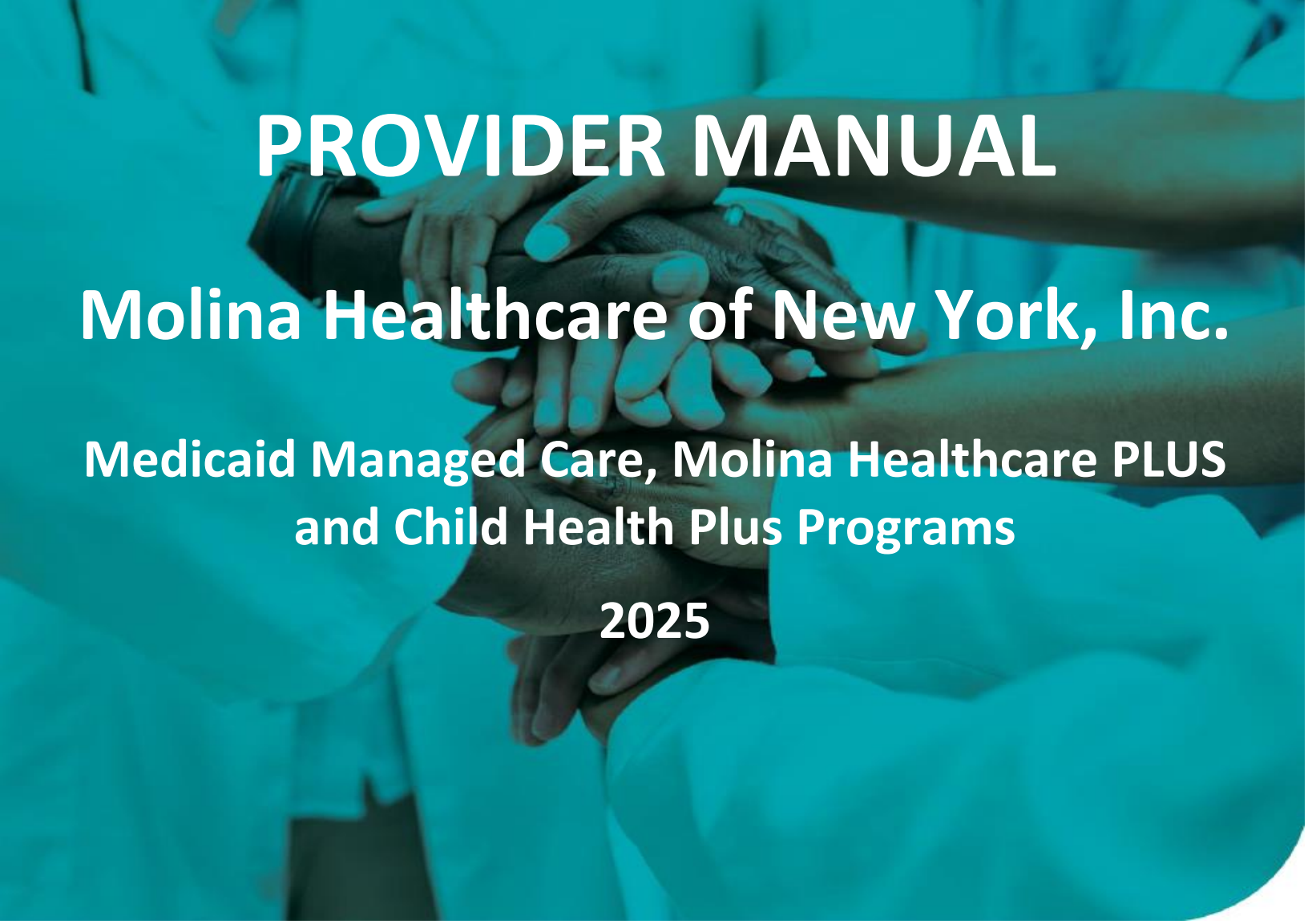


PROVIDER MANUAL

Molina Healthcare of New York, Inc.

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

2025

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in the Provider Agreement with Molina. “Molina Healthcare” or “Molina” have the same meaning as “Health Plan” in the Provider Agreement with Molina. The Provider Manual is customarily updated annually but may be updated as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: March 2025

MOLINA® HEALTHCARE

CONTENTS

INTRODUCTION

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

This manual will provide you with the necessary information 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 governing 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, 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

Molina Healthcare of New York State, Inc.
2900 Exterior Street Suite 202
Bronx, NY 10463

Provider Services

The Molina Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available 8:00 a.m.- 6:00 p.m., excluding state and federal holidays.

Molina strongly encourages Participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials (Availity) portal whenever possible.

EDI Payer ID Number: 16146

To verify the status of your Claims please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the Molina Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity Essentials Portal.

Phone:	(877) 872-4716
Availity portal:	provider.molinahealthcare.com
Hearing Impaired (TTY/TDD):	711

Provider Relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of Molina's Provider network.

Email:	NHNYProviderServices@MoilinaHealthcare.com

Member Services

The Molina Member Contact Center handles all telephone and written inquiries regarding, benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (PCPs) and Member complaints. Molina Member Contact Center representatives are available 8:00 a.m. – 6:00 p.m. Monday through Friday, excluding state and federal holidays.

Phone:	(800) 223-7242
Hearing Impaired (TTY/TDD):	711

Molina Community-Based Offices

Molina has various community offices throughout its service area. For more information about the plan, including how to enroll or renew your coverage, please visit one of our community service centers or call the number listed below.

- **Downstate (Affinity by Molina Healthcare):** We have multiple offices within our 10-county service area, including NYC, Long Island, and the Lower Hudson Valley. You can find a list of locations at Community Service Centers | Molina Healthcare or call (866) 243-3174.

- **Upstate (Molina NY):** Call (844) 239-4911 to find the nearest office location across our 19-county service area, Community Service Centers | Molina Healthcare, including Syracuse, Rochester, and Buffalo*.

*Buffalo's Community Service Center is slated to open in the Summer, 2025

Claims

Molina strongly encourages Participating Providers to submit Claims electronically via a clearinghouse or the Availity portal whenever possible.

- Availity portal
- EDI Payer ID **16146**

To verify the status of Claims, please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal or by contacting the Molina Provider Contact Center. For additional information please refer to the **Claims and Compensation** section of this Provider Manual.

Phone:	(877) 872-4716

Claims Recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of Claims.

Provider Disputes:	Molina Healthcare of New York PO BOX 2470 Spokane, WA 99210-2470
Refund Checks Lockbox:	Molina Healthcare of New York PO Box 744627 Atlanta, GA 30374-4627
Phone:	(866) 642-8999
Fax:	(844) 305-2186

Compliance and Fraud Alertline

Suspected cases of fraud, waste or abuse, must be reported to Molina. You may do so by contacting the Molina Alertline or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste and abuse, please refer to the **Compliance** section of this Manual.

Molina Healthcare Alert Line	
Address:	Attn: Compliance Officer 2900 Exterior Street, Suite 202 Bronx, NY 10463
Phone:	(866) 606-3889
Website:	MolinaHealthcare.Alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years, or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information please refer to the **Credentialing and**

Recredentialing section of this Provider Manual.

Email:	MHNYNetworkOperations@MolinaHealthCare.Com

24-Hour 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, 7 days a week.

Phone:	(844) 819-5977
TTY/TDD:	711

Health Care Services

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The 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. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Managing prior authorizations/service requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs 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 Availity portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance

Availity Essentials Portal:	Provider.MolinaHealthcare.com
Phone:	(877) 872-4716
Prior Authorization Fax:	(866) 879-4742
Advanced imaging Fax:	(877) 731-7218
Transplants Fax:	(877) 813-1206

Health Management

Molina provides health management programs designed to assist members and their families to better understand their chronic health condition(s) and adopt healthy lifestyle behaviors. The programs include:

- Molina My Health – Tobacco Cessation Program
- Molina My Health – Weight Management Program
- Molina My Health – Nutrition Consult Program

Phone:	(833) 269-7830
Fax:	(800) 642-3691

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For member behavioral health needs, please contact Molina directly at (877) 872-4716. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card. For additional information please refer to the **Behavioral Services** section of this Provider Manual.

Pharmacy

The prescription drug benefit is administered through Molina Healthcare. A list of in-network pharmacies is available on Molina's website at MolinaHealthcare.com or by contacting Molina. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Phone:	(877) 872-4716

Dental

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

DentaQuest®	
Claims/ Utilization Management/Appeals Address:	DentaQuest IPA of New York LLC PO Box 2906 Milwaukee, WI 53201-2906
Phone:	(888) 308-2508
Fax:	Claims/payment issues: (262) 241-7379 Claims to be processed: (262) 834-3589 All Other: (262) 834-3450
Email:	Claims Questions: denclaims@dentaquest.com Eligibility/Benefit Questions: denelig.benefits@dentaquest.com

Vision

Vision services are covered by Molina, via our Vision Vendor, Versant Health.

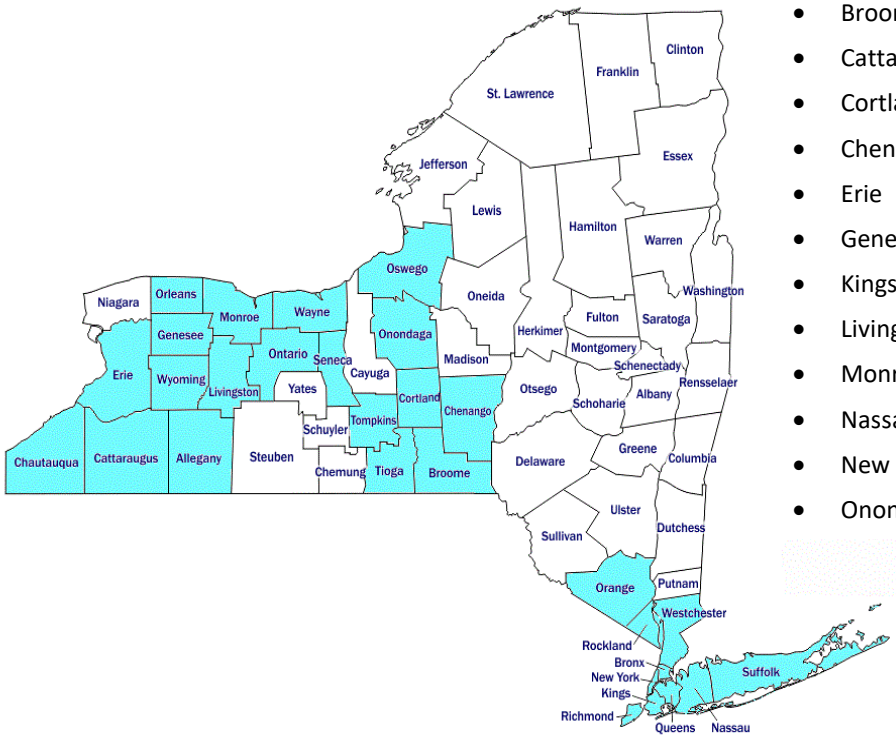
Versant Health	
Address:	Versant Health Complaints & Appeals Department PO Box 791 Latham, NY 12110 Paper Claims Attn: Claims Dept PO Box 967 Rancho Cordova, CA 95741
Phone:	(866) 819-4298

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement (QI) Program. For additional information please refer to the **Quality** section of this Provider Manual.

Email: MHNYQuality@MolinaHealthcare.com

Molina Healthcare of NY, Inc., service area



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

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 Care 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 at 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 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 a signed acknowledgment from the Member before rendering non-covered services, confirming the Member's awareness that the service is not covered under their Benefit Plan. If a service is not a covered benefit, Providers are expected to inform the enrollee before initiating the service and disclose the cost.
- 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)

PCPs are required to:

- Deliver primary care services
- Supervise and coordinate medically necessary health care of the enrollee, including 24/7 coverage
- Follow Molina's standards of care, which are reflective of professional and generally accepted standards of medical practice
- Follow Medicaid requirements for screening for children and adolescents and Medicaid behavioral health screening by PCP for all Members, as appropriate
- 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
- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

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 in Health Care 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.

Nondiscrimination in health care service delivery

Providers must comply with the non-discrimination in health care service delivery requirements as outlined in the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost-sharing from a government-funded 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.

Address:	Molina Healthcare, Inc. Civil Rights Coordinator 200 Oceangate, Suite 100 Long Beach, CA 90802
Phone:	(866) 606-3889
Hearing Impaired (TTY/TDD):	711
Website:	MolinaHealthcare.AlertLine.com
Email:	Civil.Rights@MolinaHealthcare.com

For additional information please refer to the Department of Health and Human Services(HHS) website at https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority

Facilities, Equipment, Personnel and Administrative Service

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 that Molina has accurate practice and business information. Accurate information allows Molina to better support and serve its Members and Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate claim processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider's Agreement with Molina, Providers must notify Molina of any changes as soon as possible, but at a minimum thirty 30 calendar days in advance of changes in any Provider information on file with Molina. Changes include but are not limited to:

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

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit Molina's Provider Online Directory at MolinaProviderDirectory.com/NY to validate the Provider's information. For corrections and updates, Providers can make updates through the CAQH portal, or Providers may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal or roster process should contact their Molina Provider relations representative for assistance.

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 and Recredentialing** 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 Molina's validation efforts, Molina may reach out to its Network of Providers through various methods such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the New York State Department of Health and meet the Medicaid Provider enrollment requirements set forth in the Provider Enrollment for fee-for-service Providers of the appropriate provider type.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, the Centers for Medicare & Medicaid Services (CMS) recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages its Provider network to verify Provider data via nppes.cms.hhs.gov/. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible.

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 Claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claim appeal and registration for and use of the Availity portal.

Electronics Claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity portal within 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 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 Molina's website at MolinaHealthcare.com.

Electronic Solutions/Tools Available To Providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claim submission options
- Electronic payment: EFT with ERA
- Availity portal

Molina Mobile App

Molina encourages Providers to engage and assist Members in using our health plan's customized Mobile App.

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 Claim Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic claim submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with Paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling Claims to reach Molina faster

Molina offers the following electronic Claim submission options:

- Submit Claims directly to Molina via the Availity portal
- Submit Claims to Molina through the Provider's EDI clearinghouse using Payer ID 16146. Please refer to Molina's website at MolinaHealthcare.com for additional information.

While both options are embraced by Molina submitting Claims via the Availity portal (available to all Providers at no cost) offer a number of additional Claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity portal Claims submission includes the ability to:

- Add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular Claim
- Ability to save incomplete/un-submitted Claims
- Create/manage Claims templates

For additional information on EDI Claim submission and Paper Claim submission please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic Payment Requirement

Participating Providers are required to enroll for EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (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 processes.

Molina Healthcare of New York has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/Automated Clearing House (ACH), a physical check or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina Healthcare of New York or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment (EOP) and contacting ECHO customer service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated all payments will go out in the method requested.

If you would like to opt out of receiving a virtual card prior to your first payment, you may contact ECHO

customer service at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of New York be opted out of virtual cards.

Once you have enrolled for electronic payments, you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO Provider portal providerpayments.com.

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO customer services team at (888) 834-3511.

As a reminder, Molina's Payer ID is 16146.

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two (2) year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: MolinaHealthcare.com.

Availity Portal

Providers and third-party billers can use the no-cost Availity portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
    - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
    - Correct/void Claims
    - Add attachments to previously submitted claims.
    - Check Claim status
    - View ERA and EOP
    - Create and manage Claim templates
    - Create and submit a Claim appeal with attached files
- Prior authorizations/service requests
    - Create and submit prior authorization/service requests
    - Check status of authorization/service requests
- Download forms and documents
- Send/receive secure messages to/from Molina

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Balance Billing

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 that are the

legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member rights and responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

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: 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, refer to the Member Rights and Responsibilities section of this Provider Manual, or 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.

Providers should contact Molina Provider Relations representatives for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina Healthcare of New York ID Card does not guarantee Member eligibility or coverage. Providers should verify the 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.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity portal
- Molina Provider Contact Center automated IVR system at (800) 223-7242

For additional information please refer to the **Enrollment, Eligibility and Disenrollment** section of this Provider Manual.

Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay co-pay, coinsurance, 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).

Health Care 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, 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 **Health Care 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 under Communications > Updates and Bulletins, titled 'Effective 11.19.24 Provider Office Laboratory Testing (POLT) - Additional Codes Added.'

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Provider's respective website at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your Provider 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

A referral may become necessary 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 unless the situation is one involving the delivery of emergency services. 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 referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

Providers should direct Molina 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 hospital emergency room. 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.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

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

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 Providers and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate 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.

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 Improvement Programs

Providers are expected to participate in Molina's Quality Improvement (QI) Programs and collaborate with Molina in conducting peer reviews 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.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that 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 protected health information.

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

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)

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.

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.

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 Use 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 Disorder Outpatient Clinic, including a PROS clinic visit** 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 Disorder 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 Disorder Treatment 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 Use 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 opted 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)
        iv. 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
        xvi. Medicaid State Plan services
    c) Screening, diagnosis and treatment services related to physical health, including but not limited to:
        i. Ongoing treatment of chronic conditions as specified in treatment plans
        ii. Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
        iii. Primary pediatric/adolescent care
        iv. Immunizations in accordance with NYS recommended childhood immunization schedule
        v. Reproductive health care
    d) Screening, diagnosis and treatment services related to developmental and behavioral health. This includes the following:

i. Psychiatric consultation, assessment and treatment
ii. Psychotropic medication treatment
iii. Developmental screening, testing and treatment
iv. Psychological screening, testing and treatment
v. Smoking/tobacco cessation treatment
vi. Alcohol and/or drug screening and intervention
vii. 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:

- Children/youth placed in foster care;
- Babies residing with their parent who are placed in a 29-I Health Facility and in foster care (8D Babies);
- Children/youth placed in a 29-I Health Facility by Committee on Special Education (CSE);
- 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 in follow 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.

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.

Confidentiality of Member Health Information 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 protected health information.

For additional information, please refer to the **Compliance** section of this Provider Manual.

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 submits an appeal, the Provider will participate by providing medical records or statement as needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the **Adverse Determinations, Appeals and Complaints (Grievances)** section of this Provider Manual.

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.

For additional information on Molina's credentialing program, please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight please refer to the **Delegation** section of this Provider Manual.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from care management

- Participate in the development of care management treatment plans

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 Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, national origin, sex, age and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) 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, genders, gender identities, sexual orientations, ages 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 Molina Healthcare of New York, Inc. Provider Website, from local Molina Provider Relations representatives and by calling the Molina Provider Contact Center at (877) 872-4716.

Non-Discrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, Providers and their staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), State law and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

- You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need for frequent or high-cost care.
- You **MUST** post in a conspicuous location in your office a Non-discrimination Notice. A sample of the Non-discrimination Notice that you will post can be found in the Molina website located at https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/members/ny/en-us/Affinity/AbM_MMC_Member-Handbook_EN_508.pdf (Page 2).
- You **MUST** post in a conspicuous location in your office a Tagline Document that explains how to access non-English language services. A sample of the Tagline Document can be found in the MMC Member Handbook located at https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/members/ny/en-us/Affinity/AbM_MMC_Member-Handbook_EN_508.pdf (Page 3).
- If a Molina Member is in need of language assistance services while at your office and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at and hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

- If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc.	**Office of Civil Rights**
200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (866) 606-3889 TTY/TDD: (711) civil.rights@MolinaHealthcare.com	U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information call the Office of Civil Rights at (800) 368-1019 or TTY/TDD: (800) 537-7697 for persons with hearing impairments.

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

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staff and quality monitoring are the cornerstones of successful, culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about Molina Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and community-based organizations. Molina conducts Provider training during Provider orientation, with annual reinforcement training offered through Provider Relations and/or online/web-based training modules. Web-based training modules can be found on Molina's website at https://www.molinahealthcare.com/providers/ny/medicaid/resource/care_diverse.aspx

Training modules, delivered through a variety of methods, include:

- Provider written communications and resource materials.
- On-site cultural competency training.
- Online cultural competency Provider training modules.
- Integration of cultural competency concepts and non-discrimination of service delivery into Provider communications.

Integrated Quality Improvement

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL) and written translation. Molina must also ensure access to programs, aids and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (ie., Braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on 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, is also available in threshold languages on the Molina Member website.

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.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Member Contact Center at (800) 223-7242. If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect the Provider 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 with 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, limited reading proficiency (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.

An individual with LEP has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964
- Be given access to Care Managers trained to work with individuals with cognitive impairments
- Be notified by the medical Provider that interpreter services are available at no cost
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf
    - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan

Interpreters include people who can speak the Member's native language, assist with a disability or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding onsite interpreter services.
    - Providers needing assistance finding translation services.
    - Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service at 711.
    - Providers with Members with limited vision may contact Molina for documents in large print, Braille or audio version.
- Providers with Members with LRP:
    - the Molina Member Contact Center representatives will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

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 Providers on the electronic Member lists that are sent to Providers 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 their right to have a qualified interpreter at no cost.

Members Who are Deaf or Hard of Hearing

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

Molina strongly recommends that Provider offices make assistive listening devices available 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 its Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the Molina Member Contact Center.

24-Hour Nurse Advice Line

Molina provides nurse advice services for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call the 24-hour Nurse Advice Line directly at 1-844-819-5977 (TTY:711). The 24-hour Nurse Advice Line telephone numbers are also printed on Molina

Member ID cards.

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.
    - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider network.
- Collection of data and reporting for the Diversity of Membership Healthcare Effectiveness Data Information Set (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 Consumer Assessment of Healthcare Provider and Systems (CAHPS®)/Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

SECTION 4. 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 Molina website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of Molina's website at https://www.molinahealthcare.com/members/ny/en-us/-/media/Molina/PublicWebsite/PDF/members/ny/en-us/Medicaid/MNY_MMCMemberHandbooks_110121_508_FINAL.pdf.

The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website at MolinaHealthcare.com/Providers/ny/medicaid/policies/Member_rights.aspx

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 the Molina Provider Contact Center at (800) 223-7242, Monday- Friday, 8:00 a.m. – 6:00 p.m. TTY/TDD: 711 for persons with hearing impairments.

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 the Member Contact Center to find out how to get a second opinion. Second opinions may require Prior Authorization.

SECTION 5. Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

The New York Medicaid programs are administered by the Department of Health. Eligibility is determined by the New York State 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

- For MMC Members, Molina, NYSoH and the LDSS are responsible for notifying the Member of the expected Effective Date of Enrollment.
- Notification may be accomplished through a "Welcome Letter." To the extent practicable, such notification must precede the Effective Date of Enrollment.
- 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.
- 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 a 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
- Availity Essentials portal
- Eligibility can also be verified through the ePACES system of New York

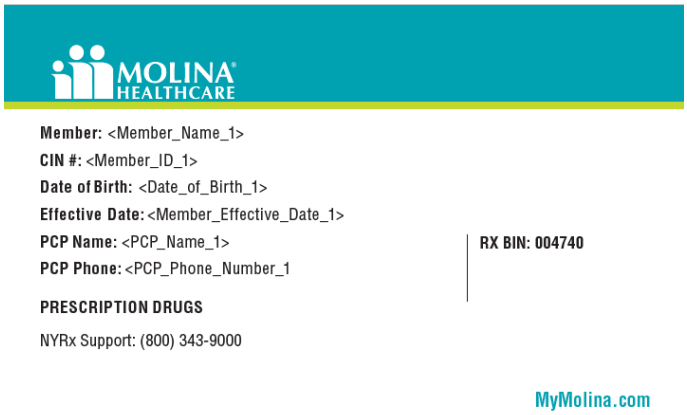
Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone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

Identification Cards

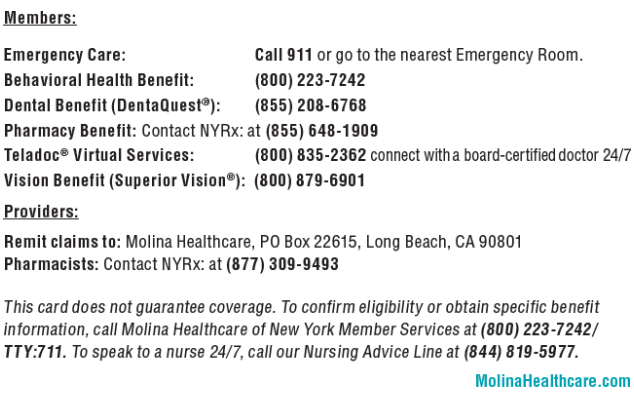
Molina Healthcare of New York, Inc. Sample Member ID Cards

Molina Healthcare of New York, Inc.

Upstate Card Front

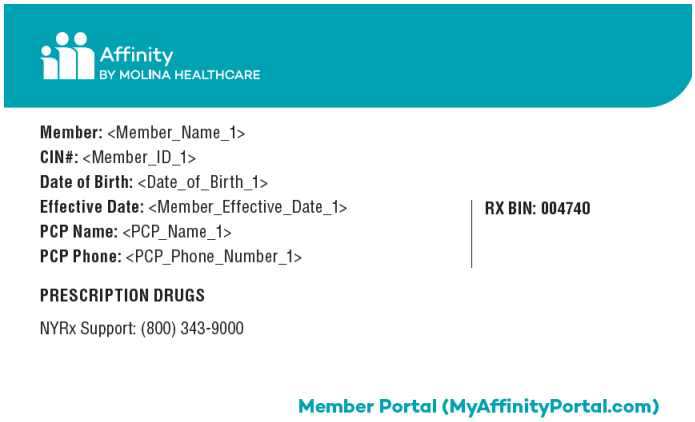


Upstate Card Back



Affinity by Molina Healthcare

Downstate Card Front



Downstate 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 or New York State of Health exchange.

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 restrictions where the enrollee's actions meet the criteria for such restrictions 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.

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

Molina assigns all Members a PCP upon enrollment.

PCP Changes

A Member can change their PCP at any time by calling the Molina Member Services department at (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, Inc. and Affinity by Molina Healthcare Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization (PA), please reference the prior authorization tools located on the Molina website and the Availity portal. Providers may also contact Molina Healthcare at (877) 872-4716 (Monday through Friday, 8:00 a.m. to 6:00 p.m.).

Member Cost Sharing

Cost share is the deductible, co-payment or co-insurance that Members must pay for Covered Services provided under their Molina plan. The Cost Share amount Members will be required to pay for each type of Covered Service is summarized on the Molina Member's ID card.

It is the Provider's responsibility to collect the co-payment and other Member cost share from the Member to receive full reimbursement for a service. The amount of the co-payment and other cost share will be deducted from the Molina payment for all Claims involving cost share. If a service is not a covered benefit, Providers must inform the enrollee before initiating the service and disclose the cost.

Service Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires PA please reference the PA tools on the Molina website and the Availity Portal. Providers may also contact Molina at (877) 872-4716 (Monday through Friday, 8:00 a.m. to 6:00 p.m.).

Link(s) to Benefit Information

For the most up-to-date coverage information, please visit the What's Covered page at MolinaHealthcare.com and view the Benefits at a Glance. Benefits at a Glance is an easy-to-use list of services covered under the Molina Medicaid Health Plan.

Providers should utilize the Prior Authorization Code LookUp Tool on the Provider Website for specified services that require PA.

Obtaining Access to Certain Covered Services

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:

- Unlimited Mental Health and Substance Use disorder services with a Participating Provider 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 Mental Health and Substance Use assessments.

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.

For CHP/EP:

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

For MMC/HARP FFS:

Topic	Description	Contact Information	Website Links
Claims Processing for Outpatient Pharmacy Benefits	Questions regarding billing and pharmacy claims processing, lost or stolen medications and remittances.	eMedNY Support: (800) 343-9000, Option 1	• General Information found on the eMedNY homepage • eMedNY Pharmacy Manual • New York State (NYS) Department of Health (DOH) Office of Health Insurance Programs (OHIP) NCPDP D.0 Standard Companion Guide - Transaction Information
NYRx, the New York Medicaid Pharmacy Program Prior Authorization (PA) criteria	Questions regarding PA or inquiries about quantity/age/day's supply and other edits or medication questions	• Magellan Health, Inc. Clinical Call Center: (877) 309-9493 • NYRx Medicaid Prior Authorization Request Form for Prescriptions	• Magellan Health, Inc. NYRx, the Medicaid Pharmacy Program • Magellan Health, Inc. NYRx, the Medicaid Pharmacy Program Preferred Drug List (PDL) Listserv email notification sign-up
Preferred Diabetic Program	Questions regarding billing.	eMedNY Support: (800) 343-9000, Option 2	N/A
	PA requests	Magellan Health, Inc. Clinical Call Center: (877) 309-9493	N/A
	Preferred Diabetic Supply List (PDSL), etc.	N/A	NYRx, the Medicaid Pharmacy Program, Preferred Diabetic Supply Program

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (DME) Procedures and Supplies	Questions regarding DME PA criteria; frequency/quantity/durations limits, etc. and billing information	• OHIP DME: (800) 342-3005 • ohipmedpa@health.ny.gov	eMedNY DME Manual

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 MolinaHealthcare.com.

Non-Preferred Drug Exception Request Process

The Provider may request a PA for clinically appropriate drugs that are not preferred under the Member's Medicaid Plan. Using the FDA label, community standards and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring PA.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision per any requirements set forth by New York State Department of Health.
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a PA is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty Drug Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider.
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.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require PA. In some cases, they will be made available through a vendor, designated by Molina. For additional information about Molina's PA process, including a link to the PA request form, please refer to the Healthcare Services section of this Provider Manual.
Physician administered drug claims require the appropriate NDC number with the exception of vaccinations or other drugs as specified by CMS.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

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	
Phone:	(888) 308-2508
Fax:	Claims Issues: (262) 241-7379 Claims to be Processed: (262) 834-3589 All other: (262) 834-3450
Email: Claims questions:	Claims Questions: denclaims@dentaquest.com Eligibility or Benefit Questions: denelig.benefits@dentaquest.com

Access to Behavioral Health Services Mental Health and Substance Use

Behavioral Health services are a direct access benefit and are available with no referral required. Health care professionals may assist Members in finding a Behavioral Health Provider or Members may contact Molinas's Member Contact Center at (877) 872-4716 or Members can self-refer. Molina's Nurse Advice Line is also available 24 hours a day, seven days a week, 365 days per year week at (844) 819-5977 for mental health or substance use needs. The services Members receive will be confidential.

Additional detail regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Molina. If in-patient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation and inpatient Member cost share will apply.

Emergency Mental Health and Substance Use Disorder Services

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.

Members are directed to call 988, 911 or go to the nearest emergency room (ER) if they need emergency mental health or substance abuse. 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
- Acute withdrawal
- 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

In general, 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:	(877) 872-4716
Member Services:	(800) 223-7242 (TTY: 711)
Prior Authorizations:	(877) 223-7242
Clinical Appeals Coordinator:	(800) 223-7242
Crisis Option through Carenet:	(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
Website:	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 MHNY 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 the 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 988, 911 or go to the nearest emergency room if they need Emergency mental health or substance use disorder services. Examples of Emergency mental health or substance use disorder 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
- Acute withdrawal
- 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 the Molina Member ID card
- Call Member's PCP and follow-up within 24 to 48 hours

For out-of-area Emergency services, out-of-network Providers are directed to call the Molina contact number on the back of the Member's ID card for additional benefit information and may be asked to transfer members to an in-network facility when the 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~~in 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. Additional information regarding the availability of this benefit is available by contacting the Molina Provider Contact Center at 877-872-4716.

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

Preventive Care Guidelines (PCG) are located on the Molina website at:
MolinaHealthcare.com/Providers/ny/medicaid/resource/guide_prevent.aspx

Provider's can help by conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well childcare, please call our Health Education line at (866) 891-2320.

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

Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the AAP and/or the CDC are available on the following website at cdc.gov/vaccines/hcp/imz-schedules.

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 and the 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 childcare, please call our Health Education line at (877) 872-4716.

Medical Complications	
Severe Anemias associated with chronic disease	~~Thrombocytopenias~~Thrombocytopenia
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

Stage of pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month
9 months	1 visit a week

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:

- 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
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- 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 in CHP and EP, 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 a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization is also available.

24-hour 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 days a week, 365 days a year.

Nurse Advice Line (24 Hours)	
Phone:	1-844-819-5977 (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 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 overutilization of the health care system.

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

Health Management Programs

Molina offers programs to help our Members and their families manage various health conditions.

For additional information, please refer to the **Health Care Services** section of this Provider Manual.

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services by Participating Providers, through the use of telehealth and Telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are a method of accessing Covered Services and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Member cost sharing may apply based the applicable benefits guide found in the Member Handbook.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery.

For additional information on Telehealth and Telemedicine claims and billing, please refer to the **Claims and Compensation** section of this Provider Manual.

SECTION 7. Health Care Services

Introduction

Health care services (HCS) is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated 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. Molina provides CM services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina UM program include pre-service authorization review, inpatient authorization management that includes admission and concurrent medical necessity review and restrictions on the use of out-of-network or non-participating Providers. You can contact Health Care Services toll free at (877) 872-4716. The UM department fax number is (866) 879-4742. The CM department fax number is (844) 879-4482 and CM department email inbox is MHNYCaseManagement@MolinaHealthcare.com.

Utilization Management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing and monitoring the quality and cost effectiveness of health care resource utilization
- Implementing comprehensive processes to monitor and control the utilization of health care resources
- Ensuring services are available in a timely manner, in appropriate settings, are planned, individualized and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring qualified health care professionals perform all components of the UM processes
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision

Key Functions of the UM program

All prior authorizations (PA) are based on a specific standardized list of services. The key functions of the UM program are listed below:

Eligibility and Oversight

- Eligibility verification
- Benefit administration and interpretation
- Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan
- Verifying of current Physician/hospital contract status

Resource Management

- PA and referral management
- Admission and Inpatient Review
- Referrals for Discharge Planning and Care Transitions

- Staff education on consistent application of UM functions

Quality Management

- Evaluate satisfaction of the UM program using Member and Provider input
- Utilization data analysis
- Monitor for possible over- or under-utilization of clinical resources
- Quality oversight
- Monitor for adherence to Center for Medicare & Medicaid (CMS), National Committee for Quality Assurance (NCQA), State and health plan UM standards

For more information about Molina's UM program or to obtain a copy of the HCS Program description, clinical criteria used for decision making and how to contact a UM reviewer, access the Molina website or contact 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.

UM Decisions

An organizational determination is any decision 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 delay, modify, or deny authorization or payment of request (adverse determination)

Molina follows a hierarchy of medical necessity decision making with federal and state regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

Board-certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny authorization of services to a Member.

Providers can contact Molina's Healthcare Services department at (877) 872-4716 to obtain Molina's UM Criteria.

Where applicable, Molina Clinical Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

"**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.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

- In accordance with generally accepted standards of medical practice.
- 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.
- 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, by itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support Member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking PA approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging PA requests.

Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is your primary submission route, for advanced imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and How Does it Work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs and PET scans. For a full list of imaging codes that require PA, refer to the PA code LookUp Tool at MolinaHealthcare.com.

For Behavioral Health, Molina has partnered with LOCUS/CALOCUS for Mental Health and LOCATDTR III for Substance Use Disorder Services. MCG is used for services not contained within these two criteria sets.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, CMS guidelines, state guidelines, Molina clinical policies, guidelines from recognized professional societies and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider and benefit coverage. The clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Molina (medical director, pharmacy director, or appropriately licensed health care professional).

Molina's Provider training includes information on the UM processes and authorization requirements.

Clinical Information

Molina requires copies of clinical information be submitted for documentation. 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 care manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

Molina requires PA for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with Molina. The list of services that require PA is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. Molina PA documents are customarily updated quarterly but may be updated more frequently as appropriate and are posted on the Molina website at 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 PA request must include the following information:

- Member demographic information (name, date of birth, Molina ID number)
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number)
- Requested service/procedure, including all appropriate CPT and HCPS codes
- Location where service will be performed
- Member diagnosis and ICD-10 codes
- Clinical information sufficient to document the medical necessity of the requested service is required

including:

- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested length of stay (for inpatient requests)
- Rationale for expedited 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 PA requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA.

Molina follows all PA requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMPHA).

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state or in the opinion of the Providers with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Molina will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the Provider indicates or if Molina determines that a standard authorization decision timeframe could jeopardize a Member's life or health.

Providers who request PA for services and/or procedures may request to review the criteria used to make the final decision. A Molina Medical Director is available to discuss medical necessity decisions with the requesting Provider at (877) 872-4716 during business hours.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone, or fax, or via Availity portal. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider via fax.

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 a 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 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 applicable to Child Health Plus). A notice of the extension to Member is required.

Concurrent: Molina must make a 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 seventy-two (72) hours 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 the expedited request. Expedited Concurrent reviews must be completed within one (1) business day after all information received; no more than 72 hours. 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.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days from the notification.

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional) Contracted external parties, administrators or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and Molina Member ID number
- Authorization ID number
- Requesting Provider Name and contact number and best times to call

If a Medical Director is not immediately available, the call will be returned within one business day. Every effort will be made to return calls as expeditiously as possible.

Requesting Prior Authorization

Notwithstanding any provision in the Provider's Agreement with Molina that requires the Provider to obtain a PA directly from Molina, Molina may choose to contract with external vendors to help manage PA requests.

For additional information regarding PA of specialized clinical services, please refer to the PA tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Availity portal: Participating Providers are encouraged to use the Availity portal for PA submissions whenever possible. Instructions for how to submit a PA request are available on the Availity portal. The benefits of submitting PA request through the Availity portal are:

- Create and submit PA requests
- Check status of PA Requests
- Receive notification of change in status of PA 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.

- Advanced Imaging Fax: (877) 731-7218
- Transplants Fax: (877) 813-1206

If the request is not on the form provided by Molina, be sure to send it 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 following:

- Member demographic information (name, date of birth, Molina ID number, etc.) needed for Molina to make a determination along with the request to facilitate your request being processed as expeditiously as possible.
- 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.

Phone: PA request can be initiated by contacting Molina HCS 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.

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 perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies, 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

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (877) 872-4716, Monday through Friday (except for state and federal holidays) from 8:00 a.m. to 6:00 p.m. All staff members identify themselves by providing their first name, job title and organization.

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

After business hours, Providers can utilize fax and the Availity portal for UM access. Providers can utilize fax and CM department email (MHNYCaseManagement@MolinaHealthcare.com) to submit Care Management referrals.

Molina's Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (844) 819-5977. Molina's 24-hour Nurse Advice Line may handle after-hours UM calls.

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:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

Emergency services are covered on a 24-hour basis without the need for PA for all Members experiencing an Emergency Medical Condition.

Post-Stabilization Care Services are covered services that are:

1. Related to an Emergency Medical Condition

2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the Member's condition

Providers requesting an in-patient admission as a Post Stabilization service must request this type of service by contacting Molina at (877) 872-4716.

Inpatient admission requests (not including Post Stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames

Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility may not be covered and the Member may be responsible for payment.

Molina Care Managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using Emergency Services.

Care 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.

Inpatient Management

Planned Admissions

Molina requires PA for all elective inpatient procedures to any facility. Facilities are required to notify Molina within 24 hours or by the following business day once an admission has occurred for concurrent review. Elective inpatient admission services performed without PA may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC) and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at Time of Termination of Coverage

When a Member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge unless Law or program requirements mandate otherwise.

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 investigative 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
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 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, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that 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. Upon discharge the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions and disposition.

Inpatient Status Determinations

Molina's UM staff follow federal and state guidelines along with evidence-based criteria to determine if the collected 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 (refer to the Medical Necessity Review subsection of this Provider Manual).

Discharge Planning

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.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for Molina Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

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 when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 14 days of discharge and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
    - Premature or inadequate discharge from the same hospital
    - Issues with transition or coordination of care from the initial admission
    - For an acute medical complication plausibly related to care that occurred during the initial admission
- Readmissions that are excluded from consideration as preventable readmissions include:
    - Planned readmissions associated with major or metastatic malignancies, multiple trauma and burns
    - Neonatal and obstetrical readmissions
    - Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed
    - Behavioral health readmissions
    - Transplant related readmissions

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 the patient was a Molina Member or there was a Molina error. In those cases, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Exceptions

- 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.

- The readmission is part of a Medically Necessary, prior authorized or staged treatment plan.
- 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.
- Certain diagnoses are excluded from a readmission review including cancer, maintenance chemotherapy, behavioral health, transplants, pregnancy and delivery, elective admissions and planned procedures.
- 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

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified practitioners and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Service

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to 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 PA 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.

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 HCS staff work with Providers to assist with coordination referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

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 provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practices or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) 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.
    - 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 the 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 in 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

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

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.

Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

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

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;

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.

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.

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

An organizational determination is any decision 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 delay, modify, or deny authorization or payment of request (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

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

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny authorization of services to a Member.

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.

Providers can contact Molina's Healthcare Series department at (877) 872-4716 to obtain Molina's UM Criteria.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving 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 themselves, or unable to protect themselves 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 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 caregivers
- 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 HCS Committee and the proper State agency.

Care Management

Molina Care Management includes Health Management (HM) and Care 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 care manager provides the PCP with the Member's Individualized Care Plan (ICP), interdisciplinary care team (ICT) updates and information regarding the Member's progress through the ICP when requested by the PCP. The care 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 care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial 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 care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Member's needs warrant care management
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member needs warrant

- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICP and revises the plan as suggested and needed
- Coordinates appropriate education and encourages the Member's role in self-management
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to 60 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Molina offers programs to help its Members and their families manage various health conditions. The programs include telephonic outreach from Molina clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings by calling (866) 891-2320. Members can request to be enrolled or disenrolled in these programs at any time. Molina My Health programs include:

- Molina My Health - Weight Management
- Molina My Health - Tobacco Cessation
- Molina My Health - Nutrition

For more information about these programs, please call (833) 269-7830, or TTY/TDD at 711 Relay. Fax: (800) 642-3691.

Maternity Screening and High Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant Member outreach, screening, education and care management are initiated by Provider notification to Molina, Member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high risk pregnant Members via faxed Pregnancy Notification Report Forms.

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. The form should be emailed to MHNYCaseManagement@Molinahealthcare.com.

Member Newsletters

Member newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access Molina's easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression and other relevant health topics identified during Molina's engagement with Members. Materials are available through the My Molina Member portal, direct mail as requested, email and the My Molina mobile app.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims 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.
- External referrals from Provider(s), caregivers or community-based organizations.
- Internal referrals from the 24-hour Nurse Advice Line, Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

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
- Preventive Health Guidelines
- Care Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from the local Molina HCS department.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP by contacting Molina's Member Contact Center.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM department. Referrals to specialty care outside the network require PA from Molina.

Care Management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services and resources needed by members throughout the continuum of care. Molina adheres to Care Management society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers are licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM 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 ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will complete an assessment with the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services and preventive services. The Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP, specialty care Provider, themselves, caregiver, discharge planner or Molina Healthcare Services to the ICM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary Providers, the local Health Department or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.).
- High-technology home care requiring more than two (2) weeks of treatment.
- Preterm infants.
- Member accessing emergency department services inappropriately.
- Children with Special Health Care Needs.

Referrals to the ICM program may be made by contacting Molina at:	
Phone:	(877) 872-4716
Fax:	(844) 879-4482
Email:	MHNYCaseManagement@MolinaHealthcare.com

Criteria for Referral

Members with the following conditions should be referred to our Care 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 Care 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

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 against 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:(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 recommendations 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 care 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 State 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 State 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 care 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 (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 care 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 Care 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 Care 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.

SECTION 8. Behavioral Health

Overview

Molina provides a behavioral health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health and other specialty Providers to ensure whole-person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Some behavioral health services may require prior authorization.

Behavioral health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at (877) 872-4716. Providers requesting after-hours authorization for these services should utilize the Availity Essentials portal or fax submission options.

Emergency psychiatric services do not require prior authorization. All requests for behavioral health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted medical necessity criteria for prior authorization reviews.

For additional information please refer to the prior authorization subsection found in the **Health Care Services** section of this Provider Manual.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP, medical specialist; or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice. A formal referral form or Prior authorization is not needed for a Member to self-refer or be referred to a PCP, specialist, or behavioral health Provider. However, individual services provided by non-network behavioral health Providers will require prior authorization.

Behavioral health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Providers to manage their health care needs. Behavioral health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of the discharge date.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral health, primary care and other specialty Providers shall

collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery and create opportunity for optimal health outcomes. Molina's care management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Molina's care management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a behavioral health professional or PCP to the ICM program.

Referrals to the CM program may be made by contacting Molina at:	
Phone:	(877) 872-4716
Email:	MHNYCaseManagement@MolinaHealthcare.com
Fax:	(844) 879-4482

For additional information on the ICM program please refer the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in an effort to provide quality care coordination to Members. Behavioral health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to Molina Members. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure Members can obtain needed health services within acceptable appointment timeframes. Please see the **Quality** section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (800) 223-7242, 24 hours a day, 7 days a week, 365 days per year, or calling the Member service telephone number listed on the back of their Molina ID card.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support or anyone with concerns about someone else, can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Toolkit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment and diagnosis of common behavioral health conditions, plus access to behavioral health Healthcare Effectiveness Data and Information Set (HEDIS®) tip sheets and other evidence-based guidance, training opportunities for Providers and recommendations for coordinating care. The material within this toolkit is applicable to Providers in both medical care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab on the MolinaHealthcare.com Provider website.

Behavioral Health Care Management

Molina Healthcare of New York's Behavioral Health Care 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 care management is provided by licensed behavioral health clinicians.

Referrals for care management are taken from inpatient facilities, outpatient Providers, health plan representatives, PCPs, state agencies, Members and their families.

Molina Care Management staff are trained to assess and monitor Member's needs for care 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 Care Management staff are trained to assess and monitor the Member's needs for care 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 a 60-day period
- First inpatient hospitalization following serious suicide attempt or treatment for first psychotic episode
- Member has a 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 care management team determines the benefit of inclusion beyond standard criteria

SECTION 9. Quality

Maintaining Quality Improvement Processes and Programs

Molina Healthcare of New York, Inc. works with Members and Providers to maintain a comprehensive Quality Improvement (QI) Program. You can contact the Molina Quality Department at (877) 872-4716 for additional information.

The address for mail requests is:
Molina Healthcare of New York, Inc.
Quality Department
2900 Exterior Street, Suite 202
Bronx, NY 10463

This Provider Manual contains excerpts from the Molina QI program. For a complete copy of Molina's QI program, you may contact Molina's Provider Relations representative or call the telephone number above to receive a written copy.

Molina has established a QI program that complies with regulatory requirements and accreditation guidelines. The QI program provides structure and outlines specific activities designed to improve the care, service and health of Molina Members. Molina's QI program description describes the program governance, scope, goals, measurable objectives, structure and responsibilities.

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. Molina medical groups/IPAs must:

- Have a quality improvement program in place
- Comply with and participate in Molina's QI program, including reporting of access and availability survey and activity results and provision of medical records as part of the Healthcare Effectiveness Data and Information Set (HEDIS®) review process; and during potential quality of care and/or critical incident investigations
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service and access and availability
- 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 PCPs. Molina continues to support safe health practices for Molina Members through its safety program, pharmaceutical management and care management/health 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) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has established a 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

Molina is not required to pay for inpatient care related to "never events."

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 medical record. PCPs should maintain the following medical record components, that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records
- Medical record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- 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 medical records:

- Each patient has a separate medical record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available during each visit and archived records are available within 24 hours
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language and sexual orientation and gender identity
- 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
- 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 year s 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

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 include the following information, but not limited to the following information.

All medical records should contain:

- The patient's name or ID number on each page in the record
- The patient's 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
- A list of Providers who participate in the Member's care
- Information about services that are 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
- Medication reconciliation within thirty (30) days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known)
- Documentation that shows 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 Provider
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls or visits that include 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 and follow-up care, inpatient and outpatient care, including the hospital discharge summaries, hospital history and physicals and operative report
- Labor and delivery record for any child seen since birth
- 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

- A release document for each Member authorizing Molina to release medial information for the 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 the Provider at each encounter
- The medical record is available to Molina for purposes of quality improvement
- The medical record is available to state and/or federal agency, including NYSDOH, CMS, LDSS, 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 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

Providers shall develop and implement confidentiality procedures to guard Member protected health information, including information specific to Mental 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 law 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
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA please see the **Compliance** section of this Provider Manual.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive 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 the Member Contact Center or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ 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 regulations 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 of an individual Member's advance directive 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. Advance directive forms are state specific to meet state regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating Specialist. Provider surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists) and behavioral health Providers. 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 PCP or their designee must be available 24 hours a day, 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

Appointment Type	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

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within 6 hours
Urgent Care	Within 24 hours
Initial Routine Care Visit	Within 14 calendar days
Follow-up Routine Care Visit	Within 7 calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

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 24-hour telephone service, 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. Voicemail alone after hours is not acceptable.

Appointment Scheduling

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

- 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;
- 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;
- 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;
- 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;
- A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
- 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 obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric 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 from your local Molina Quality department.

Monitoring Access for Compliance with Standards

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

Provider network adherence to access standards is monitored via one(1) or more of the following mechanisms:

- Provider access studies – Provider office assessment of appointment availability, and after-hours access, Provider ratios and geographic access.

- Member complaint data – assessment of Member complaints related to access and availability of care.
- 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 and Health Equity Transformation 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 and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

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

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record-keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. 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 as applicable, to ensure that Members have safe and appropriate access to the office site. This access includes but is not limited to ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

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

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 and Confidentiality of Facilities

Facilities contracted with Molina must demonstrate 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 the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway and the restroom is 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 (2) office exam rooms per Provider.
- 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 (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, blood-borne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts and evidence of hazardous waste management system in place.
- 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 Clinical Laboratory Improvement Amendment (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.

Early and Periodic Screening, Diagnostic and Treatment Services to Enrollees Under 21 Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or the Provider Relations departments are 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, that include but not limited to:

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool
- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one eye exam per year) is assessed by Members through the Superior Vision network
- Hearing screening for preventive services
- Dental assessment and services
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention
- Periodic objective screening for social-emotional development using a recognized, standardized tool
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit
- 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. Performance below Molina's standards may result in a corrective action plan (CAP) with a request that the Provider submits a written CAP to Molina within 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 QI Program. The QI Program provides structure and key processes to carry out our ongoing commitment to the improvement of care and service. Molina focuses on reducing health care disparities through the QI program. The goals identified are based on an evaluation of programs and services, regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management and Care Management

The Molina health management and care management program provides for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please refer to the Health Management and Care Management headings in the **Health Care Services** section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates clinical practice guidelines (CPG) 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.

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression

- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care New York State Department of Health, AIDS Institute New York State Prenatal Care Standards

All CPGs are updated at least annually, and more frequently, as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, CPGs are distributed to Providers at Molinahealthcare.com and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.

All preventive health guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, preventive health guidelines are distributed to Providers at 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 Appropriate 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 refer to 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®)
- Behavioral Health Satisfaction Assessment
- Provider satisfaction survey
- 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 Agreement with Molina. 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. 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 30 to 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 department staff toll-free at (877) 872-4716 or by visiting our website: 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 on-site 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-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against 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 Providers, 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 (for Medicare). The CAHPS® survey is administered annually in the spring 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.

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey 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 the Provider's 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. The 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 are properly coding all services provided.
- 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 the Availity portal. There is a variety of resources including HEDIS® CPT/CMS – approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

Provider Performance

Molina collects and maintains Provider performance data from results of the annual New York State Department of Quality Assurance Reporting Requirements (QARR®)/ 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 gaps 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 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 Quality Improvement committees and Medicaid Behavioral Health Quality Management Subcommittee that 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. The Committee Members provides oversight, guidance and ongoing performance monitoring of all aspects of the Molina Healthcare of New York, Inc.'s Quality Improvement Program.

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 Improvement Subcommittee (BHQI) the Behavioral Heath Utilization Management Subcommittee (BHUM), Children's Advisory Committee and the HARP Advisory Committee that provide oversight, guidance and ongoing performance monitoring related to the benefits and services outlined within the BH and Children's BH 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 related to individuals with behavioral health conditions and substance use disorders who access behavioral health benefits and/or HCBS. The committee is co-chaired by the BH Medical Director and the AVP of Quality Improvement, who also maintains records documenting attendance, as well as committee findings, recommendations and actions.

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 BHUM 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/Subcommittees, please contact Molina Quality Improvement department at MHNYQuality@MolinaHealthcare.com.

SECTION 10. 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, detection and correction 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 prevent, detect and correct 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

Our mission is to pay claims correctly the first time and that mission begins with the understanding that we need to proactively detect fraud, waste and abuse, correct it and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate and report suspected health care fraud, waste and abuse in order to reduce health care costs 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.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation or 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 whistleblower
- Administrative remedies for false Claims and statements

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 (2) 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 payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

Anti-kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti- Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Molina's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving favors, preferential hiring, or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and

marketing statutes and regulations – both State and Federal.

Under **Molina's policies**, marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and forms of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare of Medicaid from entities with which the physician or an immediate family Member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

The **Sarbanes-Oxley Act** 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: means 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 State and Federal Health Care Programs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the State and Federal Health Care programs 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 costs to the State and Federal Health Care 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 Member ID 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 service 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 State and Federal Health Care programs
- 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

Self-Disclosure Program

Medicaid entities/Providers are required to report, return, and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self- Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) § 363-d(6).

Identification

Pursuant to SOS § 363-d (6)(b), an overpayment has been identified when a Medicaid entity/Provider has, or should have, through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was

received, and they have quantified the amount of the overpayment.

Medicaid entities/Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received. Additionally, if a Medicaid entity/Provider is the subject of a government audit, part of that Medicaid entity's/Provider's due diligence is to review the results of the audit and look at past and future periods - not covered in the audit scope - to identify any overpayments resulting from similar issues. If overpayments exist, Medicaid entities/Providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program.

Please Note: Voiding or adjusting claims does not satisfy the Medicaid entity's/Provider's obligation to report and explain the identified overpayment.

Timeframes
While both Federal and State regulations require a Medicaid entity/Provider to report, return, and explain an overpayment within sixty (60) days from identification, the actual timeframes for processing can vary. A Medicaid entity's/Provider's 60-day time frame will be tolled, or paused, when a completed Self-Disclosure Full Statement is received from an eligible Medicaid entity/Provider. The time frame to repay will remain tolled during OMIG's review.

More Information
Visit the New York State Office of the Medicaid Inspector General's Website
Self-Disclosure | Office of the Medicaid Inspector General (ny.gov)

Other Disclosures
Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

Submission Process
Follow the steps outlined below or visit our website where you will also find our process and required form for submission. Self- Disclosure Program (molinahealthcare.com)

Step 1
Timely report any Medicaid overpayments to the New York State Office of the Medicaid Inspector General (OMIG) via two pathways, full process, or abbreviated process, both of which are located at the link below.
Self-Disclosure Submission Information and Instructions | Office of the Medicaid Inspector General (ny.gov)

Timely report damaged, lost and/ or destroyed records to the New York State Office of the Medicaid Inspector General (OMIG) via the submission of a complete Statement of Damaged, Lost or Destroyed Records and Certification, both of which are located at the link below.
Self-Disclosure Submission Information and Instructions | Office of the Medicaid Inspector General (ny.gov)

Step 2
Damaged/Lost/Destroyed Records

- Notify Molina Healthcare's Compliance Department via email MNY.Compliance@molinahealthcare.com
    - Subject Line: *Damaged/ Lost/ Destroyed Records <Insert Entity Name>*

    - Body of the Email: include all details provided to the New York State Office of the Medicaid Inspector General
- A member of the Compliance Department will respond directly to you for next steps
- If this is not applicable to your situation, skip to Step 3

Step 3
Self-Disclosures

- Complete Molina's "Provider Early Reversal Permission Form"
    - In the Comments please indicate "Self-Disclosure as reported to the New York State Office of the Medicaid Inspector General"
- Fax and/ or mail the completed form and refund to Molina Healthcare's lockbox for processing (fax/ mail information is located within the form)
- Notify Molina Healthcare's Compliance Department of the Medicaid overpayment
    - Subject Line: *Self-Disclosure <Insert Entity Name>*
    - Body of the Email: confirm you have completed the steps outlined above
- A member of the Compliance Department will respond directly to you

Review of Provider Claims and Claim System

Molina Claims Examiners are trained to recognize unusual billing practices, which is key in key in trying to identify fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance AlertLine/reporting repository.

The claim 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 of Fraud, Waste and Abuse Detection Activities

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

Molina has a pre-payment Claim auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid guidelines, federal CMS guidelines, AMA and published specialty specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD) and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-Payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with Molina 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 with Molina or at Law or equity.

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

The 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 the 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 charge-back.

The 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 164.501). 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.

Claim Auditing

Molina shall use established industry Claim 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.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's SIU and audits of Claims and payments by providing access at reasonable times to requested Claim information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, Molina reserves the right and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. Molina asks that you provide Molina, or Molina's

designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's SIU suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

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.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

Suspected cases of fraud, waste, or abuse, must be reported to Molina by contacting the Molina AlertLine. The Molina AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. The Molina AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina AlertLine, a trained professional at NAVEX Global will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

The Molina AlertLine can be reached at (**866) 606-3889** or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

Fraud, waste or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.

Molina Healthcare of New York
Attn: Compliance
2900 Exterior Street, Suite 202
Bronx, NY 10463

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

Phone: (877) 87FRAUD ((877) 873-7283)

Certification Statement for Provider Billing Medicaid (ETIN)

It is a requirement of The New York State Office of the Medical Inspector General (OMIG) that participating MCO providers supply a copy of their Certification Statement for Provider Billing Medicaid (ETIN) form to each MCO for

which they are a participating provider upon signing the provider agreement with the MCO, and annually thereafter.

Submission Process:

Step 1
Obtain a copy of your completed "Certification Statement for Provider Billing Medicaid" form.

- Ensure all twelve (12) spaces of required information are filled in
- If a clean copy is needed, click this link and download the PDF

Step 2
Obtain a copy of Molina's Attestation

- Click this link and download the PDF
- Ensure all seven (7) spaces of required information are filled in

Step 3
Attach the following documents to an email and send them to MNY.Compliance@molinahealthcare.com

- Certification Statement for Provider Billing Medicaid form
- Molina's Attestation

HIPAA Requirements and Information

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 Providers 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 the privacy of health information, including, without limitation, the following:

- **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

- **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.

Artificial Intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.
Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

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 entity1. 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:

- 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]."
- 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
    - Care 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.

1See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
2See 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.

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-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

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 strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to 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 MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

- Click on the area titled "I'm a Health Care Professional"
- Click the tab titled "HIPAA"
- 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.

National Provider Identifier (NPI)

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
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s) and in connection with such delegated functions.

1. Definitions:
    a. "Molina Information" means any information:
        - Provided by Molina to Provider;
        - Accessed by Provider or available to Provider on Molina's Information Systems; or
        - Any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information. "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.
    b. "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

c. “HITECH” means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

d. “Industry Standards” mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:
    - HIPAA and HITECH
    - HITRUST Common Security Framework
    - Center for Internet Security
    - National Institute for Standards and Technology (“NIST”) Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
    - Federal Information Security Management Act (“FISMA”)
    - ISO/ IEC 27001
    - Federal Risk and Authorization Management Program (“FedRamp”)
    - NIST Special Publication 800-34 Revision 1 – “Contingency Planning Guide for Federal Information Systems.”
    - International Organization for Standardization (ISO) 22301 – “Societal security – Business continuity management systems – Requirements.”

e. “Information Systems” means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form. “Multi-Factor Authentication” means authentication through verification of at least two of the following types of authentication factors:
    - Knowledge factors, such as a password;
    - Possession factors, such as a token or text message on a mobile phone;
    - Inherence factors, such as a biometric characteristic; or
    - Any other industry standard and commercially accepted authentication factors.

f. “Nonpublic Information” includes:
    - Molina’s proprietary and/or confidential information;
    - Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, “nonpublic personal information”, “personal data”, “personally identifiable information”, “personal information” or any other similar term as defined pursuant to any applicable law; and
    - Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain, appropriate administrative, technical and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical and physical safeguards pursuant to HIPAA, HITECH and other applicable U.S. federal, state and local laws.

a. Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request and which shall include at least the following:
    - Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider
    - Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider
    - Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene
    - Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is and remains, secure from vulnerabilities in accordance with the applicable Industry Standards
b. Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:
    - Network Security Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.
    - Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a “zero-trust architecture” satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).
    - Data Storage. Provider agrees that any and all Molina Information will be stored, processed and maintained solely on designated target servers or cloud resources. No Molina Information 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 is encrypted in accordance with the requirements set forth herein.
    - Data Encryption. Provider agrees to store all Molina Information 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 Information, 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 the Federal Information Processing Standard Publication 140-2 (“FIPS PUB 140-2”).
    - 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 FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.
    - Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina

Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.
    a. Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.
    b. BC/DR Plan
        - Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:
            - Notification, escalation and declaration procedures
            - Roles, responsibilities and contact lists
            - All Information Systems that support services provided to Molina
            - Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina
            - Recovery procedures in connection with a Cybersecurity Event, including ransomware
            - Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors and other dependencies
            - Detailed procedures to restore services from a Cybersecurity Event including ransomware
            - Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents
        - To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
        - Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.
    c. Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:
        - Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.
        - Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.
    d. BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once

each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events
    a. Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to and resolve Cybersecurity Events.
    b. In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.
        - In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.
        - Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.
    c. Notification to Molina's Chief Information Security Officer shall be provided to:

        Molina Chief Information Security Officer

        Telephone: (844) 821-1942

        Email: CyberIncidentReporting@MolinaHealthcare.com

        Molina Chief Information Security Officer
        200 Oceangate Blvd., Suite 100
        Long Beach, CA 90802
    d. In the event of a Cybersecurity Event, Provider will, at Molina's request:
        - Fully cooperate with any investigation concerning the Cybersecurity Event by Molina,
        - Fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and
        - Be liable for any expenses associated with the Cybersecurity Event, including without limitation:
            - The cost of any required legal compliance (e.g., notices required by applicable law) and
            - The cost of providing two years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.
    e. Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:

- Make a determination as to whether a Cybersecurity Event occurred;
- Assess the nature and scope of the Cybersecurity Event;
- Identify Molina's Information that may have been involved in the Cybersecurity Event; and
- Perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

f. Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:
   - The date of the Cybersecurity Event;
   - A description of how the information was exposed, lost, stolen, or breached;
   - How the Cybersecurity Event was discovered;
   - Whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   - The identity of the source of the Cybersecurity Event;
   - Whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   - Description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
   - The period during which the Information System was compromised by the Cybersecurity Event;
   - The number of total consumers in each State affected by the Cybersecurity Event;
   - The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
   - A description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
   - A copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
   - The name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

g. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider:

   a. Warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire;

b. Agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and

c. Agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider, but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

SECTION 11. Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Molina relies on its Provider Network to care for our Members based on their health care needs. Risk adjustment considers numerous clinical data elements of a Member's health profile to determine documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions.
- Identify Members for Care Management referral
- Ensure adequate resources for the acuity levels of Molina Members
- Have the resources to deliver the highest quality of care to Molina Members

Interoperability

The 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 the Provider's electronic medical records (EMR), including, but not limited to, Epic Payer Platform, 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).

The CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The 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.

The 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 the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having the Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).

If the Provider's EMR does not support the Direct Protocol, the Provider will work with <Molina>'s established interoperability partner to get an account established.

Your Role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

Contact information

For questions about Molina's risk adjustment programs, please contact your Molina Provider Services representative.

SECTION 12. Claims and Compensation

Payer ID	16146
Availity Essentials Portal	Provider.MolinaHealthcare.com
Clean Claim Timely Filling	90 calendar days after the discharge for inpatient services or the Date of Service for outpatient services

Electronic Claim Submission

Molina strongly encourages Participating Providers to submit Claims electronically, including secondary Claims. Electronic Claim 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 Claim submission options:

- Submit Claims directly to Molina Healthcare of New York via the Availity portal
- Submit Claims to Molina via your regular EDI clearinghouse

Availity Portal

The Availity portal is a no-cost online platform that offers a number of Claim processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
- Correct/void Claims
- Add attachments to previously submitted Claims
- Check claim status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim templates
- Create and submit a Claim appeal with attached files

Clearinghouse

Molina uses The SSI Group as its getaway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

For Providers that do not have a clearinghouse, Molina offers additional electronic claim submission options as shown by logging on to the Availity portal.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important that Providers track their electronic transmissions using their acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When claims are filed via a clearinghouse:

- You should receive a 999 acknowledgment from your clearinghouse
- You should also receive 277CA response file with initial status of the Claim from your clearinghouse
- You should refer to the Molina Companion Guide for information on the response format and messages
- You should contact your local clearinghouse representative if you experience any problems with your

transmission

EDI Claim 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 should contact their Molina's Provider relations representative for additional support.

Timely Claim Filing

Providers 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 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 the 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, the 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 the Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines as well as any criteria explicitly required in the Molina Provider billing manual and any criteria explicitly required in the Claim Form Instructions. Providers must utilize electronic billing through a clearinghouse or the Availity portal whenever possible and use current HIPAA-compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims and 837D for dental Claims). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Member ID card.

Providers must 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.

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 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at Molina Healthcare of New York under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the state health plan-specific companion guides, which are also available on our Molina's website (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claim data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- 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
- Place and type of service code
- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Unit of Measure and Days or Units for medical injectables
- E-signature
- Service facility location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Providers should validate this data in advance of Claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete or untimely submissions and re-submissions may result in denial of the Claim.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission is required to follow electronic Claim standardized ASC X12N 837 formats. Electronic claims are validated for compliance SNIP levels 1 to 5. The 837 Claim format allows Providers to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Fata Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submissions

Participating Providers should submit Claims electronically. 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

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or, the Availity Essentials Portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 Claim forms or the Uniform Billing (UB) Editor for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within sixty (60) calendar days of most recent adjudicated date of the Claim.

Corrected claim submission options:

- Submit Corrected Claims directly to Molina via the Availity portal
- Submit corrected Claims to Molina via the Provider's regular EDI clearinghouse

Claims submitted without the correct coding will be returned to the Provider for resubmission.

Coordination of Benefits (COB) and Third Party Liability (TPL)

Subrogation — Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor at Optum: submitreferrals@optum.com

COB — Coordination of Benefits (COB) exists when an individual has more than one (1) policy at the same time, and the order of benefits is established pursuant to national and/or state guidelines. Primary payers should be billed prior to Claim submission to secondary/tertiary payers to cover any remaining liability.

Workers' Compensation — Workers' compensation is the primary payer when a Member's damages are related to an incident that occurred while working. Claims related to a workers' compensation incident should be submitted to the carrier prior to submitting to Molina for payment.

Medicare — Medicare is the primary payer for covered services and Providers accepting Medicare assignments except in the following instances:

- Members Entitled to Medicare due to Age: Commercial health plans are primary to Medicare if the employer has 20 or more employees and the Member is actively working.
- Disabled employees (large group health plan): Commercial health plans are primary to Medicare if the employer has 100 or more employees and the Member is actively working.

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Provider must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the State regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third-party policy information required for billing.

Hospital-Acquired Conditions and Present on Admission Program

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 prevented by the use of evidence-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA):

The following is a list of CMS hospital-acquired conditions. 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) Diabetic Ketoacidosis
    b) Non-Ketotic Hyperosmolar Coma
    c) Hypoglycemic 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, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
10) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    a) Laparoscopic Gastric Bypass
    b) Gastroenterostomy
    c) Laparoscopic Gastric Restrictive Surgery
11) Surgical Site Infection Following Certain Orthopedic Procedures.
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
12) Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement
14) Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers:

- Acute Inpatient Prospective Payment System (IPPS) hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at http://www.cms.hhs.gov/ HospitalAcqCond/.

Molina Coding Policies and Payment policies

Frequently requested information on Molina's coding policies and payment policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to Molina's Provider Relations representatives.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.
- For procedures:
    - Professional and outpatient Claims, require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 HCPCS codes
    - Inpatient hospital claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes

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 claim adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & 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 (NCD).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
    - CMS Physician Fee Schedule RVU indicators.
- 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.
- If the billed charges for covered medical services provided are less than the contractual allowed amount, the payment will be reduced to only pay up to the billed charges. This does not apply to covered behavioral health services. For specific details regarding billing and coding of behavioral health services such as HARP, please visit https://www.omh.ny.gov.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with the correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the resources located at:

State	Link 1	Link 2	Link 3
NY	DOH Bulletin 2023 Number 3: February 2023 Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency Special Edition published: 3/14/2023 Updated 5/8/2023	Office of Mental Health (OMH) Telehealth Guidelines To be used with the above link: Effective Date Memo on OMH Telehealth Guidance Telehealth Services Guidance for Providers Telehealth Modifier Use for OMH-licensed/Designated Programs	https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/index.htm
Additional resources: Center for Connected Health Policy: https://www.cchpca.org/all-telehealth-policies/ This website tracks and compiles telehealth-related laws and regulations across all 50 States and the District of Columbia, as well as at the Federal level.			

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.

NCCI procedure to procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on the NCCI coding manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process Claims. Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA, CPT, HCPCS code books and NYS billing guidelines.

ICD-10-CM/PCS Codes

Molina utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny Claims that do not meet Molina's ICD-10 Claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

POS codes are two (2)-digit codes placed on health care professional Claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of Bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Molina processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The NDC number must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

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 (3) 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 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

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.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at

reasonable times to requested Claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina reserves the right, and where unprohibited by regulation, to select a statistically valid random sample or a smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion, or error rate, may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claim review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. Molina asks that Providers provide Molina or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina. 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 as follows: 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 MolinaHealthcare.com or by contacting the Provider Contact Center. Upon signing up, please allow for one check run before EFT/ERA takes effect.

Overpayments and Incorrect Payments Refund Requests – NY MEDICAID (MANAGED CARE)

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within sixty 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

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 copy of the overpayment request letter and details are available in the Availity portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment or check status. This is Molina's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within 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 Payment Inquiry/Reconsiderations

A Claim Payment Inquiry/Reconsideration is a review of a claim you believe was paid or denied incorrectly due to a minor error. These inquiries are typically straightforward and can be quickly resolved. Examples of reconsideration requests:

- ✓ Retro-eligibility issues
- ✓ Coordination of benefit updates
- ✓ Claims denied as a duplicate in error
- ✓ Claims denied for no authorization when authorization is not required or when an approved authorization is on file

Clam Payment Inquiry/Reconsiderations can be sent through an integrated messaging feature from the claim status screen in the Availity Essentials provider portal.

You can submit secure messages from the claim status screen directly to Molina using Availity's messaging application. Go to Claims and Payments, then Claims Status.

Please note: Supporting documentation **cannot** be submitted with a claim payment inquiry. The outcome of a payment inquiry may result in either a claims adjustment or a directive to submit a **Corrected Claim** or initiate the **Claim Payment Dispute/Appeal** process.

Additionally, **Corrected claims are considered new claims** and are to be directed through the original claim submission process, clearly identified as a corrected claim. Corrected claims are not considered an appeal or dispute and will be rejected if submitted as such.

Please refer to the **Corrected Claim Process** section of this manual.

Claim Payment Dispute/Appeals

A Claim Payment Dispute/Appeal is the adjustment request of the processing, payment or nonpayment of a claim

by Molina. Examples of appeal requests:

- ✓ A reduction, suspension or termination of a previously authorized service.
- ✓ A denial, in whole or in part, of payment for a service.
- ✓ Failure to provide services in a timely manner.
- ✓ Failure to make a coverage decision in a timely manner.
- ✓ Denials for code edits
- ✓ Untimely filing
- ✓ Non-covered benefits
- ✓ Absent or denied authorizations

Clam Payment Disputes/Appeals can be submitted through one of the following options:

- Availity Portal
  - Providers are **strongly encouraged** to use the online Availity Essentials portal to submit Provider Claims Disputes.
- Fax
  - Provider Claims Disputes/Appeals can be faxed to Molina at **(315) 234-9812** with a completed Medicaid Provider Claim Appeal/Dispute Form.
- Mail
  - Molina Healthcare of New York, Inc.
    Attention: Appeals and Grievances Department
    2900 Exterior Street, Suite 202
    Bronx, NY 10463

The Provider **must** include a completed Medicaid Provider Claim Appeal/Dispute Form or the dispute will be returned. The Medicaid Provider Claim Appeal/Dispute Form can be found on the Provider website and the Availity Essentials portal. The form must be filled out completely to be processed. All requests submitted without appropriate documentation will be denied for lack of information.

The Provider will be notified of Molina's decision in writing within 90 calendar days of receipt of the Claims Payment Dispute/Appeal.

Timely Filing

Providers disputing a Claim previously adjudicated must request such action within 90 days of Molina's original remittance advice date regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.) unless otherwise noted in your Contract. All requests received after this time frame will be denied for untimely filing. An upheld resolution letter will be sent to the Provider.

If additional documentation is required, providers will be responsible for providing the appropriate requested documentation within 90 calendar days from the original dispute process. The Provider shall not charge the Enrollee or Molina for requested records submitted for the dispute.

To dispute timely filing, Providers must submit documentation to support they filed timely. Acceptable documentation of timely filing is submission of a record from a clearinghouse and/or a copy of a fax document providing the date of the fax submission. 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 adjustment
- The Claim number clearly marked on all supporting documents
- Copy of Authorization form (if applicable) must accompany the reconsideration request

Submission Process:	
Availity Essentials portal:	Provider.MolinaHealthcare.com
Fax:	(315) 234-9812
Claim Disputes containing medical records may be sent to:	Molina Healthcare of New York, Inc. Attention: Appeals and Grievances Department 2900 Exterior Street, Suite 202, Bronx, NY 10463

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.

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.

Balance Billing

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 that are the legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud, Waste and Abuse

Failure to report instances of suspected fraud, waste and abuse is a violation of the law and subject to the penalties provided by law. For additional information please refer to the Compliance section of this Provider Manual.

Encounter data

Each Provider, capitated Provider, or organization delegated for Claims or processing is required to submit

Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, 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 has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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 Providers should receive two (2) types of responses:

- First, Molina will provide a 999 acknowledgment of the transmission.
- Second, Molina will provide 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 13. 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
- 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
- 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
2900 Exterior Street, Suite 202
Bronx, NY 10463

or Members may call (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 the 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 the 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, date of service 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 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 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 acknowledgment of any complaint within fifteen (15) business days of the receipt of the complaint. The written acknowledgment 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 acknowledgment is sent, Molina may include the acknowledgment 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 (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 acknowledgment 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 (800) 233-7242 or submit their appeal or grievance in writing to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
2900 Exterior Street, Suite 202
Bronx, NY 10463

Members may also contact their Local Department of Social Services. They can do this by calling the New York State Department of Health toll-free at (800) 206-8125 or visiting 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

Reporting

Grievance & Appeals trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

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 14. 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. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting Molina Provider Relations representatives.

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.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet the cultural needs of Members.

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.

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
- Doctoral or master's-level psychologists Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- 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
- Speech and Language Pathologists
- Telemedicine Practitioners

HIV/AIDS Specialist

On an annual basis, Molina will ensure all HIV Specialist PCPs meet the following qualifications for HIV Specialist PCP as defined in State of New York Medicaid Managed Care Model Contract:

"HIV Specialist PCP" (for HIV SNPs only) means an HIV experienced Primary Care Provider who has met the criteria of one of the following recognized bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced Provider
- HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM)
- Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB)

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 Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. 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, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners 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 Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application -** Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other State-mandated practitioner applications. The attestation must be signed within 120 days. The applications must include all required attachments.
- **License, Certification or Registration -** Practitioners must hold a current valid license, and certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located and the State the Member is located.
- **Drug Enforcement Administration (DEA) Certificate -** Practitioners must hold a current, valid, unrestricted (DEA) certificate. Practitioners must have a DEA in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to his/her DEA or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) Certificate** – Practitioners working from CT or MA practice locations must meet CDS requirements in those states.
- **Specialty -** Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when

providing services to Molina Members.

- **Education –** Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training -** Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program.
    - As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three-(3) year residency or is not board-certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training -** Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **Board Certification -** Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board-certified will be considered for participation if they have satisfactorily completed residency training from an accredited program in the specialty in which they are practicing. Molina recognizes certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina.
- **Work History –** Practitioners 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. If a gap in employment exceeds six month, the Practitioner must clarify the gap verbally or in writing. The

organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.

- **Malpractice History –** Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[1]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration 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.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance –** Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

[1] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions including convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

At the time of initial credentialing, Practitioner must not have any pending criminal charges in the categories listed above.

- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **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 & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the practitioner immediately if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification actions, or sanctions of exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.

- The Practitioner's response must be sent to:

  Molina Healthcare, Inc.
  Attention: Credentialing Director
  PO Box 2470
  Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner'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 Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioners' information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and a Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner 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 practitioner are documents which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of Credentialing Decisions

Within sixty (60) days of receiving a completed initial application to participate in the network, Molina will send a letter notifying the Practitioner of the following:

- Whether they are credentialed, or;

- Additional time is needed to complete credentialing due to necessary documentation needed from a third party. Upon receipt of the requested information, Molina will make its final determination regarding credentialing of the Practitioner within twenty-one 21 days of receipt of such required information.

Recredentialing

Molina recredentials every Practitioner at least every thirty-six 36 months.

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 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 and Exclusions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner'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.
- **The OIG High Risk List –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** - Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** - Monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **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 Practitioner types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Providers Responsibility of Ongoing Monitoring of Sanctions

Molina requires Providers to have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, the National Plan and Provider Enumeration System (NPPES), the SAM, the List of Excluded Individuals and Entities (LEIE) and any such other databases as the Secretary may prescribe; and check the LEIE, the SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and the NYS OMIG Exclusion List no less frequently than monthly. Molina reserves the right to confirm such procedures are in place.

Provider Appeal Rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

Provider Administrative Appeal Rights

In cases where the Professional Review Committee denies a Practitioner's initial credentialing request, a letter is sent to the Practitioner informing them of the denial, the reason for it and informing the Practitioner of their right to an administrative appeal. The administrative appeal will be considered by a committee of Health Plan staff that includes the Chief Medical Officer and Vice President of Network and a decision to reconsider the credentialing application will be made. Practitioners are entitled to only one (1) administrative appeal.

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 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.

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
  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.

SECTION 15. 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
    - 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 16. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Utilization Management
- Credentialing and Recredentialing
- Claims
- Complex Care Management
- CMS Preclusion List Monitoring
- Other Clinical and Administrative Functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline indicated by Molina. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

Providers with questions related to delegated functions should contact their 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 busine ss 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.

SECTION 17. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

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.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

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

Drug Formulary

Molina keeps a list of drugs, devices and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. A complete list of covered medications is available on Molina's website at MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this document and also available on Molina's website at MolinaHealthcare.com.

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document.

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits and can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may be processed under the pharmacy benefit without PA if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form which is available on Molina's website at molinahealthcare.com. Clinical evidence must be provided and considered when evaluating the request to determine medical necessity. The use of manufacturer samples of non-formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred. If the use of a particular brand name non-preferred drug becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used for cosmetic purposes may not be part of the benefit. For a complete list of drug excluded from the plan benefit please refer to the formulary document on Molina's website at MolinaHealthcare.com.

Submitting a Prior Authorization Request

Molina will only process completed PA request forms, the following information MUST be included for the request form to be considered complete:

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Diagnosis
- Clinical information sufficient to document the medical necessity of the requested pharmaceutical including pertinent medical history (including treatment, diagnostic tests, examination data)
- Drug name, strength and directions of use

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call the provider's office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication Prior Authorization Request form to Molina at (844) 823-5479. A blank Medication Prior Authorization Request Form is available on Molina's website at MolinaHealthcare.com or by calling (877) 872-4716.

Providers and office staff can review Molina's Clinical Criteria and Clinical Policies online to ensure all required information is submitted for review.

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA-required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via electronic medical Claim submission.

During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements and the Member's specific benefit plan coverage prior to determination of benefit processing.

Molina may conduct a peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.

If it is determined to be a Pharmacy benefit, 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 Molina's Provider Services representative with any further questions about the program.

Newly FDA approved medications 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 P&T committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers and for which the Provider submits a medical claim including the drug NCD to Molina for reimbursement.

Molina clinical services completes utilization management for certain Healthcare Administered Drugs. Any drugs on the PA list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require PA for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the PA list.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority. 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 Molina's Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab. Please consult with Molina's Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Molina Healthcare of New York, Inc.

Behavioral Health Policy and Procedure Manual

Molina Healthcare PLUS (Health and Recovery Plan)

SECTION 18. BEHAVIORAL HEALTH HCBS HOME AND COMMUNITY BASED SERVICES

HCBS Overview

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.

BH HCBS Benefits and Approved Services

These include the following services for Adult HARP Members:

- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Habilitation

Adult BH HCBS can help Members achieve life goals and be more involved in their community.

These services can help with:

- Independence

Daily Living and Social Skills

- Gain or Regain life skills like making social connections or budgeting
- Learn how to advocate for oneself and negotiate relationships
- If needed, get treatment and rehabilitation services in one's own home

Education and Employment

- Individual Employment Support
    - Choice of employment goal and benefits counseling
    - Support in finding and keeping a job
    - Support to help stay on the job and start career planning
- Education support to start, return to, or graduate from school to learn skills to get or keep a job

Eligibility

BH HCBS are available for people 21 and over who are enrolled in a Medicaid Managed Care (MMC) Health and Recovery Plan (HARP) and found eligible after completing the NYS Eligibility Assessment. People enrolled in a Special Needs Plan (SNP) may also be eligible for BH HCBS.

NYS Eligibility Assessment

- NYS Eligibility Assessments are completed with Health Home Care Managers or State Designated Entities
- HARP Members and their care managers use the NYS Eligibility Assessment to develop a Person-Centered Plan of Care
- After the assessment, care managers work together with HARP Members to identify and select Home and Community Based Services to include in the Plan of Care.

For additional information please access NYS HCBS Provider Manual:
https://omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf

Adults Services Include:

- Adults Day Care Services
- AIDS Day Care Services
- Consumer Directed Personal Services
- Agency based Personal Care Services

There are also HCBS Services especially for Children. As part of the Children's Medicaid System Redesign, the 1915(c) Children's Waiver and 1115 Demonstration Waiver work together to offer an array of services to provide the right support, in the right amount, at the right time to maintain children/youth in their homes or in their communities in the least restrictive settings. The goals of the Children's Waiver are to keep children/youth on their developmental trajectory, identify needs early and intervene, focus on recovery and building resilience, prevent escalation and need for higher-end services, maintain accountability for improved outcomes and delivery of quality care and make more services available to children/youth from birth to age 21.

Children's HCBS Services include:

- Respite (Crisis and Planned)
- Community Habilitation
- Day Habilitation
- Caregiver Family Supports and Services
- Prevocational Services
- Supported Employment
- Community Advocacy and Support
- Palliative Care
- Expressive Therapy
- Palliative Care
- Massage Therapy
- Palliative Care
- Bereavement
- Palliative Care
- Pain and Symptom Management

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)
- 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 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 began to cover additional Children and Family Treatment and Support Services (CFTSS). These services help children and their families improve their health, well-being and quality of life.

FTSS 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 include:

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 Care 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), Care 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 receiving Adult Day Services, Consumer Directed Personal Assistant Services or Personal Care Services via an agency will be assigned a Care manager no later than 30 days after enrollment. The Care 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. At a minimum, the Care 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 Care 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 Care Manager from the Molina Plan.

Person Centered Services Plan (PCSP) Team will include at minimum the Member and/or their authorized representative, Medical Care 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:

- 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
- 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.
- 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 and will require coordination and approval. 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 Care 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 Care Managers are trained on the transitions of care approach that Molina follows for transitions between care settings. The care 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 care 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 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 one-time 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
    - 0 0001 – Totals Charges
    - 0 0100 - All-inclusive Room and Board-Custodial Care & Respite
    - 0 0101 - All-inclusive Room and Board-Vent
    - 0 0120 - All-inclusive Room and Board-AIDS
    - 0 0199 - All-inclusive Room and Board-Head Injury
    - 0 0183 - Therapeutic leave
    - 0 0185 - Hospital leave
    - 0 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 19. 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. CORE Services and Health Home Care Coordination are also benefits available to HARP Membership.

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 disenroll from their current plan to join a HARP plan, but plans 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 care 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.

Specific triggers that may result in a referral for Molina care management include needs for assistance with assessment, identification of Providers, timely access to services and supporting 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 care management/ supportive care 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

- 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.

Additional CORE Services (Formerly in the HCBS Array)

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric support and Treatment (CPST)
- Family Support and Training
- Empowerment Peer Support Services

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:

- Delivery primary care services
- Supervise and coordinate medically necessary health care of the enrollee, including 24/7 coverage
- Follow Molina's standards of care, which are reflective of professional and generally accepted standards of medical practice

- Follow Medicaid requirements for screening for children and adolescents and Medicaid behavioral health screening by PCP for all Members, as appropriate
- 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 hour
- 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 20. 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 Providers 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: 1) The Member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool. 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. 3) Upon receipt of notification from the HCBS Provider(s), up to 3 visits over 14 days is authorized for intake and evaluation. 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. 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. 6) The Member must be willing to receive home and community-based services. 7) There is no alternative level of care or co-occurring service that would better address the Member's clinical needs.	**All of the following criteria 1 – 5 must be met:** 1) Member continues to meet admission criteria and an alternative service would not better serve the Member. 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. 3) One of the following is present: • 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; Or • Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration 4) There is care coordination with physical and behavioral health Providers, State and other community agencies. 5) Family/guardian/caregiver is participating in treatment where appropriate. 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	**Any one of the following: Criteria 1, 2, 3, 4, or 5; criteria #6 is recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member does not appear to be participating. 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) Member's goals have been met. 6) Member's support system is in agreement with the aftercare service plan

Health Home care managers facilitate administration of the assessment to determine eligibility for HCBS services.

- The HH care manager will conduct a brief screening for HCBS eligibility with the Member.
- 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.
- 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.
- The Health Home care manager will share results of the HCBS assessment and Plan of Care with the Plan for review and feedback.
- 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.
- 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.
- 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 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.

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) model, 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 support that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of support and who, because of their disabilities, need support 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 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.

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 clusters. 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 support 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 other.
- 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 support to help the individual stabilize and return to the previous level of functioning or 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.

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.

Community Oriented Recovery and Empowerment (CORE) Services

CORE 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.

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 the 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.

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 the standard is 24 hours.

Family Support and Training

Training and support are 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

updates, 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.

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 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.

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
All the following criteria must be met: 1) The Member must be deemed eligible to receive HCBS or HCBS like services, using the HCBS Eligibility Assessment tool. 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. 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. 4) The HCBS Provider develops an (ICP) that is informed and signed by the Member and HCBS Provider staff responsible for ISP implementation. 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. 6) The Member must have the desire and willingness to receive rehabilitation and recovery services as part of their ISP. 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.	**All of the following criteria must be met:** 1) Member continues to meet admission criteria and an alternative service would not better serve the Member. 2) Interventions are timely, need based and consistent with evidence based/best practice and provided by a designated HCBS Provider. 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 4) There is care coordination with physical and behavioral health Providers, State and other community agencies. 5) There is care coordination with physical and behavioral health Providers, State and other community agencies. 6) Family/guardian/ caregiver is participating in treatment where appropriate. 7) 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.	**Criteria #1, 2, 3, 4, or 8 are suitable; criteria #6. is recommended, but optional:** 1) Member no longer meets admission criteria and/ or meets criteria for another more appropriate service, either more or less intensive. 2) Member or parent/ guardian withdraws consent for treatment. 3) Member does not appear to be participating in the ISP. 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. Member's goals have been met. Member's support system is in agreement with the aftercare service plan

SECTION 21. PROVIDER PARTICIPATION

Network Development and Network Operations

Molina Provider Relations & 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 (HCBS)

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.

Community Oriented Recovery & Empowerment Services (CORE)

In order to provide CORE 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 CORE Provider qualifications. Molina will contract with State-designated Behavioral Health (BH) CORE 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 Relations department of the Health Plan. The training materials will be available on our website for physicians who prefer 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 Relations representatives 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 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 sessions which they can attend.
Within 30 days of Provider go live	New Provider Curriculum	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 Relations 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 on Molina Healthcare of New York's Availity Essentials 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 22. 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 the 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 underutilization.
- 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:

- 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
- Expected to improve an individual's condition or level of functioning
- Individualized, specific and consistent with symptoms and diagnosis and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less resource intensive treatment is available
- Not primarily intended for the convenience of the recipient, caretaker, or Provider
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency
- Not a substitute for non-treatment services addressing environmental factors

Molina utilizes LOCUS and CALOCUS as its' Mental Health criteria and LOCADTR III as its' criteria for Substance Use Disorder Treatment. Services not specified within either criteria set are reviewed using MCG

Molina utilizes LOCUS and CALOCUS as its' Mental Health criteria and LOCADTR III as its' criteria for Substance Use Disorder Treatment. Services not specified within either criteria set are reviewed using MCG.

Molina's application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of and or evaluate the medical necessity, appropriateness, efficacy and efficiency of behavioral health care services.

Molina's mental health LOC criteria, LOCUS/CALOCUS 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 LOCUS/CALOCUS. Substance Use Disorder Treatment determinations are made based on medical necessity and LOCADTR III 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 and/or 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 requires, 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 inpatient 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 determination action. LOCATDR 3 tool will 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 (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 and or 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:

- Failure to provide covered services in a timely manner in accordance with the waiting time standards
- Denial or limited authorization of a requested service, including the determination that a requested service is not a covered service
- Reduction, suspension, or termination of a previous authorization for a service
- 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
    - Failure to act within the timeframes for making authorization decisions
    - 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:

- 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
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person; or
- 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 non-urgent are considered, for the purposes of this policy, as new pre-service requests.

Post-Service Review and Decisions

Any review of 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. Members 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

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).

See Molina Healthcare's Provider Manual Section 8 for General Accessibility Standards. HCBS Specific Standard 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 use visit with a participating Provider per year for evaluation
- Vision services with participating Providers
- 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, family collateral 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 2-4 weeks 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

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
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, family collateral 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

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
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 basis, 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 (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:	2900 Exterior Street, Suite 202 Bronx, NY 104
Or Members may call:	(800) 223-7242 (TTY: 711)

Expedited Appeals

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.

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 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, date of service 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 notices 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 department 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 (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 (800) 233-7242 or submit their appeal or grievance in writing to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
2900 Exterior Street, Suite 202
Bronx, New York 10463

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 visit 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 care 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 the 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, concerns 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 and or 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 care 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 care 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 and or 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 23. 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 use 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 toward 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 health care 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 practitioner Provider 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., alcohol drugs, 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 outpatient 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, family collateral 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. MMCOsY HARPs 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.

Molina Healthcare of New York, Inc. Provider Manual.

Last Updated: 2025