursuant to emergency or hospital discharge, in which case the standard is 8 days; or if services are needed urgently for symptom management, in which case the standard is 24 hours).

Providers are required to meet these standards, and to notify Molina if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

Utilization Management Review Requirements

New York Ambulatory Behavioral Health Services Authorization Rules

The New York State Office of Mental Health, (OMH), and Office of Alcoholism and Substance Abuse Services, (OASAS), has issued guidance on authorization rules for ambulatory behavioral health services for adults. Below are the authorization guidance and expectations for timely appointments for BH services within Mainstream Managed Care, HIV Medicaid SNP and Health and Recovery Plans cover. Following an emergency, hospital discharge or release from incarceration, if known, follow up visits with a behavioral health participating provider should be offered within a minimum of five days of request or as clinically indicated.

Members may also self-refer for at least ob-gyn care: prenatal care, two routine visits per year and any follow-up care, acute gynecological condition. For Medicaid, they may also self -refer for:

- At least one mental health visit and one substance abuse visit with a participating provider per year for evaluation
- Vision services with participating provider
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from participating provider or Medicaid provider

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Outpatient mental health office and clinic services including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family1collateral, and group psychotherapy	No	Yes	Molina must pay for at least 30 visits per treatment episode without requiring authorization. Molina must ensure that concurrent review activities do not violate parity law. Non-urgent appointments should be offered within 2-4weeks of request.
Psychological or neuropsychological testing	Yes	N/A	Non-urgent appointments should be offered within 2-4 weeks of request.
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	Yes	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit. Appointment should be given within 24 hours of request.
Personalized Recovery Oriented Services (PROS) Admission: Individualized Recovery Planning	Yes	Yes	Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base1 Community Rehabilitation and Support (CRS) and Clinic Treatment services. Appointments should be offered within 2 weeks of request.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	Appointment should be offered within 2-4 weeks of request
Mental Health Intensive Outpatient (note: NOT State Plan)	Yes	Yes	Appointment should be offered within 1 week of request
Mental Health Partial Hospitalization	Yes	Yes	

Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made within 24 hours and should be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT.
Outpatient Office and Clinic Services provided by OASAS-certified agencies including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family1collateral, and group psychotherapy	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Medically Supervised Outpatient Substance Withdrawal	No	No	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Opioid Treatment Program (OTP) Services	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Substance use Disorder Intensive Outpatient	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 1 week of request.
Substance use Disorder Day Rehabilitation	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 2-4 weeks of request.
Stabilization and Rehabilitation services for residential SUD treatment	Yes	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

If a service is not a covered benefit, providers are expected to advise the enrollee prior to initiating the service and to state the cost of the service.

Out-Of-Network Exceptions

Providers must be in-network with Molina to request authorization (when applicable) and be reimbursed. However, some exceptions are reviewed on a case-base case bases, including:

- Member cannot access a provider with the appropriate specialty required to treat the presenting issue.

- Member cannot access an in-network covered service provider due to geographic limitations
- Transition of Care needs up to a period of 90 days

Provider must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care;
- Adhere to organization's quality assurance program and provide medical information related to the enrollee's care;
- Adhere to Molina's policies and procedures including referrals and
- Obtain pre-authorization and a treatment plan approved by the organization.

Emergency Prescription Supply

For prescribers, a 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

A seven-day emergency supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization is also available.

Adverse Determinations, Appeals and Complaints (Grievances)

Background

Molina will maintain an efficient complaint process that seeks to resolve Member or Member Designee complaints regarding the dissatisfaction with any aspect of Molina's operations, benefits, employees, vendors or Providers, within the timeframes defined by the contract with the State of New York and any other related Medicaid policies. The Member Services department has primary oversight for the accurate classification, review and timely resolution of all complaints.

Molina will work with the New York State Department of Health (SDOH) and the Local Department of Social Services (LDSS) on the investigation of any complaint filed with SDOH or the LDSS.

Molina will provide Members and Member Designees with reasonable assistance in filing a complaint, complaint appeals or action appeals, completing forms and other procedural steps including, but not limited to providing interpreter services, and toll-free numbers with TTY/TDD capability.

Molina will not retaliate or take any discriminatory action against a Member because a complaint or complaint appeal has been filed.

Molina subcontracts utilization management functions for Dental Molina members. These subcontractors will collaborate with the Member Services and Utilization Management Team on any Actions, Action Appeals, Complaints or Complaint Appeals related to these benefits. Molina keeps all complaints and complaint appeals strictly confidential.

Molina conducts all pharmacy reviews in-house.

Molina must provide written Notice of Action to Members/Member Designee and Providers including, but not limited to, the following circumstances:

- Molina makes a coverage determination or denies a request for a referral, regardless of whether the Member has received the benefit;
- Molina determines that a service does not have appropriate authorization;
- Molina denies a claim for services provided by a Non-Participating Provider for any reason;
- Molina denies a claim or service due to medical necessity;
- Molina rejects a claim or denies payment due to a late claim submission;
- Molina denies a claim because it has determined that the Member was not eligible for Managed Medicaid coverage on the date of service;
- Molina denies a claim for service rendered by a Participating Provider due to lack of a referral;
- Molina denies a claim because it has determined it is not the appropriate payer; or
- Molina denies a claim due to a Participating Provider billing for Benefit Package services not included in the Provider Agreement between the Contract and the Participating Provider.

Molina is not required to provide written Notice of Action to Members in the following circumstances:

- When there is a prepaid capitation arrangement with a Participating Provider and the Participating Provider submits a fee-for-service claim to Molina for a service that falls within the capitation payment;
- If a Participating Provider of Molina itemizes or "unbundles" a claim for services encompassed by a previously negotiated global free arrangement:
- If a duplicate claim is submitted by the Member or a Participating Provider, no notice is required, provided an initial notice has been issued;
- If the claim is for a service that is carved-out of the MMC Benefit Package and is provided to a MMC Member through Medicaid fee-for-service, however, Molina should notify the Provider to submit the claim to Medicaid;
- If Molina makes a coding adjustment to a claim (up-coding or down-coding) and its Provider Agreement with the Participating Provider includes a provision allowing Molina to make such adjustments;
- If Molina has paid the negotiated amount reflected in the Provider Agreement with a Participating Provider for the services provided to the Member and denies the Participating Provider's request for additional payment; or
- If Molina has not yet adjudicated the claim. If Molina has pended the claim while requesting additional information, a notice is not required until the coverage determination has been made.

Adverse Determination

Adverse Determination: A clinical peer reviewer who is different from the one making the initial determination will review the appeal and render a final determination.

Behavioral Health - all denial, grievance, and appeal decisions will be peer-to-peer and are subject to the following requirements:

- A physician board certified in general psychiatry will review all inpatient level of care denials for psychiatric treatment
- A physician certified in addiction treatment will review all inpatient level of care denials for SUD treatment

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, LOCATOR2 and other third-party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. The criteria is updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice. The UM criteria is applied in a manner that considers the individual health care needs of the Member and characteristics of the local delivery system.

At least annually, the determination process is evaluated for the consistency with which those involved in the Utilization Review process apply the criteria in the determination of coverage. Individual circumstances and needs will be taken into account in the development, adoption, and application of clinical UM criteria.

The following factors may be considered:

- Age
- Co-morbidities and complications
- Progress of treatment
- Treatment goals
- Psychosocial situation
- Home environment

Characteristics of the local health care delivery system, including but not limited to Member access and Member circumstances are considered in the development, adoption, and application of clinical UM criteria.

A written notice of an adverse determination (initial adverse determination) will be sent to the Member and Provider and will include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals and

- Notice of the availability, upon request of the Member or the Member's Designee of the clinical review criteria relied upon to make such determination.
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained by Molina in order to render a decision on the appeal.

For Medicaid the notice will also include:

- Description of Action to be taken
- Statement that Molina will not retaliate or take discriminatory action if appeal is filed
- Process and timeframe for filing/reviewing appeals, including Member right to request expedited review
- Member right to contact DOH, with toll-free number, regarding their complaint
- Fair Hearing notice including aid to continue rights
- Statement that notice is available in other languages and formats for special needs. as well as how to access

The adverse determination notice will also include a description of action to be taken and a statement that Molina will not retaliate or take discriminatory action if an appeal is filed.

Members may request and file an appeal and request an expedited review. The Member may contact the New York State Department of Health at 1-800-206-8125 regarding their complaint. The Member will be issued a fair hearing notice including aid to continue rights and a statement that the fair hearing notice is available in other languages and formats for special needs and how to access these formats. Fair hearing notice will also inform the Member of liability for services if a denial is upheld in a fair hearing.

Molina may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and
- The information existed at the time of the pre-authorization review but was withheld or not made available; and
- Molina was not aware of the existence of the information at the time of the pre-authorization review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Reconsideration (Peer-to-Peer Discussion)

The first step in the appeals process after an adverse determination is a reconsideration.

In the event that Molina renders an adverse determination without attempting to discuss such matter with the Member's health care provider who specifically recommended the health care service, procedure or treatment under review, the health care provider will have the opportunity to request a reconsideration (peer-to-peer discussion) of the adverse determination.

- Providers may request a reconsideration within five (5) business days from the date of Initial Adverse Determination Denial Notice.
    - A provider's request for a reconsideration must be made verbally.
- If a provider verbally requests a reconsideration **within** the five (5) business day reconsideration timeframe, the new information can be used for the reconsideration discussion.
- If a provider makes new information available (either verbally or in writing) outside the five (5) business day reconsideration timeframe, the provider will receive written notification that their reconsideration timeframe has expired and they have the right to appeal.
- Reconsideration shall occur within one (1) business day (except if it is a retrospective review) of receipt of the request and shall be conducted by the health care provider and the clinical peer reviewer making the initial determination or another designated peer reviewer.
- If an adverse determination is upheld, Molina shall re-issue the written Initial Adverse Determination Denial Notice.

The failure of Molina to make a UR determination within the time periods prescribed in this section is deemed to be an adverse determination subject to appeal. If the timeframes allotted for the appeal expire, Molina will send a notice of denial on the date review timeframes expire.

Appeal of Adverse Determinations

Members may appeal an adverse determination on an expedited or standard appeal within sixty (60) business days of the initial adverse determination notice. The appeal process will begin upon receipt of the appeal either by mail or by telephone.

Appeals can be mailed to:

1776 Eastchester Road
Bronx, NY 10461

or Members may call:

1-800-223-7242 (TTY: 711)

Expedited Appeal

An expedited appeal may be filed for the following:

- Continued or extended health care services, procedures or treatments
- Additional services for a Member undergoing a course of continued treatment
- When the Provider believes that an immediate appeal is warranted
- For Medicaid/FHP, when Molina honors member request for expedited review, Molina will immediately notify the Member and the Member's referring Provider by telephone or fax to identify any additional information that is required to conduct the appeal and follow up with a written request. If Molina determines that the expedited request is denied, the Member must be notified by telephone immediately followed by written notice of the decisions within two (2) business days.

Molina will provide reasonable access to a clinical peer reviewer within one (1) business day of receiving an expedited appeal request.

An expedited appeal must be decided within:

- Two (2) business days of receipt of necessary information
- For Medicaid/FHP, as fast as the Member's condition requires and within two (2) business days of receipt of necessary information but no more than three (3) business days of receipt of appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request; or if MCO demonstrates more information is needed and delay is in best interest of Member and so notices Member.

Written notice of final adverse determination concerning an expedited UR appeal shall be transmitted to Member within twenty-four (24) hours of rendering the determination. For Medicaid, Molina will make reasonable effort to provide oral notice to Member and Provider at the time the determination is made.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Standard Appeal

These appeals may be filed by a Member or a Member's Designee. A Provider may file a UR appeal for a retrospective denial. Appeals may be filed in writing or by phone. Any appeal received by phone must be followed up with a written appeal. The acknowledgement of the appeal and request for additional information required to review the appeal will be provided in writing within fifteen (15) days of receipt of appeal. If the information provided is incomplete, Molina will request the missing information in writing within five (5) business days of receipt of information. During appeal review period, the Member or their Designee may see their case file and the Member may present evidence to support their appeal in person or in writing. Molina will make a determination, and fast as the Member's condition requires and no later than thirty (30) days from receipt of the appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request; or if Molina demonstrates more information is needed and delay is in best interest of the Member and notifies the Member in writing. Molina will notify the Member or the Member's Designee within two (2) business days of the appeal decision in writing.

Each notice of final adverse determination will be in writing, dated, and include:

- The basis and clinical rationale for the determination
- The words "final adverse determination"
- Molina contact person and phone number
- Member coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/Provider and developer/manufacturer of service as available
- Statement that Member may be eligible for external appeal and timeframes for appeal

- If health plan offers two levels of appeal, cannot require Member to exhaust both levels. Must include clear statement in bold that Member has 4 months from the final adverse determination to request an external appeal and choosing 2nd level of internal appeal may cause time to file external appeal to expire.
- Standard description of external appeals process attached
- Summary of appeal and date filed
- Date appeal process was completed
- Description of Member's fair hearing rights if not included with initial denial
- Right of Member to complain to the Department of Health at any time via a toll-free number
- Statement that notice available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer; provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. In the case of Behavioral Health, a physician board certified in general psychiatry, will review all inpatient level of care denials for psychiatric treatments. A physician certified in addiction treatment will review all inpatient level of care denials for SUD treatment. If Molina fails to make a determination with the applicable time periods it would be considered a reversal of the adverse determination.

The Member and Molina may jointly agree to waive the internal appeal process; if this occurs, Molina must provide a written letter with information regarding filing an external appeal to Member within twenty-four (24) hours of the agreement to waive the MCO's internal appeal process.

External Review

Members have the right to an external appeal of a final adverse determination. The external appeal must be submitted within four (4) months of the receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a Member chooses to request a second level internal appeal, the time may expire for the Member to request an external appeal.

The Member or the Member's Designee in connection with retrospective adverse determinations, and the Molina Provider have the right to request an external appeal.

The circumstances when an external appeal may be filed are:

1. When the Member has had coverage of a health care service, which would otherwise be a covered benefit under the health benefit plan and the benefit is denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and Molina has rendered a final adverse determination with respect to such health care service or if Molina and the Member have jointly agreed to waive any internal appeal.
2. Member has had coverage of a health care service denied on the basis that such service is experimental or investigational, and

- the denial has been upheld on appeal or both the MCO and the Member have jointly agreed to waive any internal appeal, and
- the Member's attending physician has certified that the Member has a life-threatening or disabling condition or disease
  - for which standard health services or procedures have been ineffective or would be medically inappropriate or
  - for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or
  - for which there exists a clinical trial, and
- the Member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member's life-threatening or disabling condition or disease, must have recommended either
  - a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Member than any covered standard health service or procedure; or
  - a clinical trial for which the Member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and
  - the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

If Molina offers two levels of internal appeals, Molina may not require the Member to exhaust the second level of internal appeal to be eligible for an external appeal.

Complaints and Grievances

Definitions:

Complaint: Any expression of a Member's dissatisfaction with any aspect of Molina operations, his or her care other than an action (See TC OPS.001 Actions). This includes written or verbal contact to Molina, SDOH or the LDSS, in which the Member, or the Member's Designee, describes dissatisfaction with any aspect of Molina's operations, benefits, and employees, vendors or Providers. A complaint is the same as a Grievance.

Complaint Appeal: a request for a review of a complaint determination.

Complaint Determination: Any decision made by or on behalf of Molina regarding a complaint whereas a Member is dissatisfied.

Grievance System: Molina's complaint and appeal process including a complaint and a complaint appeal process, a process to appeal actions and access to the State's fair hearing system.

Inquiry: Any oral or written request to Molina, a Provider, or facility, without an expression of dissatisfaction, e.g., a request for information. Inquiries are routine questions about benefits (i.e. inquiries are not complaints) and do not automatically invoke the grievance or appeals or request for Service Authorization process.

Complaint Process

Complaints will be accepted either orally or in writing. Written complaints will be responded to in writing. Verbal complaints may be responded to verbally or in writing, unless the Member or a Member representative requests a written response, which will be responded to in writing.

Complaints and/or complaint appeals will be accepted during call center hours. Molina staff are available to assist with filing of complaints, complaint appeals, and action appeals.

If any other departments or staff at Molina receives a complaint from a Member, the Member Services Department will be notified and the complaint will funnel through the process identified in this policy. Any complaints involving Marketplace Facilitated Enroller or Marketing Representatives will be forwarded to the Marketing Manager. Molina recognizes that a Member has the right to designate an authorized legal representative (Member Designee) to act on his/her behalf at any time during the complaint process. The designated representative may be anyone to whom the Member designates, in writing, the authority to speak for him/her and may include a health care Provider or attorney and will follow any State specific requirements.

Written Complaints

All written complaints will be reviewed by one or more qualified personnel who were not involved in previous decision making roles. Complaints pertaining to clinical matters, complaints that are an action appeal denial based on lack of medical necessity, or a complaint regarding the denial of expedited resolution of an action appeal will be reviewed by one or more licensed, certified or registered health care professionals in addition to non clinical personnel.

If a Member files a complaint regarding difficulty accessing a needed service or referral from a Participating Provider, and, as part of or in addition to the complaint, requests the service or referral directly from Molina, Molina will accept and review the service authorization request and make a determination in accordance with Plan Policy and Procedure.

For all written complaints an acknowledgement of the complaint and a notice of the determination will be sent to the Member or Member Designee.

If a determination was unable to be made because insufficient information was presented or available to reach a determination, Molina will send a written statement that a determination could not be made to the complainant on the date the allowable time to resolve the complaint has expired. All interactions regarding the complaint including, but not limited to, Provider inquiries and interactions, interactions with Members, interactions with other Molina staff, letters, etc. will be documented.

Complaint Appeals

A Complaint Appeal may be filed within sixty (60) business days after the receipt of the notice of complaint determination. Complaint Appeals may be submitted in writing by letter or by completion

of the complaint appeal form after a complaint determination is received. A Member may also call and specifically request a complaint appeal based on the receipt of a complaint determination. Within fifteen (15) business days of the receipt of the Complaint Appeal, Molina will provide a notice of Complaint Appeal Acknowledgement. Complaint Appeals of clinical matters will be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL §4900(2)(a).

Complaint Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original complaint determination.

Members and Providers will be notified of the process to request an Appeal of a Complaint Determination in the Complaint Determination notification and in Member and Provider Handbooks.

Expedited complaint

If a delay in processing a complaint would significantly increase the risk to a Member's health, complaints will be resolved within two (2) business days from the receipt of necessary information and no more than seven (7) calendar days from the receipt of the complaint.

Standard Complaint

Complaints will be resolved within forty-five (45) calendar days after the receipt of necessary information and no more than sixty (60) calendar days from the receipt of the complaint.

Complaint appeals will be decided, and notification provided within two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health.

Complaint appeals will be decided, and notification provided within thirty (30) business days after the receipt of all necessary information when Member health is not at risk.

Complaint Acknowledgement

Molina will provide written acknowledgement of any complaint within fifteen (15) business days of the receipt of the complaint. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the complaint.
- Identification of any additional information required from any source to make a determination.
- If a complaint determination is made before the written acknowledgement is sent, Molina may include the acknowledgement with the notice of determination (one notice).

Complaint Determination

A complaint determination will be made in writing to the Member, and/or the Member Designee and will include:

- Detailed reasons for the determination.

- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- The procedure and form for filing an appeal of the complaint determination within sixty (60) business days.
- Notice of the right for the Member or Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number 1.800.206.8125.
- For Medicaid Members only – the right to complain to their local Department of Social Services.

In cases where delay would significantly increase the risk to a Member's health, Molina will provide notice of a determination by telephone directly to the Member or to the Member's Designee, or when no phone is available, some other method of communication, with written notice to follow within three (3) business days.

When a Member's complaint is related to dissatisfaction with a Provider, the notice of determination will include the names and addresses and telephone numbers of three alternative Providers within the Molina network.

When a Member is required to meet certain criteria to achieve a goal related to their care and the Member did not meet the criteria, Molina will include recommendations to the Member in how to reach the goal.

Complaint Appeal Acknowledgement

Molina will provide written acknowledgement of any Complaint Appeal within fifteen (15) business days of the receipt. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the Complaint Appeal.
- Identification of any additional information required from any source to make a determination.

Complaint Appeal Determination

Complaint appeal determination notifications will be sent within thirty (30) business days of the receipt of the complaint appeal. The complaint determination will be made in writing to the Member, the Member Designee and may include:

- A detailed reason for the determination.
- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- A Notice of the right for the Member, Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number.
- Instructions for any further appeal, if applicable.

Important Telephone Numbers and Addresses

Members/Member Designees and Providers may contact the following agencies at any time with a grievance:

Molina Member Service Department

Members may call toll free at 1-800-233-7242 or submit their appeal or grievance in writing to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
5232 Witz Drive
North Syracuse, New York 13212

Members may also contact their Local Department of Social Services. They can do this by calling New York State Department of Health Toll free (800) 206-8125 or viisit their website at: https://www.health.ny.gov/health_care/medicaid/ldss.htm for a complete listing by county.

Members may also write to:

New York State Department of Health
Bureau of Certification and Surveillance
Corning Tower
Albany, New York 12237

Care Management

Molina's Care Management Program (CM) is designed to ensure the coordination of care for children and adults at significant clinical risk due to behavioral health conditions and psychosocial factors. The program includes assessment, care planning, advocacy and linkage to necessary support and services. Individualized care plans are developed in collaboration with members and their healthcare teams aimed at improving a member's overall functioning. Molina case management is provided by licensed behavioral health clinicians.

Referrals for CM are taken from inpatient facilities, outpatient providers, health plan representatives, PCPs, state agencies, members and their families.

Screening criteria for CM include, but are not limited to, the following:

- Member has a prior history of acute psychiatric, or substance use admissions authorized by Molina with a readmission within a 60-day period
- First inpatient hospitalization following serious suicide attempt, or treatment for first psychotic episode
- Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family, or social support along with an inadequate outpatient treatment relationship, which places the member at risk of requiring acute behavioral health services
- Presence of a co-morbid medical condition that, when combined with psychiatric and/or substance use issues, could result in exacerbation of fragile medical status

- Adolescent or adult who is currently pregnant, or within a 90-day postpartum period that is actively using substances, or requires acute behavioral health treatment services
- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services who requires support to link family, providers and state agencies, which places the member at risk of requiring acute behavioral health services
- Multiple family members who are receiving acute behavioral health and/or substance use treatment services at the same time
- Other, complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond standard criteria

Members who do not meet criteria for CM may be eligible for care coordination. Members identified for care coordination have some clinical indicators of potential risk due to barriers to services, concern related to adherence to treatment recommendations, new onset psychosocial stressors, and/or new onset of co-morbid medical issues that require brief targeted care management interventions.

Care coordination is a short-term intervention for members with potential risk due to barriers in services, poor transitional care, and1or co-morbid medical issues that require brief care management interventions.

CM and care coordination are voluntary programs, and member consent is required for participation. For further information on how to refer a member to case management services, please refer to the health plan-specific Contact Information sheet.

Molina staff are trained to additionally assess a member's need and eligibility for Health Home case management. New York State's Health Home eligibility criteria is as follows:

- Medicaid eligible/active Medicaid
- Two or more chronic condition
- One single qualifying condition of either HIV/AIDS or a Serious Mental Illness (SMI)

Qualifying chronic conditions are defined in the State Plan Amendment as any of those included in the "Major" categories of the 3MTM Clinical Risk Groups (CRGs). A table of qualifying conditions included in these categories has been compiled and is shown below. Substance use disorders (SUDs) are in the list of qualifying chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDs must have another chronic condition (chronic medical or mental health) to qualify. A chronic condition in the context of determining eligibility for Health Homes implies a health condition that requires ongoing monitoring and care. The condition should not be incidental to the care of the member but have a significant impact on their health and well-being. In addition to having a qualifying condition, an individual must be appropriate for Health Home services. Individuals who are Medicaid eligible and have active Medicaid and meet diagnostic eligibility criteria may not necessarily be appropriate for Health Home care management. Individuals that meet the eligibility criteria for Health Homes and manage their own care effectively, do not need the level of care management provided by Health Homes. An individual must be assessed and

found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home services. An assessment must be performed for all presumptively eligible individuals to evaluate whether the person has significant risk factors and is appropriate for referral to Health Home care management services. Determinants of medical, behavioral, and1or social risk can include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission);
- Lack of or inadequate social/family/housing support;
- Lack of or inadequate connectivity with healthcare system;
- Non-adherence to treatments or medication(s) or difficulty managing medications;
- Recent release from incarceration or psychiatric hospitalization;
- Deficits in activities of daily living such as dressing or eating; and
- Learning or cognition issues.

For more information on determining eligibility for Health Home services, see https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm

SECTION 20. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

Molina administers, on behalf of the partner health plan, a Quality Improvement (QI) Program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Molina's QI Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.

Program Principles

- Continually evaluate the effectiveness of services delivered to health plan members
- Identify areas for targeted improvements
- Develop QI action plans to address improvement needs
- Continually monitor the effectiveness of changes implemented, over time

Program Goals and Objectives

- Improve the healthcare status of members
- Enhance continuity and coordination among behavioral health providers and between behavioral health and physical health providers
- Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders
- Ensure members receive timely and satisfactory service from Molina and network providers
- Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Molina services
- Responsibly contain healthcare costs

Provider Role

Molina employs a collaborative model of continuous quality improvement, in which provider and member participation is actively sought and encouraged. With a provider joining Molina, all providers agree to cooperate with Molina's Quality Intervention initiatives. Molina also requires each provider to have its own internal Quality Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

Quality Monitoring

Molina monitors provider activity and uses the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual provider and network -wide improvement initiatives. Molina's quality monitoring activities include, but are not limited to:

- Treatment record reviews
- Satisfaction surveys

- Internal monitoring of: timeliness and accuracy of claims payment; provider compliance with performance standards, including but not limited to:
    - Timeliness of ambulatory follow-up after mental health hospitalization
    - Discharge planning activities; and
    - Communication with member PCPs, other behavioral health providers, government and community agencies
- Tracking of adverse incidents, complaints, grievances and appeals
- Other quality improvement activities

Treatment Records

Treatment Record Reviews

Molina reviews member charts and uses data generated to monitor and measure provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care providers and other treaters
- Explanation of member rights and responsibilities
- Inclusion of all applicable required medical record elements as listed below
- Allergies and adverse reactions, medications, and physical exam

Molina may conduct chart reviews onsite at a provider facility or may ask a provider to copy and send specified sections of a member's medical record to Molina.

Treatment Record Standards

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below. All documentation must be clear and legible.

Member Identification Information

The treatment record contains the following member information:

- Member name and health plan identification # on every page
- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Informed Member Consent for Treatment

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to interagency communications
- Individual consent forms for release of information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than
- Molina) requires its own signed consent form.
- Consent to release information to Molina (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.)
- For adolescents, ages 12-17, the treatment record contains consent to discuss substance abuse issues with their parents.
- Signed document indicating review of patient's rights and responsibilities

Medication Information

The treatment records contain medication logs clearly documenting the following:

- All medications prescribed
- Dosage of each medication
- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted.
- Lack of known allergies and sensitivities to substances are clearly noted.

Medical and Psychiatric History

The treatment record contains the member's medical and psychiatric history including:

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

Substance Abuse Information

Documentation for any member 12 years and older of past and present use of the following:

- Cigarettes
- Alcohol, and illicit, prescribed, and over-the-counter drugs

Adolescent Depression Information

Documentation for any member 13-18 years screened for depression:

- If yes, was a suicide assessment conducted?
- Was the family involved with treatment?

ADHD Information

Documentation for members aged 6-12 assessed for ADHD:

- Was family involved with treatment?
- Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information

- Risk management issues (e.g. imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures
- All relevant medical conditions are clearly documented and updated as appropriate.
- Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status

A complete mental status evaluation is included in the treatment record, which documents the member's:

(a) Affect
(b) Speech
(c) Mood
(d) Thought control, including memory
(e) Judgment
(f) Insight
(g) Attention/concentration
(h) Impulse control
(i) Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
(j) Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

- Initial and updated treatment plans consistent with the member's diagnoses, goals and progress
- Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems
- Treatment interventions used and their consistency with stated treatment goals and objectives

- Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning
- Copy of Outpatient Review Form(s) submitted, if applicable

Treatment Documentation

The treatment record contains clear documentation of the following:

- Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives
- Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidal, suicidal ideations or the inability to function on a day-to-day basis
- Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record.
- Member's response to medications and somatic therapies

Coordination and Continuity of Care

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities. (See Behavioral Health – PCP Communication Protocol, and the Behavioral Health – PCP Communication Form)
- Dates of follow-up appointments, discharge plans and referrals to new providers

Additional Information for Outpatient Treatment Records

These elements are required for the outpatient medical record:

- Telephone intake/request for treatment
- Face sheet
- Termination and/or transfer summary, if applicable
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information:
- Clinician's name
- Professional degree
- Licensure
- Clinician signatures with dates

Additional Information for Inpatient and Diversionary Levels of Care

These elements are required for inpatient medical records:

- Referral information (ESP evaluation)
- Admission history and physical condition

- Admission evaluations
- Medication records
- Consultations
- Laboratory and X-ray reports
- Discharge summary and Discharge Review Form

Information for Children and Adolescents

A complete developmental history must include the following information:

- Physical, including immunizations
- Psychological
- Social
- Intellectual
- Academic
- Prenatal and perinatal events are noted.

Performance Standards and Measures

To ensure a consistent level of care within the provider network, and a consistent framework for evaluating the effectiveness of care, Molina has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of care they provide to members, which include, but are not limited to:

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent and emergent appointments

Practice Guidelines and Evidence-Based Practices

Molina supports the use of nationally-recognized and validated Clinical Practice Guidelines (CPGs) and other evidence-based practice (EBPs) to provide Molina with a mechanism to ensure the highest quality care for members through use of acceptable standards of care, and to reduce undesirable variance in diagnosis and treatment by ensuring compliance with established guidelines.

The selection of particular guidelines and standards of practice allows Molina to provide its network of practitioners and providers with:

- Widely accepted established methods of treatment with proven efficacy
- Scientifically based materials that reflect current national trends and updated research in treatment
- A mechanism to provide input into decisions regarding the content of clinical practice guidelines

An essential component of assessing the efficacy of the selected clinical practice guidelines is to monitor practitioner and provider adherence with these guidelines. Measuring the extent to which practitioners and providers are able to effectively implement evidence-based practices allows Molina to identify opportunities for improvement in the selection of such clinical resources and to identify venues to educate providers about implementing clinically-proven standards of care.

The process for such assessing adherence to guideline standards is as follows:

1. Annually, three CPGs are selected for monitoring of practitioner/provider adherence and compliance. One of the three CPGs selected must address children and adolescents.
    a. For each CPG selected, there are two or more important aspects of care selected for monitoring.
    b. The annual assessment or practitioner1provider adherence includes but is not limited to chart reviews and claims data. This assessment may be population or practice based.
    c. Results are measured annually through analysis of performance against the measures adopted. These results are used by Molina to identify opportunities for improvement.
    d. Interventions are implemented to improve practitioner/provider performance and to continually improve the quality of care provider to members.

The guidelines that Molina promulgates include:

- Depression: APA "Practice Guideline for the Treatment of Patients with Major Depressive Disorder" published in 2010
- ADHD: AACAP "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder" published in 2007, 2011
- Adolescent depression: AACAP "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorder" published in 2007
- Substance abuse: APA "Treatment of Patients with Substance Use Disorders" published in 2010
- Schizophrenia: APA "Practice Guidelines for the Treatment of Patients with Schizophrenia" published in 2004, 2009
- Molina also supports best practice in the identification, screening, treatment and referral of members who are experiencing First Episode Psychosis (FEP).

Note: The CPGs and EBPs supported by Molina may be subject to change based on ongoing review of the literature. Updates to resources and tools will be posted on Molina's website.

Molina expects providers to be aware of Clinical Practice guidelines when making treatment referrals for in-network services to ensure members are accessing appropriate levels of care to best meet their clinical needs.

Outcomes Measurement

Molina strongly encourages and supports providers in the use of outcome measurement tools for all members. Outcome data is used to identify potentially high -risk members who may need intensive behavioral health, medical, and/or social care management interventions. Molina provides aggregate data by provider, including demographic information and clinical and functional status without member-specific clinical information.

An essential aspect of Molina's contracts with its health plan partners and the State of New York OMH and OASAS is to report at least quarterly regarding provider performance deficiencies and corrective actions related to performance issues. In addition, Molina will report any Molina serious or significant health and safety concerns to OMH and OASAS immediately upon discovery. Please see the section regarding reporting of Adverse Incidents and other reportable events for more information.

Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Communication between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within three days post-discharge:

- Date of discharge
- Diagnosis
- Medications
- Discharge plan
- Aftercare services for each type, including;
- Name of provider
- Date of first appointment
- Recommended frequency of appointments
- Treatment plan

Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Molina's member record.

Transitioning Members from One Behavioral Health Provider to Another

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Members who refuse treatment to the extent permitted by law must be informed of the consequences of that action prior to termination.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Molina. In certain cases, an exception is made to the out -of-network benefit restriction. These situations include when the member is new to the plan and needs transitional visits for 60 days; when cultural or linguistic resources are not available within the network; or when Molina is unable to meet timeliness standards or geographic standards within the network.

Reportable Incidents and Events

Molina requires that all providers report adverse incidents, other reportable incidents and sentinel events involving the health plan members to Molina as follows:

Adverse Incidents

An adverse incident is an occurrence that represents actual or potential serious harm to the well -being of a health plan member who is currently receiving or has been recently discharged from behavioral health services.

Sentinel Events

A sentinel event is any adverse incident occurring within or outside of a facility that either results in death of a member or immediately jeopardizes the safety of a health plan member receiving services in any level of care.

1. Medicolegal deaths: Any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction (i.e., unexplained or violent death)
2. Any abduction or absence without authorization (AWA) involving a member who is under the age of 18 or who was admitted or committed pursuant to state laws and who is at high risk of harm to self or others
    a. Any serious injury resulting in hospitalization for medical treatment
3. A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted.
4. Any sexual assault or alleged sexual assault involving a member
5. Any medication error that requires medical attention beyond general first aid procedures
6. Any physical assault or alleged physical assault by a staff person against a member
7. Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for members

8. Suicide attempt at a behavioral health facility resulting in serious injury requiring medical admission

Other Reportable Incidents

An "other reportable incident" is any incident that occurs within a provider site at any level of care, which does not immediately place a health plan member at risk but warrants serious concern.

9. Non-medicolegal deaths
10. Suicide attempt at a behavioral health facility not requiring medical admission
11. Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above
12. Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event
13. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
    a. A serious injury is an injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.
14. Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response
15. Member fall unrelated to a physical altercation on a behavioral health unit
16. A medical event resulting in admission to a medical unit or facility
17. Any possession or use of contraband to include illegal or dangerous substances or tools (i.e., alcohol1drugs, weapons, or other non-permitted substances or tools)
18. Self-injurious behavior exhibited by a member while at a behavioral health facility
19. Illegal behavior exhibited by a member while at a behavioral health facility defined as illegal by state, federal or local law (i.e., selling illegal substances, prostitution, public nudity)

Reporting Method

- Molina's Clinical Department is available 24 hours a day.
- Providers must call, regardless of the hour, to report such incidents.
- Providers should direct all such reports to their Molina clinical manager or UR clinician by phone.
- In addition, providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Molina Healthcare at (866) 879-4742.
- Incident and event reports should not be emailed unless the provider is using a secure messaging system.

Provider Responsibilities

Members Discharged from Inpatient Psychiatric Facilities

Molina requires that all members receiving inpatient psychiatric services must be scheduled for out - patient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Molina providers will follow up with Medicaid members and attempt to reschedule missed appointments. Providers should be prepared to present:

- All relevant information related to the nature of the incident
- The parties involved (names and telephone numbers)
- The member's current condition

Attachment 1: Ambulatory Mental Health Services for Adults

Ambulatory mental health services for adults for which Mainstream Managed Care and Health and Recovery Plans may require prior and/or concurrent authorization of services.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family1collateral, and group psychotherapy	No	yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; b) off-site clinic services; or c) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations https://www.health.ny.gov
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	yes	
Outpatient mental health office and clinic services: off-site clinic services	yes	yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	yes	N/A	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
PROS Admission: Individualized Recovery Planning	yes	No	Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for Clinical Treatment, Intensive Rehabilitation (IR), or Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.
Mental Health Continuing Day Treatment (CDT)	yes	yes	
Mental Health Intensive Outpatient (note: Not State Plan)	yes	yes	
Mental Health Partial Hospitalization	yes	yes	
Assertive Community Treatment (ACT)	yes	yes	New ACT referrals must be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
OASAS-certified Part 822 clinic services, including off-site clinic services	No	yes	See OASAS guidance regarding use of LOCATDR tool to inform level of care determinations. OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 30-80 visits per year are within an average expected frequency for OASAS clinic visits. The contractor will allow enrollees to make unlimited self- referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
Medically supervised outpatient substance withdrawal	No	yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
OASAS Certified Part 822 Opioid Treatment Program (OTP) services	No	yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 180-200 visits per year are within an average expected frequency for opioid treatment clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs1HARPs must ensure that concurrent review activities do not violate parity law.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
OASAS Certified Part 822 Outpatient Rehabilitation	No	yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.

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