Molina Healthcare of New York, Inc.

Provider Manual

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

Effective July 1, 2017

Contents

Introduction

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

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

We currently offer the following to eligible individuals:

- a NYS Managed Medicaid product in Onondaga, Cortland and Tompkins counties
- a Child Health Plus program in Onondaga, Cortland, Tompkins and Oswego counties
- Molina Healthcare PLUS (formerly HARP) in Onondaga, Cortland and Tompkins counties

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

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

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

Section 1. Addresses and Phone Numbers

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied Claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina Healthcare of New York (Molina or Molina Healthcare) Provider network. Eligibility verifications can be conducted at your convenience via Molina's Provider Web Portal (Provider Portal).

Provider Services	
Address:	Molina Healthcare of New York, Inc. 5232 Witz Drive North Syracuse, NY 13212
Phone:	(877) 872-4716 An answering service will be available after business hours.
Fax:	(844) 879-4509

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 a.m. – 5:00 p.m. Monday through Thursday and Friday 9:00 a.m.-5:00 p.m., excluding State holidays.

Member Services	
Address:	Molina Healthcare of New York, Inc. 5232 Witz Drive North Syracuse, NY 13212
Phone:	(800) 223-7242
TTY/TDD:	711

Claims Department

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

- Access the Provider Portal (https://provider.molinahealthcare.com)

- EDI Payer ID **16146**.

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions contact Provider Services at the number listed below.

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

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

Claims Recovery Department

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

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

Compliance and Fraud AlertLine

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

Molina Healthcare AlertLine	
Phone:	(866) 606-3889
Website: **https://molinahealthcare.alertline.com**	

Credentialing Department

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

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

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

Nurse Advice Line **24 hours per day, 365 days per year**
Phone: (800) 223-7242
TTY/TDD: 711

Healthcare Services (Utilization Management) Department

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

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

- Easy to access 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status

- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces cost associated with fax and telephonic interactions

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

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

Healthcare Services (UM) Authorizations & Inpatient Census	
Provider Portal: https://provider.molinahealthcare.com	
Address:	Molina Healthcare of New York, Inc. 5232 Witz Drive North Syracuse, NY 13212
Phone:	(800) 223-7242 An answering service will be available after business hours.
Fax:	(866) 879-4742

Health Management

Molina's Health Management includes weight management, motherhood matters, smoking cessation, and disease related programs. These services can be incorporated into the Member's treatment plan to address the Member's health care needs.

Weight Management and Smoking Cessations Programs	
Phone:	(866) 472-9483
Fax:	(562) 901-1176

Health Management and Maternity Programs	
Phone:	(866) 891-2320

Fax:	(800) 642-3691

Behavioral Health

Beacon Health Options manages all components of our covered services for behavioral health. For Member behavioral health needs, please contact Beacon directly at:

Beacon Health Options
Website: https://www.beaconhealthoptions.com/ Address: Beacon Health Options 500 Unicorn Park Drive, Suite 401 Woburn, MA 01801
Phone: (844) 265-7592
Crisis Line: (24) Hours per day, (365) day per year: (844) 265-7594

Pharmacy Department

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

Express Scripts	
Customer Service:	(800) 753-2851
Prior Authorization Fax:	(877) 328-9799

Accredo Specialty Pharmacy	
Phone:	(800) 803-2523

Dental Services

Dental services are covered by Molina, via our Dental Vendor, HealthPlex.

HealthPlex	
Address:	HealthPlex PO Box 9255 Uniondale, NY 11553-9255
Phone:	(888) 468-2183
Fax:	(516) 228-5025

Quality Department

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

Quality Department	
Phone:	(877) 872-4716
Fax:	(315) 234-9812

Molina Healthcare of New York, Inc. Service Area

Section 2. Provider Responsibilities

Participation Guidelines and Standards of Care

Provider Guidelines:

All Participating Providers are expected to:

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

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

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

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

Standards of Care

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

- Guidelines established by the Federal Center for Disease Control Prevention (or any successor entity)
- New York State Department of AIDS Institute
- All federal, state, and local laws regarding the conduct of their profession
- Participation on committees and clinical task forces to improve the quality and cost of care
- Referral Policies
- Preauthorization and notification requirements and timeframes

- Participating Provider credentialing requirements
- Care Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of Member medical record information to fulfill the business and clinical needs of Molina
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with Molina personnel and fellow Participating Providers, and
- Providing equal access and treatment to all Members

Role of Primary Care Provider (PCP)

The Primary Care Provider (PCP) is responsible for delivering primary care services and coordinating the Member's health care. 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 making a selection (A Primary Care Provider is a Pediatrician, Family Practitioner or Internist). If all attempts to contact the Member are unsuccessful, the Member is notified by mail of a selection made by Molina. At this time, the Member is again afforded the opportunity to select his or her own PCP.

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

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

Specialist or Specialty Center as PCP

For Members with a degenerative and disabling condition or disease, the Member or Members' Representative or a PCP may request a specialist or specialty center as PCP. The Molina Medical Director will, in consultation with the Primary Care Provider and the specialist or

specialty center, review the Member's medical record and determine whether, based on existing clinical standards, the Member's disease or condition is degenerative and disabling.

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

Nondiscrimination of 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, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

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

Section 1557 Investigations

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

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

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

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

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

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

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

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

Please visit our Provider Online Directory at https://providersearch.molinahealthcare.com to validate your information. Please notify your Provider Services Representative or contact our Provider Services department at (877) 872-4716 if your information needs to be updated or corrected.

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

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

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

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

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by registering for Molina's Provider Web Portal, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network. Providers that are unwilling to participate in Molina's Electronic Solutions requirements may be ineligible to participate in the Molina Network.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

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

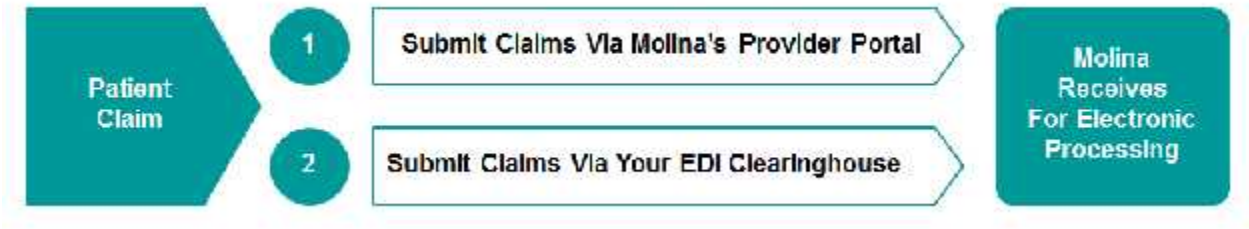
Electronic Claims Submission Requirement

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

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

Molina offers the following electronic Claims submission options:

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



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

- Ability to add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

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

Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices:

https://providernet.adminisource.com/Start.aspx

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

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Provider Web Portal

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

- Verify and print Member eligibility
- Claims Functions
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization Requests
    - Check status of Authorization Requests
    - Receive notification of change in status of Authorization Requests
- View HEDIS® Scores and compare to national benchmarks

Member Information and Marketing

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

Member Eligibility Verification

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

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

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider

Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

Referrals

When a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Healthcare Services section of this Manual) 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 Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare of New York except in the case of Emergency Services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

Admissions

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

Participation in Utilization Review and Care Management Programs

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

Continuity and Coordination of Provider Communication

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

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote

and facilitate training in self-care and other measures Members may take to promote their own health.

Pregnancy Notification Process

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

Newborn Process

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

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

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

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

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

Prescriptions

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

Participation in Quality Programs

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

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

Member to Provider Ratios

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

Minimum Office Hours

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

Access to Care Standards

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.
- **Urgent Care**: Within twenty-four (24) hours of request.
- **Non-Urgent "Sick" Visit**: Within forty-eight (48) to seventy-two (72) hours of request.
- **Routine Appointments**: Within four (4) weeks of request.
- **Specialist Referrals (not urgent):** 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 thereafter.
- **Adult Baseline and Routine Physicals**: Within twelve (12) weeks from enrollment.
- **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** Visits (pursuant to an emergency or hospital discharge): within five (5) days of request, or sooner as clinically indicated.
- **In-Plan, Non-Urgent Mental Health or Substance Use Visits**: Within two (2) weeks of request.
- **Initial PCP Office Visit for Newborns**: Within two (2) weeks of hospital discharge.
- **Provider Visits To Perform Health, Mental Health and Substance Use Assessments** for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a Local Department of Social Services (LDSS) Provider: within ten (10) days of request by a Member, in accordance with Benefit Agreement.

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.

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.

Site and Medical Record-Keeping Practice Reviews

Medical Record Review

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

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (hard copy or electronic) 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 six (6) years (for minors: six (6) years from date of service or three (3) years from date of maturity, whichever is later) 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.

Delivery of Patient Care Information

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that its contracted Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations.

Participation in Grievance and Appeals Programs

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

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

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria

established by Molina. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office.

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

Section 3. Cultural Competency and Linguistic Services

Background

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

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

Nondiscrimination of Health care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, 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.

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

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

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

Molina Institute for Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which integrates Cultural Competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our 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 Services or online training modules.

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

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina website; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

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

Molina will translate outreach material in a language other than English whenever a minimum of five percent (5%) of the population in a county of the service area speak a particular language. Molina develops Member materials according to Plain Language Guidelines resulting materials written at a reading level between fourth and sixth grade. Molina prints materials in twelve (12) point font size. 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.

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

Interpreter Services

Molina will reimburse outpatient departments, hospital emergency rooms, diagnostic and treatment centers, federally qualified health centers, and office-based Providers for interpreter services offered to Molina Members. A third party interpreter who is employed by the Provider or contracts with the medical Provider must provide medical language interpreter services during a medical visit. The interpreter must demonstrate proficiency in medical interpreter terminology and techniques.

Members with Hearing Impairment

Molina provides a TTY/TDD connection, which may be reached by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), Quality Improvement, Healthcare Services and all other health plan functions.

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

Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly at (800) 223-7242 for assistance in other languages. The Nurse Advice TTY/TDD is 711.

Section 4. Member Rights and Responsibilities

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

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

Molina Healthcare Member Rights & Responsibilities Statement

Your Rights:

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

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

*Applies only to Molina Healthcare PLUS Members

Your Responsibilities:

As a Member of Molina Healthcare, you agree to:

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

Second opinions

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

Section 5. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in Medicaid Programs

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

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

Effective Date of Enrollment

a) For MMC Members, Molina, NYSoH and the LDSS are responsible for notifying the Member of the expected Effective Date of Enrollment.
b) Notification may be accomplished through a "Welcome Letter." To the extent practicable, such notification must precede the Effective Date of Enrollment.
c) In the event that the actual Effective Date of Enrollment changes, Molina, and for MMC Members the LDSS or NYSoH, must notify the Member of the change.
d) As of the Effective Date of Enrollment, and until the Effective Date of Disenrollment, Molina shall be responsible for the provision and cost of all care and services covered by the Benefit Package and provided to Members whose names appear on the Prepaid Capitation Plan Roster, except as hereinafter provided.

Newborn Enrollment

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

Inpatient at time of Enrollment

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

Eligibility Verification

Medicaid Programs

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

Eligibility Listing for Medicaid Programs

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

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

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 Medicaid Managed Care

Card Front

Card Back

hcare of New York, Inc. Provider Manual.

Molina Child Health Plus

Card Front


MOLINA HEALTHCARE

5232 Witz Drive, North Syracuse, NY 13212 | molinahealthcare.com

X X ID# X
DOB X EFF X
PCP X X X

FOR A LIFE-THREATENING MEDICAL CONDITION
- Call 911 or go to the nearest emergency facility.
- Then **WITHIN 48 HOURS** of receiving care, you or someone on your behalf, must call your **Molina Primary Care Provider (PCP)**
- All follow-up care must be coordinated by your Molina PCP.

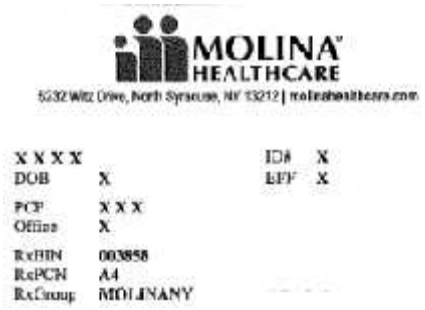
For ROUTINE APPOINTMENTS AND REFERRALS
- Non-urgent/non-life threatening or routine care, and/or referrals, call your Molina PCP.
- Submit Medical and Hospital claims to Molina, Attn: Claims Dept.

INQUIRIES and CLAIMS: This card does not guarantee coverage. To confirm eligibility, obtain specific benefit information, or to speak with a Nurse 24/7, call Molina at **1-800-223-7242/ TTY: 1-800-662-1220.**

Pharmacy Benefit: Contact Express Script at 1-877-891-5276.
Pharmacy Helpdesk at **1-800-922-1557.**
Dental Benefit: Contact Healthplex at **1-800-468-9868.**
Mental Health Benefit: Contact Beacon Health Solutions at **1-844-265-7504.**

Molina Healthcare PLUS (formerly HARP)

Card Front


MOLINA HEALTHCARE

5232 Witz Drive, North Syracuse, NY 13212 | molinahealthcare.com

X X X X ID# X
DOB X EFF X
PCP X X X
Office X
RxBIN 003858
RxPCN A4
RxGroup MOLINANY

Card Back


ENROLLEE CO-PAYS

Non-preferred Brand Name Drugs.....$1.00
Preferred Brand Drugs.....$1.00
Generic Drugs.....$1.00
Over The Counter (OTC) Drugs.....$0.00

This card does not guarantee coverage. To confirm eligibility, obtain specific benefit information, including copayment exclusions or to speak with a Nurse 24/7, call Molina at **1-800-223-7242/ TTY: 1-800-662-1220.**

Pharmacy Benefit: Contact Express Script at 1-877-891-5276.
Pharmacy Helpdesk at **1-800-922-1557.**
Dental Benefit: Contact Healthplex at **1-800-468-9868.**
Mental Health Benefit: Contact Beacon Health Solutions at **1-844-265-7504.**

thcare of New York, Inc. Provider Manual.

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

Disenrollment

Voluntary Disenrollment

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

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

PCP Assignment

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

PCP Changes

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

Section 6. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare of New York Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina Healthcare at (877) 872-4716 (Monday-Thursday 8:00 a.m. to 5:00 p.m. and Friday 9:00 a.m. to 5:00 p.m.).

Member Cost Sharing

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

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

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

Service Covered by Molina Healthcare of New York

Molina Healthcare covers the services described in the Summary of Benefits documentation. Some services require prior authorization. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina Healthcare at (877) 872-4716. (Monday-Thursday 8:00 a.m. to 5:00 p.m. and Friday 9:00 a.m. to 5:00 p.m.)

Summary of Benefits

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

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

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

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

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

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Blood Clotting Factors (Outpatient)	Not Covered by MHNY (covered FFS)	Not Covered by MHNY (covered FFS)	Covered	Blood clotting factors in outpatient settings, including the home, will be covered by MHNY for MMC and Molina Healthcare PLUS 07/01/17
Blood Products	Covered	Covered	Covered	Autologous blood donation and storage are not covered
Breast Implants	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	Breast implants for cosmetic purposes are not covered. Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	
Cardiac Rehabilitation	Coverage is limited to 36 visits per calendar year and (1) one session per day.	Coverage is limited to 36 visits per calendar year and (1) one session per day.	Coverage is limited to 36 visits per calendar year and (1) one session per day.	
Chemical Dependency	Covered inpatient and/or outpatient. For individuals younger than 21, OASAS outpatient clinic, OASAS OTP, OASAS outpatient rehabilitation programs, Outpatient Chemical	Covered inpatient and/or outpatient.	Covered inpatient and/or outpatient.	Members can self-refer for one (1) one chemical dependence assessment from a Detoxification or Chemical Dependence Participating Provider in any calendar year period without requiring

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	Dependence for Youth Programs are currently excluded from the MMC benefit package but are covered fee for service			preauthorization or referral from the Member's Primary Care Provider. There are no limitations for the diagnosis or treatment of alcoholism and substance abuse.
Chemotherapy	Covered	Covered	Covered	
Chiropractic Care	Not covered	Not covered	Not covered	
Contact Lenses	Covered when medically necessary and for ocular pathology	Covered when medically necessary and for ocular pathology	Covered when medically necessary	Contact lenses may be replaced when lost or damaged.
Court Ordered Treatment	Covered for services included in the benefit package	Covered for services included in the benefit package	Covered for services included in the benefit package	
Dental Services	Up to (4) four annual fluoride varnish treatments for children from birth to age 7 years when applied by a dentist, physician or nurse practitioner Dental care includes preventive, prophylactic and other routine dental	Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability	-Prophylaxis at 6 month intervals -Topical fluoride at 6 month intervals where local water supply is not fluoridated -Dental examinations,	Non-medical dental services will be covered by our dental vendor, HealthPlex

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability		visits, and consultations covered (1) once within 6 months consecutive period -X-rays, full mouth x-rays or panoramic at 36 month intervals -Bitewing –rays at 6-12 month intervals Prosthodontics -Fixed bridges are not covered unless: -Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a Member with an otherwise full complement of natural, functional and/or restored teeth -Required for cleft-palate treatment or stabilization -Required as demonstration by medical documentation, due to the	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
			presence of any neurologic or physiologic condition that would preclude the placement of a removal prosthesis	
Detoxification Services	Covered	Covered	Covered	There are no limitations for the diagnosis or treatment of alcoholism and substance abuse
Diabetes Self-Management Training	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus	Limited to one (1) hour (or 2 units) every six (6) months with a diagnosis of diabetes mellitus	
Diabetic Supplies	Covered	Covered	Covered	Pharmacy Benefit
Dialysis	Covered	Covered	Covered	
Durable Medical Equipment (DME)	Covered subject to limitations	Covered subject to limitations	Covered subject to limitations	Coverage includes durable medical equipment, prosthetics and orthotics, prescription footwear, medical supplies, enteral therapy products, and hearing aid batteries and is subject to limitations. Contact the health plan for authorization requirements and/or limitations

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Emergency Medical Services	Covered	Covered	Covered	
Emergency Transportation	Covered Fee for Service not through MHNY	Covered Fee for Service not through MHNY	Covered, ground or air	
Enteral Products	Covered Standard milk-based infant formulas are not covered. Enteral therapy is not covered as a convenient food substitute.	Covered Standard milk-based infant formulas are not covered. Enteral therapy is not covered as a convenient food substitute.	Covered	
Experimental Treatment or Devices	Covered on a case by case basis	Covered on a case by case basis	Not covered	These services require prior authorization, see the prior authorization guide above for more information
Family Planning and Reproductive Health Services	Covered	Covered	Covered	
Fertility Drugs	Not covered	Not covered	Not covered	
Gender Transition Services	Covered	Covered	Covered	Contact the health plan for coverage criteria
Genetic Testing	Covered	Covered	Covered	A laboratory must hold a permit in Genetic Testing in order to bill for

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				molecular diagnostic procedures (procedure codes 83890 – 83912).
Hearing Aids and Hearing Aid Accessories	Covered	Covered	Covered	
Hearing Screening/Exam	Covered. Hearing screening and testing can be provided by any licensed practicing Provider who may administer hearing services within their scope of practice using accepted standards and practices for screening, medical clearance, testing, and evaluation	Covered. Hearing screening and testing can be provided by any licensed practicing Provider who may administer hearing services within their scope of practice using accepted standards and practices for screening, medical clearance, testing, and evaluation.	Covered. Hearing examinations are covered to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist	
Health Education	Covered	Covered	Covered	Contact the health plan for more information
Adult Home and Community Based Services (HCBS)	Not Covered	Coverage includes: Psychosocial Rehabilitation (PSR); Community Psychiatric Support and Treatment (CPST); Habilitation/ Residential Support Services; Family support and training; Short-term crisis respite; Intensive crisis respite; Family support and training,	Not Covered	HCBS services will be subject to utilization caps at the recipient level that apply on a rolling basis (any 12 month period). These limits will fall into three categories: 1. Tier 1 HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
		Education support services; Peer support services (Empowerment Services); Pre-vocational services; Transitional employment; Intensive supported employment; On-going supported employment; and staff transportation for select services Staff Transportation for only for these selected HCBS services: •Psychosocial Rehabilitation (PSR) (Individual per diem) •Community Psychiatric Support and Treatment (CPST) •Habilitation/Residential Support Services •Family Support and Training (FST) •Education Support Services •Empowerment Services – Peer Supports (OMH) •Pre-Vocational Services •Transitional Employment •Intensive Supported Employment (ISE) •Ongoing Supported Employment		on this threshold that will allow plans to go up to $10,000 without a disallowance. 2. There will also be an overall cap of $16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to $20,000 without a disallowance. 3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crisis respite services are limited within their own individual caps (7 days per episode, 21 days per year).
Home Health	Covered	Covered	Limited to 40 visits	Covered services

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Care			in a calendar year Private Duty Nursing is not covered.	include skilled nursing (MMC and Molina Healthcare PLUS only), Therapy (Physical, Occupational and Speech/Audiology), Home Health Aide, Pregnant/Postpartum Visits, Telehealth Services, Personal Care Services
Home Health Services for Mom and Baby after Delivery	Covered	Covered	Covered	The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician. Postpartum home visits are also covered. **All women enrolled are presumed eligible for (1) one medically necessary postpartum home health care visit** which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet medical necessity criteria.
Hospice Care	Covered for Members with a life expectancy of one (1) year or less For child Members aged 20 and under who are receiving Hospice services curative services are also covered in addition to palliative care.	Covered for Members with a life expectancy of one (1) year or less	Covered for Members with a life expectancy of six (6) months or less Up to 5 visits of bereavement counseling are covered for family Members	Routine Home Care, Respite Care, Continuous Care, General Inpatient Care, Palliative and supportive Care, Room and Board The following programs are not allowed in combination with the hospice benefit: Private Duty Nursing, Long Term Home Health Care Program/Lombardi Program, Certified Home Health Agency Services, Adult Day Health Services
Hospitalization	Covered	Covered	Covered	
Hysterectomy	Covered except when performed for the purpose of sterilization.	Covered except when performed for the purpose of sterilization.	Covered except when performed for the purpose of sterilization.	When hysterectomy procedures are performed and in all cases when procedures identified by MMIS codes 51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260,

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				58262,58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58570, 58571,58572, 58573, 58951, 58953, 58954, 58956, 59135, or 59525 are billed, a properly completed "Hysterectomy Receipt of Information Form" must be attached to the bill f or payment. No bill will be processed without a properly completed "Hysterectomy Receipt of Information Form", (DSS-3113).
Immunizations	Covered	Covered	Covered	Vaccine purchase costs associated with childhood immunizations that may be obtained free of charge from the Vaccine for Children Program are not reimbursable.
Infertility Services	Not covered	Not covered	Not covered	
Laboratory Services	Covered	Covered	Covered	In-home phlebotomy services are limited to 24 visits per calendar year
Mammogram	Covered	Covered	Covered	

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

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Transportation	Service, not by MHNY	Service, not by MHNY		
Nursing Homes (Long Term Care)	Inpatient nursing home services authorized by the Contractor for MMC Members age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay	Inpatient nursing home services authorized by the Contractor for MMC Members age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay	Not Covered	Leave of absences are limited to a combination of 18 days in a calendar year.
Certified Nurse Practitioner Services	Covered	Covered	Covered	Certified nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the certified nurse practitioner's licensure and collaborative practice agreement with a licensed physician The following services are also included in the certified nurse practitioner's scope of services, without limitation: -Child/Teen Health Program(C/THP) services which are comprehensive primary health care services

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				provided to persons under twenty-one (21) -Physical examinations, including those which are necessary for school and camp.
Observation Services	Covered	Covered	Covered	The Member must be admitted to the inpatient service, transferred to another hospital, or discharged to self-care or the care of a physician or other appropriate follow-up service within forty-eight (48) hours of assignment to the observation unit.
OB/GYN Services	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	Covered including routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care	
Outpatient Therapies (Speech, Physical, and Occupational)	Limited to 20 visits per therapy per calendar year Certain Members, settings, and circumstances are exempt from the 20-visit limitation. These include:	Limited to 20 visits per therapy per calendar year Certain Members, settings, and circumstances are exempt from the 20-visit limitation. These include: -Children from birth to age 21 (until their 21st	Limited to 20 visits per therapy per calendar year	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	-Children from birth to age 21 (until their 21st birthday) -Recipients with a developmental disability (R/E code 95) -Recipients with a traumatic brain injury (TBI) (waiver recipients R/E code 81, or any claim with a primary diagnosis code (850-854) for traumatic brain injury) -Recipients with both Medicare Part B and Medicaid coverage (dually eligible Members) when Medicare Part B payment is approved -Rehabilitation services received as a hospital inpatient -Recipients receiving rehabilitation services in a nursing home in which they reside -Rehabilitation services provided by a certified home health agency (CHHA)	birthday) -Recipients with a developmental disability (R/E code 95) -Recipients with a traumatic brain injury (TBI) (waiver recipients R/E code 81, or any claim with a primary diagnosis code (850-854) for traumatic brain injury) -Recipients with both Medicare Part B and Medicaid coverage (dually eligible Members) when Medicare Part B payment is approved -Rehabilitation services received as a hospital inpatient -Recipients receiving rehabilitation services in a nursing home in which they reside -Rehabilitation services provided by a certified home health agency (CHHA)		
Organ Transplants	Covered	Covered	Covered	Contact the health plan for further information

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Orthodontics	Coverage is limited to: Members aged 20 years or under up to (3) three years of active orthodontic care, plus (1) one year of retention care, to treat a service physically handicapping malocclusion. Part of such care can be provided after the Member reaches the age of 21; provided that the treatment was approved and active therapy began prior to the Members 21st birthday. Members aged 21 years and over in connection with necessary surgical treatment.	Not covered except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts.	Coverage includes Rapid Palatal Expansion (RPE); Placement of component parts (e.g. brackets, bands); Interceptive orthodontic treatment; Comprehensive orthodontic treatment; Removable appliance therapy; Orthodontic retention	Transitional care for a Member that changes MCOs for orthodontic appliances that are in place and active treatment has begun transitional care policies will apply if the orthodontist is not in the Provider network for a sixty day period. Non-medical dental services will be covered by our dental vendor, HealthPlex
Out-of-Area Care (Emergent)	Covered	Covered	Covered	Limited to the 50 states in the United States and US territories only
Outpatient Surgery	Covered	Covered	Covered	
Pap Smears	Covered	Covered	Covered	
Physical Exams	Covered	Covered	Covered	
Personal Care Services	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS)) for

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				more details
Consumer Directed Personal Assistance Services	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS)) for more details
Personal Emergency Response System (PERS)	Covered	Covered	Not Covered	See section 13 (Home and Community Based Services (HCBS)) for more details
Private Duty Nursing	Covered	Covered	Not covered	
Pregnancy and Delivery	Covered	Covered	Covered	
Prenatal Care	Covered	Covered	Covered	
Prescription Drugs/Pharmacy	Covered	Covered	Covered	Contact the health plan for most current formulary list for specific coverage
Preventive Health Services	Covered	Covered	Covered	
Physician Services	Covered	Covered	Covered	Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice. The following are also

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				included without limitations: -Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit Note: All physician administered drugs (including drugs administered by nurse practitioners, licensed midwives and drugs administered in an ordered ambulatory setting) require the 11-digit NDC, the NDC dispensing quantity, and the NDC unit of measure, in addition to the CPT/HCPCS code and units to be billed or the claim will deny. -Physical examinations, including those which are necessary for school and camp; -Physical and/or mental health, or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care;

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				-Health and mental health assessments for the purpose of making recommendations regarding a Member's disability status for Federal SSI applications; -Annual preventive health visits for adolescents; -New admission exams for school children if required by the LDSS; -Health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms; -Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) years of age in the MMC program
Podiatry Services	Covered for children under age 21 and adult Members with a diagnosis of diabetes Covered services include routine foot care provided by qualified	Covered for children under age 21 and adult Members with a diagnosis of diabetes Covered services include routine foot care provided by qualified Provider	Services of a podiatrist are not covered for CHP Routine foot care is not covered when done by any type of Provider	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	Provider types **other than podiatrists** when any Member's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.	types **other than podiatrists** when any Member's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.	for CHP	
Radiology	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	Covered including, but not limited to, X-rays, PET scans, CT scans, MRIs, etc.	DXA scans are covered at a maximum of once (1) every two (2) years for women over the age of 65 and men over the age of 70. Medically necessary DXA scans to women younger than 65 and men younger than 70 who present with significant risk factors for developing osteoporosis will also be reimbursed at a maximum of once (1) every two (2) years
Reconstructive Surgery	Covered when medically necessary	Covered when medically necessary	Covered when medically necessary	
Respite Care	Covered	Covered	Covered	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
Second Opinions Surgical Care	Covered	Covered	Covered	
Second Opinions Medical Care	Covered	Covered	Covered in the event of a positive or negative diagnosis of cancer, recurrence of cancer, or a recommendation of a course of treatment for cancer	
Skilled Nursing Facilities	Covered	Covered	Not Covered	
Smoking Cessation	Up to 8 counseling sessions per calendar year; Up to two (2) of these sessions can be provided by a dental practitioner	Up to 8 counseling sessions per calendar year; Up to two (2) of these sessions can be provided by a dental practitioner	Up to 8 counseling sessions per calendar year; Up to two (2) of these sessions can be provided by a dental practitioner	
Sterilization	Covered for Members over the age of 21 unless medically necessary	Covered	Not covered unless medically necessary	Reversals of sterilizations are not covered Codes 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58670 and 58671 require the sterilization consent form (DSS-3134) to be signed not less than 30 days nor more than 180 days prior to the performance

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
				of the procedure. In cases of premature delivery and emergency abdominal surgery, consent must have been given at least 72 hours prior to sterilization. The consent form must be submitted with the claim for reimbursement.
Tuberculosis Directly Observed Therapy	Covered	Covered	Covered	
Urgent Care	Covered	Covered	Covered	
Vision	Coverage includes: -Emergency, preventive and routine eyes care services; -Eyeglasses (frames and lenses); -Contact lenses when medically necessary and for ocular pathology; -Polycarbonate lenses (monofocal, bifocal, or multifocal/trifocal) -Artificial eyes (stock or	Coverage includes: -Emergency, preventive and routine eye care services; -Eyeglasses (frames and lenses); -Contact lenses when medically necessary and for ocular pathology; -Polycarbonate lenses (monofocal, bifocal, or multifocal/trifocal) -Artificial eyes (stock or	Coverage is limited to: -Emergency, preventive and routine vision services; -Exams to determine the need for corrective lenses and/or to provide a prescription; -Eyeglasses (frames and lenses), limited to	

Benefit	MMC Coverage Information	Molina Healthcare PLUS Coverage Information	CHP Coverage Information	Additional Information
	custom-made); -Low vision services (including rehab) and low vision aids; -Replacement and/or repair of lost or destroyed eyeglasses (frames and lenses); -Orthoptic training; -Specialist referrals for eye diseases or defects The vision benefit is subject to the limits below: -Complete Routine Optometric Eye Exams are limited to one (1) every two (2) calendar years -Non-diabetic Members may self-refer for complete routine optometric exams once (1) every two (2) calendar years - Members diagnosed with diabetes may self-refer to any participating provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than (1) once in any twelve (12) month	custom-made); -Low vision services (including rehab) and low vision aids; -Replacement and/or repair of lost or destroyed eyeglasses (frames and lenses); -Orthoptic training; -Specialist referrals for eye diseases or defects The vision benefit is subject to the limits below: -Complete Routine Optometric Eye Exams are limited to one (1) every two (2) calendar years - Non-diabetic Members may self-refer for complete routine optometric exams once (1) every two (2) calendar years -Members diagnosed with diabetes may self-refer to any participating provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than (1) once in any twelve (12) month	once in 12 months unless appropriate documentation supports the need to exceed this limit -Contact lenses when medically necessary	

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

Obtaining Access to Certain Covered Services

Self-Referral

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

- One mental health and one substance use visit with a Participating Provider per year for evaluation
- Vision services with a Participating Provider
- Diagnosis and Treatment of TB by public health facilities
- Family planning or reproductive health services from a Participating Provider or a Medicaid Provider
- HIV Testing and Counseling

- OB/GYN Services including prenatal care, two routine office visits per year and any follow up care for an acute gynecological condition

Prescription drugs

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

Express Scripts	
Customer Service:	(800) 753-2851
Prior Auth Fax:	(877) 328-9799
Accredo Specialty Pharmacy	
Phone:	(800) 803-2523

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

Injectable and Infusion Services

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

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

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

Access to Dental Benefits

Molina Dental Benefits are administered through Healthplex:

Customer Service: 1-800-468-9868

Provider Hotline: 1-888-468-2183

Provider Relations Fax #: 1-516-228-9571

UM Clinical Review: 1-516-542-5182

Web Support #: 1-888-468-5171

Access to Behavioral Health Services

Mental Health and Substance Use

Molina is partnering with Beacon Health Options to manage behavioral health benefits. Beacon is responsible for the following functions related to Behavioral Health and Substance Use Disorder services for Molina Members:

Beacon Health Options

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

Beacon/ Molina Provider Manual

http://www.beaconhealthstrategies.com/Provider_login.aspx?ReturnUrl=%2fprivate%2fprovider%2fprovider_tools.aspx. Enter "Molina Healthcare of New York" under plan name.

Provider Relations: 1-844-265-7592

Member Services: 1-844-265-7594 (TTY: 1-866-727-9441)

Prior Authorizations: 1-844-265-7594 option 4

Clinical Appeals Coordinator: 1-844-265-7594

Hours of operation: Monday through Friday, 8:00 am-6:00 pm EST. Emergency coverage available 24/7.

Behavioral Health Claims Submissions:

Change Healthcare ID: 43324

Claims Mailing Address:

Molina Healthcare of New York
c/o Beacon Health Strategies

500 Unicorn Park Drive, Suite 103
Woburn, MA 01801

1-888- 249-0478

Joining the Beacon Network:

Behavioral Health Providers interested in joining Beacon's network should contact the Network Operations Department as follows:

E-mail: provider.relations@beaconhs.com

Provider Network and Contracting: 1-781-994-7556

Letter of Interest: For Behavioral Health Providers interested in participating in Beacon's network, the Letter of Interest Form is available at beaconhealthstrategies.com – *Providers – How to become a provider – Letter of Interest Form*

Transfer of Mental Health and Substance Use Information

It is the policy of Molina to promote continuity of care and ensure adequate communication of all services received by a Member to the Plan PCP. Mental Health and Substance Use Specialists will obtain signed patient release of information forms at initial visits to ensure consistent communication between Mental Health and Substance Use Specialists and the Plan PCP.

Emergency Mental Health or Substance Abuse Services

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

- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm

Out of Area Emergencies

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

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

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

Emergency Transportation

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

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

Non-Emergency Medical Transportation

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

To access nonemergency transportation, the Member or the Member's Provider must call Medical Answering Services (MAS) at the number below (based on county in which Member resides):

Onondaga County: 855-852-3287

Cortland County: 855-733-9397

Tompkins County: 866-753-4543

Preventive Care

Clinical Practice Guidelines

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

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

- *Adults ages 19 and older* – U.S. Preventive Services Task Force Clinical Practice Guidelines
    - http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/
- *Healthy Children to age 19* – American Academy of Pediatrics and Bright Futures

- https://brightfutures.aap.org/clinical-practice/Pages/default.aspx
- https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx

- *Diabetes* – American Diabetes Association
  - http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf

- *Asthma* – NYS Asthma Practice Guidelines
  - http://www.health.ny.gov/diseases/asthma/pdf/2009_asthma_guidelines.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/_asset/fnhdm3/Depr.pdf

- 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/
  - http://www.hivguidelines.org/ordering-publications/

Immunizations

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

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

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

Well Child Visits and EPSDT Guidelines

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

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

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

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

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

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

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

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

Severe Anemias associated with chronic disease	Thrombocytopenias
Sickle Cell Anemia	Hemoglobin C Disease
Thalassemia	Hemophilia
Von Willebrand's Disease	Cardiovascular Disease
History of Valvular Replacement	Pulmonary Hypertension
History of Cardiomyopathy	Peripartum Cardiomyopathy
Endocarditis	Pulmonary Edema
History of Pulmonary Embolism	Renal Failure (acute or chronic)
Glomerulonephritis	Polycystic Disease
Previous Nephrectomy	Insulin Dependent Diabetes
Collagen Vascular Disease	Hyperthyroidism
Pre-eclampsia	Eclampsia
Pregnancy Induced or Chronic Hypertension	Seizure Disorder
Active Syphilis	AIDS
Pregnancy Related Issues	
Previous Infant Fetus with Congenital Abnormality	Recurrent abortion
Isoimmunization	Previous Neural Tube Defect
Stillbirths	Abnormal Alpha Fetal Protein
Multiple Gestation with Growth Discrepancy	Placenta Previa

Amniocentesis	Fetal Abnormality Noted on Ultrasound
Maternal Age Over 35 for Genetic Counseling	Breech (36 weeks) for Possible Version
Polyhydramnios/Oligohydramnios	Intrauterine Growth Retardation
Any Acute or Chronic Material Illness Which Will Increase The Risk to the Mother or Infant	Positive Material Blood Antibody Screen or Evidence of Isoimmunization/Fetal Hydrops

Prenatal Care

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

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

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

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

Referrals for High Risk Pregnancies

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

Emergency Services

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

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

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

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

Nurse Advice Line

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

Nurse Advice Line (24 Hours)	
English Phone:	(800) 223-7242
TTY/TDD:	711

Molina is committed to helping our Members:

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

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

Case Management

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

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

Health Management Programs

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

- Asthma
- Diabetes

For more info about our programs, please call:

Provider Services Department at (877) 872-4716
TTY at 711

Program Eligibility Criteria and Referral Source

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

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

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;

- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

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

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

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

Section 7. Healthcare Services

Introduction

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

Utilization Management

Molina's Utilization Management (UM) program ensures appropriate and effective utilization or services. The UM team works closely with the Care Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels 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, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided;
- 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 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;
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decision.

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

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

Medical Necessity Review

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

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all Medical Necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or

imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

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

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section. If using a different form, the prior authorization request must include the following information:

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

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements.

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

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

Pre-authorization: Molina must make decision and notify Member/Member's Representative and Provider, by phone and in writing, within three (3) business days of receipt of necessary information. For Medicaid, Molina's decision must be made as fast as the Member requires or

within three (3) business days of receipt of necessary information but no more than fourteen (14) days of the request. Member/Member's Representative notification may be delegated to the Provider by Molina via this manual. Expedited and standard review timeframes for pre-authorization and concurrent inpatient review may be extended by an additional fourteen (14) days if the Member, Member's Representative or Provider requests an extension or Molina demonstrates there is a need for more information and the extension is in the Member's interest. A notice of the extension to Member required.

Concurrent: Molina must make decision and notify Member/Member's Representative and Provider by phone and writing within one (1) business day of receipt of necessary information. For Medicaid, 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 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 three (3) business days of receipt of expedited request. Molina can deny an expedited request and process within standard timeframes. If not all necessary information is received, Molina has up to fourteen (14) days to make a determination.

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

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

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and the information existed at the time of the pre-authorization review but was withheld or not made available; and
- Molina was not aware of the existence of the information at the time of the pre-authorization review; and had Molina been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Requesting Prior Authorization

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

Web Portal: Participating Providers are required to use the Molina Web Portal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Portal.

Fax: The Prior Authorization form can be faxed to Molina at: (866) 879-4742. **If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department.** Please indicate on the fax if the request is urgent or non-urgent. **The Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the Member, or could jeopardize the Member's ability to regain maximum function.** Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being processed as expeditiously as possible.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of New York
Attn: Healthcare Services Dept.
5232 Witz Drive
North Syracuse, NY 13212

Affirmative Statement about Incentives

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

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

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

Open Communication about Treatment

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

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

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina (or by an entity acting on behalf of Molina) and are never delegated:

1. Transplant Case Management - Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts medical necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. Clinical Trials - Molina does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina's contracts.
3. Experimental and Investigational Reviews - Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

Molina HCS staff is accessible (877) 872-4716 during normal business hours, Monday through Thursday from 8:00 a.m. to 5:00 p.m. and Friday from 9:00 a.m. to 5:00 p.m. (except for Holidays) for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (800) 223-7242. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly

through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

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

Levels of Administrative and Clinical Review

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

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

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

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

The Determination/Authorization requirements, timelines and procedures are published in the Provider Manual and are available on the www.molinahealthcare.com website.

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

Hospitals

Emergency Services

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

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

e) 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;

f) Serious impairment to such person's bodily functions;
g) Serious dysfunction of any bodily organ or part of such person; or
h) 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 prior authorization from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services. Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

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

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health,

some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

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

Inpatient Review

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

Inpatient Status Determinations

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

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge

planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

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

Post Service Review

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

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

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

Non-Network Providers

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

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

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.

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

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

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches

to care. Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

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

1. The first occurs when a new Member enrolls in Molina and needs to transition medical care to Molina contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc.

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

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

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

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

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

Continuity of Care and Transition of Members

Continuity of Care when Provider Leaves Network

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. 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 ninety (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.

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 (877) 872-4716.

Organization Decisions

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

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

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

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

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

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

Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Molina reports suspected or potential abuse, neglect or exploitation of vulnerable adults as required by state and Federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina employees who have knowledge or suspect the abuse, neglect, or exploitation;
- Law enforcement officer;
- Social worker; Professional school personnel; Individual Provider; an employee of a facility; an operator or a facility; and/or
- An employee of a social service, welfare, mental/behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or health care Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina or one of its contracted Providers encounters potential or suspected abuse as described above, a call must be made to:

Onondaga County Adult Protective (315) 435-2815

Tompkins County Adult Protective (607) 274-5323

Cortland County Adult Protective (607) 753-5265

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Any safety concerns.

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

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

Emergency Services

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

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

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

For Members within our service area: Molina Healthcare of New York, Inc. contracts with vendors that provide (24) hour Emergency Services for ambulance and hospitals.

Continuity and Coordination of Provider Communication

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

Care Management

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

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

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

Health Management

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

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

- Weight Management – For information about the telephonic Molina Weight Management Program or to enroll Members, please contact our Member Assessment Unit.

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

Case Management (CM)

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

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

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

Criteria for Referral

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

- Hospitalizations (Primary Diagnoses):
  - Psychiatric
  - Substance Use
  - Admissions for Controllable Diseases, for example—diabetes, asthma, hypertension
- Social Issues:
  - Medical Child Neglect
- Life Threatening Chronic Diseases:
  - HIV/AIDS
  - Cancer

- Tuberculosis

- Members with Three or More Consecutive Missed Appointments.

- Members with Significant Impairments.
  - Hearing Impaired
  - Vision Impaired
  - Mobility Impaired
  - Cognitively/Mentally Impaired

- Pregnant Patients

- Members That Failed To Meet the following Health Prevention Guidelines:
  - Delayed Immunizations Three (3) Months Or More. (Ages 0-18 Years)
  - Absence or Delayed Lead Screening of More Than Six (6) Months. (Ages 1-6 Years)
  - Mammograms Delayed For Two (2) Years. (40 Years And Older)
  - Pap Smears Delayed Two (2) Years. (From Onset Sexual Activity Or 18 Years And Older)
  - Inability to have Member patient return for follow-up of an abnormal lab or condition which may result in significant morbidity or mortality, for example—TB test, suspected cancer, etc.

- Newly Diagnosed Patients With:
  - Asthma
  - Diabetes
  - HIV/AIDS
  - Mental Illness
  - Substance Use
  - Failure to Thrive
  - Low Birth Weight Infants
  - Critically Ill Newborn
  - Newborns with NICU stay greater than 24 hours

- Identify through claims data high risk populations that would benefit from Case Management Services. High risk populations will include Members who meet the following criteria:
  - Members with at least one (1) ER/hospitalization for diabetes
  - Members with inpatient admission for asthma
  - Members with more than one admission for mental health/chemical dependency within 6 months
  - Members with inpatient admissions for acute MI, Coronary Artery Bypass Graft (CABQ), or Percutaneous Transluminal Coronary Angioplasty (PTCA)

- Cases Identified By:
  - Primary Care Provider
  - Quality Improvement Program
  - Complaint or Grievance Procedure
  - Molina Medical Director
  - Member

- Hospital Discharge Planner
- Quarterly Administrative Claims Review
- New York State Department of Health

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

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

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

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

HIV Confidentiality

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

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

For complete details, please see the following websites:

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

http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=$$PBH2782$$@TXPBH02782+&LIST=LAW+&BROWSER=EXPLORER+&TOKEN=42601282+&TARGET=VIEW

Role of the Primary Care Provider (PCP)

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

HIV Provider Access

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

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

At Risk Members

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

- Injection drug users (IDU) – Injected drugs or steroids with others, piercing, tattooing, or used shared equipment (e.g. syringes, needles, works) currently or any time in the past;
- Member has been diagnosed with or been treated for hepatitis, tuberculosis (TB), or a sexually transmitted disease such as gonorrhea, Chlamydia or syphilis;
- Unprotected anal, vaginal and oral sex – Had unprotected vaginal, anal, or oral sex with multiple partners, anonymous partners, or men who have sex with men;
- Sexual partner with known HIV infection;
- Had sex with a partner they located on the Internet;
- Infants born to HIV infected mothers - Babies can potentially become infected during their mother's pregnancy, during delivery, or after birth in the immediate postpartum period. They can also become infected through breastfeeding.
- Health care and maintenance workers who may be exposed to blood and/or body fluids at work sometimes are infected through on-the-job exposures like needle-stick injuries.
- Individuals who received a transfusion of blood or blood products before screening of the blood supply for HIV antibody was initiated in 1985.

Symptoms

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

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

Counseling, Screening

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

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

Every individual between the ages of 13 and 64 years (or younger or older if there is evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in Subdivision 10 of Section 2801 of the Public Health Law or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under Article 28 of the Public Health Law or from a physician, physician assistant, nurse practitioner, or midwife providing primary care in any office, clinic, facility or other setting shall be offered an HIV-related test unless the health care practitioner providing such services reasonably believes that:

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

Qualified OB/GYN Providers are required to provide HIV pre-test counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.

Consent for Testing

If HIV testing is done, informed verbal consent must be obtained and documented in the medical record. Consent can remain in effect for a period of time stipulated by the patient or until revoked by the patient orally or in writing. The Member still must be informed each time an HIV test is to be performed and must be given the opportunity to decline. Multi-lingual translated consent templates can be found at: https://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm.

Prior to being asked to consent to HIV testing, patients must be provided information about HIV required by the Public Health Law. Prior to asking for consent to perform the HIV test, the following key points must be provided. The key points may be delivered orally, in writing or via electronic means. These 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.
- Consent for HIV-related testing remains in effect until it is withdrawn verbally or in writing. If the consent was given for a specific period of time, the consent applies to that time period only. Persons may withdraw their consent at any time.
- 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. Providers offering HIV testing must make a determination as to the patient's capacity to consent. If a practitioner determines a person under 18 years old does not have the capacity to consent, the offer of testing for the young person should be made to a parent or other person authorized to provide consent.
- If a Member is tested, pre- and post-test counseling must be completed and documented in the 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/NYCRR10.nsf/11fb5c7998a73bcc852565a1004e9f87/8525652c00680c3e8525652c004f3d82?OpenDocument)

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

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

Negative Results

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

Pregnant Women

Identifying Acute HIV Infection (AHI) During Pregnancy:

- Immediate testing is recommended for any pregnant woman who presents with a clinical syndrome compatible with Acute HIV Infection (AHI) without a known cause, even if she tested HIV-negative earlier in pregnancy. General information on AHI may be found at http://www.hivguidelines.org.
- In suspected cases of AHI during pregnancy:
  - *Immediate testing* using an HIV antibody test and an HIV RNA test should be performed. If either is positive or there is strong clinical suspicion:
  - *Immediate consultation* with an HIV specialist regarding diagnosis and treatment;
  - *Confirmatory antibody* testing 3-6 weeks later if the HIV RNA test is positive and the initial antibody test is negative or indeterminate.

- Testing for AHI in pregnancy may be accessed by contacting:
  - In New York City: New York City Department of Health & Mental Hygiene, HIV Surveillance and Epidemiology Program, Provider Line 1-212-442-3388;
  - Outside New York City: New York State Department of Health, Wadsworth Center, Diagnostic HIV Laboratory 1-518-474-2163.

HIV Testing in the Third Trimester:

- In concert with the Centers for Disease Control and Prevention (CDC), the New York Department of Health recommends that prenatal Providers routinely recommend repeat HIV testing, preferably at 34-36 weeks, for all women who test negative early in prenatal care.
- The second test ideally should be at least three months after the initial test. Repeat testing will identify women who become infected with HIV during pregnancy, a group that accounts for an increasing proportion of Mother-to-Child Transmission (MTCT).

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

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

The New York Department of Health recommends**:**

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

Assuring Access to Care and Supportive Services:

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

Resources

- Consultation and technical assistance for prenatal care Providers and hospital obstetrical departments is available from:
  - HIV Clinical Education Initiative (CEI): call 1-866-637-2342 or visit
  - HIVAIDS Regional Training Centers: These centers offer training on reducing MTCT and expedited and rapid testing in obstetrical settings. See http://nyhealth.gov/diseases/aids/training/index.htm.

- NYSDOH AIDS Institute has a resource directory intended for use by individuals seeking services and as a referral tool for Providers. The directory can be found at http://www.health.ny.gov/diseases/aids/general/resources/resource_directory/
- Resources specific to case management of HIV patients are available at: www.cobracm.org

Tuberculous Screening, Diagnosis and Treatment

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

Screening

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

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

Diagnosis and Testing

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

Treatment

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

Directly Observed Therapy for Tuberculosis Disease (TB/DOT)

- TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the prescribed medication regimen
- TB/DOT is the standard of care for all patients with active TB
- Molina Case Management is responsible for the coordination, communication and cooperation of the Clinical Management of the TB/DOT Provider but where applicable, services may be billed directly to eMedNY by an SDOH approved Medicaid Fee-for-Service TB/DOT Provider
- The service may be provided in the community at the local health department (LDH), in the patient's home, or on an inpatient basis.
- Outpatient TB/DOT involves the observation of dispensing of medication, assessing any adverse reactions to the medications and case follow up.
- Inpatient long term treatment may be indicated where the LHD has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.

- Molina is contracted with four local Department of Health agencies that provide this service. The contracted agencies are listed below:

Onondaga County Department of Health
421 Montgomery Street
Syracuse, New York 13202
315-435-3252

Tompkins County Department of Health
401 Harris B. Dates Drive
Ithaca, NY 14850
607-274-6674

Cortland County Department of Health
60 Central Avenue
Cortland, NY 13045
607-753-5209

Oswego County Department of Health
70 Bunner Street
Oswego, NY 13126
315-349-3545

- Clinical protocols followed by the LDH agencies above are established by the Centers for Disease Control and can be found at: http://www.cdc.gov/tb/publications/guidelines/default.htm

Medical Record Standards

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

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

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

The Provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services

for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the Member was referred to the Provider.

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

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means Any determination that requires clinical review to determine if the service will be covered. The decision is based on the clinical review and is justified as reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care. 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:

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

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

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

Specialty Pharmaceuticals/Injectable and Infusion Services

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

Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and

alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Section 8. Quality

Quality Department

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

The address for mail requests is:

Molina Healthcare of New York, Inc.
Quality Department
5232 Witz Drive
N. Syracuse, NY 13212

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

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process; and
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

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

Quality of Care

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

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

Medical Records

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

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

Medical Record Keeping Practices

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

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available at each visit and archived records are available within twenty-four (24) hours
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for Quality and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

Providers must demonstrate compliance with Molina Healthcare of New York's medical record documentation guidelines. Medical records are assessed based on the following standards:

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification and signatures (electronic or written);
- All entries are dated;
- The record verified that PCP coordinates and manages care
- Problem list, including medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Advanced Directives are documented for those 18 years and older;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the Member's health status;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnosis
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the Members health status;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate and filed in chart;
- Lab and other studies are initialed by ordering Provider upon review;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the Provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- Developmental screenings as conducted through a standardized screening tool.
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services.
- Documentation of a pregnant Member's refusal to consent to testing for HIV infection and any recommended treatment.

Organization

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

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality;
- The medical record is available to Molina Healthcare of New York Quality Department and the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request;
- Medical record retention process is consistent with State and Federal requirements and record is maintained for not less than six (6) years and for a minor, three (3) years after the date of maturity or six (6) after date of service, whichever is later; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State low in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;
- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- *Parties who should have access to records*: Molina representatives or their delegates (for UR or QA), Molina physician(s), and/or any duly authorized third party. This would include: NYSDOH, CMS and the LDSS (Medicaid only).

Parties who should have access to records

- Molina representatives or their delegates (for UR or QA),

- Molina physician(s),
- Any duly authorized third party. This would include: NYSDOH, CMS and the LDSS.

Additional information on medical records is available from your local Molina Quality Department **toll free at (800) 223-7242**. See also the Compliance Section of this Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/Gyn, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 100% availability for Emergency Services and 75% or greater for all other services. The PCP or his/her designee must be available 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 Types	Standard
Routine, asymptomatic	Within 28 calendar days
Routine, symptomatic	Within 2-3 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 28 – 42 calendar days
Specialty Care (High Impact)	Within 28 - 42 calendar days
Urgent Specialty Care	Within 24 hours
Obstetrical Care	Within 21 calendar days in the first trimester, within 14 calendar days in the second trimester and within 7 days

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

Additional information on appointment access standards is available from your local Molina Quality Department **toll free at (577) 872-4716**.

Office Wait Time

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

After Hours

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

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;

2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

Women's Health Access

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

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

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. All appointment standards are addressed. Results of

the audit are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met. In addition, Molina's Member Services Department reviews Member inquiry logs, Grievances and Appeals related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the Quality Department for review.

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

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

Physical accessibility

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

Physical appearance

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

Adequacy of waiting and examining room space

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

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one medical/treatment record for the areas described in the Medical Records 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 80% compliance with the Office Site Review Guidelines listed above. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Administration & Confidentiality of Facilities

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

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

- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Improvement Plans/Corrective Action Plans

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

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

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

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

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

Advance Directives (Patient Self-Determination Act)

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

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

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions

- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment**: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

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

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

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

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org/stateaddownload 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.

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

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

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

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

Well child / adolescent visits

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

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

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within thirty (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a corrective action plan (CAP) with a request the Provider submit a written corrective action plan to Molina within thirty (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The

goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

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

Care Management

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

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- New York State Department of Health, AIDS Institute
- New York State Prenatal Care Standards

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina website.

Individual Providers or Members may request copies from the local Molina Quality Department **toll free at (877) 872-4716**.

Preventive Health Guidelines

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

- Perinatal/Prenatal Care
- Care for children up to 24 months old
- Care for children 2-19 years old
- Care for adults 20-64 years old
- Care for adults 65 years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.molinahealthcare.com and the Provider Manual.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

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

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public

reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

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

HEDIS®

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

Provider Satisfaction Survey

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

sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

Provider Performance

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

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

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

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

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

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

Provider Performance Evaluations:

Molina will perform Provider performance evaluations including:

- The information maintained by the health plan to evaluate the performance/practice of health care professionals
- The criteria against which the performance of health professionals will be evaluated
- The process used to perform the evaluation that the plan is required to provide Providers with any information and profiling data used to evaluate the Providers performance
- The plan shall make available on a periodic basis and upon the request of the health care professional the information, profiling data and analysis used to evaluate the Provider's performance
- Each Provider shall be given the opportunity to discuss the unique nature of the Provider's professional patient population which may have bearing on the Provider's profile and to work cooperatively with the plan to improve performance

Provider Specific Reviews:

Random Provider specific reviews will be conducted in regard to:

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

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

Section 9. Compliance

Fraud Waste & Abuse

Health care fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any health care benefit program.

Health care waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Health care abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the program, improper payment and payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Examples of health care fraud:

- ***Services not rendered*** - A health care Provider bills for medical services, supplies or items that were not provided
- ***Up-Coding*** - A health care Provider bills for a more expensive service or procedure than what was actually provided or performed
- ***Unnecessary Services*** - A health care Provider performs medically unnecessary services to obtain the insurance payment
- ***Misrepresentation/False claims*** - A health care Provider misrepresents a non-covered service as medically necessary to obtain the insurance payment
- ***Recipient fraud*** - A beneficiary or policyholder misrepresents his/her personal information such as identity, eligibility or medical condition in order to illegally receive a benefit or allows a third party to use his/her benefit information to obtain medication and/or medical services

Molina's Commitment

Molina is committed to fighting health care fraud, waste and abuse through a dedicated Special Investigations Unit (SIU) whose mission is to protect employees, Members, Providers, as well as first tier, downstream and related entities.

The SIU works diligently to investigate all allegations, correct known offenses, recover lost funds and partner with federal and state agencies to prosecute violators to the fullest extent of the law.

Providers engaged in fraud or abuse activities may be subject to disciplinary or corrective actions including but not limited to: warnings, Corrective Action Plans, monitoring, suspension or termination of Participating status, loss of licensure, civil or criminal prosecution, other fines and punishments

Medical Identity Theft

Medical identity thieves may use a person's name and personal information such as their health insurance number to make doctor's appointments, obtain prescription drugs, and file claims with their Medicare Advantage Plans. This may affect the person's health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

To limit the number of alleged incidents of medical identity theft by Members, Provider claim personnel should verify Member account numbers when filing medical claims for processing.

Program Integrity

Molina is obligated, through a contract with New York State, to require all network Providers to monitor their staff and managing employees against the State and Federal Exclusion databases, including the List of Excluded Individuals and Entities (LEIE) and the NYS OMIG Exclusion List. This is a requirement set forth in the standard clauses. Molina requires all Providers attest they are monitoring their staff and managing employees against the exclusion databases. Documentation of these checks is subject to audit to Molina.

False Claims Act

The federal False Claims Act establishes penalties for individuals or organizations that knowingly present (or cause to be presented) false claims for the payment or approval to the federal government. The civil penalty for individuals or organizations found liable is up to $11,000 and three times the amount of the actual damages. The Federal Claims Act also authorizes persons (i.e. potential qui tam plaintiffs or whistleblowers) to bring civil actions for suspected violations against the federal government and provides legal protection for these individuals.

Anti-Kickback Statute

The Anti-Kickback statute prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business. Criminal penalties include fines up to $25,000 per violation and up to 5 years prison term per violation.

Stark law

The Stark Law prohibits a Provider from referring patients for designated health services to an entity with which the physician or immediate family member has a financial relationship, unless an exception applies. The Stark Law also prohibits the designated health service entity from submitting claims for those services resulting from a prohibited referral. Penalties include overpayment/refund obligations, False Claims Act liability, and other civil monetary penalties and program exclusions.

Record Retention

In accordance with the NYS Medicaid Program, General Policy, Providers are required to maintain and make available medical records for 6 years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a Provider's eligibility to continue as a Medicaid participant.

Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse may be reported anonymously to the Compliance AlertLine (Fraud, Waste and Abuse Hotline) via the following methods:

Phone: (866) 606-3889

Email: (via the AlertLine webpage): https://molinahealthcare.alertline.com

In Writing:

Molina Healthcare of New York
Attn: Fraud, Waste & Abuse Department
5232 Witz Drive
North Syracuse, NY 13212

Suspected incidents of fraud, waste and abuse may also be reported directly to the state of New York:

NYS Medicaid Inspector General 1-877-87FRAUD (1-877-873-7283)

Compliance and HIPAA

As a Molina Provider, you must maintain medical and non-medical records. You and Molina agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with Molina in the processing of claims and medical treatment. You must also make any medical, financial, or administrative records available to Molina, as requested, either for Molina's administrative purposes, quality assurance purposes, or to comply with state and federal law.

Section 10. Claims and Compensation

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:

- Hospital-Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Editing Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayments and Incorrect Payments
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would reduce reimbursement for certain conditions that occur as a direct result of a hospital stay. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC and POA). The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC and POA).

Hospital Acquired Conditions include the following events occurring during a hospital stay The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries

    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-ketotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic gastric bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information:

http://www.cms.hhs.gov/HospitalAcqCond/

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate Sate and CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse or Molina's Provider Portal, and use current

HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 16146**.** For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

Claims that do not comply with Molina's electronic Claim submission requirements will be denied.

Providers must use good faith effort to bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

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

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed within thirty (30) calendar days from the change.

Electronic Claims Submission

Molina requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of New York via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 16146

Provider Portal:

Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available 24 hours per day, 7 days per week
- Ability to add attachments to claims
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse:

Molina is affiliated with Claimsnet, an electronic claims clearinghouse. Claimsnet has relationships with many other clearinghouses. Typically, Providers can continue to submit Claims to Molina through their usual clearinghouse. Claimsnet offers accurate and rapid submission of your Molina claims (Professional and Institutional) as well as electronic claims submission to other Payers. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed electronically:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 227CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Paper Claim Submissions

When the submission of an electronic claim is not possible, paper claims should be submitted to the following address:

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

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Third Party Liability

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within ninety (90) calendar days after the discharge for inpatient services or the Date of Service for

outpatient services, unless otherwise noted in your Contract. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within ninety (90) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Editing Process

Molina has a Claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate Claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are generally based on State fee for service Medicaid edits, American Medical Association (AMA), Current Procedural Terminology (CPT), Health Resources and Services Administration (HRSA) and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit please refer to the Claim Disputes/Adjustments section below.

Claim Review

Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), Federal, and State billing and payment rules, National Correct Coding Initiative ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Molina's right to conduct Medical Necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain Medical Necessity criteria.

Claim Auditing

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P.

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - "1" –ORIGINAL (initial claim)
    - "7"–REPLACEMENT (replacement of prior claim)
    - "8" --VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information) must include the original reference number (Internal Control Number/Document Control Number – ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1," "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF segment (claim information) must include the original reference number (Internal Control Number/Document Control Number – ICN/DCN).

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within forty-five (45) days after receipt of Clean Paper Claims, and within thirty(30) days of receipt of electronic claims All hard copy claims received by Molina will be clearly stamped with date of receipt. Claim payment will be made to contract Providers in accordance with the timeliness standards set forth by the Provider Agreement.

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 our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Molina will not reduce payment to that Provider for other services unless the Provider agrees to the reduction or fails to respond to Molina's Claim as required in this subsection.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within ninety (90) days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all written Claim disputes must be submitted on the form found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed*. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

Providers should submit the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents

Forms may be submitted via fax, or mail. Claims Disputes/Reconsideration requests may be sent to the following address:

Molina Healthcare of New York, Inc.
Attention: Claims Disputes / Adjustments
5232 Witz Dr.
North Syracuse, NY 13212

Submitted via fax:

(844) 879-4509

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within thirty (30) working days of receipt of the Claims Dispute/Adjustment request and all necessary supporting information.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
    - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data

Each capitated Provider/organization delegated for Claims administration is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

Molina will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

Billing Instructions for Ancillary Service Providers

Molina follows the instructions of EMedNY in the submission of ancillary service claims. The billing form listed in the EMedNY instructions is the form Molina will accept to process claims. Please use the appropriate claim form for the services provided to Molina Members.

Section 11. Adverse Determinations, Appeals and Complaints (Grievances)

Background

Molina will maintain an efficient complaint process that seeks to resolve Member or Member Designee complaints regarding the dissatisfaction with any aspect of Molina's operations, benefits, employees, vendors or Providers, within the timeframes defined by the contract with the State of New York and any other related Medicaid policies. The Member Services department has primary oversight for the accurate classification, review and timely resolution of all complaints.

Molina will work with the New York State Department of Health (SDOH) and the Local Department of Social Services (LDSS) on the investigation of any complaint filed with SDOH or the LDSS.

Molina will provide Members and Member Designees with reasonable assistance in filing a complaint, complaint appeals or action appeals, completing forms and other procedural steps including, but not limited to providing interpreter services, and toll-free numbers with TTY/TDD capability.

Molina will not retaliate or take any discriminatory action against a Member because a complaint or complaint appeal has been filed.

Molina subcontracts utilization management functions for Dental, Pharmacy and Mental Health/Substance Use Benefits. 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 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.

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®, other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. The criteria is updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice. The UM criteria is applied in a manner that considers the individual health care needs of the Member and characteristics of the local delivery system.

At least annually, the determination process is evaluated for the consistency with which those involved in the Utilization Review process apply the criteria in the determination of coverage. Individual circumstances and needs will be taken into account in the development, adoption, and application of clinical UM criteria.

The following factors may be considered:

- Age
- Co-morbidities and complications

- Progress of treatment
- Treatment goals
- Psychosocial situation
- Home environment

Characteristics of the local health care delivery system, including but not limited to Member access and Member circumstances are considered in the development, adoption, and application of clinical UM criteria.

A written notice of an adverse determination (initial adverse determination) will be sent to the Member and Provider and will include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals and
- Notice of the availability, upon request of the Member or the Member's Designee of the clinical review criteria relied upon to make such determination.
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained by Molina in order to render a decision on the appeal.

For Medicaid the notice will also include:

- Description of Action to be taken
- Statement that Molina will not retaliate or take discriminatory action if appeal is filed
- Process and timeframe for filing/reviewing appeals, including Member right to request expedited review
- Member right to contact DOH, with toll-free number, regarding their complaint
- Fair Hearing notice including aid to continue rights
- Statement that notice is available in other languages and formats for special needs. as well as how to access

The adverse determination notice will also include a description of action to be taken and a statement that Molina will not retaliate or take discriminatory action if an appeal is filed.

Members may request and file an appeal and request an expedited review. The Member may contact the New York State Department of Health at 1-800-206-8125 regarding their complaint. The Member will be issued a fair hearing notice including aid to continue rights and a statement that the fair hearing notice is available in other languages and formats for special needs and how to access these formats. Fair hearing notice will also inform the Member of liability for services if a denial is upheld in a fair hearing.

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

- Relevant medical information presented to Molina upon retrospective review is materially different from the information that was presented during the pre-authorization review; and

- The information existed at the time of the pre-authorization review but was withheld or not made available; and
- Molina was not aware of the existence of the information at the time of the pre-authorization review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

When an initial adverse determination is rendered without Provider input, the Provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request and shall be conducted by the Member's health care Provider and the clinical peer reviewer making the initial determination.

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:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
5232 Witz Drive, North Syracuse, NY 13212

or Members may call

1-800-223-7242.

Expedited Appeal

An expedited appeal may be filed for the following:

- Continued or extended health care services
- Additional services for a Member undergoing a course of treatment
- When the Provider believes that an immediate appeal is necessary
- 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, as fast as the Member's condition requires and within two (2) business days of receipt of necessary information but no more than three (3) business days of receipt of appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request; or if MCO demonstrates more information is needed and delay is in best interest of Member and so notices Member

Written notice of final adverse determination concerning an expedited UR appeal shall be transmitted to Member within twenty-four (24) hours of rendering the determination. For Medicaid, Molina will make reasonable effort to provide oral notice to Member and Provider at the time the determination is made.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Standard Appeal

These appeals may be filed by a Member or a Member's Designee. A Provider may file a UR appeal for a retrospective denial. Appeals may be filed in writing or by phone. Any appeal received by phone must be followed up with a written appeal. The acknowledgement of the appeal and request for additional information required to review the appeal will be provided in writing within fifteen (15) days of receipt of appeal. If the information provided is incomplete, Molina will request the missing information in writing within five (5) business days of receipt of information. During appeal review period, the Member or their Designee may see their case file and the Member may present evidence to support their appeal in person or in writing. Molina will make a determination no later than thirty (30) days from receipt of the appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request; or if Molina demonstrates more information is needed and delay is in best interest of the Member and notifies the Member in writing. Molina will notify the Member or the Member's Designee within two (2) business days of the appeal decision in writing.

Each notice of final adverse determination will be in writing, dated, and include:

- The basis and clinical rationale for the determination
- The words "final adverse determination"
- Molina contact person and phone number
- Member coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/Provider and developer/manufacturer of service as available
- Statement that Member may be eligible for external appeal and timeframes for appeal

- If health plan offers two levels of appeal, cannot require Member to exhaust both levels. Must include clear statement in bold that Member has 4 months from the final adverse determination to request an external appeal and choosing 2nd level of internal appeal may cause time to file external appeal to expire.
- Standard description of external appeals process attached
- Summary of appeal and date filed
- Date appeal process was completed
- Description of Member's fair hearing rights if not included with initial denial
- Right of Member to complain to the Department of Health at any time via a toll free number
- Statement that notice available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer; provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. If Molina fails to make a determination with the applicable time periods it would 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, employees, vendors or Providers. A complaint is the same as a Grievance.

Complaint Appeal: a request for a review of a complaint determination.

Complaint Determination: Any decision made by or on behalf of Molina regarding a complaint whereas a Member is dissatisfied.

Grievance System: Molina's complaint and appeal process including a complaint and a complaint appeal process, a process to appeal actions and access to the State's fair hearing system.

Inquiry: Any oral or written request to Molina, a Provider, or facility, without an expression of dissatisfaction, e.g., a request for information. Inquiries are routine questions about benefits (i.e. inquiries are not complaints) and do not automatically invoke the grievance or appeals or request for Service Authorization process.

Complaint Process

Complaints will be accepted either orally or in writing. Written complaints will be responded to in writing. Verbal complaints may be responded to verbally or in writing, unless the Member or a Member representative requests a written response, which will be responded to in writing.

Complaints and/or complaint appeals will be accepted during call center hours. Molina staff are available to assist with filing of complaints, complaint appeals, and action appeals.

If any other departments or staff at Molina receives a complaint from a Member, the Member Services Department will be notified and the complaint will funnel through the process identified in this policy. Any complaints involving Marketplace Facilitated Enroller or Marketing Representatives will be forwarded to the Marketing Manager. Molina recognizes that a Member has the right to designate an authorized legal representative (Member Designee) to act on his/her behalf at any time during the complaint process. The designated representative may be anyone to whom the Member designates, in writing, the authority to speak for him/her and may include a health care Provider or attorney and will follow any State specific requirements.

Written Complaints

All written complaints will be reviewed by one or more qualified personnel who were not involved in previous decision-making roles. Complaints pertaining to clinical matters, complaints that are an action appeal denial based on lack of medical necessity, or a complaint regarding the denial of expedited resolution of an action appeal will be reviewed by one or more licensed, certified or registered health care professionals in addition to non-clinical personnel.

If an Member files a complaint regarding difficulty accessing a needed service or referral from a Participating Provider, and, as part of or in addition to the complaint, requests the service or referral directly from Molina, Molina will accept and review the service authorization request and make a determination in accordance with Plan Policy and Procedure.

For all written complaints an acknowledgement of the complaint and a notice of the determination will be sent to the Member or Member Designee.

If a determination was unable to be made because insufficient information was presented or available to reach a determination, Molina will send a written statement that a determination could not be made to the complainant on the date the allowable time to resolve the complaint has expired. All interactions regarding the complaint including, but not limited to, Provider inquiries and interactions, interactions with Members, interactions with other Molina staff, letters, etc. will be documented.

Complaint Appeals

A Complaint Appeal may be filed within sixty (60) business days after the receipt of the notice of complaint determination. Complaint Appeals may be submitted in writing by letter or by completion of the complaint appeal form after a complaint determination is received. A Member

may also call and specifically request a complaint appeal based on the receipt of a complaint determination. Within fifteen (15) business days of the receipt of the Complaint Appeal, Molina will provide a notice of Complaint Appeal Acknowledgement. Complaint Appeals of clinical matters will be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL §4900(2)(a).

Complaint Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original complaint determination.

Members and Providers will be notified of the process to request an Appeal of a Complaint Determination in the Complaint Determination notification and in Member and Provider Handbooks.

Expedited complaint

If a delay in processing a complaint would significantly increase the risk to a Member's health, complaints will be resolved within two (2) business days from the receipt of necessary information and no more than seven (7) calendar days from the receipt of the complaint.

Standard Complaint

Complaints will be resolved within forty-five (45) calendar days after the receipt of necessary information and no more than sixty (60) calendar days from the receipt of the complaint.

Complaint appeals will be decided and notification provided within two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health.

Complaint appeals will be decided and notification provided within thirty (30) business days after the receipt of all necessary information when Member health is not at risk.

Complaint Acknowledgement

Molina will provide written acknowledgement of any complaint within fifteen (15) business days of the receipt of the complaint. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the complaint.
- Identification of any additional information required from any source to make a determination.
- If a complaint determination is made before the written acknowledgement is sent, Molina may include the acknowledgement with the notice of determination (one notice).

Complaint Determination

A complaint determination will be made in writing to the Member, and/or the Member Designee and will include:

- Detailed reasons for the determination.
- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- The procedure and form for filing an appeal of the complaint determination within sixty (60) business days.
- Notice of the right for the Member or Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number 1.800.206.8125.
- For Medicaid Members only – the right to complain to their local Department of Social Services.

In cases where delay would significantly increase the risk to a Member's health, Molina will provide notice of a determination by telephone directly to the Member or to the Member's Designee, or when no phone is available, some other method of communication, with written notice to follow within three (3) business days.

When a Member's complaint is related to dissatisfaction with a Provider, the notice of determination will include the names and addresses and telephone numbers of three alternative Providers within the Molina network.

When a Member is required to meet certain criteria to achieve a goal related to their care and the Member did not meet the criteria, Molina will include recommendations to the Member in how to reach the goal.

Complaint Appeal Acknowledgement

Molina will provide written acknowledgement of any Complaint Appeal within fifteen (15) business days of the receipt. The written acknowledgement will include:

- The name, address and phone number of the individual or department handling the Complaint Appeal.
- Identification of any additional information required from any source to make a determination.

Complaint Appeal Determination

Complaint appeal determination notifications will be sent within thirty (30) business days of the receipt of the complaint appeal. The complaint determination will be made in writing to the Member, the Member Designee and may include:

- A detailed reason for the determination.

- In cases where the determination has a clinical basis, the clinical rationale for the determinations.
- A Notice of the right for the Member, Member Designee to contact the State Department of Health (SDOH) regarding the complaint, including the SDOH toll-free number.
- Instructions for any further appeal, if applicable.

Important Telephone Numbers and Addresses

Members/Member Designees and Providers may contact the following agencies at any time with a grievance:

The Molina Member Service Department

Members may call toll free at 1-800-233-7242 or submit their appeal or grievance in writing to:

Molina Healthcare, Inc.
Attention: Appeals and Grievances
5232 Witz Drive
North Syracuse, New York 13212

Members may also contact:

Cortland County Department of Social Services

1-607- 753-5248

Onondaga County Department of Social Services

1-315- 435-3525

Oswego County Department of Social Services

1-315- 963-5481

Tompkins County Department of Social Services

1-607- 274-5667

New York State Department of Health

Toll free 1-800- 206-8125

Or write to:

New York State Department of Health
Bureau of Certification and Surveillance
Corning Tower
Albany, New York 12237

Reporting

All Grievance/Appeal data, including Provider specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the State in accordance with regulatory requirements. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

Section 12. Provider Credentialing and Termination

Credentialing

Application Process

Molina will credential all licensed and certified Providers who are seeking to join the Molina Participating Providers Network.

Participating Providers are those who have contracted with Molina give services to Molina Members, are listed as Participating in the Molina Provider Directory, and are listed by Molina as Participating on all reports to NYSDOH (i.e. HPN submissions).

Participating Providers to be credentialed will include, but not be limited to:

MD	CDN	PT	Audiologist
DO	RPAC	MC, MA Counselors	
DDS	OD	CASAC Counselors	
DMD	PhD	CM	
DPM	OT	CNM	
NP	SLP	CSW	

HIV Specialist Criteria

Every Participating Primary Care Provider (PCP) that follows HIV-infected Members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies:

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

Eligibility requirements include:

- Current and valid MD, DO, PA or NP state license year,
- Provision of direct, ongoing care to at least 20 HIV patients over the 24 months preceding the date of application, and
- Completing a minimum of 30 credits of HIV-related Category 1 CME/CEU/CE within the 24 months preceding the date of application.

Criteria and Verification

Molina requires Primary Source Verification of the following criteria for credentialing:

- Evidence of a valid current license (license must be in effect at the time of the credentialing decision)
- Evidence of valid DEA as applicable (Certificate must be in effect at the time of credentialing decision)
- Education and training Provider
- Board certification
- Applicable work history
- Malpractice history
- History of professional liability claims that resulted in settlements of judgments paid by or on behalf of the practitioner.

Additional Credentialing Criteria will include an Application and Attestation including:

- Reasons 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 activity
- Current malpractice insurance coverage
- Correctness and completeness of the application
- The application must be signed and dated within 180 calendar days of the credentialing decision
- Query National Practitioner Data Bank (NPDB) for any sanctions imposed by Medicare/Medicaid and includes it in the credentialing files. (Within 180 days of credentialing decision)
- License sanctions or limitations
- Previous sanction activity by Medicare and Medicaid
- Review of Provider's physical site of practice including review of medical record documentation
- Query the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master File, and the National Plan Provider Enumeration System (NPPES)
- Hospital privileges indicated by Providers on the Contract Request Form will be validated
- Hospital privileges may be waived if the physician provides ALL of the following documentation and information:
    - Description of the circumstances that merit consideration of a waiver
    - Either a copy of a letter of active hospital appointment other than admitting or evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has active admitting

privileges and will monitor and provide continuity of care to the Provider's patients who are hospitalized
- a CV
- Proof of malpractice insurance
- Two letters of reference from physicians who can attest to the applicant's qualifications as a practicing physician
- Graduation from medical School as verified by written documentation from Medical College or AMA Master Physician File
- Completion of a residency program as verified by written documentation

Re-Credentialing

Molina re-credentials Providers at least once every three years. During such re-credentialing, plan will reexamine the items covered during the initial credentialing, as well as complaints lodged against the Provider by plan Members and the results of chart audits and other quality improvement activities.

In the event that Molina denies credentialing or terminates a Provider's contract (including in response to the re-credentialing process) for program integrity related reasons, Molina will report such adverse action to the New York State Department of Health and the Office of the Medicaid Inspector General.

Credentialing Validation Organization Vendor

Molina contracts with a credentialing validation organization (Aperture) contracted to provide primary source verification and other credentialing duties.

Molina will retain responsibility to ensure that every Participating Provider in the network meets the credentialing criteria set forth by the Plan. The agreement with Aperture specifically authorizes such duties and Molina is indemnified by Aperture for services rendered Aperture.

Aperture provides a written document to Molina that each Participating Provider meets the established credentialing criteria, or clearly indicates where, if applicable, any criterion is omitted.

Molina will review and approve the vendor credentialing and re-credentialing policies and procedures to ensure compliance with the NYSDOH guidelines. If applicable, this evaluation will include a review of the files for the presence of:

- Plan Approved criteria collection
- Availability of required data elements and primary source verification per Plan Policy;
- Evaluation of Provider credentialing files for completeness including all supporting documentation per Plan policy and procedure.

If applicable, Molina shall provide technical assistance and consultation to Aperture as appropriate.

Aperture must obtain approval from Molina before making any changes to the credentialing policy.

Aperture provides Molina with an accurate detailed Provider file and if applicable, any reports of the Vendor Credentialing Activities.

The Medical Director shall ensure that an annual audit of the vendor credentialing procedures and files is done to assess the vendor's activity through evaluation of the adequacy and completion of the Provider credentialing files per Plan Credentialing Policy and Procedure.

Once Provider information is received from Aperture, the file is reviewed for completeness by QA/UR staff. Once all information is reviewed, the Provider is added to the listing for acceptance by the Credentialing Committee.

Molina will review and approve the credentialing and recredentialing of each Provider by obtaining approval and acceptance of each Provider by the Credentialing Committee.

For Providers new to the Molina network, a notification is sent to the Provider confirming their acceptance into the network. This notification must occur within ninety (90) days of when Molina received the completed application. Molina will notify the Provider as to whether the Provider is credentialed; or whether additional time is necessary to make a determination despite Molina's best efforts or because a third party failed to provide necessary documentation.

Non-Routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, Molina will make every effort to obtain such information as soon as possible, but not more than ninety (90) days from receipt of the application.

Annual Validation Process:

Because Molina contracts with a Credentialing Validation Organization, a representative sampling of Provider credentialing files will be audited by Molina annually. The criteria for selection of files are:

Credentialing Validation Organization - At a minimum, five (5) percent or 50 Provider files (whichever is less) from the various specialty types will be reviewed. The selection should include both initial credentialing and re-credentialing files.

The credentialing files reviewed must demonstrate that the Vendor is effective in applying collection criteria uniformly, processing new applications and reapplications within the time frames established by policy, bylaws, and the Managed Care Contract. Credentialing files/data are kept in accordance with Plan Credentialing Policy and Procedure.

Molina Chief Medical Officer will bring results of the Annual Validation Audit to Molina Credentialing Committee and Quality Management Committee. As issues arise with the Vendor, they should be resolved by the Chief Medical Officer. A summary of issues with the

Vendor and resolutions should be included in the Chief Medical Officer's annual report to the board of directors on the annual validation.

Molina's audit report will be presented by the Chief Medical Director to the Molina Board of Directors for approval and/or recommendations for corrective action annually.

In instances where findings of the validation audit show significant disagreement between the Vendor policies and its functional credentialing, the Plan Chief Medical Officer may choose to provide technical assistance or may rescind the vendor agreement.

Chief Medical Officer Role

The Chief Medical Officer is responsible to present the credential findings to the Credentialing Committee. The Credentialing Committee has the delegated authority to approve, or approve with conditions and/or deny/terminate participation in Molina's network.

The Chief Medical Officer will at a minimum refer to the full Credentialing Committee review the following:

- Primary Care Provider with more than three (3) malpractice awards/settlements within the past 10 years
- Primary Care Provider with more than $1,000,000 in aggregate malpractice awards/settlements within the past ten (10) years
- Specialists with more than five (5) malpractice awards/settlements >$20,000 within the past ten (10) years. Specialists with more than $2 million in malpractice awards /settlements within the past ten (10) years. For the purposes of this calculation any one malpractice award/settlement is capped at $1,000,000.
- Any disciplinary action by NYSDOH, Medicare of Medicaid
- Any criminal conviction or pending prosecution within the past fifteen (15) years

Board of Directors' role

The approval process is delegated to the Chief Medical Officer and the Credentialing Committee. The Chief Medical Officer is responsible to provide quarterly reports to the Board of Directors on the results of the credentialing process.

Provider Termination

Molina will immediately remove any Provider from the network who is unable to provide health care services due to a final disciplinary action. Providers that are sanctioned by the DOH's Medicaid Program will be excluded from participation in Molina's Medicaid panel.

To afford a health care professional the opportunity for review or hearing, Molina will provide a written explanation of reasons for a proposed termination with the health care professional. However, written notification will not be required in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other

governmental agency such as sanctioning by NYS DOH Medicaid Program that impairs the health care professional's ability to practice, nor are they eligible for hearing or review.

The notification of the proposed termination by Molina to the health care professional will include:

- The reasons for the proposed action;
- Notice that the Provider has the right to request a hearing or review before a panel appointed by Molina;
- A time limit of not less than thirty (30) days within which a health care professional may request a hearing, and
- A time limit for a hearing date that will be held within thirty (30) days after the date of receipt of a request for a hearing.

Molina will not terminate a contract or employment, or refuse to renew a contract, solely because a health care Provider has:

- Advocated on behalf of a Member;
- Filed a complaint against Molina;
- Appealed a Molina decision;
- Provided information or filed a report pursuant to PHL §4406-c regarding prohibitions by plans, or
- Requested a hearing or review pursuant to PHL §4406-d and the following sections.

Except as provided above, no contract or agreement between Molina and a health care professional will contain any provision, which will supersede or impair a Provider's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination.

Right to Hearing

A health care professional that has been notified of his or her proposed termination will be allowed a hearing. The health care professional must request a hearing within thirty (30) days of notification by Molina. A hearing will be held within thirty (30) days after the date of receipt of a request for a hearing. The procedures for this hearing must meet the following standards:

- The hearing panel will be comprised of three (3) persons appointed by Molina. At least one (1) person on such panel will be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three (3) persons, provided however that the number of clinical peers on such panel will constitute one-third or more of the total membership of the panel.
- The hearing panel will render a decision on the proposed action in a timely manner. Such decision will include reinstatement of the health care professional by Molina, provisional reinstatement subject to conditions set forth by Molina or termination of the

health care professional. Such decision will be provided in writing to the health care professional.

- A decision by the hearing panel to terminate a health care professional will be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision. Notwithstanding the termination of a health care professional for cause or pursuant to a hearing, Molina will permit a Member to continue an on-going course of treatment for a transition period of up to ninety (90) days, and post-partum care, subject to Provider agreement, pursuant to §4406(6)(e).
- In no event will termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

Termination and Continuity of Care

If a Member's health care Provider leaves the managed care organization's network of Providers for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, the managed care organization will permit the Member to continue an ongoing course of treatment with the Member's current health care Provider during a transitional period.

The transitional period date begins the date the Provider's contractual obligation to provide services to Molina terminates and ends no later than ninety (90) days, or if health care professional is providing obstetric care and the Member has entered her second trimester of pregnancy at the time of the Provider's termination, the transitional period includes post-partum care directly related to the delivery.

The care will be authorized by Molina for the transitional period only if the health care Provider agrees to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full; to adhere to quality assurance requirements and to provide medical information related to such care; and to adhere to the organization's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the organization.

In no event will this paragraph be construed to require Molina to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the Member's benefit plan.

Duty to Report

Molina is obligated under New York State Public Health Law (Article 4405-b) to make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Article One Hundred Thirty One Section 6530.

Molina will report the following to the Office of Medical Misconduct:

- The termination of a health care Provider contract pursuant to New York State Public Health Law (4406-d) for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare;
- The voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures; or
- The termination of a health care Provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

Molina will submit the information, in writing to:

Director, Central Intake Operations
Office of Professional Medical Conduct
New York State Department of Health
433 River Street, Suite 303
Troy, New York 12180-2299

The report will include the Provider's full name, license number, address, account/date of event/incident, of actions taken by the health plan (including date of termination of contract or withdrawal), and contact persons at the managed care organization (MCO). Molina will seek an "advisory opinion" if Molina is reasonably unable to determine whether a report must be made. These advisory opinions will be sought by written request to the Director of OPMC at the address listed above.

Any report or information furnished to an appropriate professional discipline agency in accordance with the provisions of Section 4405-b will be deemed a confidential communication and will not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issue in a pending action or proceeding.

Non-Renewal

Either party to a contract may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one (1) year, upon sixty (60) days' notice to the other party; provided, however, that any non-renewal will not constitute a termination for purposes of this section. PHL §4403(6) (e), concerning continuation of course of treatment and post-partum care, also applied to disaffiliations based upon non-renewal. Notification of non-renewal will contain explanation of the right of non-renewal, time frames and language that non-renewal does not constitute termination.

Section 13. Home and Community Based Services (HCBS)

HCBS Overview

HCBS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community.

Molina Healthcare of New York understands the importance of working with our Providers and Community Based Organizations (CBO's) in your area to ensure our Members receive HCBS services that maintain their independence and ability to remain in the community.

Molina's HCBS Provider network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our HCBS Provider network and achieve a successful partnership in serving those in need.

HCBS Benefits and Approved Services

These include the following services:

- Adult Day Care Services
- AIDS Day Care Services
- Consumer Directed Personal Services
- Agency based Personal Care Services
- Personal Emergency Response (PERS) Services

Getting Care, Getting Started

Molina Healthcare of New York Case Manager will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and HCBS services. Specifically, along with providing the fully integrated Person Centered Services Plan (PCSP), Case Managers provide verbal, written and/or alternate format information on:

- After-hours assistance for urgent situations
- Access to timely appointments
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication
- Advocacy, engagement of family members and informal supports

Each Member will be assigned a Case manager no later than 30 days after enrollment. At a minimum, the Case Managers name and their contact information and hours of availability are included in, which is shared with all Person Centered Services Plan (PCSP) (also known as the Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Case Managers are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Members:

- HCBS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Service Management
- Medicaid Resolution
- Assessment of LTSS Need
- Member Education

Molina Healthcare of New York will work closely with the various Community Based Organizations (CBO's) for home and community based services (HCBS) to ensure that the Member is getting the care that they need.

Once a Provider of service has been located, billing for services will be the responsibility of the Provider. Please see the billing section of this manual for additional information.

Person Centered Services Plan (PCSP) Team (also known as Care Management Team or Interdisciplinary Care Team)

All Members will receive care management and be assigned a Case Manager from the Molina Plan.

Person Centered Services Plan (PCSP) Team will include at minimum the Member and/or their authorized representative, Medical Case Manager, the Member's PCP, a registered nurse, social worker, service Providers, family members, and others chosen by the Member to be involved with the service planning and delivery. PCSP team members may also include HCBS Providers (e.g. Adult Day Health Care Center staff Nursing Facility staff, etc.), PCP, specialist(s), behavioral health clinician, and pharmacist. The PCSP can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required Members.

Person Centered Services Plan (PCSP) Coordination

HCBS services to be covered by Molina Healthcare of New York will require coordination and approval.

The Person Centered Services Plan (PCSP) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The PCSP includes informal care, such as family and community supports. Molina Healthcare will ensure that a person centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A Person Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301),

The Person Centered Services Plan (PCSP) will be developed under Member's direction and implemented by assigned Members of the PCSP team no later than the end date of any existing SA or within the state specific timeframes for initial and reassessments. All services and changes to services must be documented in the PCSP and be under the direction of the Member in conjunction with the care manager. Reassessment and update of the PCSP will be done at least once every six (6) months.

The Person Centered Services Plan (PCSP) Team under Member's or Member's representative's direction, is responsible for developing the PCSP, and is driven by and customizable according to the needs and preferences of the Member. As a Provider you may be asked to be a part of the PCSP Team.

Additional services can be requested through the Member's Case Manager anytime including during the assessment process and through the PCSP process. Additional service need must be at the Members' direction and can be brought forward by the Member, the care manger, and/or the PCSP team as necessary. Once an additional need is established, the PCSP will be updated with the Member's consent and additional services approved. For additional information regarding HCBS service coordination and approvals in the Member's PCSP, please contact Molina Healthcare of New York at (877) 872-4716.

Transition of Care Programs

Molina has goals, processes and systems in place to ensure smooth transitions between Member's setting of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

All Case Managers are trained on the transitions of care approach that Molina follows for transitions between care settings. The case managers can use tablet technology to facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

HCBS Transitional Care Policy and Requirements

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, and Providers for ninety (90) days from the effective date of enrollment or until the Member's PCSP is in place, whichever is later. Ongoing Provider support and technical assistance will be provided especially to community behavioral health, LTSS Providers, and out

of network Providers during the continuity of care period. All existing Person Centered Services Plan (PCSP) and Service Authorizations (SAs) will be honored during the transition period.

A Member's existing Provider may be changed during the ninety (90) days transition period only in the following circumstances: (1) the Member requests a change; (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or New York State Department of Health (SDOH) identify Provider performance issues that affect a Member's health or welfare; or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network Providers. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the ninety (90) days, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility (NF) at the time of Molina HCBS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their families or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or SDOH identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider is excluded under state or federal exclusion requirements.

Molina will perform the initial health risk assessment within the first thirty (30) days of enrollment to determine type of case management. Reassessment will be performed every one hundred eighty (180) days.

For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at (877)872-4716.

Members have the choice of how their services are delivered through various models, which may include consumer-direction.

In a consumer-directed model, the state requires Molina to maintain a contract with state Fiscal Intermediary (FI) agencies. Currently, Molina contracts with the following three FI agencies: ARISE, AccessCNY, and Finger Lakes Independent Center (FLIC).

Consumer Directed Personal Assistance Services (CDPAS) is available for the MMC program. CDPAS Authorizations will not exceed six (6) months. A copy of the authorization will be sent to the Fiscal Intermediary (FI) selected by the Member or Members' representative.

Molina will be providing each Member with the name, address, and phone number of at least two (2) Fiscal Intermediaries. The Member will arrange through the Fiscal Intermediary for the wage and benefit processing of the Members consumer directed personal assistant.

Claims for HCBS Services

Providers are required to bill Molina Healthcare of New York for all HCBS services through EDI submission, or through the Web Portal. After registering on the Molina Web Portal a Provider will be able to check eligibility, claim status and create/submit claims to Molina Healthcare. To register please visit: Provider Self Services Web Portal

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).

Member Responsibility

Molina Healthcare of New York will be responsible to deduct the Net Available Monthly Income (NAMI) from claims where Members reside in a nursing home when applicable.

Nursing Facility Billing Guidance

Providers must bill with the following codes:

- Bill Type: 021X
- Revenue Codes
    - 0001 – Totals Charges
    - 0100 - All inclusive Room and Board-Custodial Care & Respite
    - 0101 - All inclusive Room and Board-Vent
    - 0120 - All inclusive Room and Board-AIDS
    - 0199 - All inclusive Room and Board-Head Injury
    - 0183 - Therapeutic leave
    - 0185 - Hospital leave
    - 0189 - Therapeutic leave when authorized by medical professional

Note: A separate claim must be completed if the period of service includes therapeutic or hospital leave days. Leave of absences are limited to a combination of 18 days in a calendar year.