2018 Provider Manual

Partners Health Plan is a specialty Prepaid Health Services Plan (PHSP) that serves eligible individuals with intellectual and other developmental disabilities

Table of Contents

Section 1: Introduction 8

Welcome 8
About Partners Health Plan 8
Mission and Values 9
About Intellectual and Other Developmental Disabilities 9
Physical Health Issues 10
Behavioral Health Issues 10
Professional Competencies for Providers 11
Knowledge 11
Skills 11
Attitudes 12
About the PHSP Program for People with I/DD 12
About this Provider Manual 13
How PHP Works with Providers and Members 13
Provider Relations 13
Care Management 13
Member Services 14
Claims 14
Contact Information 14
Important Phone Numbers 14
To Report a Complaint 16
Important Addresses 17

Section 2: PHP's Model of Care for Persons with I/DD 19

Care Management 19
Interdisciplinary Teams (IDTs) 20
Definition 20
IDT Composition Tailored to Member Needs 20
Care and Service Planning (Life Plan) 21
Life Plan and Electronic Care Management Record Features 22
Life Plan Monitoring 23
Service Authorization 23
Provider Network 24

Section 3: Rights and Responsibilities 26

Member Rights 26
Member/Caregiver Responsibilities 27
The Provider's Roles and Responsibilities 27
Additional Roles and Responsibilities for Hospitals 29
Restricted Recipient Program 29
Cultural Sensitivity 29
Communication Access 29
Physical Access 30
Confidentiality 30

Section 4: Covered Services and Supports 31

Services Covered by PHP 31
Physical Health Services 31
Behavioral Health Care 34
Pharmaceutical Services 34
Dental Care 35

Vision Care ... 35
Transportation Services ... 35
Non-Covered Medical Services ... 36
Client Acknowledgement Statement ... 36
Balance Billing ... 37

Section 5: Eligibility and Enrollment ... 38

PHSP Eligibility ... 38
Enrollment ... 39
New Enrollees ... 39
Disenrollment Procedures ... 40
Disenrollment Denials ... 40
Cancellation of Voluntary Disenrollment ... 40
Required Involuntary Disenrollment ... 41
Discretionary Involuntary Disenrollment ... 41
Continuation of Services Pending an Appeal ... 42

Section 6: Provider Roles and Responsibilities ... 44

Informed Consent ... 45
Confidentiality ... 45
You Can Help Protect Patient Confidentiality ... 45
Member Complaints and Grievance Procedures ... 46
New York State Confidentiality Law and HIV ... 46
HIV and Developmental Disabilities ... 48
Advance Directives ... 48
Health Care Proxy ... 49
Health Care Decisions Act ... 50
Decisions Regarding Life Sustaining Treatment (LST) ... 51
Member Access to Care ... 51
Appointment Availability/Waiting Time ... 52
Mental Health Clinics ... 52
Community-Based Long-Term Services and Supports (LTSS) ... 53
Facility-Based LTSS ... 54
Primary Care Services ... 54
Office Wait Times ... 54
Missed Appointments ... 54
Second Medical or Surgical Opinion ... 55
Laws Relating to Federal Funds ... 55
Cultural Competency ... 55
Americans with Disabilities Act Requirements ... 56

Section 7: Primary Care Services ... 58

Primary Care Provider Responsibilities ... 58
Choice of Network PCP ... 59
New Member Transitional Care ... 59
Member Access to Primary Care Services ... 60
Office Hours ... 60
24/7 Telephonic Access ... 60
Changing PCPs ... 61
Member-Initiated Change ... 61
Provider-Initiated Change ... 61
Closed Panel ... 62

PCP Leaves PHP's Network 62
Required Reporting to Local Department of Health 62

Section 8: Specialist Provider Services 64

Responsibilities 64
Appointment System 65
Verification of Member Eligibility 65
Authorized Services 65
Coordination of Care 66

Section 9: Emergent, Urgent, and Inpatient Services 67

Emergency Services 67
Definition ..... **Error! Bookmark not defined.**
Emergency and Post-Stabilization Care 67
Emergency Behavioral Health Services 68
Urgent Care Services 68
Definition 68
Urgent Care Policy 68
Inpatient Services 69
Transfer to another Hospital 69
Concurrent Review and Discharge Planning 69

Section 10: Women's Health Providers 71

Responsibilities 71
Direct Access to Obstetrics and Gynecological (OB/GYN) Services 71
Preventive Care 71
Appointment Systems 71
Maternity Admissions 71

Section 11: Member Transitions In Care 73

Transition Coordinator 73
Provider/Practitioner Responsibilities 74
Continuity of Care Requirements 74
Continued Access to Providers/Practitioners 74
Exceptions 74
Transfer of Medical/Service Records 75
Medical Equipment and Supplies 75

Section 12: Medical/Service Record Documentation Standards 76

Medical/Service Record Reviews 76
Content of the Medical/Service Record 76
Performance Goals 79
Corrective Actions 79
Medical/Service Record Retention Requirements 79
Confidentiality 79
Confidentiality of HIV-Related Information 80
Access to Medical/Service Records 80

Section 13: Evidence-Based Practice Guidelines 81

Introduction 81
References 81
Process for Adopting and Updating Practice Guidelines 81

Updating Practice Guidelines 82
Clinical Practice Guidelines (CPGs) for Persons with IDD 82
Evaluating the Use of Practice Guidelines 86

Section 14: Prior Authorization and Referrals 87

Prior Authorization Protocols 87
Services Requiring Prior Authorization (PA) 88
Services That Do Not Require PA 88
Services Requiring Authorization by a Specialist Provider 89
Utilization Management Process 89
Service Authorization Timeframes 91
An Approved Care and Service Plan (Life Plan) is the Service Authorization Document for Covered Services 93
Service Authorization Denials 93
Prior Authorization Appeals 94
Referrals 96
Specialist Visits 96
Self-Referrals 96
Out-of-Network Services 97

Section 15: Credentialing and Re-credentialing 98

General Policy Statement 98
Anti-Discrimination 98
Credentialing and Performance Committee 98
Required Credentials 99
Independent Practitioners 99
Organizational Providers 100
Laboratories 100
Delegated Credentialing 100
Credentialing Process 101
Confidentiality 103
Approval Process 103
Notification to Providers 103
Ongoing Monitoring of Provider Status 104
Review and Verification for Re-credentialing 104
Council for Affordable Quality Healthcare (CAQH) Credentialing Application Process 104

Section 16: Out-of-Network/Non-Par Providers 105

Provider Responsibilities 105

Section 17: Non-Clinical Provider Appeals 106

Requests for Reconsideration of Administrative Denials or Paid Amount 106

Section 18: Member Complaints/Grievances and Appeals 107

Grievance Process 107
Same-day Grievance 107
Standard Grievance 107
Expedited Grievance 108
Grievance Acknowledgment 108
Grievance Appeals 109
Appeals Processes 110
Appeals of an Action 110
Appeals of a Prior Authorization or Concurrent Review Action 114

Appeal Documentation 116

Section 19: Health Insurance Portability and Accountability Act (HIPAA) Guidelines 117

Section 20: Marketing 118

General Requirements 118
Provider Affiliation Information 119
New Affiliations 119

Section 21: Fraud, Waste, and Abuse (FWA) 120

Section 22: Provider Performance & Termination 122

Performance Standards and Compliance 122
Performance Standards 122
Compliance 122
Provider Misconduct 122
Corrective Actions 123
Provider Termination and Appeals 123
Provider Terminations 123
Notification to Members 124
Transitional Care 125
Duty to Report 125

Section 23: Claims Processing and Encounter Reporting 127

General Payment Guidelines 127
Timeliness of Claims Submission 127
"Clean" Claims 127
Duplicate Claims 127
Additional Guidelines 128
Electronic Claims Submission 128
Lower Volume Electronic Claim Submitters 128
Paper Claims Submission 129
Claims Adjudication Processes 129
Auto Adjudication 129
Manual Pended Claim Resolution 130
Claims Adjustments 130
Claims Processing Timeframes 130
Identification of Late and Interest Due Payments 131
Coordination of Benefits 131
Overpayment 131
High-Cost Outliers 132
Reimbursement 132
Medical/Service Claim Review 132
Anesthesia Billing: Frequently Asked Questions 133
Fraud and Abuse Monitoring 134
Never Events 135
Frequently Asked Questions and Answers 136
Claims Appeals 137
Encounter Reporting 137
Definition 137
Encounter Reporting Policy 138
Fee-for-Service Providers 138
Capitated Providers 138

Section 24: Quality Management **140**

Provider Consultation 140
Professional Practice and UM Guidelines 140
Provider Participation on PHP Committees 140
Policy of Non-Interference with Provider Advice to Members 140
Provider Site Visits 141
Potential Quality of Care Concerns (PQoC 141
Member Satisfaction Surveys 142
Quality Oversight Committees 142
Board of Directors 142
Quality Oversight Committee (QOC) 142
Pharmacy and Therapeutics Committee 143
Utilization Management Committee 143
Credentialing and Performance Committee 143
Policies and Procedures Committee 144

Section 25: Member Resources **145**

Member Services Representatives 145
Call Center/Nurse Hotline 146
Access to After-Hours Clinical Advice 146
Language Translation Services 147
Member and Family Education 147

Section 26: Provider Training and Education **148**

New Provider Orientation 148
Provider Site Visits 150
Additional Educational Activities 150
Documentation of Provider Education 150
Additional Provider Resources 151

Section 27: Behavioral Health **152**

Basic Primary Behavioral Health Care Principles for Persons with I/DD 152

Attachment A: ADA Attestation Checklist **156**

The Americans with Disabilities Act (ADA) Attestation 156

SECTION 1: INTRODUCTION

Welcome

Welcome to Partners Health Plan (PHP). We are proud to be the first Prepaid Health Services Plan (PHSP) that specializes in managing all covered acute and behavioral health care services for Medicaid-eligible persons with intellectual and other developmental disabilities (I/DD). PHP's PHSP provides all Medicaid-covered services to non-dually eligible people with I/DD (i.e., persons eligible for Medicaid but not Medicare) with the exception of OPWDD waiver services, which will continue to be covered under the state's current fee-for-service system. Our PHSP additionally welcomes Medicaid-eligible persons who have not been diagnosed with I/DD and wish to enroll in our plan, such as family members of persons with I/DD. For dually eligible adults with I/DD, PHP also operates the nation's only FIDA-IDD Demonstration program that manages all Medicaid- and Medicare-covered supports and services, including OPWDD waiver services. Our FIDA-IDD and PHSP products are offered in all five boroughs of New York City as well as Nassau, Rockland, Suffolk, and Westchester Counties

Our ability to serve our members effectively is dependent on the quality of our provider network. By joining our network, you are helping us to serve eligible individuals by providing high-quality and accessible services and supports. You are one of the most critical components of our service delivery approach and Partners Health Plan appreciates your participation.

This Manual is intended to serve as an extension of our provider agreement. It includes valuable information to help you understand our program and provides helpful tips on how to work with PHP. It should be a valuable resource for you and your office staff. Importantly, information in this Manual is not intended to alter or modify the benefits to which the member is entitled. If and when operational policies change, the Manual will be updated accordingly, and a notice will be posted on PHP's Provider Portal. The most current version is the operative version that providers are required to follow, and it is always available on our website (PHPcares.org).

About Partners Health Plan

Partners Health Plan, Inc. ("PHP") is a federal 501(c)(4) tax exempt New York not-for-profit corporation aligned with the Downstate New York chapters of the NYSARC, Inc. and the ADAPT Community Network (formerly UCP of New York). PHP's sole corporate member is Partnerships for Healthcare Solutions, Inc. ("Partnerships"), which is also a New York not-for-profit corporation. Partnerships has one corporate member, PHSI, Inc., which is also a New York not-for-profit corporation.

PHP is led by invested stakeholders, family members, and advocates with decades of experience in health care, health insurance, and in managing services and supports for people with I/DD. These industry leaders have collaborated in a pioneering effort to implement a high-quality managed care program for persons with intellectual and other developmental disabilities and those who support them.

Since 1994, regardless of budget cuts and changes in New York's political and economic climate, the Downstate AHRCs/ARCs have worked tirelessly to ensure that compassionate

community-based programs for people with I/DD continue now and into the future. With more than six decades of experience serving persons with I/DD, PHP has the expertise to ensure that each enrolled member receives the essential medical, dental, behavioral, habilitation, and social services needed to support his or her health, safety, personal preferences, and valued outcomes in a manner that promotes courtesy, respect, and compassion.

Mission and Values

PHP is a person-centered managed care plan that supports members to live the life they choose. PHP's values and goals include:

- Promoting wellness
- Supporting choice
- Integrating services
- Respecting diversity
- Promoting quality of life

PHP's objective is to manage and/or coordinate a seamless array of supports and services with the individual at the center. We are dedicated to keeping each of our members healthy, happy, and as independent as possible while they pursue their dreams and valued outcomes in the diverse communities they call home. Working in close collaboration with families and other members of the community, PHP will work tirelessly to support the unique needs and wishes of the individuals in our care, coordinating their supports and services, advocating on their behalf, and assisting members throughout their lives. Our goals are lofty, but so too are the expectations of the people we are committed to supporting.

About Intellectual and Other Developmental Disabilities

According to the New York State Mental Hygiene Law, an intellectual or other developmental disability (I/DD) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism that originates before a person attains age twenty two and is expected to continue indefinitely. Persons with I/DD have widely varying degrees of abilities and deficits that often require direct-support professionals to know their unique forms of verbal and non-verbal communication to provide necessary supports. In addition, many people with I/DD display challenging behaviors often associated with an inability to communicate effectively. For example, a person experiencing pain or medical illness may rely on self-injurious behavior as a means of expressing physical discomfort.

The average life expectancy of people with I/DD was just 22 years in 1931, compared to 59 years in 1976, 66 years in 1993, and 76 years at present. Currently, the cause of death for all individuals with I/DD mirrors that of the general population (i.e., coronary heart disease, type 2 diabetes, respiratory illnesses, and cancer), except for those with Down syndrome, who typically die earlier due to dementia-related causes (over half of those with Down syndrome are expected to live into their 50s and roughly 13 percent will reach age 65). There are approximately six

million individuals in the US with an I/DD diagnosis and nearly 315,000 are over the age of 65 – a number that is expected to increase to more than 500,000 by 2020.[1]

Despite their handicaps, the issues confronting aging persons with IDD are not dissimilar from those of their non-disabled counterparts, including locating safe and affordable housing, living independently, accessing assistance when it is needed, leading productive and meaningful lives, and staying healthy. However, the situation is especially challenging for older adults with I/DD owing to an array of issues unique to this population, including aging caregivers, work-related issues, and medical and behavioral health problems.

Physical Health Issues

There are many physical health factors associated with intellectual and other developmental disabilities, and these often manifest in chronic health conditions as persons with I/DD age. For example, recent studies have documented higher incidents of disease and death for aging adults with I/DD due to a number of health conditions, such as difficulty eating or swallowing, dental disease, gastroesophageal reflux, esophagitis, respiratory disease and infections (leading cause of death), and constipation. Several chronic conditions also seem to be more widespread among persons with I/DD than in the general population, including non-atherosclerotic heart disease, hypertension, hyperlipidemia, diabetes, obesity, reduced mobility, bone demineralization, and osteoporosis. In addition, thyroid disease, the effects of taking multiple psychotropic drugs, and deaths due to pneumonia, bowel obstruction, and intestinal perforation have a higher prevalence among aging adults with I/DD.[2]

Some specific syndromes and diagnoses are inherent (e.g., epilepsy, sensory problems like poor vision and hearing, poor heart function in people with Down syndrome), while others are avoidable but overrepresented among the developmentally disabled (e.g., obesity, diabetes, poor dental health). Also, symptoms of aging like diminished hearing, the development of cataracts, respiratory difficulties, the onset of menopause, and obesity-related diseases like high cholesterol and diabetes can all occur earlier in those with Down syndrome than in the general population.

Behavioral Health Issues

In general, older adults are more prone to depression and other behavioral health issues than younger persons and this tendency is even more pronounced among individuals with I/DD, although it is frequently under-assessed, under-diagnosed, and left untreated. It is often challenging to identify behavioral health problems among aging individuals with I/DD because they are generally less capable of describing and conveying their feelings, and symptoms of conditions like depression may be expressed as physical complaints instead (e.g., headaches). Anti-depressant medication is generally effective in addressing these conditions, but

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[1] Laura Walker, Christine Rinck, Ph.D., Vim Horn, M.P.A., and Tom McVeigh, "Aging with Developmental Disabilities: Trends and Best Practices," University of Missouri Kansas City Institute for Human Development and The Missouri Division of MR/DD (2007); Toby Long and Sarkis Kavarian, "Aging with Developmental Disabilities: An Overview," *Topics in Geriatric Rehabilitation* 24 (2008).
[2] Beth Marks and Jasmina Sisirak, "Age-Related Health Changes for Adults with Developmental Disabilities," University of Minnesota (2009). http://ici.umn.edu/products/impact/231/20.html

considerable care must be taken to prevent potentially harmful interactions with other prescribed medications.[3]

Persons with a dual diagnosis of I/DD and a co-occurring behavioral health condition can be found at all ages and levels of intellectual and adaptive functioning. Estimates of the frequency of dual diagnoses vary widely; however, current professional consensus is that 30-40 percent of all persons with I/DD have a psychiatric disorder, although this percentage could be as high as 60 percent if aggressive and disruptive behavior is included. The full range of psychopathology that exists in the general population also can co-exist in persons who have I/DD.

Professional Competencies for Providers

This section highlights the core competencies, skills, and attitudes necessary to provide high quality care and services to persons with I/DD.

Knowledge

- **Clinical Knowledge Specific to I/DD**: Clinical knowledge includes causes, symptomology, characteristics, and the natural history of developmental disorders, as well as the specific medical conditions that are known to co-occur with developmental disabilities. Additional topics include diagnostic testing, psychotropic medications, behavioral interventions, use of adaptive equipment, and management of chronic disease.
- **Legal Rights of People with I/DD**: This knowledge area includes relevant legislation for people with I/DD, as well as the rights of individuals and their families. Examples of rights for people with I/DD include the right to prompt medical care and treatment; freedom from harm, unnecessary physical restraint, or isolation; freedom from excessive medication, abuse, and neglect; and freedom from hazardous procedures.

Skills

- **Communication and Interviewing Skills**: This skill includes strategies to gain a history, screen, and evaluate an individual with I/DD, particularly when he or she may be nonverbal. Communication skills also include the ability to effectively obtain and share information with families or caregivers.
- **Observation Skills**: Observation skills are critical when working with people with I/DD, especially to identify behaviors that may be affecting or may be resulting from the individual's health condition. This skill includes the ability to observe subtle changes in a person's behavior as these changes may in some cases require medical attention. Observing subtle changes, as well as gathering the information about such changes and being alert to caregiver reports about such changes, requires additional time and openness on the part of the provider.
- **Physical Examination Skills**: Physical examination skills specific to working with persons with I/DD include providing assistance with the positioning of the physical exam as well as

[3] Alan R. Factor, Ph.D., "Growing Older with a Developmental Disability: Physical and Cognitive Changes and Their Implications," Institute on Disability and Human Development, University of Illinois at Chicago (1997). http://depts.washington.edu/aedd/growing_older_dd_Factor.html

patience in working with individuals who may need extra time to be coaxed and talked through the exam procedure. This also includes the ability to engage in preplanning and diagnostics in order to assist the individual immediately and effectively.

- **Ability to Identify, Coordinate, and Communicate with Participants on the Member's Interdisciplinary Team (IDT)**: This skill encompasses the recognition that a multi-disciplinary team is often required in order to adequately care for a person with I/DD. Participants on the member's IDT include those who conduct the assessment and develop and implement the care plan, including care managers and coordinators, service providers, specialists, and caregivers. In addition to understanding the various roles of the team members, this skill also includes the ability to effectively coordinate the services for the member.

Attitudes

- **Compassion and Sensitivity**: Sensitivity to the needs and experiences of people with I/DD includes having compassion, good listening skills, and flexibility, as well as an understanding of the context in which individuals live and how that may influence treatment compliance. This also encompasses recognition of the challenges that people with I/DD face on a daily basis and the types of accommodations they may need.
- **Member- and Family-Centered Attitude**: Health care providers should strive to tailor their care according to what the member prefers. This encompasses extending respect to the member by using appropriate terminology, interacting directly with the member, and including him or her in the conversation. In addition, this attitude includes being respectful towards families and providing support when needed. Strong relationships with persons with I/DD and their families are necessary in order for members to trust and have confidence in their providers.
- **Cultural Sensitivity**: Cultural appropriateness reflects the ability for providers to be sensitive to differences. In this context, culture encompasses not only race/ethnicity and language, but also the disability culture. Cultural sensitivity includes using respectful terminology (e.g., people-first language), providing language assistance when necessary to enable communication with members, and providing care in a manner that takes into consideration the member's background and culture.
- **Recognition of the Additional Time Necessary to Serve Persons with I/DD**: In order to adequately serve and meet the needs of people with I/DD, providers must be prepared to spend additional time with them, as they often experience more complex problems compared to the general population.

About the PHSP Program for People with I/DD

PHP's specialized PHSP coordinates OPWDD waiver services such as habilitation and residential services with covered acute and behavioral health care services as well as with child and adolescent educational services (i.e., Individualized Family Service Plan (IFSP), Individualized Education Program (IEP)) to provide the full continuum of services and supports to persons with I/DD. This program is designed to:

- Link primary, specialty, and community-based services for some of New York's most vulnerable residents
- Break down service delivery silos
- Reduce or eliminate duplicative and/or unnecessary services and supports
- Promote timely and effective communications among the various stakeholders involved in a member's care
- Improve outcomes
- Enhance member and family satisfaction

About this Provider Manual

This Manual is designed to enable providers to easily access information on the majority of issues that may affect working with Partners Health Plan. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Relations staff at 1-855-747-5483.

Partners Health Plan will update the Provider Manual at least annually and distribute bulletins as needed to alert you about any changes. Please check our website regularly at www.PHPcares.org for the most up-to-date version of the Provider Manual.

The Partners Health Plan PHSP Provider Manual is available in hard copy form or on CD-ROM at no charge by contacting our Provider Relations Department at 1-855-747-5483.

How PHP Works with Providers and Members

Provider Relations

PHP's Provider Relations staff is dedicated to fostering durable, long-term partnerships with all contracted providers and practitioners. This relationship begins with an initial orientation and continues with ongoing training, education, and support on policies, procedures, and issues that concern service delivery within PHP's guidelines and requirements.

Care Management

PHP's Care Management staff, including Quality Management and Utilization Management, evaluates the quality and appropriateness of the covered services provided to PHP's members. Our Care Managers and Coordinators can provide assistance to you and your staff with service authorizations, care management and coordination, and referrals as well as with members that are proving challenging to treat owing to communication difficulties or who resist being touched or examined. In most cases the member's caregiver will accompany the member to the appointment, but if this is not possible or if other types of assistance are required, our trained and experienced Care Managers and Coordinators will gladly provide any needed help.

Care Management staff is available to provide any needed assistance — including assistance with service authorizations. Each member will have a dedicated, clinically licensed care manager

or QIDP care coordinator (depending on the member's assessed needs) assigned to them whose name and phone number can be found on the front of the Member's ID card.

Member Services

The Member Services Call Center is available 24 hours a day, 7 days a week at 1-855-747-5483. A live person is available on all business days from 8:00 a.m. to 8:00 p.m. to assist members and their caregivers and to respond to any questions or concerns regarding their coverage. This includes information regarding eligibility and enrollment, covered benefits, choosing or changing a primary care provider, orienting members to PHP, and member rights and responsibilities, among other topics. At all other times the Call Center employs an interactive voice response system to record voice messages. All voicemail messages will be promptly responded to on the next business day.

Importantly, Call Center staff never provides health-related advice to members or their families/caregivers. Calls of this nature are instead "soft-transferred" without losing contact with the caller (during business hours) to an appropriate care manager or clinician who is trained to assist with members' health care needs. At all other times the IVR system phone tree will automatically transfer calls of a clinical nature to our Nurse Hotline that is manned 24/7 with a trained clinician to provide general health-related information as well as assistance in accessing services outside of normal business hours.

Translation services are available at no charge for members and/or families/caregivers with limited English proficiency (LEP), and NY Relay and other accommodations are available in accordance with members' individual needs. Member Services staff also solicits feedback from members and their caregivers regarding their satisfaction with the services and supports provided by PHP. It is always our goal to address concerns or complaints quickly and efficiently.

Claims

PHP's claims processing staff adjudicates and pays claims for covered services and supports in accordance with the provider contract and PHP's policies and procedures. The claims department also collects encounter data for services and supports.

Contact Information

Important Phone Numbers

Name of Department or Organization	Phone Number	Email Address or Fax Number	Hours of Operation
Partners Health Plan	1-646-844-4020		Mon.-Fri. 8:00 a.m. – 5:00 p.m.
PHP Administration	1-646-844-4020		Mon.-Fri. 8:00 a.m. – 5:00 p.m.
Member Services	1-855-747-5483		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)

Name of Department or Organization	Phone Number	Email Address or Fax Number	Hours of Operation
Nurse Hotline	1-855-769-2507		24/7, 365 days per year
Grievances & Appeals	1-855-747-5483		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)
Utilization Management	855-769-2508	1-855-769-2509	Mon.-Fri. 8:00 a.m. – 6:00 p.m. (after hours voicemail)
Fraud and Abuse Hotline	1-855-747-0013		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)
Provider Relations	1-855-747-5483		Mon.-Fri. 8:00 am – 5:00 pm
Language Line (Translation Services)	1-866-874-3972 Client Code 706926		
NY Relay	7-1-1 1-800-662-1220 for out-of-state		24/7, 365 days per year
Pharmacy Services (PerformRx)	1-855-508-1719 (Pharmacy) 1-855-508-1718 (Member Services)		24/7, 365 days per year
Transportation (Logisticare)	1-855-369-3721		Reservations Mon.-Fri. 8:00 a.m. – 5:00 p.m.
Vision Services (NVA)	1-877-865-7925		24/7, 365 days per year
Dental Services (Benecare)	1-800-903-3335		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)
Audiology/Hearing Services	Call Member Services at 1-855-747-5483		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)

Name of Department or Organization	Phone Number	Email Address or Fax Number	Hours of Operation
NY Health Insurance Information, Counseling, and Assistance Program (HIICAP)	1-800-701-0501	www.aging.ny.gov	
NY Quality Improvement Organization (Livanta)	1-866-815-5440 TTY: 1-866-868-2289	1-844-420-6671 (main fax) 1-855-236-2423 (appeals) www.livanta.com	Mon.-Fri. 8:30 am – 4:30 pm
Social Security	1-800-772-1213	www.ssa.gov	Mon.-Fri. 7:00 am – 7:00 pm

To Report a Complaint

Organization Name	Phone Number	Email Address or Fax Number	Hours of Operation
Adult Care and Assisted Living Complaints http://www.health.state.ny.us/facilities/assisted_living/ **Mail Complaints to:** **NYS Department of Health** **Division of Long-Term Care** **Bureau of Certification & Finance** **875 Central Avenue** **Albany, NY 12206**	1-866-893-6772	na	Mon.-Fri. 8:30 am - 4:30 pm (after hours voicemail)
Complaints About Home Care Agencies **The New York State Department of Health, Division of Home and Community-Based Care** http://homecare.nyhealth.gov/ about.php?p=help **Mail Complaints to:** **Division of Home & Community-Based Services** **875 Central Avenue** **Albany, NY 12206**	1-800-628-5972	1-518-408-5309	Mon.-Fri. 10:00 a.m. – 4:00 p.m.

Managed Care Complaints managedcarecomplaint@health.state.ny.us **Mail Complaints to**: **NYS Department of Health** **Bureau of Managed Care Certification and Surveillance** **Complaint Unit Room 2019** **Corning Tower ESP** **Albany, NY 12237**	1-800-206-8125		
Nursing Home Complaints **The New York State Department of Health, Division of Residential Services (DRS)** **http://www.health.state.ny.us/facilities/nursing/complaints.htm** **Mail Complaint Forms to**: **NYSDOH DRS/SNHCP** **Mailstop: CA/LTC** **Empire State Plaza** **Albany, NY 12237**	1-888-201-4563	1-518-408-1157	24/7
Health Plan Compliance Hotline	1-518-473-3782	na	24/7
NYS Office of Advocate for Persons with Disabilities **http://cqc.ny.gov/**	1-800-624-4143	na	Online 24/7

Important Addresses

PHP Main Office	Partners Health Plan 655 Third Avenue, 2nd Flr. New York, NY 10027
Provider Correspondence	Partners Health Plan P.O. Box 16309 Lubbock, TX 79490
Provider Claims Disputes	Partners Health Plan Attn: Provider Relations Manager P.O. Box 16309 Lubbock, TX 79490
PHP Claims Submission and Resubmission (including paper claims)	Partners Health Plan Claims Department P.O. Box 16309 Lubbock, TX 79490
Provider Grievances	Partners Health Plan P.O. Box 16309 Lubbock, TX 79490

SECTION 2: PHP'S MODEL OF CARE FOR PERSONS WITH I/DD

The preponderance of individuals that Partners Health Plan's (PHP) PHSP serves are markedly different from elderly and physically disabled populations, and their care and services must reflect these differences. The most significant contrast is that intellectual and other developmental disabilities (I/DD) are life-long, and as these individuals grow older they require differing levels of support based not only on their assessed needs and abilities, but also on the strengths and abilities of their caregivers and extended circles of support. Parents and other family members often remain close and most have very definitive ideas about their loved ones' care and treatment. Consent for treatment is complex, based on the abilities of the person, his or her legal status, and the level of family involvement. Adding a further layer of complexity, the individual may not be able to communicate wishes or even pain or discomfort, thus requiring ongoing monitoring by a person who knows the individual well.

To meet this challenge, PHP must not only manage and coordinate the member's health-related care and services, but non-covered waiver services such as habilitation and respite care as well. We must work in collaboration with OPWDD Medicaid Service Coordinators (MSCs) to ensure that all needed services and supports are provided under the umbrella of a comprehensive, individualized plan of care, known as their Life Plan. Our goal is to provide a seamlessly coordinated array of services and supports that keeps each of our members as healthy, happy, and independent as possible while simultaneously assisting them in pursuing their "valued outcomes" and dreams.

Care Management

Upon initial enrollment in PHP, each PHSP member is either assigned a clinically licensed care manager (e.g., RN, social worker, or psychologist) or a QIDP care coordinator, depending on the member's needs. The care manager/coordinator is in turn responsible for managing all covered acute and behavioral health services the member may require as well as coordinating with the member's OPWDD MSC and any other professionals and stakeholders involved in the member's care to ensure his or her "Life Plan" is responsive to his or her medical history, assessed needs, personal preferences, and valued outcomes.

A member's individual characteristics and living environment will also help to determine the intensity of care management he or she receives. Intellectual and other developmental disabilities are life-long and all such individuals require permanent care and services tailored to their cognitive and functional abilities, behavioral challenges, medical conditions, and ability to communicate.

This approach is different from the Primary Care Provider (PCP) gatekeeper model employed by most Medicaid managed care plans. Our care managers/coordinators are responsible for identifying member needs in collaboration with the member's MSC, treating providers, and circle of support and assisting him or her in accessing needed supports and services in a timely manner. This includes making appointments; arranging transportation; accompanying members to the appointment, if needed (e.g., member's caregiver is not available); and documenting the results of all provider encounters in PHP's electronic care management application.

Moreover, since most of our members attend day habilitation or are involved in supported employment programs each weekday and are transported to and from their daytime activities in I/DD Agency-operated vehicles (and a large percentage of them reside in Agency-operated residences) they have almost constant "eyes on" supervision from trained personnel who are sensitive to their needs and understand their capabilities, normal behavior patterns, and personal desires. If Agency staff should identify any changes in a member's behavior or health condition, they are trained to document the issue and immediately report it to the member's care manager/coordinator for follow-up.

Our care managers/coordinators thus represent the key element in our model of service delivery for three reasons: 1) they have direct access to the member and his or her family and caregivers and are the most familiar with the member's needs, abilities, preferences, and goals; 2) they provide the interface/connection between the member, his or her medical and long-term services and supports providers, and community-based habilitation programs; and 3) as the member's advocate, they assure that authorized covered services meet availability, accessibility, and quality standards.

Under our person-centered model, PHSP care managers/coordinators have four primary roles:

- Overseeing the often-confusing array of services necessary to help the member navigate the complex medical and long-term care system and to efficiently coordinate the services and supports the member needs
- Breaking down barriers to care through member advocacy within the plan, the provider network, and other related entities and systems
- Coordinating and making appropriate referrals for covered, clinically necessary covered services and supports (this includes facilitating appointments and transportation)
- Crisis management to address events or issues that may cause the member to lose independence and/or move to a more restrictive residential placement

Interdisciplinary Teams (IDTs)

Definition

An IDT represents a group of health care professionals and other individuals from diverse fields appropriate to meeting the member's needs and preferences (e.g., treating providers, personal/home care support staff, designated individuals in the member's circle of support, etc.) who work in a coordinated fashion toward a common goal for the member. Each IDT participant will be appropriately licensed/certified/credentialed in his or her area of practice, experienced in working with persons with I/DD, and qualified to meet the member's needs and preferences. As applicable, PHP's care managers will coordinate with members' IDTs.

Importantly, not every PHSP member will have an IDT, especially children and adolescents and/or members who are otherwise healthy and functioning well with a minimum level of services and supports. This also includes PHSP members who are physically healthy and not diagnosed with a cognitive disability.

IDT Composition Tailored to Member Needs

Upon initial enrollment in PHP's PHSP, each member will be assigned a clinically licensed care manager (e.g., RN, LSW, or Psychologist) or QIDP care coordinator (depending on the member's needs) who is responsible for coordinating with the member's IDT (if applicable) to provide consultation and clinical expertise in the development and implementation of each member's written Person-Centered Care Plan or "Life Plan," assisting members in accessing the services called for in the Life Plan, and carrying out assigned duties with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.

If an IDT is assigned to a member with I/DD, the composition of the team will vary depending on the member's specific needs and preferences. An IDT will typically include:

- The member and/or his or her caregiver/guardian or designee
- The I/DD waiver program Medicaid Services Coordinator (MSC), who will also serve as the member's single point of contact
- The PHP care manager or coordinator
- Key providers of OPWDD waiver services (which are not covered by PHP's PHSP and are instead paid under the State's traditional FFS system), who have knowledge of the member's desired outcomes and service needs
- The member's Primary Care Provider or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the member

Depending on the member's assessed needs, the composition of the team may additionally include:

- A Behavioral Health Professional, or a designee with clinical experience from the Behavioral Health Professional's practice who has knowledge of the needs of the member
- The Member's home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of the needs of the member, if the member is receiving home care and approves the home care aide/designee's participation on the IDT
- A representative caregiver from the member's residential placement (e.g., Individualized Residential Alternative (IRA) or ICF-IID)
- Other providers either as requested by the member or his/her designee or as recommended by the IDT participants as necessary for adequate care planning and approved by the member and/or his or her designee

Again, members and/or their authorized representatives may request the inclusion or exclusion of any specific clinician or other member of the IDT. Once added, any participant on the IDT may be excused from further involvement, unless objected to by the member. IDT participants may also be added or dropped based on the member's needs.

Care and Service Planning (Life Plan)

PHP's approach to care management and coordination reflects our commitment to treating members respectfully and to placing an individual member's needs and preferences at the center of the care and service planning process, which culminates in the development of the individual's

person-centered care plan or "Life Plan." The initial comprehensive assessment process enables the member's care manager/coordinator, waiver program MSC, and IDT participants (as applicable) to integrate relevant information and develop a mutually agreed upon plan of care and service with the member, his or her circle of support, and other stakeholders involved in the member's care.

Under this coordinated model of care, member Life Plans will include all covered and non-covered long-term services and supports (LTSS) as well as medical, dental, and behavioral health specialty referrals, referrals to community-based supportive services programs, habilitation and employment programs, transportation assistance, and other services, as needed and appropriate. The relationship between the PHP care manager/coordinator, the waiver program MSC, the IDT, and the member and his or her formal and informal supports is collaborative in nature, and options are presented accordingly.

Life Plan and Electronic Care Management Record Features

The member's Life Plan and Electronic Care Management Record are designed to include the following information:

- The member's:
  - Desired outcomes
  - The care and services needed to meet the member's desired outcomes
  - Known and anticipated medical, functional, social, and cognitive needs identified through the initial Comprehensive Assessment process
  - Active chronic problems, current non-chronic problems, and problems that were previously controlled and/or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions.
  - All current medications.
- For each identified need, the Life Plan/Electronic Record must:
  - State the problem
  - List the covered and non-covered interventions to resolve or mitigate the problem
  - List the measurable outcomes to be achieved by the interventions
  - State the anticipated timelines in which to achieve the desired outcomes
  - Identify the internal and external staff responsible for conducting the interventions and monitoring the outcomes
  - Document reasonable long-term and/or short-term goals
- The Life Plan/Electronic Record must further:
  - List all covered and non-covered services that have been authorized for the member as well as their scope and duration.
  - Provide a schedule of preventive service needs or requirements.
  - Document the member's goals and preferences and how they will be addressed, taking into consideration the member's expectations, characteristics, and previous daily routines.

- Identify the method and frequency of evaluating progress toward goals and documenting progress including successes, barriers, and/or obstacles.
- Identify any anticipated potential problems, including the risks and how these risks can be minimized to promote the member's highest feasible level of well-being.
- Document the member's decisions regarding self-directed care and whether or not he or she is participating in Consumer-Directed Personal Assistance Services (CDPAS) or HCBS self-directed services.
- Include a Communications Plan.
- Identify how frequently specific services will be provided.
- Describe how technology and telehealth will be used, as applicable.
- Document the right of the member to appeal his or her Life Plan, including the steps for submitting an appeal.
- As applicable, document the member's consent to his or her participation in the Money Follows the Person initiative.
- List the member's choice of:
  - ◊ Service providers
  - ◊ Individualized back-up plans
  - ◊ Persons/providers responsible for specific interventions/services
  - ◊ Informal support network and services
- Identify the member's need for and plan to access community-based resources and other non-covered services, including any reasonable accommodations.
- Identify anything appropriate for the needs of the member.

Again, owing the limited scope of services and supports covered under the PHSP program, PHP's care managers/coordinators will typically serve in a supporting role to assist in the coordination of covered acute and behavioral health services with all the non-covered services and supports the member may be authorized to receive, with the member's waiver program MSC serving as the member's **primary point of contact**.

Note: This does not apply to PHSP members who are not diagnosed with a cognitive disability and are ineligible for waiver services.

Life Plan Monitoring

- PHSP members' Life Plans will typically be reviewed and revised, based upon a functional assessment, as follows:
  - Every 12 months
  - When the member's needs or circumstances significantly change
  - At the request of the individual or his or her authorized representative

Service Authorization

Once the assessment and Life Planning process has been completed, the member's care manager/coordinator, OPWDD waiver service MSC, and other stakeholders involved in his or her care will review the approved Life Plan with the member and his or her family/caregiver and copies will be provided to his or her treating providers (including the PCP and any additional specialists or other professionals engaged in the member's care). As applicable, authorized users can also access member Life Plans through PHP's website at www.phpcares.org. All covered acute and behavioral health care services (e.g., weekly visits with a psychiatrist or quarterly visits with a cardiologist) included in the Life Plan will be deemed approved by PHP and not subject to additional prior authorization (PA) requirements. The member's providers will also be notified about the member's authorized services and they will be entered into the claims system to ensure timely payment.

Please see the Service Authorization section of this Manual for a detailed description of PHP's prior authorization process and requirements.

Provider Network

PHP's global criteria for provider network participation include:

- Providers' past experience and current capacity to serve individuals with I/DD, including those with co-morbid chronic medical conditions (e.g., diabetes, heart disease, dementia)
- Providers' compliance with state and federal licensure and qualifications, including credentialing criteria and state regulatory requirements
- Providers' ability and commitment to maintain and improve member health status and promote greater independence and service options
- Providers' commitment to collaborate with PHP, its members/families/caregivers, other providers, and SDOH/OPWDD to improve service availability, quality, and members' satisfaction with their care

Many of PHP's network providers have specific experience and expertise in serving individuals with I/DD, which is of vital importance for individuals with moderate to severe cognitive impairments, many of whom are non-verbal. They also have experience in desensitization, which has proven to be very effective when delivering certain types of services to persons with /IDD without the use of anesthesia or sedatives (e.g., dental cleanings, gynecological exams). The most common barriers to effective care for individuals with I/DD include:

- May not be able to communicate history or symptoms
- May be unable to tolerate waiting room stay
- May be threatened by aspects of the office or hospital environment such as needles, physical examinations of private areas, unfamiliar clinicians
- May resist or fight when confronted with an examination
- May require ancillary or family help for even the smallest procedures

Should you wish to learn more about treating individuals with I/DD or you have questions or concerns, please feel free to contact our Care Management staff at 1-855-769-2507.

SECTION 3: RIGHTS AND RESPONSIBILITIES

Member Rights

PHP’s PHSP members are guaranteed the 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 they need from PHP and their practitioner.
- Be told about their member rights and responsibilities.
- Suggest changes to PHP’s policies and member rights and duties.
- Be told by their PCP what is wrong, what can be done for them, and what will likely be the result in language they understand.
- Get a second opinion about their care.
- Give their consent to any treatment or plan for their care after that plan has been fully explained to them.
- Discuss treatment options regardless of cost of benefit coverage.
- Refuse care and be told what they may risk if they do.
- Get a copy of their medical record and talk about it with their PCP, and to ask, if needed, that their medical record be amended or corrected.
- Be sure that their medical record is private and will not be shared with anyone except as required by law, contract, or with their approval.
- Make complaints and/or appeals about PHP and its services.
- Use the PHP complaint system to settle any complaints or complain to the New York State Department of Health or the local Department of Social Services any time they feel they were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

PHP’s policies and procedures require that neither PHP nor our participating providers can adversely regard a member who exercises his or her rights as described above. In the event PHP is made aware of a member being denied any of the rights identified above, PHP will initiate an investigation into the matter and report the findings to the Chief Compliance Officer and the Quality Oversight Committee. Any PHP staff member or network provider who violates this policy will be appropriately disciplined, up to and including termination of employment/contract.

PHP members and their authorized representatives will not be penalized or suffer any negative consequences for exercising their rights.

Member/Caregiver Responsibilities

PHP members and/or their authorized representatives have the responsibility:

- To try to understand Covered Items and Services and the rules around getting Covered Items and Services
- To tell providers that they are enrolled in PHP and show their PHP ID card
- To treat providers and PHP staff with respect
- To communicate problems immediately to PHP
- To keep appointments or notify the member's care manager/coordinator if an appointment cannot be kept
- To supply accurate and complete information to PHP's staff
- To actively participate in Care/Life Plan development and implementation
- To notify the state and PHP about any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets
- To ask questions and request further information regarding anything not understood
- To use PHP's network providers for services included in PHP's benefit package
- To notify PHP of any change in address or lengthy absence from the area
- To comply with all PHP policies as noted in the Member/Family Handbook
- If sick or injured, to call their doctors or care managers/coordinators for direction right away
- In case of emergency, to call 911
- If emergency services are required out of the service area, to notify PHP as soon as possible

In the event PHP is made aware of a member not complying with the responsibilities outlined above, PHP will make a good faith effort to address the issue with the member and his or her authorized representative, educate the member and his or her authorized representative about their responsibilities, and document the interaction in PHP's MediSked care management system.

The Provider's Roles and Responsibilities

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control.
- Providers shall immediately notify PHP's Chief Medical Officer, in writing:

  - If their ability to practice medicine is restricted or impaired in any way
  - If their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor or is limited in any way
  - If any adverse action is taken
  - An investigation is initiated by any authorized Local, State or Federal agency
  - Of any new or pending malpractice actions
  - Of any reduction, restriction, or denial of clinical privileges at any affiliated hospital
- Providers shall comply with all PHP administrative, patient referral, quality assurance, utilization management, and reimbursement procedures.
- Providers shall not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, or source of payment and shall observe, protect, and promote the rights of members as members and any other category protected by law.
- Providers shall cooperate and participate in all PHP peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by PHP.
- Providers shall comply with all final determinations rendered by PHP peer review programs, or external third-party reviewers for grievance procedures consistent with the terms and conditions of the provider's agreement with PHP and this Provider Manual.
- Providers shall notify PHP in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) calendar days advance notice is requested.
- Providers shall notify PHP at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with PHP or as required by the provider's agreement with PHP.
- Providers shall not under any circumstances, including non-payment by or insolvency of PHP, bill, seek or accept payment from PHP members for covered services with the exception of any applicable copayments.
- Providers may freely communicate with members about all treatment options, regardless of benefit coverage limitations.
- In the event that a member requires or requests a service that is not covered or authorized by PHP and the service is also not covered by another program through which the member is entitled to receive services (e.g., waiver program services), the provider is required to:
  - Inform the member and/or the member’s representative that the member will be personally responsible for all fees related to the service and the estimated fee for the service
  - Obtain an executed acknowledgment of financial responsibility from the member/representative prior to the time such services are provided
  - Obtain express prior approval from the member/representative and PHP

Only if these steps have been taken shall a provider be entitled to bill the member and collect for such services.

- At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat PHP members.
- Providers agree to maintain standards for documentation of medical records and confidentiality for medical records as specified in the provider contract and this Manual.
- Providers agree to retain medical records for six (6) years) for PHSP members after the last date of service or, in the case of a minor, for six (6) years after the patient reaches the age of majority, or the length of time required by applicable law.
- Providers will maintain appointment availability in accordance with New York State standards as defined in the provider contract and this Manual).
- Providers will maintain twenty-four (24)-hour access in accordance with New York State standards. Providers shall notify PHP of any extended coverage arrangements for sick leave, vacation, etc.

Additional Roles and Responsibilities for Hospitals

- Provide all contracted services that are within the scope of the facility's operating certificate
- Discuss discharge planning with PHP to coordinate the most appropriate care for the member and to ensure services are in place prior to discharge

Restricted Recipient Program

In the unlikely event that a PHSP member demonstrates a pattern of abusing or misusing the Medicaid program, he or she may be placed in the Restricted Recipient Program, which is a medical review and administrative mechanism that restricts members to one or more health care providers. Restricted recipients are PHSP members whose care must be coordinated and authorized through a provider assigned by PHP. This restriction applies to all non-urgent and non-emergent services. Failure to coordinate care with the member's PHP assigned provider may result in a denial of services. Restricted recipients are clearly identified when checking member eligibility.

Cultural Sensitivity

Cultural sensitivity begins with the recognition that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another, and they carry over into interactions with health care providers. However, cultural sensitivity does not mean that a person need only be aware of the differences to interact effectively with people from other cultures. If health care providers and their patients are to interact effectively, they must move beyond both cultural sensitivity and cultural biases that create barriers. Developing this kind of culturally competent attitude is an ongoing process. A culturally competent clinician views all patients as unique individuals and realizes that their experiences, beliefs, values, and language affect their perceptions of clinical service delivery, acceptance of a diagnosis, and compliance.

Communication Access

Communication is an integral part of providing care to a patient. Communication may become an issue if there are barriers based on physical, social, or language limitations — all of which are common among individuals with I/DD. If a family member or other authorized representative is not available to assist with communication, PHP providers should contact the member's care manager for assistance. If a translator is not available, a language line or TTY line can be accessed by calling PHP at 1-855-747-5483.

Physical Access

An accessible examination room has features that make it possible for members with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the member to enter the examination room, move around in the room, and utilize the accessible equipment provided. Detailed diagrams can be found at: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to Federal and State laws, rules and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by Federal or State laws, rules, and regulations. Medical records of all PHP members shall be confidential and only be disclosed to and by the provider's personnel as necessary to provide medical care and quality, peer, or complaint and appeal review of medical care as required in accordance with applicable laws and regulations.

Protecting members' privacy is an essential part of building a provider/patient relationship. You and your staff can help protect member confidentiality by following these simple measures:

- Avoid discussing cases within earshot of other patients or visitors.
- If voices can be heard easily through exam room walls, consider adding soundproof panels or piping in soft music.
- Arrange office space to allow privacy for members who are making appointments or discussing other confidential matters.
- Make sure computer screens that contain patient information are protected from general view.
- Be sure all patient care is provided out of sight from other members (e.g., weighing, lab draws).
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.
- Ask your members/authorized representatives to sign an Authorization to Release Information prior to releasing medical records to anyone.
- Have a protocol for sending confidential information via fax.

SECTION 4: COVERED SERVICES AND SUPPORTS

PHP's PHSP product pays for a comprehensive array of Medicaid-covered acute and behavioral health care services, including dental care. However, unlike our FIDA-IDD program, PHP's PHSP is not responsible for I/DD waiver program services such as habilitation, supported employment, and residential services, etc., which will continue to be paid for under New York Medicaid's traditional fee-for-service system. That said, as applicable, PHP's trained and experienced care managers and coordinators will work in partnership with OPWDD Medicaid Service Coordinators (MSCs) to assist in coordinating the full array of covered and non-covered services and supports our members may be authorized to receive. Keeping informed about our members' health-related needs helps us to do our job better and to keep our members as healthy and independent as possible.

The covered supports and service(s) each PHSP member receives and how often and how long they get them is based on their medical condition(s), assessed health, abilities, personal preferences, and valued outcomes. PHSP members will continue to receive PHP-covered services as long as they are determined necessary to prevent, diagnose, correct, or cure conditions that may cause acute suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity, or threaten some significant handicap.

Services Covered by PHP

All services must be medically or clinically necessary and provided or referred by the member's PCP and/or Interdisciplinary Team (IDT), as applicable, and meet all other UM requirements. Please call our Member Services Department at 1-855-747-5483 if you have any questions or need help with any of the services listed below.

Physical Health Services

- **Standard Medical Care**:
  - PCP consultation, treatment, and referrals
  - Vision/hearing exams
- **Preventive Care**:
  - Well-baby and well-child care
  - Well-woman care
  - Regular check-ups
  - Immunizations for children from birth through childhood
  - Pneumonia and flu vaccines
  - EPSDT services for children and adolescents under age 21
  - Smoking cessation counseling
  - HIV education and risk reduction
- **Specialty Care**:

- Includes the services of most specialized medical practitioners such as cardiologists, pulmonologists, urologists, dermatologists, chiropractors, audiologists, midwives, therapists (occupational, physical, and speech), and neurologists as well as behavioral health practitioners (see below). In most cases members can schedule an initial specialist appointment without a referral. Please see the UM section of this Manual for more information on PHP's referral and prior authorization requirements.

- Referral to Specialty Care Centers If the member presents with a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, a referral may be made to an accredited or designated specialty care center with expertise in the condition. The decision to make such referrals is made by PHP's Chief Medical Officer or designee after consultation with the member's PCP, Specialist pursuant to a treatment plan.
- **Emergency Care**:
  - All emergent, urgent, and post-stabilization services accessed in an emergency room, inpatient hospital, or other setting
- **Hospital Care**:
  - Inpatient care
  - Outpatient care, including ambulatory surgeries
  - Lab, x-ray, and other screenings/tests
- **Residential Health Care Facility Services**:
  - Skilled nursing facility services, including:
    - ◊ Medical supervision
    - ◊ 24-hour nursing care
    - ◊ Assistance with activities of daily living (ADLs)
    - ◊ Physical, occupational, and speech therapy
    - ◊ **Note**: PHP covers long-term placement in a participating nursing facility when medically necessary for members 21 years of age and older
  - Rehabilitation facilities (short-term)
- **Maternity Care**:
  - Pregnancy care
  - Doctors/mid-wife and hospital services
  - Newborn nursery care
  - Screening for depression during pregnancy and up to a year after delivery
- **Home Health Care**:
  - One (1) medically necessary post-partum home health visit, with additional visits as necessary for high-risk women
  - At least two (2) visits for high-risk infants (newborns)

  - Other home health visits as determined to be medically necessary and referred by the member's PCP or specialist

- **Personal Care/Home Attendant Services**:
  - As determined to be medically necessary and ordered by the member's PCP/specialist and not otherwise available through the OPWDD waiver (may also be arranged through the Consumer-Directed Personal Assistance Services (CDPAS) program)

- **Personal Emergency Response System (PERS)**:
  - Only available to members receiving personal care/home attendant services through PHP

- **Adult Day Health Care Services**:
  - Requires the recommendation of the member's PCP or IDT, as applicable, and is not otherwise available through the OPWDD waiver program. Includes assistance with ADLs and IADLs

- **AIDS Adult Day Health Care Services**:
  - Requires a referral from the member's PCP/specialist. Services include:
    - ◊ General medical and nursing care
    - ◊ Substance abuse supportive services
    - ◊ Mental health supportive services
    - ◊ Individual and group nutritional services
    - ◊ Structured socialization, recreational, and wellness/health promotion activities

- **Directly Observed Therapy for Tuberculosis Disease**:
  - Provides observation and dispensing of medication, assessment of any adverse reactions to medications, and case follow-up.

- **Hospice Care**:
  - Must be determined to be medically necessary and arranged through PHP
  - Provides support services and some medical services to members who are ill and expect to live for one (1) year or less
  - Services are available either at home or in a hospital or nursing facility
  - Children under age 21 can also receive medically necessary curative services and palliative care

- **Other covered services**:
  - Durable Medical Equipment (DME) including hearing aids, prosthetics, and orthotics
  - Court-ordered services
  - Case management
  - Assistance with accessing community-based services
  - Federally Qualified Health Center services
  - Podiatry services for children under age 21 and persons with diabetes

Behavioral Health Care

Behavioral health services include mental health and substance use disorder treatment as well as rehabilitation services. Specific services include:

- **Mental Health Care**:
  - Intensive psychiatric rehab treatment
  - Day treatment
  - Clinic continuing day treatment
  - Inpatient and outpatient mental health treatment
  - Partial hospital care
  - Rehab services within a community home or family-based treatment
  - Continuing day treatment
  - Personalized Recovery Oriented Services
  - Assertive Community Treatment Services
  - Individual and group counseling
  - Crisis intervention services
- **Substance Use Disorder Services**
  - Inpatient and outpatient substance use disorder (alcohol and drug) treatment
  - Inpatient detoxification services
  - Opioid, including Methadone Maintenance Treatment
  - Residential Substance Use Disorder Treatment
  - Outpatient alcohol and drug treatment and detox services

Pharmaceutical Services

New York Medicaid prescription drugs are only available by prescription, are used or sold in the United States, and must be used for medically accepted indications. Prescription drugs covered by Partners Health Plan are listed in the Medicaid formulary, which includes all generic drugs covered under New York Medicaid as well as many brand-name drugs, non-preferred brands, and specialty drugs. In addition, NYS Medicaid provides coverage for barbiturates, benzodiazepines, some prescription vitamins, and a number of non-prescription drugs. A complete copy of the formulary is included on the PHP website at www.PHPcares.org. Some of these drugs have prior authorization or step-therapy requirements or quantity limits. Members should obtain covered drugs from a network pharmacy pursuant to a physician's prescription.

Covered pharmaceutical benefits include:

- Prescription drugs
- Over-the-counter medications
- Insulin and diabetic supplies

- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Medical and surgical supplies

PerformRx

Pharmacy claims are processed by PerformRx, PHP's pharmacy benefit management vendor. PerformRx services also include home infusion, specialty pharmacy, and mail-order pharmacy. PerformRx contact information and applicable forms are available on the PHP website. For pharmacy inquiries, including authorization requests, please dial the PerformRx phone number included on the Member ID Card (i.e., 1-855-508-1719 for pharmacy services and 1-855-508-1718 for Member Services).

Dental Care

PHP recognizes that good dental care is a vitally important component of members' overall health care. We offer dental care through a contract with Benecare, an expert in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care. Members under age 21 are also eligible for certain orthodontic services. Members do not need a referral to see a dentist.

Benecare can be contacted by calling 1-800-903-3335. PHP can also assist with scheduling dental appointments by contacting our Member Services Department at 1-855-747-5483.

Vision Care

Vision care services are available to PHP members through our contract with NVA. Covered services include:

- Eye exams (typically every 2 years unless needed more frequently)
- Glasses (every 2 years unless needed more often), including the replacement of lost or destroyed glasses, including repairs as appropriate
- Contact lenses, polycarbonate lenses, artificial eyes
- Low vision exam and vision aids
- Optometrist services
- Ophthalmologist services and ophthalmic dispensers
- Specialist referrals for eye diseases or defects

NVA can be contacted at 1-877-865-7925.

Transportation Services

Members requiring emergency transportation should call 911. PHP covers non-emergent transportation to medical appointments and other services through a contract with Logisticare, although in many cases members can access transportation services through their I/DD agency. PHP-covered transportation services must be scheduled in advance by 3:00 pm the business day prior to the appointment. To arrange non-emergent transportation please contact Member Services at 1-855-747-8453.

Non-Covered Medical Services

Non-covered services include services not available from PHP or from Medicaid or services that were delivered without prior approval when advance approval is required (please see the UM section of this Manual for more information). These include:

- Cosmetic surgery if not medically necessary
- Podiatry services for adults over age 21 unless they are diabetic
- Personal and comfort items
- Infertility treatments
- Out-of-network services without prior approval except for emergent/urgent care

Before rendering non-covered acute and/or behavioral health care services, providers should always inform members and/or their authorized representatives that the cost of services not covered by PHP will be charged to the member.

A provider who chooses to provide a non-covered service(s):

- Recognizes that PHP only reimburses for covered services that are medically necessary
- Understands that he or she may not bill or take recourse against a member for denied or reduced claims for services within the amount, duration, and scope of benefits of the NYS Medicaid program
- Obtains the member's or the member's authorized representative's signature on the Client Acknowledgement Statement (see below) specifying that the member will be held responsible for payment of non-covered services prior to rendering services

Client Acknowledgement Statement

A provider may bill a PHP PHSP member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are met:

- The member and/or the member's authorized representative requests the specific item or service
- The provider obtains a written acknowledgement statement signed by the member or by the member's authorized representative and the provider stating:

> I understand that, in the opinion of (provider's name), the services or items I have requested to be provided to me on (dates of service) may not be covered under Partners Health Plan as

being reasonable and medically necessary for my care or are not a covered benefit. I understand Partners Health Plan has established the medical necessity standards for the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Partners Health Plan medical necessity standards for my care or are not a covered benefit.

Signature: ____
Date: ____

Balance Billing

PHP members must NOT be balance billed for the difference between the amount paid by PHP and the billed amount for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to submit a claim in a timely manner, including claims not received by PHP
- Failure to submit a claim to PHP for initial processing within the 90-day filing deadline
- Failure to submit a corrected claim within the 90-day filing resubmission period
- Failure to appeal a claim within the 60-day administrative appeal period
- Failure to appeal a utilization review determination within 60 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission, or the appeal process

SECTION 5: ELIGIBILITY AND ENROLLMENT

PHSP Eligibility

Partners Health Plan's (PHP) PHSP product serves persons who are eligible for Medicaid and reside in PHP's service area. Our primary focus is on serving non-dually eligible individuals (i.e., persons eligible for Medicaid but not Medicare) with an intellectual or other developmental disability (I/DD), but we are also authorized to enroll people who are eligible for Medicaid and have not been diagnosed with a cognitive disability. At present, our PHSP program is voluntary and members may enroll and disenroll on a month-to-month basis.

To be eligible for enrollment in Partners Health Plan, applicants must meet the following criteria:

- Permanently reside in PHP's authorized service area (i.e., the five boroughs of NYC and Nassau, Rockland, Suffolk, and Westchester Counties)
- Eligible for full Medicaid benefits as determined by the Local Department of Social Services (LDSS) or the New York City Human Resources Agency (HRA)
- Complete an enrollment request and include all the information required to process the enrollment through the state's enrollment broker

The following populations are ineligible for PHP's PHSP product:

- Residents of a New York State Office of Mental Health (OMH) facility
- Residents of a Skilled Nursing Facility and Residents of Developmental Centers. Upon leaving the SNF/NF or Development Center, the person with I/DD is then eligible for either our FIDA-IDD Demonstration or PHSP depending on whether or not they are dually eligible for Medicaid and Medicare. A PHSP member who after enrolling in PHP subsequently requires placement in a SNF/NF or Development Center will remain in PHP for up to 90 days. If the individual remains in the SNF or DC beyond 90 days, the placement will no longer be considered temporary and the individual will be disenrolled from PHP.
- Residents of psychiatric facilities
- Individuals expected to be Medicaid eligible for less than six months
- Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
- Individuals with a "county of fiscal responsibility" code 99 in MMIS (individuals eligible only for breast and cervical cancer services)
- Individuals receiving hospice services (at time of enrollment)
- Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a State OMH facility)
- Individuals eligible for the family planning expansion program
- Individuals under 65 years of age (who have been screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection

program who need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage

- Residents of alcohol/substance abuse long-term residential treatment programs
- Individuals eligible for Emergency Medicaid
- Individuals enrolled in a Section 1915(c) waiver other than the OPWDD Comprehensive Waiver. Individuals enrolled in the following Section 1915(c) waivers programs are not eligible to enroll in PHP: Traumatic Brain Injury (TBI); Nursing Home Transition and Diversion Waiver; and Long-Term Home Health Care Waiver.
- Residents of Assisted Living Programs
- Individuals in the Foster Family Care Demonstration

If a potential applicant and/or his or her authorized representative expresses a desire to enroll in PHP, Member Services staff will confirm the applicant's:

- Area of residence
- Eligibility for Medicaid (if the applicant is not enrolled in Medicaid but appears eligible, Partners Health Plan will provide assistance)

Enrollment

All voluntary enrollments must be processed through the state's Enrollment Broker (i.e., Maximus) consistent with the PHSP program's Enrollment Effective Date requirements. If a potential applicant and/or his or her authorized representative directly contacts PHP and expresses a desire to enroll in our PHSP product, Member Services staff will arrange a 3-way call with Maximus and warmly transfer (i.e., directly connect) the applicant for enrollment counseling and assistance with enrollment.

New Enrollees

After the enrollment form has been completed and the state has confirmed the Enrollment Effective Date (generally, the effective date for voluntary enrollment is the first day of the month following the state's receipt of an enrollment request), the new member will be scheduled for an initial assessment and evaluation at his or her residence or other agreed-upon venue within the first 30 days of enrollment. (If the member is also enrolled in the I/DD waiver program or is a child or adolescent with an IEP or IFSP, the initial assessment will be scheduled in collaboration with the new member's MSC or educational coordinator, as applicable, and covered under the state's fee-for-service system. PHP will also notify the LDSS/HRA and OPWDD of the applicant's enrollment, if needed, and notify the state about the existence of any third-party liability. Member Services staff will further ensure that new members have been provided with a Welcome Packet within the first 10 business days following receipt of confirmation of Enrollment or by the last calendar day of the month prior to the Effective Date. The Welcome Packet will include:

- A comprehensive formulary that includes Medicaid-covered outpatient prescription drugs and pharmacy products

- A combined Provider and Pharmacy Directory
- A single Member ID Card
- A Member Handbook

Applicants who fail to meet the eligibility criteria will be provided with a full explanation of the reasons why he or she is not eligible for the program and offered referrals to other available resources in the community.

Disenrollment Procedures

PHP will not, either orally or in writing, request or encourage a member to disenroll nor will PHP attempt to discourage members from disenrolling if they indicate a desire to do so. PHP will contact disenrolling members to determine the reason behind the decision and explain how Medicaid coverage will be provided going forward, but PHP staff will make no effort to convince the member and/or the member's authorized representative to remain enrolled. All disenrollments will be effective the first day of the following month unless the request is submitted after the state's "pull-down" date (usually around the 20th of the month).

If a member and/or the member's authorized representative requests to disenroll, PHP will instruct the member how to submit the request. All disenrollment-related transactions will be performed by Maximus, the state's Enrollment Broker. Disenrollment requests submitted to Maximus by the last calendar day of the month will be effective on the first calendar day of the following month (e.g., a member that requests disenrollment at the end of May will have a Disenrollment Effective Date of July 1st).

A member may request to disenroll from PHP at any time and for any reason. Members and/or their authorized representatives may disenroll by:

- Enrolling in another Medicaid managed care plan
- Giving or faxing a signed written disenrollment notice to the state or PHP
- Calling the state's enrollment broker (i.e., Maximus)

Providers are strongly encouraged to verify a patient's enrollment in PHP each time he or she presents for services. PHP also encourages disenrolling members to inform us of their decision as soon as possible so that we can assist with the transition.

Disenrollment Denials

The state may deny a voluntary request for disenrollment only if:

- The request was made by someone other than the member and that individual is not the member's authorized representative.
- The request was incomplete and the required information is not provided within the required time frame.

Cancellation of Voluntary Disenrollment

A member's voluntary disenrollment request can be cancelled only if the request to do so is made prior to the effective date of the disenrollment, unless otherwise directed by the state. If PHP receives a request to cancel a disenrollment, PHP will notify the member that he or she has to contact Maximus in order to remain enrolled without disruption.

Required Involuntary Disenrollment

New York State must disenroll a member from PHP under the following circumstances:

- A change in residence (includes incarceration) makes the member ineligible to remain enrolled in PHP (i.e., member permanently moves out of PHP's authorized service area or a temporary absence exceeds six months)
- The member loses Medicaid eligibility
- The member dies
- PHP's contract with the state is terminated, or PHP reduces its service area to exclude the area where the member resides
- The member materially misrepresents information to PHP regarding reimbursement for third-party coverage (requires state approval)

PHP will continue to offer the full continuum of covered services and supports to affected member through the end of the calendar month in which the state notifies PHP of the loss of Medicaid eligibility or loss of other state-specific eligibility requirements.

Discretionary Involuntary Disenrollment

PHP must never seek to terminate enrollment because of:

- An adverse change in a member's health status
- Because of the member's utilization of covered services and supports
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from the member's special needs (except to the extent the member's continued enrollment seriously impairs PHP's ability to furnish covered services and supports to that particular member or other members)
- A member who attempts to exercise, or is exercising, his or her appeal or grievance rights

That said, PHP may submit a written request accompanied by supporting documentation to the SDOH to disenroll a member for one of the following causes:

- **Disruptive Behavior**: The member engages in disruptive behavior to the extent that his or her continued enrollment substantially impairs PHP's ability to arrange for or provide services to either that particular member or other members. However, PHP and the state (if appropriate) must make a serious effort to resolve the issue prior to submitting a disenrollment request, including providing reasonable accommodations for members with mental illness and/or I/DD. The member/representative must also be informed of his or her

right to exercise grievance procedures. This process requires three verbal and written notices to the member/representative, as follows:

1) Advance notice to inform the member that the consequence of continued disruptive behavior may be disenrollment (if the disruptive behavior ceases after this notice has been received and then later resumes, PHP must begin the process all over, including sending another advance notice).
2) Notice of PHP's intent to request that the state disenroll the member, which must include information on grievance procedures and contact information for SDOH. PHP must also provide prior written notice to SDOH of its intent to request disenrollment.
3) A planned action notice advising the member/representative that SDOH has approved the disenrollment request.

- **Fraud and Abuse**: The member provides fraudulent information on an enrollment request form or other enrollment mechanism that materially affects the eligibility determination. PHP may also request to disenroll a member that intentionally permits others to use his or her ID card to obtain services or supplies. PHP will further notify the state immediately so the Office of the Medicaid Inspector General may initiate an investigation of the alleged fraud and/or abuse.
- **Failure to Pay**: The member/representative fails to pay or make satisfactory arrangements to pay the amount, as determined by the LDSS, owed to PHP as spend-down/surplus or Net Available Monthly Income (NAMI) within 30 days after such amount first becomes due, provided that during that 30-day period PHP first made a reasonable effort to collect the amount owed, including making a written demand for payment, and advised the member and/or the member's authorized representative in writing of his or her prospective disenrollment.
- **Failure to Consent to Release Information**: The new member/representative knowingly fails to complete and submit any necessary consent or release allowing PHP and/or its network providers to access necessary health information for the purpose of implementing PHP's Model of Care.

In order for SDOH to process a discretionary request for disenrollment, PHP must submit all required documentation of the steps we have taken to locate and engage the member/representative as well as the results of these efforts or responses we have received. If SDOH elects to grant the involuntary disenrollment request for cause, it will notify PHP of its decision and instruct us to send the member/representative an SDOH-developed Involuntary Disenrollment Form, with additional copies to the Enrollment Broker. The Effective Date of Disenrollment will be 11:59 p.m. on the last day of the month following the month the disenrollment is processed.

Continuation of Services Pending an Appeal

Under no circumstances will PHP cease to provide previously authorized services to a member until SDOH or the Enrollment Broker informs PHP that the services may be terminated because the member has received appropriate notice and waived or exhausted all Appeal rights. The termination will take effect on the effective date indicated by SDOH or Maximus.

If you or your staff should have any questions about eligibility and enrollment in PHP, please do not hesitate to contact our Member Services Department during any business day at 1-855-PHP-LIVE (1-855-747-5483).

SECTION 6: PROVIDER ROLES AND RESPONSIBILITIES

Contracted providers and practitioners with Partners Health Plan (PHP) are obligated to comply with the following rules, regulations, and guidelines:

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community as well as applicable OPWDD standards. These standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which providers and practitioners seek advice or guidance or to which they are subject for licensing and oversight.
- Providers must immediately notify PHP's Chief Medical Officer, in writing, of any of the following circumstances:
  - If their ability to carry out their professional responsibilities is restricted or impaired in any way
  - If their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor, or is limited in any way
  - If any adverse action is taken
  - If an investigation is initiated by any authorized local, state, or federal agency
  - If there are any new or pending malpractice actions
  - If there is any reduction, restriction, or denial of clinical privileges at any affiliated hospital
- Providers shall comply with all PHP administrative, participant referral, quality assurance, utilization management, reporting, and reimbursement protocols and procedures.
- Providers shall not differentiate or discriminate in the treatment of participants on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, source of payment, or and any other category protected by law.
- Providers shall observe, protect, and promote the rights of participants.
- Providers shall cooperate and participate in all PHP peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by PHP.
- Providers shall comply with all final determinations rendered by PHP peer review programs or external arbitrators for grievance procedures consistent with the terms and conditions of the provider's agreement with Partners Health Plan.
- Providers shall notify PHP in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) calendar days advance notice is requested.
- Providers shall notify PHP at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with PHP or as required by the provider's agreement with Partners Health Plan.

- Providers shall not under any circumstances, including non-payment by or insolvency of PHP, bill, seek, or accept payment from PHP members for covered services or benefits.
- Providers agree to maintain standards for the confidentiality of and documentation of participant medical/service records.
- Providers agree to retain medical/service records for six (6) years after the last date of service or the length of time required by applicable law.
- Providers shall maintain appointment availability in accordance with federal and state requirements.
- Primary Care Providers shall maintain 24-hour access in accordance with federal and state standards. PCPs shall notify PHP of any extended coverage arrangements for sick leave, vacation, etc.
- Providers agree to continue care in progress during and after termination of a member's enrollment in PHP for up to 60 days (so long as they maintain coverage under Medicaid), or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider.
- Providers must establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act (ADA).

Informed Consent

The provider must adhere to all federal and state requirements, including applicable OPWDD requirements, for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent. Providers must additionally provide members/representatives with complete information concerning their diagnosis, evaluation, treatment, and prognosis and grant them the opportunity to take part in decisions involving their health care.

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to federal and state laws, rules, and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by federal or state laws, rules, and regulations.

Medical/Service records of all PHP members shall be confidential and only be disclosed to and by the provider's staff in accordance with applicable laws and regulations.

Confidentiality of Behavioral Health and Substance Abuse Information

Each healthcare provider shall develop policies and procedures to assure confidentiality of mental health and substance abuse related information. These policies and procedures must include:

(a) initial and annual in-service education of staff, contractors
(b) identification of staff allowed access and limits of access
(c) procedure to limit access to trained staff (including contractors)
(d) protocol for secure storage (including electronic storage)
(e) procedures for handling requests for BH/SU information protocols to protect persons with behavioral health and/or substance use disorder from discrimination

You Can Help Protect Patient Confidentiality

Protecting privacy is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following these simple measures:

- Avoid discussing cases within earshot of other patients or visitors.
- If voices can be heard easily through exam room walls, consider adding soundproof panels or piping in soft music.
- Make sure computer screens that contain patient information are protected from general view.
- Be sure all patient care is provided out of sight from other patients (e.g., taking body weight, lab draws)
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.
- Ask your patients and/or their authorized representatives to sign an Authorization to Release Information prior to releasing medical records to anyone.
- Have a protocol for sending confidential information via fax.

Member Complaints and Grievance Procedures

All PHP providers and practitioners must respect Member Rights as outlined in this Provider Manual. In addition, providers should participate in, and are obligated to cooperate with, the resolution of any member complaint or grievance that may arise relating to the services they provided to a PHP member. Any concerns identified by members and/or their caregivers with PHP, a provider, or any of a provider's staff with respect to the provision of services will be handled in accordance with PHP's complaint and grievance procedures as described in this Manual.

New York State Confidentiality Law and HIV

Public Health Law, Article 27F, protects the confidentiality and privacy of anyone who has been tested for HIV; exposed to HIV; has HIV/AIDS-related illness; or has been treated for HIV/AIDS-related illness

The law requires that an individual may not be given an HIV test unless the provider orally, at a minimum, advises the patient (or authorized person) that the test is being performed. The HIV

test cannot be performed over the objection of the patient (or authorized person) and the patient must be able to choose either anonymous of confidential HIV testing

A person can be offered an HIV test if they are 13 and years of age or older (or younger or older if there is evidence of risk activity). An HIV test must also be offered to anyone receiving primary care services in the outpatient department of a hospital or in a free-standing diagnostic and treatment center or from a physician, physician assistant, nurse practitioner, or midwife providing primary care.

The provider must notify the patient (or authorized person) every time that the test will be performed. Documentation should be made in the patient's medical record.

Information must be shared with the member before an HIV test can be administered, this includes, but not limited to:

- HIV is the virus that causes AIDS. It can be spread through unprotected sex with someone who has HIV; contact with HIV-infected blood by sharing needles; by HIV-infected pregnant women to their infants during pregnancy or delivery, or by breastfeeding.
- 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 without giving your name at a public testing center
- By law, HIV test results and other related information are kept confidential.
- 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.

A person who has a positive HIV test should be given an appointment for follow-up care with a medical provider. The person should also be given information regarding how to prevent further exposure to HIV infection; the need to cooperate with partner notification efforts to let persons who may have been exposed to HIV know they should get an HIV test and get medical treatment, if necessary; help notifying partners is available and can be done without revealing the name of the person who tests positive or any other identifying information; HIV cases must be reported to the state Department of Health to help monitor the epidemic.

A person who received a negative HIV test should be given information about the risks of engaging in sexual activities or needle-sharing that can result in infection; how to protect against HIV infection; the potential need for further HIV testing if the person has engaged in risk behavior within the past three months or if he or she continues to engage in risk behavior in the future.

For general information, to report a breach of confidentiality, or to obtain forms and referrals, call:

New York State Department of Health
HIV Confidentiality Hot Line 1-800-962-5065

Or write:

Special Investigation Unit
New York State Department of Health
90 Church Street
New York, New York 10007

HIV and Developmental Disabilities

Consistent with OPWDD guidance, all PHP members with I/DD should be offered the opportunity to be tested for HIV. Members and the surrogates who provide consent on their behalf should be educated and encouraged to consent to an HIV test. OPWDD regulations at 14 NYCRR 633.11 must be followed when seeking informed consent from individuals receiving services or from their surrogates.

- **Individuals who are self-consenting**: Individuals who are capable of providing consent to HIV testing must be given the opportunity to consent or decline testing. If an individual refuses to consent to an HIV test, providers should document the refusal in the individual's record and continue to educate the individual regarding the benefit of knowing his or her HIV status.
- **Individuals with an authorized surrogate:** For those individuals who are not capable of providing consent to HIV testing, but who have a guardian or an actively involved family member who acts as a surrogate pursuant to 14 NYCRR 633.11, consent must be sought from such surrogate.

Use of the DOH model forms (Informed Consent to Perform HIV Testing), or its equivalent is required unless the physician's office has provided its own HIV consent form. The model form can be found at http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm

DOH requires that individuals receive seven (7) points of information about HIV before consenting. A description of these points can be found at:

http://www.health.ny.gov/diseases/aids/forms/docs/key_facts_before_testing.pdf

Advance Directives

During the initial orientation, all new PHP members and their authorized representatives are informed of their right to specify oral or written advance instructions regarding health care treatment. The PCP is responsible to ask members and their representatives if they have executed any advance directives. All participating providers are required to comply with all NYS rules and

regulations—including OPWDD regulations, if applicable—relating to advance directives and must provide care and treatment according to the wishes of the member/representative. For additional information on this policy please contact PHP at 1-855-747-5483.

Effective January 21, 2011, the New York State Office for People with Developmental Disabilities (OPWDD) approved the use of the revised NYS DOH-5003 Medical Orders for Life-Sustaining Treatment (MOLST) form for individuals with I/DD. However, the MOLST form must be accompanied by the MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities.

Use of this checklist is required for individuals with I/DD who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life-sustaining treatment (LST) must comply with the process set forth in the Health Care Decisions Act for persons with I/DD. Effective June 1, 2010, this included the issuance of DNR orders.

The advantage of the MOLST form is that it is transferable to other, non-hospital settings. Accordingly, a DNR issued on a MOLST form is effective not only in hospitals and nursing homes but in community settings as well. The MOLST includes medical orders and instructions for intubation and mechanical ventilation, future hospitalization/transfer, etc.

Call PHP or visit the OPWDD website for more information.

Health Care Proxy

A health care proxy is a document which names another person as the member's Health Care Agent with the authority to make health care decisions if and when the member is determined to be incapable of making personal medical care decisions.

A health care agent has the authority to make any and all health care decisions on the member's behalf that the member could make if he or she had the capacity. This authority can be limited by adding express limitations to the health care proxy.

A proxy may include the member's health care wishes regarding, but not limited to, the following:

- Artificial nutrition and hydration
- Blood transfusions
- Artificial respiration
- Antipsychotic medication
- Surgical procedures
- Dialysis

Importantly, if a member does not make his or her wishes known regarding artificial nutrition and hydration, a health care agent does not have the authority to accept or refuse nutrition and hydration on the member's behalf.

And finally, even if a member has appointed an agent to make health care decisions on his or her behalf, the member retains the right to object to a health care decision made by an agent. If this should occur, the member's objection or decision shall prevail unless the member is determined by a court to lack capacity.

A copy of the Health Care Proxy should be kept with the Physician, the Health Care Agent, the member, and any other family member(s) or friend(s) that the member chooses.

Health Care Decisions Act

New York's Health Care Decisions Act (HCDA) establishes the authority of a member's family member or close friend to make health care decisions for the member in cases where the member lacks decisional capacity and did not leave prior instructions or appoint a health care agent. Under HCDA, the surrogate decision-maker is empowered to make all health care decisions that the member could make if he or she had the capacity, including the withdrawal or withholding of life-sustaining treatment when standards and procedures set forth in the statute are met.

The current list of authorized surrogates, in the order of precedence, is as follows:

1) Article 17-A Guardian (i.e., a court-appointed guardian)
2) An actively involved spouse
3) An actively involved parent
4) An actively involved adult child
5) An actively involved adult sibling
6) An actively involved adult family member
7) The Consumer Advisory Board for the Willowbrook Class
8) A court-appointed surrogate

The surrogate is required to base all advocacy and health care decision-making solely and exclusively on the best interests of the member and, when reasonably known or ascertainable with reasonable diligence, on the wishes of the member, including moral and religious beliefs.

An assessment of the best interests of the member must include a consideration of five factors:

1) The dignity and uniqueness of every person
2) The preservation, improvement, or restoration of the health of the person
3) The relief of the suffering of the person by means of palliative care (care to reduce the person's suffering) and pain management

4) The unique nature of artificially provided nutrition or hydration, and the effect it may have on the person
5) The entire medical condition of the person

In addition, a surrogate's health care decisions may not be influenced by a presumption that the member is not entitled to the full and equal rights, equal protection, respect, medical care, and dignity afforded to other persons, nor by financial considerations of the surrogate.

Decisions Regarding Life Sustaining Treatment (LST)

Life-sustaining treatment means medical treatment including cardiopulmonary resuscitation and nutrition and hydration without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life sustaining treatment without the necessity of a medical judgment by an attending physician.

If a surrogate makes a decision to withdraw or withhold life-sustaining treatment (including "do not resuscitate" or DNR) from a member, the attending physician must confirm that the person lacks capacity to make health care decisions. The attending physician who makes the confirmation is required to consult with another physician or licensed psychologist to further confirm the person's lack of capacity. Either the attending physician or the consulting physician or psychologist must possess specialized training or have experience in providing services to people with mental retardation or developmental disabilities.

The surrogate may express a decision to withdraw or withhold life-sustaining treatment either orally or in writing. If done orally, it must be stated to two persons 18 years of age or older, at least one of whom is the member's attending physician. If done in writing, it must be dated and signed in the presence of one witness 18 years of age or older who must also sign the decision and presented to the attending physician.

The attending physician must then either issue an order in accordance with the surrogate's decision and advise the responsible staff members, or promptly object to the surrogate's decision. Other persons may also legally object to the surrogate's decision, including the member, an actively involved parent or adult sibling, another treating practitioner, or an authorized representative from OPWDD.

An objection by any of these individuals will result in the suspension of the surrogate's decision, pending judicial review, except if the suspension would be likely to result in the death of the member. If the surrogate's decision is suspended following an objection, the objecting party is required to notify the surrogate and the other parties who could have objected to such decision.

Surrogates cannot be subjected to criminal or civil liability as long as they make a health care decision reasonably and in good faith pursuant to the law.

If you or your staff should have any questions or concerns about this policy, please do not hesitate to contact PHP at 1-855-747-5483 or OPWDD at 1-866-946-9733.

Member Access to Care

Appointment Availability/Waiting Time

All PHP providers must have an appointment system that meets the following standards for appointment availability:

Circumstance	Required Timeframe
Medical Emergency Care	Immediately upon presentation at a licensed service delivery site
Behavioral Emergency Care (including Inpatient Psychiatric Services, CPEP, Crisis Intervention, Detoxification)	Immediately upon presentation at a licensed service delivery site
Urgent medical or behavioral problems (includes Mental Health Outpatient, ACT, PROS, Community Mental Health Services, OASA Outpatient Clinic, Opioid Treatment program).	Within 24 hours of request
Non-urgent "sick" visits	Within 48-72 hours of request, as clinically indicated
Non-Urgent MH/SUD	Within 1 week of request
Routine, non-urgent, or preventive care	Within four (4) weeks of request
Specialist appointments (non-urgent)	Within four (4) weeks of request
Pursuant to an ER visit or hospital discharge, mental health or substance abuse follow-up visits with a network provider (as included in PHP's benefit package)	Within five (5) business days of request, or sooner if clinically indicated
Non-urgent mental health or substance abuse visits with a network provider (as included in PHP's benefit package)	Within one (1) week of request
Visits to a network provider to conduct health, mental health, or substance abuse assessments for the purpose of making recommendations regarding a member's ability to perform work	Within 10 business days of request

Mental Health Clinics

Mental health clinics must provide a clinical assessment within five (5) business days of request for members in the following designated groups who are not currently receiving treatment:

- Members in receipt of services from a mobile crisis team
- Members in domestic violence shelter programs
- Homeless members and those present at homeless shelters
- Members aging out of foster care
- Members who have been discharged from an inpatient psychiatric facility within the last 60 calendar days
- Members referred by rape crisis centers
- Members referred by the state court system

Home Health Care:

- **Post-partum**: One (1) medically necessary post-partum home health visit, with additional visits as needed for high-risk women
- **Newborns**: At least two (2) visits for high-risk infants
- **Other Members**: Must be medically necessary and arranged by PHP or ordered by the member's PCP/Specialist

Directly Observed Therapy for Tuberculosis Disease:

- Provides observation and dispensing of medication, assessment of any adverse reactions to medication, and case follow-up.

Community-Based Long-Term Services and Supports (LTSS)

PHP's PHSP product covers a limited number of community-based LTSS as a supplement to authorized OPWDD waiver services, as applicable. Newly enrolled members who are not already receiving covered community-based LTSS that are determined to be medically necessary will commence receiving services within 30 calendar days of enrollment in PHP if the services are otherwise unavailable through OPWDD. Covered community-based LTSS include:

- **Personal Care**: As applicable, PHP will cover medically necessary personal care services as a supplement to services authorized through the OPWDD waiver program, including:
  - **Home Attendant Services**: Provides some or total assistance with personal hygiene, dressing, feeding, meal preparation, and housekeeping.
  - **CDPAS**: To receive information regarding Consumer-directed Personal Assistance Services, please contact PHP Member Services at 1-855-747-8453.
- **Personal Emergency Response System (PERS)**: PHP will cover this benefit as a supplement to OPWDD authorized waiver services. To qualify for this service, you must be receiving personal care/home attendant services through PHP.

- **AIDS Adult Day Health Care Services**: This service must be recommended by your PCP. The service provides general medical and nursing care, substance abuse supportive services, mental health supportive services, individual and group nutritional services, as well as structured socialization, recreational, and wellness/health promotion activities.

Facility-Based LTSS

PHP will pay for Medicaid-covered residential facility services as a supplement to OPWDD waiver program services, if applicable. Covered facility-based LTSS include:

- **Skilled Nursing Facilities**: These services must be determined to be medically necessary by your physician and authorized by PHP. Services include:
  - Medical supervision
  - 24-hour nursing care
  - Assistance with daily living
  - Physical therapy
  - Occupational therapy
  - Speech-language pathology and other services
- **Rehabilitation Services**: PHP covers short-term or rehabilitation stays in a skilled nursing facility if they are medically necessary not otherwise authorized through OPWDD.
- **Long-Term Placement**: PHP covers long-term placement in a skilled nursing facility within our network for members 21 years of age and older following approval by the Local Department of Social Services (LDSS). Eligible veterans or their spouses as well as Gold Star Parents of eligible veterans may choose to stay in a Veterans' nursing facility.

Primary Care Services

PHP must provide members with access to PCPs and OB/GYNs on a 24/7 basis and educate members and their families/caregivers on the process for obtaining services during non-business hours and on weekends and holidays.

Office Wait Times

PHP's members with a previously scheduled appointment must not be made to wait longer than one (1) hour on a routine basis.

Missed Appointments

Members and/or their caregivers may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. PHP encourages practitioners/providers to attempt to contact members/representatives who have not shown up for or canceled an appointment without rescheduling. If you or your staff experience difficulty in contacting the member/representative or if a member has a pattern of missed or canceled appointments, please contact Member Services or the member's care manager/coordinator for follow-up by calling 1-855-747-8543.

Second Medical or Surgical Opinion

Members and/or their representatives may request a second opinion if they:

- Dispute the reasonableness of a recommended treatment
- Dispute the necessity of a procedure
- Do not respond to medical treatment after a reasonable amount of time

Members must obtain a second opinion from a network provider unless a network provider with the necessary qualifications and experience is unavailable within a reasonable timeframe. Members may not visit out-of-network providers without prior authorization.

Laws Relating to Federal Funds

The payments that providers receive for furnishing services to PHP's PHSP members are derived in part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds including, but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84
- The Age Discrimination Act of 1975 as implemented by 45 CFR Part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act

Cultural Competency

Cultural Competency is a process of developing and exercising proficiency in effectively communicating in a cross cultural context. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word "competence" is used because it implies having the capacity to function effectively. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery to meet patients' social, cultural, and linguistic needs.

The term ‘‘culturally competent', as defined by the Developmental Disabilities Bill of Rights and Assistance Act of 2000 (DD Act), "means services, supports, or other assistance that is conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving the services, supports, or other assistance, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program involved."

Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language

- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include, but are not limited to:

- The perception that illness and disease and their causes vary by culture.
- The understanding that belief systems relating to health, healing, and wellness are very diverse.
- The recognition that an individual's cultural background influences help-seeking behaviors and attitudes toward health care providers.
- An acknowledgement that individual preferences affect traditional and non-traditional approaches to health care.

PHP strongly encourages providers to recognize cultural factors that shape personal and professional behavior and to accept that their own world views and those of the member and/or his or her caregiver may differ while avoiding stereotyping and misapplication of scientific knowledge.

PHP staff will gladly assist providers who may have questions or require help in accessing needed resources such as language translation services or other available community-based resources for persons with I/DD. In addition, PHP provides detailed information about the provision of culturally competent care for persons with I/DD on our website at www.PHPcares.org.

Americans with Disabilities Act Requirements

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination against individuals with disabilities in programs or activities that receive federal financial assistance, including Medicare and Medicaid. This legislation requires that medical providers offer individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable accommodations to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the essential nature of the services

PHP's policies and procedures are designed to promote compliance with the ADA. Providers are strongly encouraged to take actions to remove an existing barrier and/or to accommodate the

needs of PHP members, many of whom have some degree of physical disability. This action plan includes the following:

- Providing reasonable accommodations to individuals with hearing, vision, cognitive, and psychiatric disabilities
- Utilizing waiting room and exam room furniture that meets the needs of all individuals, including those with physical and non-physical disabilities
- Utilizing clear signage and way-finding throughout facilities
- Clearly marking handicap parking unless there is street-side parking
- Providing street-level access to provider offices
- Providing elevators or accessible ramps into facilities
- Providing wheelchair accessible entrances and restrooms
- Providing access to an examination room that accommodates a wheelchair
- Offering first and last appointment availability to accommodate special needs visits

All providers are strongly encouraged to complete the NYSDOH ADA Attestation form that is included as Attachment A to this Provider Manual. If you should have further questions about ADA provisions and provider responsibilities, please contact our Provider Relations staff at 1-855-747-5483.

SECTION 7: PRIMARY CARE SERVICES

Primary Care Provider Responsibilities

At the time of initial enrollment, each Partners Health Plan (PHP) member will select or be assigned a primary care provider (PCP) that will serve as the member's "medical home." PCPs are typically family medicine physicians, internists, pediatricians, or OB/GYNs, although nurse practitioners and physician assistants may also fulfill this role. Under certain circumstances, a specialist physician may serve as a member's PCP (e.g., member has a chronic and/or complex health condition that requires regular consultation with a specialist), but the specialist must agree to the designation and fulfill all the obligations of a PCP as described in this section.

PCPs are responsible for:

- **Primary Care**: Providing primary and preventive care services including, but not limited to:
  - Providing health counseling and advice
  - Conducting baseline and periodic health examinations
  - Diagnosing and treating conditions that do not require the services of a specialist
  - Consulting with specialists and ordering laboratory and radiological services, as needed
  - Working collaboratively with behavioral health providers, as applicable
- **24/7 Availability**: Ensuring the availability of primary care services to members 24/7, including arranging for on-call and after-hours care with other network PCPs
- **Referrals**: Serving as the member's referral source for most medically necessary specialist services and covered long-term services and supports, including inpatient care
- **IDT Participation**: Serving on the member's Interdisciplinary Team (IDT), if applicable and requested. Please see the Model of Care Section of this Manual for a description of the IDT's role.
- **Care Plans**: Assisting in the development of member care and service plans (i.e., Life Plans)
- **Coordination of Care**: Collaborating in the coordination of the member's care with PHP's care managers/coordinators and other stakeholders involved in the member's care (e.g., MSC)
- **Medical Records**: Maintaining members' medical records in accordance with all state and federal rules and regulations and contractual requirements
- **Stakeholder Communications**: Communicating members' medical records, reports, treatment summaries, and related documents to PHP and other providers, upon request and as appropriate
- **Care Transitions**: Ensuring the continuity of care of members during enrollments/disenrollments, inpatient admissions/discharges, change of PCP, and other transitions in collaboration with the members' care manager/coordinator and other applicable stakeholders (e.g., MSC)

- **Claims and Encounters**: Submitting claim forms and encounters within ninety (90) days of the date of service using appropriate procedure and diagnostic codes
- **Medical License & Insurance**: Maintaining professional credentials and liability insurance in accordance with PHP credentialing standards
- **UM Compliance**: Complying with all utilization management protocols as outlined in this Provider Manual
- **Clinical Practice Guidelines**: Adhering as appropriate to generally accepted clinical practice guidelines and protocols, including guidelines and protocols specific to persons with intellectual and other developmental disabilities (I/DD)
- **Grievances**: Working closely with PHP to resolve any problems, complaints, and disputes that may arise involving members, caregivers, providers, and PHP
- **Member Rights**: Treating members and their caregivers with courtesy and respect and honoring their right to fully understand the member's diagnosis, prognosis, and anticipated outcomes of recommended medical or surgical procedures
- **Cultural Competency**: Interacting with members and their caregivers in a culturally competent manner and not differentiating or discriminating in the treatment of members on the basis of race, gender, ethnicity, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, or any other basis prohibited by applicable federal, state, or local rules and regulations

Choice of Network PCP

At the time of initial enrollment, each member/representative will be given a list consisting of no fewer than three network PCPs located within the PHSP program's time/distance standards from which they can make a selection (note: if the member's existing PCP already contracts with PHP, the member's care manager/coordinator will encourage the member to maintain the relationship). If the member has a relationship with a Medicaid-certified PCP that is not in PHP's network, Provider Relations staff will make a reasonable effort to recruit the practitioner into PHP's network.

If the member/representative fails to express a preference on a timely basis, PHP will send the member/representative a written notification regarding the issue and make other reasonable efforts to encourage an affirmative selection. If the member/representative still does make a selection, PHP will assign a network PCP based on the member's geographic location, medical history, cultural and linguistic background, level of disability/PCP accessibility and experience with persons with IDD, and other relevant factors (if known).

If the member selects or is assigned to a multi-provider clinic in PHP's network (e.g., Article 28 Clinic), the member must choose or be assigned to a specific provider or provider team within the facility to serve as his or her PCP. This "lead" provider will then be accountable for carrying out PCP requirements.

New Member Transitional Care

If a new member has a life-threatening or degenerative disease or disabling condition, PHP will allow the new member to continue an ongoing course of treatment with the member's current health care provider for a period of up to sixty (60) days effective from the date of enrollment. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period will include the provision of postpartum care directly related to the delivery.

The transitional period applies only if the health care provider agrees to:

- Accept reimbursement, at rates established by PHP, as payment in full
- To adhere to PHP's quality assurance requirements
- To provide medical information related to such care
- To adhere to all applicable PHP policies and procedures

In no event will this requirement be construed to require PHP to provide coverage for benefits not otherwise covered as part of the member's benefit package with PHP.

Member Access to Primary Care Services

Office Hours

New York State Department of Health guidelines require PCPs to practice at least 16 hours per week at a primary care site and be available at least four (4) hours on two separate days of the week. If you cannot comply with these criteria, please contact PHP's Provider Relations staff or the Chief Medical Officer.

Wait times within a primary care site should comply with the following standards:

- Within one (1) hour for scheduled appointments on a routine basis
- Non-urgent walk-in members should be seen within two (2) hours or scheduled for an appointment consistent with the timeframes listed above under "Member Access to Care."
- Urgent walk-ins should be seen within one (1) hour

24/7 Telephonic Access

PCPs are responsible for arranging on-call and after-hours coverage to ensure 24/7 telephone access to members and their caregivers (please note that members can also access a PHP care manager and/or Nurse Hotline 24/7).

All PHP primary care providers are required to maintain 24-hour, 7-day-a-week telephone access for their impaneled members. The standard for returning a member call is 30 minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider (e.g., caller alert system, call forwarding, etc.). An automated message must direct the member/representative to a live voice.

PCPs are required to notify PHP, in writing, at least 30 calendar days in advance of any change in their office address, telephone number, or office hours.

Changing PCPs

Member-Initiated Change

Members/Representatives may request a change in PCP at any time and for any reason. Care managers/coordinators will provide any assistance the member/representative may need in selecting a new PCP and ensuring a smooth transition. After receiving a request to change PCP, PHP will process the request and inform the member/representative of the effective date of the change, which must take place within five (5) business days of the request.

Relinquishing practitioners are responsible for making members' medical records available to receiving practitioners upon request and in compliance with the confidentiality requirements of PHP and HIPAA/HITECH. At a minimum, practitioners are requested to transmit medical records related to current diagnostic tests and determinations, current treatment services, immunizations, recent hospitalizations (within the past year) with concurrent review data and discharge summaries (if data and summaries available), current medications list, recent specialist referrals, and emergency care.

PHP will facilitate the transfer of pertinent medical records (as needed) and will transfer other requested records that exceed the requirements of the policy if so directed or required.

Provider-Initiated Change

In the event that a PCP determines that he or she is unable to continue providing services to a member, the PCP must send a written notification to PHP's Chief Medical Officer stating the specific problem. PHP will not simply remove a member from a PCP's roster without good cause. Depending upon the circumstances, the member's care manager/coordinator may contact the PCP to discuss the issue and attempt to resolve it (e.g., communication issues, lack of compliance with treatment recommendations, etc.). Some examples of good cause include:

- Fraudulent acts in obtaining services
- Consistent verbal or physical abuse to the PCP or to his or her staff and/or harm to other patients
- Habitual lack of compliance with treatment recommendations
- Chronic no-show for appointments

Member disenrollment may not be initiated for refusal to accept a specific treatment or for behavior related to an underlying medical condition, alcohol or substance abuse, mental illness, or intellectual or other developmental disability.

PHP recognizes the importance of the member-PCP relationship and will make every effort to preserve and nurture it. To this end, PHP encourages network PCPs to contact the member's care manager or coordinator to communicate any issues of concern.

If a PCP-initiated change is approved, the relinquishing PCP is responsible for transferring member medical records in the same manner as a member-initiated change (see above).

Closed Panel

A PCP’s panel may be closed upon request or upon reaching the maximum number of members permitted under New York State standards based on a 40-hour, full-time employment/work status. If the PCP believes that he or she is unable to provide care for additional members, the practitioner has the option of closing his or her panel. In that case, the practitioner should send a letter to PHP's Provider Relations Department and PHP will close the panel to future members until further notice. The Provider Directory will reflect this change by indicating that the provider's panel is only open to current members.

When closing a practice to additional PHP members, PCPs are required to:

- Provide PHP with 60 days prior written notice that the practice will be closing to additional members as of a specified date
- Keep the practice open to PHP members who were patients before the panel closed
- Give PHP prior written notice of the re-opening of the panel, including a specified effective date

PCP Leaves PHP's Network

If a member’s PCP leaves PHP's network of providers, or is terminated for reasons other than imminent harm to members, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, PHP will permit the practitioner’s assigned members to continue an ongoing course of treatment during the transitional period at the previously agreed upon reimbursement rate.

The transitional period may continue up to ninety (90) calendar days from the date of notice to the member of the provider's disaffiliation from the network or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery.

PHP will authorize the care for the transitional period only if the provider agrees:

- To accept reimbursement as payment in full at the Medicaid rates applicable prior to the start of the transitional period
- To adhere to PHP's utilization management and quality assurance requirements
- To communicate medical information related to such care
- To adhere to all other applicable policies and procedures

Required Reporting to Local Department of Health

PCPs and other providers in PHP’s network are expected to report positive TB test results and active cases of TB to the New York City Department of Health (NYCDOH) or Local County Department of Health (CDOH), as required by State and City Health Codes. In New York City, reports to NYCDOH must include information on HIV+ status, IV drug, and other substance

abuse, and the status of the case. For additional information go to:
http://www.nyc.gov/html/doh/downloads/pdf/hca/appendix n.pdf

PHP also expects the PCP and other providers to cooperate with the SDOH or NYCDOH in identifying case contacts and arranging for or providing services and follow-up care. PHP encourages all providers to consult with their respective County Health Departments on TB treatment and preventive therapy. Information forms for reporting and consultation in New York City can be obtained by calling the TB Hotline for Physicians at 347-396-7400. For additional information, contact the New York State Department of Health at 518-474-7000. For additional information, go to: http://www.nyc.gov/html/doh/html/diseases/tb-provider.shtml.

Behavioral Health Clinic as a PCP – If a member is obtaining services from a behavioral health clinic that is also providing primary care, the member can choose to have the behavioral health provider to act as their Primary Care Provider

SECTION 8: SPECIALIST PROVIDER SERVICES

PHP's network specialists are encouraged to work in partnership with members' PCPs, care managers/coordinators, and other applicable stakeholders (e.g., MSC) to promote the delivery of appropriate, high-quality medical and behavioral health care services to PHP's members. Similarly, network PCPs are encouraged to communicate with members' care managers/coordinators when making referrals to specialists for specific services. Specialists play a critical role by providing care within their area of expertise and within the scope of the referral.

Although PHP strongly encourages members and their families/caregivers to discuss any issues or concerns relating to their medical or behavioral condition(s) with their PCP and care manager/coordinator before seeing a specialist, with few exceptions members are permitted to visit in-network specialists without a referral.

For a detailed description of PHP's specialist referral policies and protocols, please see Section 14 below.

Responsibilities

PHP's network specialists are responsible for:

- Coordinating care with the member's PCP and care manager/coordinator, except in an emergency
- Providing services normally performed in the practice specialty and provide care that conforms to accepted medical and surgical practice standards in the community
- Reporting findings and recommendations to the referring PCP by telephone and in writing
- Admitting and referring members to hospitals that participate in PHP's network, except in emergencies
- Maintaining medical records that meet the medical record standards described in this Manual
- Sending copies of member medical records, reports, treatment summaries, and other related documents to PHP and, upon request, to other participating providers
- Submitting claim forms for services within ninety (90) calendar days of the date of service with the appropriate treatment and diagnostic codes
- For covered services, seeking reimbursement only from PHP (network providers may not seek payment from PHP members under any circumstances)
- Maintaining professional credentials and liability insurance consistent with PHP's credentialing standards
- Complying with all utilization management protocols as outlined in this Provider Manual
- Adhering as appropriate to generally accepted clinical practice guidelines and protocols, including guidelines and protocols specific to persons with intellectual and other developmental disabilities (I/DD)

- Working closely with PHP to resolve any problems, complaints, and disputes that may arise involving members, members' caregivers, providers, and PHP
- Treating members and their families/caregivers with courtesy and respect and honoring their right to fully understand the member's diagnosis, prognosis, and anticipated outcomes of recommended medical or surgical procedures
- Interacting with members and their caregivers in a culturally competent manner and not differentiating or discriminating in the treatment of these individuals on the basis of race, gender, ethnicity, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, income level, or any other basis prohibited by applicable federal, state, or local laws, rules, and regulations
- Accepting peer review of professional services provided to PHP members
- Abiding by agreements made with PHP as a result of member complaints, peer review, quality assurance, and utilization review
- Immediately notifying PHP's Chief Medical Officer, in writing:
  - If provider's ability to practice medicine is restricted or impaired in any way
  - If any adverse action is taken, or an investigation is initiated by any authorized city, state, or federal agency
  - If any new or pending malpractice actions occur
  - If any reduction, restriction, or denial of clinical privileges at any affiliated hospital is initiated
- Immediately notifying PHP's Provider Relations Department about any changes in information included on the Provider Application (e.g., changes in address or office hours, on-call arrangements, etc.)

Appointment System

Participating specialists must abide by the applicable appointment availability standards as defined in this Manual.

Verification of Member Eligibility

Prior to providing services, the provider's office must verify the member's current eligibility either by accessing PHP's secure provider portal at www.PHPcares.org or by calling Member Services at 1-855-747-5483. **Failure to verify eligibility may result in denial of payment for services rendered if the individual was not eligible and enrolled on the date of service.**

Authorized Services

Appropriate evaluation and treatment of a member may require a provider to order certain diagnostic tests. PHP does not require prior authorization for diagnostic tests that are considered part of a routine examination and consistent with the provider's practice (e.g., an EKG or a CBC). However, PHP reserves the right to deny reimbursement if, in the opinion of the Chief Medical Officer, the test being performed was not medically necessary nor part of a routine

exam. Providers are encouraged to call PHP's UM Department at 1-855-747-5483 if they have any questions regarding a particular test. Additionally, providers are encouraged to contact the member’s care manager/coordinator if there are any questions regarding tests that may have already been ordered and conducted by other providers to prevent duplicative testing. More detailed information regarding prior authorization may be found in the UM section of the Manual and on our website (phpcares.org).

Coordination of Care

Specialists are required to provide any relevant documentation with all treatment information to the member’s PCP in order to ensure effective care coordination. If the specialty referral occurs in a hospital-based specialty clinic, it is the responsibility of the hospital to ensure that consultation reports are forwarded to the PCP in a prompt and efficient manner.

Self-Referral for Specialist Services

A member may self-refer to a participating behavioral health provider for an unlimited number of behavioral health and substance use assessments. This does not include ACT, inpatient psychiatric hospitalization, partial hospitalization and Home and Community Based Services. Members will be informed of their self-referral benefit.

SECTION 9: EMERGENT, URGENT, AND INPATIENT SERVICES

Emergency Services

- Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the individual in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

Emergency services are defined as covered inpatient and outpatient services that are furnished by a provider/practitioner that is qualified to furnish such services and such services are needed to stabilize an emergency medical condition.

Emergency and Post-Stabilization Care

PHP complies with all federal and state requirements as it relates to the provision and coverage of emergency and post-stabilization care services. This means that PHP:

- Does not require prior authorization for emergency services
- Does not deny payment for treatment if a member had an emergency medical condition or if PHP staff instructed the member to seek emergency services
- Does not limit what is considered to be an emergency medical condition on the basis of a list of diagnoses or symptoms
- Does not refuse to cover emergency services based on the provider not notifying the member’s PCP or PHP of the member’s screening and treatment within 10 calendar days of presentation for emergency services
- Does not allow a member to be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member
- Does not require prior authorization for post-stabilization care services, regardless of whether the member obtains the services within or outside of PHP’s provider network if:
    - PHP pre-approved the services.
    - The services were not pre-approved by PHP because either PHP did not respond to the provider’s request within one hour or PHP could not be reached by the provider to request pre-approval.
    - PHP and the treating physician could not reach an agreement concerning the member’s care and PHP’s Chief Medical Officer, Chief of Care Coordination, or Director of UM was not available for consultation. (PHP also assures that the attending emergency

physician or the treating provider is responsible for a binding determination of member stabilization for transfer or discharge based upon the general rule for coverage and payment.)

Emergency Behavioral Health Services

Members who need behavioral health services on an urgent or emergent basis may present directly to psychiatric facilities, hospital emergency departments, or other providers including out-of-network providers. In instances when inpatient care is appropriate, the hospital must arrange to transfer the member to a network psychiatric facility. The member's care manager/coordinator will contact the recommended facility to determine bed availability and assist with the transition, as needed and appropriate.

If the member presents or is brought to the hospital with a behavioral health emergency or requires immediate treatment related to drug or alcohol use, the hospital is responsible for:

- Stabilizing and otherwise securing the member's health and safety
- Verifying the member's PHP eligibility
- Contacting PHP's Care Management staff as soon as possible

Partners Health Plan Member Services Department will refer any member calling with an emergency behavioral health episode to PHP's Nurse Hot Line. The hotline, staffed by a Registered Nurse, will assess the call and if appropriate, inform the member to call 911. The nurse will perform a follow up call to ensure member compliance.

PHP will allow immediate access without prior authorization to a 72-hour emergency supply of a prescribed drug or medication to an individual experiencing an emergency condition. Partners will immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

For assistance with behavioral health issues, please contact PHP's Behavioral Health Coordinator at 1-855-747-5483.

Urgent Care Services

Definition

An urgent medical condition is defined as a medical or behavioral condition other than an emergency condition, manifesting itself by acute symptoms requiring prompt (within 24 hours) medical or behavioral health services in order to prevent impairment of health and are the result of an unforeseen illness, injury, or condition. Urgent care is appropriately provided in a clinic, urgent care center, practitioner's office, or in a hospital emergency room if a clinic/urgent care center or practitioner's office is not accessible. Urgent care does not include primary care services or services to treat an emergency condition.

Urgent Care Policy

PHP will not deny payment for urgent care services if the needed services are obtained from a network provider. However, if the circumstances are unusual and/or a network provider is unavailable or if the member is temporarily away from PHP’s service area, PHP will cover urgently needed care from an out-of-network provider.

Inpatient Services

Authorization is required for all inpatient admissions, including unscheduled medical and surgical hospital admissions following stabilization. PHP requires notification of the member’s hospital admission as soon as feasible but no longer than two business days following stabilization. This also applies to emergency transfers from one acute care hospital to another when the treating hospital cannot provide the needed care and the patient's clinical status makes it unsafe to wait until the next business day to obtain pre-authorization for the transfer. To request authorization or access additional information, please contact PHP's UM staff at 1-855-747-5483.

Transfer to another Hospital

Prior authorization is required to transfer a member from one hospital to another. PHP will not authorize transfers unless:

- The facility that the member is in cannot provide the care and services the member’s medical and/or behavioral health condition requires.
- The member’s attending provider has authorized the transfer.
- A physician at the receiving facility has accepted the member and the accepting facility has the resources available to care for the member.
- All statutory and regulatory requirements for the transfer of a member from one institution to another are met.

If the member is transferring to an alternative inpatient facility, PHP will assist in ensuring a seamless transition by facilitating communication between the two facilities and other treating providers, facilitate the transfer of all pertinent records, and ensure all needed supports are in place prior to transferring the member. PHP can also assist in arranging for transportation for pre-authorized transfers if necessary.

Transfer to a non-participating facility requires approval from PHP's Chief Medical Officer or Director of UM or designee and will only be approved if needed care is not available at a participating facility. The receiving institution is under the same obligation to promptly communicate clinical information to PHP so that concurrent review and discharge planning can take place.

Concurrent Review and Discharge Planning

PHP will conduct concurrent review and discharge planning (CR/DP) activities on behalf of members who are hospitalized or in a nursing facility or ICF/IID for a short-term stay. Whenever possible, PHP's CR/DP staff will collaborate with facility staff and other stakeholders involved

in the member's care to ensure that a comprehensive discharge plan is in place prior to the member's discharge from the facility. The CR/DP process enables PHP to:

- Ensure the level of service being provided is consistent with the need for continued hospitalization
- Collaborate with inpatient facility (i.e., hospital, nursing facility, ICF/IID) staff to reduce preventable injuries or harm to members within the facility
- Identify potential clinical issues and refer them to the Chief Medical Officer or the Chief of Care Coordination for discussion with the member's treating physician
- Monitor the member's status and well-being prior to discharge to ensure that progress is being achieved toward targeted milestones in his or her recovery and ability to successfully transition to a home- and community-based setting.
- Evaluate and assess the post-discharge needs of the member and ensure any needed prior authorizations are in place within 48 hours of discharge
- Identify alternative care settings post-discharge and:
  - Explain the options to the member and his or her authorized representative
  - Make recommendations to the discharge planner or treating physician in accordance with the member's needs and preferences

SECTION 10: WOMEN'S HEALTH PROVIDERS

Responsibilities

Direct Access to Obstetrics and Gynecological (OB/GYN) Services

As required by New York State law, each female enrolled in PHP is allowed unrestricted access to an annual well-woman exam for primary and preventive OB/GYN services from a qualified provider/practitioner of her choice in the PHP network. The member also has unlimited access to primary and preventive OB/GYN services required as a result of such an exam, or as the result of an acute gynecological condition or disorder.

In addition, the member is allowed unrestricted access to a qualified provider of OB/GYN services in the PHP network for any care related to pregnancy. Consistent with this policy, a referral from the member's Primary Care Physician (PCP) is not required for these services. The specialist must, however, discuss the services and treatment plan with the member's care manager/coordinator.

Members must further have after-hours access to a network OB/GYN physician or practitioner for emergency consultation and care.

Preventive Care

Providers are responsible for delivering preventive gynecological services to female members including, but not limited to:

- Cervical cancer screening
- Mammography screening services
- Annual chlamydia testing for women of child-bearing age
- Three doses of HPV vaccine between the ages of nine (9) and thirteen (13)
- Any gynecological-related clinical condition

Appointment Systems

Participating OB/GYN and nurse midwives must schedule appointments with members within three (3) weeks during the first trimester; two (2) weeks during the second trimester; and within one (1) week thereafter, unless the member's condition is urgent, in which case the appointment should be scheduled using appropriate clinical judgment. A postpartum appointment must be scheduled between twenty-one (21) and fifty-six (56) days after delivery.

Maternity Admissions

- **Pregnancy-related Complications Admission (i.e., Ante-partum admissions)**: When a pregnant member presents due to a medical condition such as eclampsia, hyperemesis, etc., and delivery is not imminent, the hospital should call PHP's UM Department for authorization for inpatient admission or other treatment unless the patient presents with an

emergent condition. In this instance, the hospital should assess and stabilize the member, and then notify PHP.

- **OB Delivery Information**: The hospital must contact PHP within two (2) business days after delivery with the following maternal and newborn admission information for authorization and care management:
  - Mother's name
  - Mother's Medicaid (CIN) number (if applicable)
  - Admission date and time
  - Delivery method (normal spontaneous, C-section etc.)
  - Newborn information:
    - Gender
    - Date of birth
    - Birth weight
    - APGAR score
    - Nursery (NICU, newborn etc.) For newborns admitted to the NICU, please provide the working diagnosis, and name and telephone number of the physician of primary responsibility
    - Gestation by week
- HIV – OB/GYN providers must provide pre-test counseling including clinical recommendation of testing for pregnant women. The woman and the newborn must have access to:
- Positive management of HIV disease
- Psychosocial support and case management for medical, social and addictive services

SECTION 11: MEMBER TRANSITIONS IN CARE

Partners Health Plan's (PHP) member transition process is designed to ensure that members' care continues without interruption or delay when transitioning into or out of PHP or from one provider/practitioner to another. The objective is to maintain the continuity and quality of members' care and services during enrollment, disenrollment, or when changing providers/practitioners. To accomplish this, PHP:

- Tracks members who are leaving or joining the health plan or changing from one service provider to another
- Identifies transitioning members who need special assistance or care during the process
- Notifies applicable stakeholders (e.g., the receiving health plan, members' practitioners and/or providers, facilities, advocates) regarding the transition
- Monitors the continuity and quality of care and services throughout the process and conducts appropriate interventions, as needed
- Carries out transition activities efficiently and within federal and state-mandated timeframes
- Maintains the confidentiality of information during the transition process

Transition Coordinator

If PHP's Chief Medical Officer, Care Management staff, or care manager/coordinator determines that a member is at risk for transferring, a licensed care manager with the appropriate education and experience will be assigned to coordinate the transition functions (this will typically be the member's assigned care manager if applicable). The primary duties of the care manager during the transition process are to:

- Coordinate transition activities within PHP and with the receiving or relinquishing health plan, as applicable
- Lead the transition team and confirm that transition activities are carried out in accordance with established policies and procedures and member needs
- Act as an advocate for transitioning members
- Coordinate transition activities between the member's providers/practitioners and the inpatient facility (as applicable) to minimize unnecessary complications relating to care setting transitions and hospital readmissions
- If applicable, coordinate with the member's Interdisciplinary Team to ensure that any needed authorizations are in place within 48 hours of readiness for discharge from an inpatient facility to the community or to a skilled nursing facility/ICF
- Communicate with network practitioners and other providers to ensure that all community supports, including housing, are in place prior to discharge
- Educate applicable network practitioners and providers to ensure they are knowledgeable and prepared to support the transitioning member effectively, and assist them in coordinating care (including both clinical services and HCBS) for the member following discharge

- Communicate and work with applicable departments and staff to identify transitioning members and notify practitioners/providers of services to be monitored during the care setting transition or hospital readmission
- Ensure the transitioning member has an adequate supply of prescribed medications
- Conduct outreach with a newly enrolled member and his or her authorized representative if he or she has been receiving either a non-covered service or a covered service from a non-participating provider to discuss potential alternatives

Provider/Practitioner Responsibilities

Providers/Practitioners participating in PHP's network are responsible for:

- Transmitting medical records as requested to a member’s receiving provider/practitioner at the new health plan or within the fee-for-service (FFS) system
- Obtaining prior authorization from a receiving health plan (i.e., the new health plan) before continuing care or services for a member who is disenrolling from PHP (e.g., maternity care, surgical follow-up). Out-of-network providers may be requested to submit supporting documentation as a condition for reimbursement from the receiving health plan
- Complying with Partners Health Plan’s contractual requirements relating to transitioning members

Continuity of Care Requirements

Parties involved in a member’s transition are required to facilitate the transfer of the following care and services as described below.

Continued Access to Providers/Practitioners

If a provider’s/practitioner’s contract is discontinued, PHP will allow affected members continued access to the provider/practitioner, as follows:

- Continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy

Continued access to providers/practitioners applies only if the provider/practitioner agrees to the following:

- To share information regarding the treatment plan with PHP
- To continue to follow PHP's Utilization Management policies and procedures
- To accept payment based on the current Medicaid fee schedule, as applicable

Exceptions

- When a member requires only routine monitoring for a chronic condition (e.g., if a member sees a physician for monitoring chronic asthma but is not in an acute phase of the condition)
- When PHP has discontinued a contract based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.)
- When a provider/practitioner is unwilling to continue to treat the member or accept PHP’s payment or other terms
- If no provider/practitioner contracts have been discontinued

Transfer of Medical/Service Records

Providers/Practitioners are responsible for making member records available to health plans to which members are transferring and/or to other providers/practitioners, upon request, and in compliance with PHP’s internal confidentiality requirements as well as HIPAA/HITECH. At a minimum, providers are requested to transmit medical/service records related to current diagnostic tests and determinations, current treatment services, immunizations, recent hospitalizations (within the past year) with concurrent review data and discharge summaries (if data and summaries available), current medications list, recent specialist referrals, and emergency care.

PHP will facilitate the transfer of pertinent medical/service records (as needed) and will transfer other requested records that exceed the requirements of the policy if so directed or required.

Receiving providers/practitioners may request records directly from the relinquishing provider/practitioner.

Medical Equipment and Supplies

PHP will provide disenrolling members with covered medical supplies and DME for up to 15 days after the transition date. Transition of services should be coordinated with the receiving health plan’s prior authorization department.

Members transitioning into PHP and receiving treatment for chronic or acute medical conditions may continue care with the out-of-network treating practitioner or provider(s) through the lesser of:

- The current cycle or phase of active treatment
- Up to 90 calendar days for members undergoing active treatment for a chronic or acute condition
- Up to two years for the active treatment of a behavioral health condition or until treatment is complete

Upon completion of treatment, the member’s care manager/coordinator will help the member choose a network practitioner/provider for future care.

SECTION 12: MEDICAL/SERVICE RECORD DOCUMENTATION STANDARDS

Unlike typical health plans that primarily focus on the management of physical and behavioral health services, PHP’s responsibilities also include assisting with the coordination of the full continuum of Medicaid-covered long-term services and supports, including OPWDD waiver services such as habilitation, supported employment, respite care, personal care, transportation, and other non-clinical supports and services. For this reason, this section refers to both “medical” as well as “service” record documentation standards.

Medical and Service Records, whether electronic or on paper, communicate the member’s treatment history, past and current health status, and future treatment plans, as applicable. Effective documentation facilitates communication, coordination, and continuity of care, and promotes the efficiency and effectiveness of treatment.

Partners Health Plan's (PHP) standards require providers/practitioners to:

- Maintain medical/service records in a manner that is up-to-date, detailed, and organized.
- Maintain a separate, distinct medical/service record for each member.
- Have an organized medical/service record-keeping system.

Medical/Service Record Reviews

Network providers/practitioners must grant PHP access to medical/service records, including confidential member information, for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing UM functions.

For this specialized managed care program, medical/service record audits will typically involve a review of five (5) randomly selected medical/service records for each applicable provider. QM staff will randomly select provider locations so that each site is reviewed at least once every three years; however, if a site has a prior identified issue PHP will continuously re-audit that site until the matter is resolved.

QM or Provider Relations staff will use a standardized assessment tool to monitor compliance with medical/service record policies and procedures as well as with evidence-based clinical/LTSS guidelines and protocols. This includes reviewing the medical records of nursing facility and ICF/IID residents for completeness, legibility, and the presence of all information required by state and federal regulations and guidelines.

Content of the Medical/Service Record

Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the PCP, and all diagnostic and therapeutic services for which the member was referred by the PCP (e.g., specialty physician reports, hospital discharge reports, physical therapy reports, etc.). Specific content standards are reflected in the following table:

Member Information	Each member record must contain appropriate biographical/personal data including age, gender, race/ethnicity, address, employer, home and work telephone numbers, emergency contact, marital status, name of member's PCP, and PHP ID number. All members must have their own chart (i.e., no family charts). A centralized medical record for the provision of prenatal care and all other services must be maintained.
Provider Information	The service provider for face-to-face encounters must be appropriately identified on medical/service records via their signature and physician/professional specialty credentials (e.g., MD, DO, DPM, LCSW, LMHP, etc). Examples of acceptable signatures include: • Handwritten signature or initials • Electronic signature with authentication by the respective provider • Facsimiles of original written or electronic signatures This means that the credentials for the service provider must be somewhere on the medical/service record, either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the service provider is not listed on the stationery, then the credentials must be part of the signature for that provider.
Date	All entries must be dated.
Legibility	All entries must be legible to someone other than the writer. The medical/service record should be complete and legible; illegible medical record entries can lead to misunderstanding and serious patient injury.
Medications	Evidence of prescribed medications, including dosages and dates of initial and refill prescriptions, must be present in the record. This list should be updated following each visit.
Medication Allergies and Adverse Reactions	The presence or absence of medication allergies and/or adverse reactions should be prominently noted as NKA (no known allergies) or NKDA (no known drug allergies).
Problem List	A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9/10 (as applicable) diagnosis code on the date of service. A problem list should be either a classical

	separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and should include health maintenance. A repetitive listing of problems within progress notes is acceptable.
Past Medical History	Past history including experiences with illnesses, operations, injuries, and treatments must be documented. Family history, including a review of medical events, diseases, and hereditary conditions that may place the patient at risk must also be documented.
History and Physical (H&P)	Past medical history including physical examinations, necessary treatments, and possible risk factors for the member relevant to the particular treatment are noted.
Substance Abuse	For patients 14 and older, there should be an appropriate notation concerning the use of tobacco, alcohol, and substances as part of risk screening in support of preventive health.
Follow-up Care	Encounter forms or notes should include a notation regarding follow-up care, calls, or visits, when indicated. The specific time of return is noted in weeks, months, or as needed (i.e. PRN).
Immunization Record	An immunization record (for children) is up-to-date or an appropriate history has been made in the medical record (for adults). Member-reported data is acceptable.
Preventive Screenings and Services	There should be evidence that preventive screenings and services are offered in accordance with Partners Health Plan's practice guidelines. Preventive screenings specific to member age/gender/illness (i.e., mammography, immunizations, HA1c, LDL, etc.) should be documented.
Advance Directives	Advance directives should be noted in a prominent place in the record and whether or not the advance directive has been executed in the chart for members over 21 years of age.
Treatment Plan	The record should include documentation of clinical/professional findings and evaluation for each visit (presenting complaints, Diagnosis and Treatment Plan, prescription, referral authorization, studies, instructions).
Inappropriate Risk	The record should document that there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure and that diagnostic and therapeutic procedures are appropriate for the patient's diagnosis and risk factors.

Referrals	If a consultation/referral is made to a specialist, there should be documentation of communication between the specialist and the PCP with a notation that the physician has seen it. There should also be documentation of discharge summaries from hospitals, ICFs, and SNFs, if applicable.

Medical/Service Records must be stored in a secure location not accessible to members, with a unique medical/service record for each member and a medical/service record identifier (either name or number) on each page. Records should also be organized and filed to ensure easy retrievability. PHP will share the results of record audits with the provider at the conclusion of the review to assist in improving adherence to service record documentation and SDOH/OPWDD guidelines. The results will also be submitted to PHP’s Quality Oversight Committee for review.

Performance Goals

PHP's goal is for 85 percent of aggregate and individual provider medical/service records to comply with the selected assessment measures listed above. PHP utilizes the National Medical Record Audit Tool to monitor, assess, and improve medical/service record documentation for participating providers who do not meet the required goal.

Corrective Actions

Quality Management staff will send written notifications to audited provider offices communicating the results of their audit and requesting corrective actions for those scoring below the overall 85 percent goal, and an educational letter to those that score less than 100 percent on individual criteria measures, including recommendations for improvements, if warranted.

When a provider scores below performance standards, PHP will require the implementation of a corrective action plan (CAP) and re-audit the provider in six (6) months to ensure that the CAP is progressing properly. QM staff will be responsible for documenting all such corrective actions and related activities, including their resolution, and entering them into providers’ confidential QM files. QM staff will further report this information to the Chief Medical Officer and the Quality Oversight Committee and it may also be used in re-credentialing/certification evaluations of Certified Home Health Agencies (CHHAs), Licensed Home Care Service Agencies (LHCSAs), and nursing facilities, among others. The Chief Medical Officer or Director of Provider Relations is also responsible for overseeing the preparation and submission of summary reports to the Quality Oversight Committee.

Medical/Service Record Retention Requirements

SDOH requires contracted providers of Medicaid managed care plans to retain member medical records for at least six (6) years.

Confidentiality

Access to medical/service records must only be permitted to authorized individuals providing services to the member. Information included in the record may be provided to PHP only for purposes directly connected with the performance of PHP's obligations.

Confidentiality of HIV-Related Information

Providers must develop policies and procedures to assure confidentiality of HIV-related information, as required by Article 27-F of the New York State Public Health Law. These policies must include:

- Initial and annual in-service education of the providers' staff and/or contractors
- Identification of those staff members allowed access, and the limits of their access to HIV-related information
- A procedure to limit access to trained staff (including contractors)
- A protocol for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV infection from discrimination

Access to Medical/Service Records

Copies of medical/service records must be made available, without charge (unless otherwise noted), to other participating providers, consultants, or practitioners involved with the member's care and treatment. They must also be made available upon request, and without charge (unless otherwise noted), to PHP (e.g., Chief Medical Officer, Chief of Care Coordination, or QM staff) for quality assurance and utilization review activities. The handling of medical/service records must comply with all federal and state laws and regulations regarding the confidentiality of member records.

Copies of medical/service records must also be made accessible to OPWDD (if applicable) and the New York State Department of Health upon request.

If you have any questions or concerns about the handling of confidential member information including medical/service records, please do not hesitate to contact PHP at 1-855-747-5483.

SECTION 13: EVIDENCE-BASED PRACTICE GUIDELINES

Introduction

Partners Health Plan (PHP) recognizes that the majority of providers/practitioners appreciate the value and importance of evidence-based practice guidelines and that the level of cooperation increases when the provider recognizes that the guidelines are based on reliable and sound standards of practice. By developing and disseminating evidence-based practice guidelines to our network providers/practitioners, PHP can both improve their practice patterns and reduce the amount of time they must allocate to literature review and independent research on current best practices. That said, PHP also appreciates that practice guidelines are not intended to dictate clinical practice and that each provider has his or her own approach to care and good professional judgment will at times supersede practice guidelines.

References

PHP adopts evidence-based practice guidelines, including Preventive Services Guidelines, from recognized sources that follow NCQA and other accreditation standards and meet the New York State Department of Health (SDOH) regulatory and legislative requirements. At a minimum, PHP adopts practice guidelines that meet the following requirements:

- Are based on valid and reliable evidence or a consensus of professionals in the particular field, including I/DD professionals
- Consider the unique needs of our members
- Are adopted in consultation with contracting providers and practitioners
- Are reviewed and updated periodically, as appropriate

PHP will maintain a comprehensive listing of current practice guidelines on our website at www.PHPcares.org.

Process for Adopting and Updating Practice Guidelines

PHP's Chief Medical Officer and Chief of Care Coordination regularly monitor multiple sources to keep current on practice guidelines including, but not limited to, the following:

- American College of Physicians/Internal Medicine
- American Psychological Association
- CQL Personal Outcome Measures
- National Core Indicators
- University Centers of Excellence in IDD
- American Academy of Family Medicine
- National Institutes of Health/National Heart Lung and Blood Institute
- American Diabetes Association

- American Heart Association
- National Guideline Clearinghouse™
- Agency for Health Research and Quality
- Hayes Medical Technology Directory™
- Milliman Care Guidelines™

PHP also adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). When there is lack of sufficient evidence to recommend for or against a preventive service by these sources, or there is a conflicting interpretation of evidence, PHP may adopt recommendations from other nationally recognized sources.

Again, PHP’s adopted guidelines are intended to augment, not replace, sound professional judgment. We welcome your feedback and will consider all suggestions and recommendations in our next review. You may submit comments to PHP’s Chief Medical Officer or the Chief of Care Coordination.

Updating Practice Guidelines

The Chief Medical Officer, Chief of Care Coordination, and their staff are responsible for reviewing and updating all practice guidelines at least every two years and responding immediately to new developments. The review process includes:

- Monitoring internal and national health trend data as well as published research from the I/DD community for developments of potential concern to PHP and its members
- Reviewing medical and other professional literature
- Seeking and receiving input from providers, practitioners, local medical societies, and other relevant organizations

Prior to updating practice guidelines, PHP's Chief Medical Officer and Chief of Care Coordination will consult with the following individuals/organizations (non-inclusive):

- Network providers and practitioners in relevant specialties
- External consultants (if applicable)
- SDOH and OPWDD
- Professional associations
- PHP’s Quality Oversight Committee for review and recommendation
- Internal Professional Guideline Committees (e.g., Quality Oversight Committee)

Clinical Practice Guidelines (CPGs) for Persons with IDD

Because of the unique characteristics of the majority of PHP's PHSP members, our primary focus is on the adoption of nationally-recognized practice guidelines for medical and behavioral health conditions that are prevalent among individuals with intellectual and other developmental

disabilities (I/DD), especially such common diagnoses as hyperlipidemia, osteoporosis, seizure disorders, obesity, and anxiety. Moreover, medications commonly prescribed for persons with I/DD often have certain side effects (e.g., hyperlipidemia) that make it difficult to manage these conditions. In those cases, our protocols and guidelines include alternative measures to better manage these side effects and mitigate their negative impact.

The following table lists a representative sampling of physical health considerations for adults with I/DD and current recommendations for addressing them. Please contact our Care Management staff with any questions or concerns relating to CPGs for adults with I/DD.

Physical Health Guidelines for Adults with I/DD	
Considerations	**Recommendations**
Physical inactivity and obesity are prevalent among adults with I/DD and associated with adverse outcomes, including cardiovascular disease, diabetes, osteoporosis, constipation, and early mortality. Being underweight, with its attendant health risks, is also common.	• Monitor weight and height regularly and assess risk status using body mass index, waist circumference, or waist-hip ratio measurements.
Vision and hearing impairments among adults with I/DD are often under-diagnosed and can result in substantial changes in behavior and adaptive functioning.	• Perform office-based screening of vision and hearing annually as recommended for average-risk adults, and when symptoms or signs of visual or hearing problems are noted, including changes in behavior and adaptive functioning • Refer for vision assessment to detect glaucoma and cataracts at least every 5 years after age 45 • Refer for hearing assessment if indicated by screening and for age-related hearing loss at least every 5 years after age 45 • Screen for and treat cerumen (i.e., ear wax) impaction every 6 months
Dental disease is among the most common health problems in adults with I/DD owing to their difficulties in maintaining oral hygiene routines and accessing dental care. Changes in behavior can be the result of discomfort from dental disease.	• Promote regular oral hygiene practices and other preventive care (e.g., fluoride application) by a dental professional
Cardiac disorders are prevalent among adults with I/DD. Risk factors for coronary	• When any risk factor is present, screen for cardiovascular disease earlier and more

artery disease include physical inactivity, obesity, smoking, and prolonged use of some psychotropic medications	regularly than in the general population and promote prevention (e.g., increasing physical activity, reducing smoking). • Refer to a cardiologist or adult congenital heart disease clinic • Follow guidelines for antibiotic prophylaxis for those few patients who meet revised criteria
Respiratory disorders (e.g., aspiration pneumonia) are among the most common causes of death for adults with I/DD. Swallowing difficulties are prevalent in those patients with neuromuscular dysfunction or taking certain medications with anticholinergic side effects, and they might result in aspiration or asphyxiation	• Screen at least annually for possible signs of swallowing difficulty and overt or silent aspiration (e.g., throat clearing after swallowing, coughing, choking, drooling, long mealtimes, aversion to food, weight loss, frequent chest infections). Refer as appropriate.
Gastrointestinal and feeding problems are common among adults with I/DD. Presenting manifestations are often different than in the general population and might include changes in behavior or weight.	• Screen annually for manifestations of GERD and manage accordingly. If introducing medications that can aggravate GERD, monitor more frequently for related symptoms. • If there are unexplained gastrointestinal findings or changes in behavior or weight, investigate for constipation, GERD, peptic ulcer disease, and pica.
Sexuality is an important issue that is often not considered in the primary care of adolescents and adults with I/DD.	• Discuss the patient's or caregiver's concerns about sexuality (e.g., menstruation, masturbation, fertility and genetic risks, contraception, menopause) and screen for potentially harmful sexual practices or exploitation. • Offer education and counseling services adapted for those with I/DD.
Musculoskeletal disorders (e.g., scoliosis, contractures, and spasticity, which are possible sources of unrecognized pain) occur frequently among adults with I/DD and result in reduced mobility and activity, with associated adverse health outcomes.	• Promote mobility and regular physical activity • Consult a physical or occupational therapist regarding adaptations (e.g., wheelchair, modified seating, splints, orthotic devices) and safety

Osteoporosis and osteoporotic fractures are more prevalent and tend to occur earlier in adults with I/DD than in the general population. In addition to aging and menopause, risk factors include severity of I/DD, low body weight, reduced mobility, increased risk of falls, smoking, hypogonadism, hyperprolactinemia, the presence of particular genetic syndromes (e.g., Down syndrome and Prader-Willi) and long-term use of certain drugs (e.g., glucocorticoids, anticonvulsants, injectable long-acting progesterone in women). Diagnosis and management of osteoporosis related to the side effects of current treatments can be challenging in adults with I/DD.	• Periodically assess risk of developing osteoporosis in all age groups of male and female patients with I/DD. Those at high risk warrant regular screening starting in early adulthood. • Recommend early and adequate intake or supplementation of calcium and vitamin D unless contra-indicated.
Epilepsy and other forms of seizures are prevalent among adults with I/DD and increases with the severity of the I/DD. It is often difficult to recognize, evaluate, and control, and has a pervasive effect on the lives of affected adults and their caregivers.	• Refer to guidelines for management of epilepsy in adults with I/DD • Review seizure medication regularly (e.g., every 3-6 mo) • Consider specialist consultation regarding alternative medications when seizures persist, and possible discontinuation of medications for patients who become seizure-free • Educate patients and caregivers about acute management of seizures and safety-related issues
Endocrine disorders (e.g., thyroid disease, diabetes, and low testosterone) can be challenging to diagnose in adults with I/DD. Adults with I/DD have a higher incidence of thyroid disease compared with the general population.	• Monitor thyroid function regularly. Consider testing for thyroid disease in patients with symptoms (including changes in behavior and adaptive functioning) and at regular intervals (e.g., every 1-5 years) in patients with elevated risk of thyroid disease (e.g., Down syndrome). • Establish a thyroid baseline and test annually for patients taking lithium or atypical or second-generation antipsychotic drugs.

PHP reviews and updates all practice guidelines at least every two years and responds immediately to new clinical developments.

Evaluating the Use of Practice Guidelines

On an annual basis, PHP will evaluate sample medical and pharmacy records, analyze claims and encounter data, review HEDIS/QARR results, and evaluate CQL Personal Outcome Measures to determine whether providers and practitioners are adhering to our guidelines and conduct follow-up to address any identified issues. Interventions may include conducting in-person visits to provider offices to discuss the issue, emphasize the importance of evidence-based guidelines, provide additional education or training, and/or implement a corrective action plan, as needed and appropriate. This would include specific education on the unique issues related to providing services and supports to individuals with I/DD, including those who have co-morbid chronic health conditions that are linked to their underlying developmental disability (e.g., early onset dementia in patients with Down syndrome or dysphagia among persons with cerebral palsy).

SECTION 14: PRIOR AUTHORIZATION AND REFERRALS

Partners Health Plan's (PHP) prior authorization policy is designed to support our utilization management program and ensure compliance with NCQA requirements and SDOH/OPWDD regulations and standards. The policy is further designed to provide a system of managing care and services that offers timely access to necessary, appropriate, high-quality services for members and that supports providers in delivering these services with minimal administrative barriers.

The objective is to assist each member, provider, and other applicable stakeholders in determining the appropriate utilization of covered services and supports, identify opportunities to optimize members' health and well-being, improve the quality of service delivery, and manage costs. Our service authorization process serves as a vital tool for monitoring the use of covered services and supports prior to their being rendered in order to make certain:

- Members are provided services at an appropriate level of care and setting and are consistent with the member's assessed needs and preferences
- Members receive services that are covered, necessary, appropriate, timely, and cost efficient
- Members' authorized services and supports are coordinated in a manner designed to ensure that services are non-duplicative and appropriate for the member's needs
- Information regarding a service authorization request is communicated in a timely manner to all applicable operational areas, as appropriate (e.g., care management, quality management)
- Authorized services are properly documented to facilitate accurate and timely reimbursement
- Duplication of services and inappropriate delivery of services is minimized or eliminated

Medical Necessity

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

Prior Authorization Protocols

PHP's specialized managed care program applies utilization review criteria for covered services and supports that are consistent with state and federal regulations and nationally recognized best practices. We use evidence-based clinical guidelines (e.g., Milliman Care Guidelines®) to review and determine the appropriate utilization of acute care services. Prior to adopting practice guidelines, PHP ensures they are:

- Based on valid and reliable evidence or a consensus of appropriately qualified professionals
- Consistent with the needs of PHP's members
- Adopted in consultation with network providers and practitioners, as appropriate
- Reviewed and updated on an annual basis or as needed

Service authorization is based upon the individual member's service and support needs and preferences as well as state and federal regulations governing the provision of services, as applicable. Our focus is on maintaining the member in the least restrictive and most integrated setting consistent with the member's needs, preferences, and safety. PHP's licensed care managers (i.e., RNs, Social Workers, and psychologists) and QIDP care coordinators will work with the member, family/caregiver, his or her primary care and specialist physicians, and other stakeholders (e.g., residential services providers) to identify services that will promote the optimal outcomes and goals for each member throughout the continuum of care.

Services Requiring Prior Authorization (PA)

The list of services and/or procedures that require PA includes, but is not limited to, the following:

- Non-emergent inpatient admissions to a hospital, skilled nursing facility, or ICF/IID
- Ambulatory surgeries
- Certain radiological/imaging tests such as an MRI or CT scan
- Non-formulary medications
- A request to access a service or procedure from an out-of-network provider/practitioner
- A request for an expansion of an existing service(s) that exceeds a pre-determined threshold
- Community-based long-term services and supports (e.g., Personal Care Services)
- Durable Medical Equipment

If you have a question or are uncertain if a proposed treatment or service requires PA, please contact the member's care manager/coordinator or PHP's UM staff at 1-855-747-5483.

Services That Do Not Require PA

The services that are categorically excluded from PHP's service authorization requirements include:

- Emergency and Post-Stabilization Services, including Emergency Behavioral Health Care
- Comprehensive Psychiatric Emergency Program (CPEP)
- Crisis Intervention
- OMH and OASAS non-urgent ambulatory services
- Urgently needed care

- PCP visits
- Out-of-Network Dialysis services when the member is outside of PHP's service area
- Family Planning and Women's Health Specialist Services
- For any member who is an Indian eligible to receive services from a participating Indian health care provider; or from the Indian Health Service (IHS); or from an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services
- Public Health Agency Facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; and Directly Observed Therapy (TB/DOT)
- Immunizations
- Palliative Care
- Other Preventive Services
- Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services
- Dental Services through Article 28 Clinics Operated by Academic Dental Centers
- Cardiac Rehabilitation, first course of treatment (a physician or RN authorization is required for subsequent courses of treatment)
- Supplemental Education, Wellness, and Health Management Services
- Prescription Drugs which a) are on PHP's formulary, or b) are not on PHP's formulary but a refill request has been made for an existing prescription within the new member's 90-day transitional period

Services Requiring Authorization by a Specialist Provider

The items and services listed below must be authorized by an appropriate specialist.

- Preventive Dental X-Rays (requires authorization by a Dentist)
- Comprehensive Dental (requires authorization by a Dentist)
- Eye Wear (requires authorization by an Optometrist or Ophthalmologist)
- Hearing Aids (requires authorization by an Audiologist)

As needed, PHP's care managers/coordinators will assist members in obtaining specialist authorizations.

Utilization Management Process

PHP's trained and qualified Utilization Management (UM), Care Management, and Member Services staff will accept requests for services not already specified in the member's care and service plan from members, their authorized representatives, treating providers/practitioners, and

other appropriate stakeholders either in-person or via telephone, email, or fax. A trained and experienced clinician will be available to accept and document the request.

A service authorization request must include the following information:

- Member identifying information, including name, DOB, gender, and CIN number
- Name of treating provider/practitioner, including contact information
- Problem/diagnosis, including ICD-10 code, as applicable
- Reason for the service request
- Presentation of supporting information, such as clinical notes, treatment information, etc.

All service authorization requests will be reviewed and recommendations made according to the following UM process:

- If the review of a service authorization request through the UM process results in an approval, then notification will be given to the member, the member's authorized representative, the care manager/coordinator, and the applicable service provider by telephone and in writing within contractually mandated timeframes.
- If the review of a service authorization request through the UM process yields a potential denial or an authorization in an amount, duration, or scope that is less than requested, then UM staff will notify the Chief Medical Officer or qualified designee. In the case of clinically related requests, the Chief Medical Officer will consult with the requesting service provider and/or other health care professional that has the appropriate expertise in 1) treating the member's medical condition, and/or 2) performing the procedure, and/or 3) providing the treatment. The CMO will then make the final determination of the service authorization request.

  The UM Department will then be informed of the CMO's determination and will handle the required notification to the member, the member's authorized representative, the member's care manager/coordinator and the applicable service provider by telephone and in writing within contractually mandated timeframes. For non-clinical service authorization requests, the Chief Medical Officer or Chief of Care Coordination in consultation with appropriately licensed and experienced professionals will make the determination.

The Chief Medical Officer is also responsible for ensuring the clinical accuracy of all pharmacy coverage determinations involving medical necessity.

PHP's UM Process is designed to facilitate the timely delivery of needed services to members. Whenever needed, care managers may also consult with the Chief Medical Officer, Chief of Care Coordination, network providers, and other appropriate stakeholders to evaluate a service authorization request to ensure it meets evidence-based criteria for medical necessity and is in the member's best interests.

PHP's service authorization process serves as a vital tool for monitoring the use of covered services and supports prior to their being rendered in order to make certain:

- Members are provided services at an appropriate level of care and setting and are consistent with their assessed needs and preferences
- Members receive services that are covered, necessary, appropriate, timely, and cost efficient
- Members' needs for covered services and supports are coordinated in a manner designed to ensure that services are non-duplicative and appropriate for their needs
- Information regarding the service authorization request is communicated in a timely manner to all applicable operational areas, as appropriate (e.g., care management, utilization management)
- Authorized services are properly documented to facilitate accurate and timely reimbursement
- Duplication of services and inappropriate delivery of services is minimized or eliminated

PHP will follow a well-defined process to research and analyze each service authorization request in order to:

- Verify that the member is eligible to receive services at the time of the request and on each date of service
- Verify that the requested service is a covered benefit
- Verify the service provider's qualifications and network participation
- Evaluate and determine the necessity and appropriateness of each requested service and/or any need for additional supporting documentation
- Determine and report whether a requested service is subject to coordination of benefits or third-party liability conditions (e.g., private health insurance coverage, TRICARE)
- Research a member's authorization history before approving services in order to avoid:
  - Duplicating services the member is already receiving
  - Authorizing services PHP is not responsible for providing
  - Duplicating authorizations already documented in the system.

PHP does not require prior authorization for emergency services in any setting.

Service Authorization Timeframes

PHP is responsible for processing service authorization requests and providing notification to the member, the member's authorized representative, and the requesting service provider by telephone and in writing in a timely manner in accordance with all applicable federal, state, and NCQA standards, as described in the following table.

Standard	Request for Service Process/Timeframes
Services Requiring PA	Decisions made and notice provided no later than three (3) business days following receipt of all necessary information.

Standard Authorization Decisions	As expeditiously as the member’s health condition or other circumstances require and no later than three (3) calendar days following receipt of the request for service. Extensions for up to 14 additional calendar days may be allowed only if: • The member or the provider requests an extension • PHP can justify to the satisfaction of SDOH (if requested) that: – The extension is in the member’s interest – There is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to an approval of the request, if received – Such outstanding information is reasonably expected to be received within 14 calendar days
Notice of Decision Timeframe Extension	The member, the member’s authorized representative, and the care manager/coordinator will be notified verbally and in writing of the extension, including the right to appeal the extension.
Notification of Decision Involving: • Continued or extended health care services • Additional services for a member undergoing a course of continued treatment • Home health services following an inpatient hospital admission	Notification of decision must be made to the member, the member’s authorized representative, and/or the requesting provider by telephone and in writing within one (1) business day following receipt of all necessary information with the exception of covered home health services following an inpatient admission, in which case PHP must provide notice of its determination within 72 hours following receipt of all necessary information when the day subsequent to the request falls on a weekend or holiday.
Determination Regarding Services Already Delivered	PHP must provide notice of the determination within 14 days following receipt of the request for services.
Notice of Adverse Action	Notification of any decision to deny or authorize a service in an amount, duration, or scope that is less than requested will be provided in writing to the member, the member’s authorized representative, the member’s care manager/coordinator, and applicable providers within the timeframes specified above and within at least 10 days before the date of action, as specified in federal regulation.

Termination, Suspension, or Reduction of Service Authorization	At least 10 calendar days before the date of the action.

If PHP fails to make a determination within the specified timeframes, it is deemed a denial subject to appeal (see below). PHP does not base an adverse determination on a refusal to consent to observing any health care service or on a lack of reasonable access to a provider/practitioner's medical or treatment records without providing reasonable notice to the member, the member's authorized representative, or the requesting provider.

An Approved Care and Service Plan (Life Plan) is the Service Authorization Document for Covered Services

Following an initial assessment or reassessment of a member, the member's care manager/coordinator, MSC (if applicable), and other stakeholders (e.g., IEP coordinator) will review the finalized Life Plan with the member and his or her family/caregiver and circle of support and they will be asked to sign off on the plan indicating agreement with the services to be provided. The member and his or her treating providers (including the PCP and any additional specialists or other professionals engaged in the member's care) will be sent (via mail) a copy of the approved Life Plan. Authorized users can also access member Life Plans through PHP's website. All services included in the Life Plan are deemed approved and not subject to additional service authorization (PA) requirements. The member's providers are also notified about the member's authorized services and they are entered into the claims system to ensure timely payment.

Service authorization requests for covered benefits may be submitted to PHP at any time and will be processed and verbal and written notifications provided in accordance with the timeframes listed in the table above. If all service authorization criteria are met, UM staff will approve the request and issue an authorization number for submission with claims for approved services. Generally, a service authorization number will remain valid until the member's next scheduled review or reassessment as long as the member is enrolled and eligible on each date of service.

If the member's request does not clearly meet the review criteria, UM staff will forward their recommendation to the Chief Medical Officer for further review. Before making a determination, the CMO may consult with the member's treating physician(s) and/or a practitioner from an appropriate specialty.

Service Authorization Denials

PHP will provide written notification to the member and his or her authorized representative, the member's care manager/coordinator, applicable providers, and other stakeholders (e.g., MSC) of all adverse actions related to authorization decisions. This notice will:

- Specify the reason(s) for the denial

- Provide a reference to the benefit provision, guideline, and/or protocol on which the denial decision was based
- Explain that the member and/or his or her authorized representative may obtain a copy of the provision or protocol
- Describe the member's appeal rights and the appeals process, including:
  - The right to submit written comments, documents, or other information relevant to the appeal
  - Timeframes for deciding appeals
  - The member's right to representation
  - Statement that Partners Health Plan will not retaliate or take discriminatory action if appeal is filed.
  - Member's right to contact DOH, with 1-800 number, regarding their concern.
- Describe the expedited appeals process (if the denial was for an urgent service request) and instruct the member/designee on how to request an expedited appeal

PHP's service authorization staff will document all pertinent information relating to the decision in our care management application, including details about efforts to obtain all pertinent information and/or attempts to confer with the requesting provider before issuing a denial. Only the Chief Medical Officer or qualified designee can approve a denial of a service authorization request or a reduction in the amount, duration, or scope of a previously authorized service.

If PHP issues a denial determination without first attempting to discuss the matter with the provider/practitioner who recommended the service, procedure, or treatment under review, the provider may request a reconsideration of the adverse determination. Except in cases of retrospective review, the reconsideration will take place within one (1) business day following receipt of the request and will be conducted by the member's provider and the Chief Medical Officer or designated peer reviewer, as applicable. In the event the adverse determination is sustained following reconsideration, PHP will provide notice as required and the member retains the right to initiate an appeal of the adverse determination.

Reversal of Prior-authorized Treatment

- Partners Health Plan may reverse a prior-authorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when: (a) relevant medical information presented to PHP or utilization review agent upon retrospective review is materially different from the information that was presented during the prior-authorization review; and (b) the information existed at the time of the prior-authorization review but was withheld or not made available; and (c) Partners Health Plan or UR agent was not aware of the existence of the information at the time of the prior-authorization review; and had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Prior Authorization Appeals

A prior authorization request is a request by the member (or the member's family/caregiver or provider on behalf of the member) for a new service or a request to change a service included in a member's care and service for a new authorization period. A concurrent review request is a request by a member or a provider (upon the member's request) for additional services that are currently authorized in the member's care and service plan (e.g., an increase in the number of hours of an authorized service).

A member and/or his or her authorized representative may request an expedited review of a prior authorization or concurrent review request, although PHP will automatically expedite an appeal of a concurrent review action. If PHP denies a request for an expedited review of a prior authorization request, we will handle it as a standard review.

Oral appeals may be requested by calling 1-855-747-8453. Any oral appeal can be followed up with a written submission for the request. Please send such requests to our Appeals department at:

Medical Appeals
Partners Health Plan
655 Third Avenue, 2nd Floor
New York, NY 10027

The timeframes for standard and expedited reviews of prior authorization and concurrent review requests are as follows:

- **Prior Authorization**:
  - **Expedited**: Three (3) business days from request of service.
  - **Standard**: Within three (3) business days of receipt of necessary information, but no more than 14 days after receiving the request.
- **Concurrent Review**:
  - **Expedited**: Within one (1) business day of receipt of necessary information, but no more than three (3) business days after receiving the request.
  - **Standard**: Within one (1) business day of receipt of necessary information, but no more than 14 days after receiving the request.

Members (or others acting on a member's behalf) may request an extension of up to 14 days either verbally or in writing. PHP may also initiate an extension if we can justify the need for additional information and the extension is in the member's interest. In either case, we will fully document the circumstances behind the extension.

PHP's Notice of Decision will include the following information:

- Date and summary of the service request
- The reason for the determination and, in cases where the determination has a clinical basis, the clinical rationale for the determination

- Procedure for filing an internal appeal and an explanation that an expedited appeal can be requested if a longer timeframe would be injurious to the member's health
- A description of what additional information, if any, PHP must obtain from any source in order to make an appeal decision if an internal appeal will be requested
- An explanation of the member's or the member's authorized representative's right to file a Fair Hearing request after the internal appeal process is exhausted, as well as the option to file an External Appeal if the service denial is related to issues of medical necessity or an experimental or investigational nature of service
- An explanation that the member or his or her authorized representative has the opportunity to present evidence and examine his or her case file during an appeal
- An explanation that the member or his or her authorized representative can access the clinical review criteria relied upon in making the decision, if the action involved medical necessity or if the treatment or service was experimental or investigational
- An explanation that the member or his or her authorized representative may request assistance (for language, hearing, or speech issues) if the member decides to file an appeal as well as instructions for the accessing the assistance

If PHP decides against the member's appeal of a prior authorization or concurrent review request, the member or provider may appeal the decision under the standard appeal process.

Referrals

Specialist Visits

Although PHP strongly encourages members and their families/caregivers to discuss any issues or concerns relating to their medical or behavioral condition(s) with their care manager/coordinator and/or PCP before seeing a specialist, PHP's member's are permitted to visit in-network specialists without a referral for an initial visit/consultation; follow-up visits may be subject to PCP referral or prior authorization. If you should have any questions about this policy, please contact the member's care manager/coordinator or PHP's UM staff at 1-855-747-5483.

Self-Referrals

The following services do not require a referral or prior authorization:

- Any services for emergency conditions as defined in 42 CFR § 422.113(b)(1) and 438.114(a), which includes emergency behavioral health care
- Urgent care under unusual or extraordinary circumstances provided in the service area when an in-network provider is unavailable or inaccessible (e.g., member is temporarily outside of PHP's service area)
- Out-of-network Dialysis services from a Medicaid-certified facility when the member is temporarily outside PHP's service area
- PCP visits

- For any member that is an Indian eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has the capacity to provide the services
- Public health agency facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; and Directly Observed Therapy (TB/DOT)
- Immunizations, including flu shots, Hepatitis B vaccinations, and pneumonia vaccinations from a network provider
- Palliative care
- Other Preventive Health Screenings from in-network providers including, but not limited to:
  - Prostate Screenings
  - Colorectal Screenings
  - Bone Mass Measurement
  - Vision Services
  - Routine Dental Care
  - Hearing Exams
- Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services
- Dental Services through Article 28 Clinics Operated by Academic Dental Centers
- Cardiac Rehabilitation, first course of treatment (a physician or RN authorization is required for subsequent courses of treatment);
- Supplemental Education, Wellness, and Health Management Services
- Family planning and women's specialists' services, including sufficient information and access on the process and available providers for accessing family planning services among in-network and out-of-network providers
- Prescription drugs which are either on PHP's formulary or not on the formulary but a refill request has been made for an existing prescription within the 90 calendar day transition period.

Out-of-Network Services

With certain exceptions (see above), PHP requires prior authorization for all non-emergent and non-urgent out-of-network services. Authorization for out-of-network services is typically restricted to services that are not available on a timely basis from a network provider (with certain exceptions for transitional care services for new members).

SECTION 15: CREDENTIALING AND RE-CREDENTIALING

This section describes Partners Health Plan's (PHP) process for reviewing, approving, and periodically recertifying the credentials of all network providers and practitioners licensed to provide covered physical and behavioral health services, including covered long-term services and supports. The objective is to verify that contracted network practitioners and facilities meet state and federal requirements and possess all required licensing, certification, accreditation, or designation. The credentialing process also continuously ensures that network providers are not listed on the HHS Office of the Inspector General or the NYS Office of the Medicaid Inspector General List of Excluded Individuals/Entities or the General Services Administration System for Award Management (SAM) Excluded List.

General Policy Statement

PHP's credentialing process uses standards set forth by the SDOH and NCQA, URAC, CMS, and all other applicable state and federal regulations, including primary verification of training/experience, office site visits, etc. Each provider is re-credentialed at least every three (3) years.

PHP uses the single, uniform provider credentialing application approved for use in the NYS Medicaid program to credential all applicable providers.

Anti-Discrimination

When determining whether or not to contract with a provider/practitioner, PHP does not discriminate on the basis of race, ethnicity, age, color, gender, sexual orientation, national origin, disability, marital status, or religion. However, PHP may take the following actions:

- Refuse to grant participation because the provider's specialty is in excess of the number necessary to meet the needs of PHP's members
- Use different reimbursement amounts for different specialties or for different practitioners in the same specialty
- Implement measures designed to maintain quality and control costs consistent with PHP's responsibilities to its members

If PHP declines to include a given practitioner/provider or group of providers in its network, PHP will furnish written notice of the reason for the decision.

Credentialing and Performance Committee

PHP's credentialing activities are conducted in accordance with the standards set by its Credentialing and Performance Committee (CPC) and New York State requirements. This committee has oversight authority for all credentialing and re-credentialing activities, including individual providers/practitioners who deliver services to our members. The committee is also responsible for overseeing professional peer review activities for those providers whose professional competence or conduct adversely affects, or could adversely affect, the health or

welfare of our members and for reviewing and evaluating all credentialing and re-credentialing information and processes.

PHP’s CPC advises the Chief Medical Officer on the credentialing and re-credentialing of network providers, including their selection, approval, or denial. Importantly, the Delegation Oversight Subcommittee has responsibility for reviewing the credentialing/background checks/fingerprinting reports of delegated providers (e.g., Home Health Agencies that employ direct-service workers).

Required Credentials

Once PHP's credentialing staff receives a completed application, they are responsible for verifying the following credentials (as applicable):

- Valid License
- Board Certification
- Education and Training appropriate to the provider’s specialty
- Past History, including work and licensure history, felony convictions, sanctions, malpractice history, etc.
- Clinical Privileges (if applicable)
- Medical Malpractice Insurance (if applicable)
- DEA/CDS Certificate
- National Practitioner Data Bank Information
- Valid National Provider Identifier (NPI) number (if applicable)
- Sanctions or Limitations on Licensure or Loss of Licensure
- Eligibility for Participation in Medicaid (Excluded and Opt-Out)
- Quality of Care Issues, Grievances, etc. (usually during re-credentialing)

Secondary sources (i.e., copies of documents) are acceptable for many of the credentials, and in some cases provider attestation may be sufficient. Primary source verification (PSV) is required for the provider/practitioner's license, educational credentials, and board certification (if applicable). The most recent versions of these documents will be maintained in PHP's provider credentialing database and summary reports will be generated for the credentialing committee, as needed.

Independent Practitioners

At the time of initial application, PHP's credentialing staff conducts a review of each provider’s service record and care planning practices to verify that they meet PHP's standards. In addition, as needed, Provider Relations personnel conduct on-site visits to verify that the service sites of all initial applicants are in compliance with PHP's standards as well as state and federal regulations, including ADA and HIPAA requirements/recommendations. After completing the

verification process, credentialing staff presents the application to the CPC for review and approval within 90 days of receiving a completed application and provider contract (practitioners with non-routine or unusual circumstances may require additional time). The information used in the review must be no more than six months old on the date of the determination.

Organizational Providers

For applications received from organizational providers, PHP's credentialing staff confirms that the organization is in good standing with state and federal regulatory bodies and, if applicable, verifies that an accrediting body has approved the entity. Each organizational provider (e.g., ICF/IIDs, Skilled Nursing Facilities, etc.) must have operating certificates as required by state or local regulations. PHP does not conduct site reviews of these providers if they are Medicaid-certified.

Organizational providers must further confirm that all ancillary staff are appropriately licensed, registered, or certified in their field and practice in accordance with all applicable laws and regulations. Providers must also provide appropriate supervision to ancillary staff and ensure that their responsibilities do not exceed those set forth in applicable state laws and regulations.

Laboratories

PHP requires all contracted laboratory testing sites to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.

Delegated Credentialing

PHP delegates the credentialing process to external organizations such as the Northwell Health System and the NYC Health and Hospitals Corp. (HHC), although PHP recognizes that delegation does not relinquish responsibility and PHP must continue to provide oversight. Once a decision to delegate has been reached, the next step is to create a mutually agreed-upon MOU that describes PHP's responsibilities vis-a-vis the delegated entity that:

- Specifies the delegated activities
- Describes the process by which PHP will evaluate the delegated entity's performance
- Describes how PHP will proceed if the delegated entity does not fulfill its obligations

The MOU must further require the delegated entity to:

- Submit a complete list of providers to PHP on a quarterly basis in a format to be specified by PHP
- Maintain a file of all physician documentation, including primary source verification and compliance with the ADA

Even with delegation, PHP retains the right to approve or reject individual practitioners within the delegated entity based on quality of care issues. Finally, PHP must annually evaluate whether the delegated entity is conducting its activities according to agreed-upon standards to determine whether the contract will be renewed.

Credentialing Process

PHP's credentialing process consists of a series of steps designed to assist the CPC in determining whether to accept or reject an application to participate in PHP's provider network. At a minimum, the process consists of the following sequential activities:

- **Application**: Practitioners expressing an interest in participating in PHP's network and/or meet PHP's organizational needs and administrative requirements are invited to apply. Each applicant must complete a signed and dated application, including a signed release granting PHP access to key information, and an attestation of the correctness and completeness of the application. Each application is accompanied by a copy of the applicant's current professional license, current DEA registration (if applicable), and the face sheet of the current professional liability insurance policy. The application also includes a statement by the applicant regarding his or her:
  - Ability to perform the essential functions of the position
  - Illegal drug use
  - Loss of license or felony convictions
  - Loss or limitation of privileges or disciplinary activity
  - Correctness & completeness of the application
- **Initial Screening**: If the application is not complete, the provider will be notified within 10 business days of receipt of the application detailing the required information needed. If the application is complete and meets the basic qualifications set out in a screening policy, it is forwarded to PHP's Chief Medical Officer, who reviews it to determine if a preliminary interview is warranted and if the full credentialing process is to be initiated (i.e., verification of credentials through primary sources and new provider site visit).
- **New Provider Site Visit**: The applicant is notified that a facility assessment and medical record keeping audit will take place, which is conducted during the time of primary verification of credentials, and prior to the presentation of the practitioner's file to the CPC. The site visit includes an assessment of a number of criteria, including:
  - Physical accessibility
  - Physical appearance
  - Adequacy of waiting and examining room space
  - Availability of appointments
  - Adequacy of medical record keeping
  - Quality of care (which is determined by randomly examining medical records against PHP's standards of care)
- **Primary Source Verification**: NCQA stipulates that seven criteria must be verified from the primary source because they identify the legal authority to practice as well as the relevant training and experience. PHP has the option to contract with an NCQA-accredited CVO (see Definitions) to complete this step. The criteria that require primary source verification include:

- Valid license to practice
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility
- Valid DEA or CES certificate (if applicable)
- Education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, as applicable
- Board certification (if applicable)
- Current adequate malpractice insurance
- History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner

- **File Preparation**: Immediately following the initial screening, QM staff prepares the file for presentation to the CPC, including:
  - Completed credentialing form
  - Results from the on-site audit (facility assessment & medical recordkeeping process)
  - Primary source verification of key elements
  - Work history
  - Information from the National Practitioner Data Bank (NPDB), the NYS Board of Examiners, and sanction activity by Medicare and Medicaid
  - Any other data relevant to the credentialing of the applicant
- **Data Entry**: After all required data elements have been received, QM staff enters the credentialing file into the credentialing database that assists in tracking the application and ensuring appropriate review of time-sensitive material (e.g., license, DEA certificate, etc.)
- **The Decision**: The CPC is responsible for determining whether to accept or reject an application. The confidential minutes reflect the decisions of the Committee and any relevant discussion pertaining to the decisions. All applicants are notified of the Committee's decision and a description of the appeals process is included with all denials.
- **Re-credentialing**: A re-credentialing date is set for at least three (3) years after the initial credentialing decision (PCPs, OB/GYNs, and high-volume specialists should have site visits every two years). In considering whether to renew the practitioner's status, PHP reviews information from the following sources:
  - NPDB, State Board of Medical Examiners, and the Medicare and Medicaid Programs regarding sanction activity or practice limitations
  - Member complaints and satisfaction survey results, as applicable
  - Quality Improvement and UM activity reports, as applicable
  - Provider Profiling reports
  - Medical record reviews and facility site visit results

PHP must also verify, in the same manner as under the initial credentialing process, the practitioner's admitting privileges, malpractice coverage, and DEA/CDS certification. In

addition, PHP requires practitioners to sign an attestation regarding their ability to carry out their responsibilities and another regarding the use of illegal drugs.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Approval Process

PHP's Credentialing and Performance Committee (CPC) reviews provider files and makes appropriate recommendations. Prior to making any adverse decision regarding a provider, the Chief Medical Officer will appoint appropriately-qualified providers to conduct a peer review of the provider in question in order to evaluate whether accepted standards of care have been met. The QM department then compiles all appropriate information and presents it to the CPC as follows:

- **Providers that meet credentialing criteria (“clean” files)**: The Chief Medical Officer reviews summary information and may recommend approval of a provider without reviewing the file or may request a full or partial review of the information.
- **Providers with a deficiency/issue that does not meet all applicable criteria**: Credentialing staff provides the committee with an analysis of the issue along with supporting documentation for review at the meeting.

After reviewing information on each provider, the CPC renders a decision to approve or deny the provider. A summary report of the activity of the CPC is submitted to the Quality Oversight Committee and the Quality Management Oversight Committee of the Board.

Notification to Providers

Once the process is complete, PHP's credentialing staff notifies the Provider Relations department of the final credentialing decisions and that department in turn notifies providers of the result in writing. PHP will complete all credentialing activities within 60 days of receiving a completed application and provide written notification to the provider regarding their credentialing status including approval, denial or if PHP does not require additional providers. PHP will also close out a provider’s application, within 60 days, if they fail to supply the needed documents to complete the application.

In the case of a denial or termination, it is PHP's policy to provide due process to providers/practitioners consistent with Section 4406-d of New York State Public Health Law. To this end, PHP has a hearing procedure in place to allow practitioners/providers, under certain circumstances, to appeal a proposed decision to deny an initial application or terminate an existing provider prior to the termination date of the contract. The hearing procedure is not available when the denial or termination involves:

- Imminent harm to members
- A determination of fraud

- A final disciplinary action by the state licensing board or other governmental agency

Ongoing Monitoring of Provider Status

Following the initial recruitment, credentialing, and contracting process, PHP continuously reviews state and federal exclusion and/or debarment reports and state board sanction lists. Any provider with a license expiration, suspension, or revocation will be immediately terminated from the network. PHP also works with SDOH/OPWDD to establish protocols for receiving timely information regarding their onsite inspection findings related to ICF/IIDs and other certified settings. In addition, we review their quarterly report of nursing home violations for quality issues that need to be addressed.

Review and Verification for Re-credentialing

As applicable, PHP's CPC re-credentials providers at least every three years to verify that they continue to meet credentialing standards, and PHP employs a rigorous monitoring and oversight process to ensure that providers remain in compliance with credentialing requirements. If needed, PHP may initiate re-credentialing sooner if quality oversight and provider profiling activities have identified potential issues of concern.

As with initial credentialing, PHP conducts the primary source verification on all data elements that NCQA and state and federal agencies require. For organizational providers, PHP's credentialing staff will make positive confirmation that the entity is in good standing with the state and verify that an appropriate accrediting body has reviewed and approved the organization.

Council for Affordable Quality Healthcare (CAQH) Credentialing Application Process

CAQH is a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is the improvement of healthcare access and quality for patients and the reduction of the administrative requirements for physicians and other health care providers and their office staff members. The CAQH Provider Datasource is designed to gather credentialing data in a single repository that may be accessed by participating health plans and other healthcare organizations. Its objective is to simplify the credentialing data gathering process and enable physicians and other health care providers to easily update their information.

Beginning in 2016, PHP adopted the CAQH credentialing application process for all provider types covered by the CAQH application and uses the single, uniform Participating Provider Supplemental Information Form for providers applying through CAQH for obtaining additional information. PHP will also use the single, uniform Participating Provider Credentialing Application for providers that are not applying through CAQH for credentialing and re-credentialing of all providers within provider types not covered by the CAQH credentialing process.

SECTION 16: OUT-OF-NETWORK/NON-PAR PROVIDERS

In the unlikely event that a needed service or benefit is unavailable within PHP's provider network on a timely basis, PHP will authorize out-of-network services that are subject to utilization review (i.e., excludes emergency services, urgent care, etc.) from an appropriately licensed and qualified provider/practitioner that meets the following criteria:

- The provider is certified by Medicaid to deliver services within his or her scope of practice.
- PHP would not otherwise exclude the provider from the network due to documented quality of care concerns.
- The provider is willing to accept payment based on the current Medicaid fee schedule by entering into a single case Letter of Agreement (LOA) with PHP.
- The provider agrees to comply with PHP's practice guidelines and UM policies.
- The provider agrees to communicate as needed with the member's care manager/coordinator and share all records and documents relating to the member's care.

As appropriate, PHP's provider relations team will make reasonable efforts to recruit the provider into PHP's network to address any identified network gaps and/or enhance access to services for PHP's members.

Provider Responsibilities

PHP's network PCPs and specialist physicians have the authority to refer members to network providers for medically necessary services and should consult the Provider Directory and use participating practitioners, providers, and facilities. Authorization is only required for those services listed in Section 10 of this Manual. If you are unsure whether or not a service, treatment, or procedure requires prior authorization, please contact our UM staff at 1-855-747-8543.

If a network provider believes a member should receive care from an out-of-network provider or facility even though the recommended service is available in-network, he or she must request authorization from PHP and provide supporting clinical information. The Chief Medical Officer will review the request for medical necessity and discuss the request with PCP/referring provider, as applicable, and reach a consensus based on all available information as well as the member's personal preferences and needs. If the request is denied, the member/representative and the member's provider will receive oral and written notification along with instructions for filing an appeal.

SECTION 17: NON-CLINICAL PROVIDER APPEALS

Requests for Reconsideration of Administrative Denials or Paid Amount

On occasion, a provider may disagree with Partners Health Plan (PHP) over the amount payable for a claim or a group of claims or for the denial of a claim for administrative reasons such as the timeliness of the claim submission, existence of co-insurance, member eligibility, lack of required prior authorization/precertification, or other errors in the claim. An administrative denial is not treated in the same manner as a clinical denial relating to the medical necessity of the treatment rendered or proposed, so the normal appeals process does not apply. However, the provider may seek reconsideration of an administrative denial or of claims the provider believes have been underpaid or otherwise incorrectly paid.

To request reconsideration, the provider should submit a written explanation within 60 days of the date of the administrative denial or alleged underpayment that clearly states the reason for the appeal and provides supporting documentation. PHP will render a decision within thirty (30) business days after receiving all information necessary to process the request for reconsideration. Providers have no further appeal rights if the administrative denial is upheld. In addition, if PHP does not receive a request for reconsideration of a claim within 60 calendar days of the date the claim was denied or underpaid, it shall be deemed final and without further recourse.

SECTION 18: MEMBER COMPLAINTS/GRIEVANCES AND APPEALS

Members and their authorized representatives (including the member's provider) may file grievances directly with any PHP staff member either orally or in writing within 60 calendar days of the incident or period of dissatisfaction (if there is more than one specific incident).

PHP staff will assist members and/or their authorized representatives with completing forms and taking other procedural steps, if requested. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

PHP will ensure that the personnel who make determinations on grievances were not involved in any previous level of review or decision-making. In addition, if the grievance relates to the denial of an expedited resolution of an appeal or involves clinical issues, PHP will ensure that the persons making the determination are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease.

If a grievance determination overturns an initial denial, PHP will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

PHP will not initiate disenrollment because of a member's or a member's authorized representative's attempt to exercise his or her rights under the grievance system. PHP will likewise not initiate punitive actions against a provider who files and/or supports a member's grievance.

In keeping with regulatory requirements, PHP will cooperate with NYSDOH grievance investigations.

Grievance Process

All grievances must be filed within 60 calendar days of the incident or whenever the member's unsatisfactory experience took place (if the grievance involves more than a single incident).

Same-day Grievance

To the extent possible, PHP's goal is to resolve grievances to the member's satisfaction immediately (same day). Same-day grievances are acknowledged and resolved verbally and do not require a written response. All same-day grievances are documented for quality improvement purposes. Grievances that cannot be resolved the same day are referred to PHP's Grievances and Appeals (G&A) Coordinator for processing.

Standard Grievance

If a member's oral or written standard grievance cannot be resolved immediately, PHP will resolve it as quickly as the member's condition requires but no later than thirty (30) calendar days following receipt. The G&A Coordinator will send a written acknowledgment of the grievance within fifteen (15) calendar days following receipt unless a determination is reached beforehand, in which case no written acknowledgement will be sent.

The 30-day timeframe may be extended by up to 14 calendar days if the member, the member's authorized representative, or a provider acting on the member's behalf requests an extension or if PHP justifies a need for additional information and can document that the delay is in the member's interest. If PHP requests an extension, the member and the member's authorized representative and treating provider (if applicable) will be immediately notified in writing of the reason for the delay. Once a decision is reached, PHP will provide the member/representative with written notification within three (3) business days, including instructions on how to file a grievance appeal.

Expedited Grievance

An expedited grievance is required when a standard decision would significantly increase the risk to a member's health. Members or their representatives must file an expedited grievance within 60 calendar days of the date of the coverage decision and must include a physician certificate of need. PHP will respond to an expedited grievance as quickly as the member's condition requires, but no later than 24 hours following receipt of the grievance. PHP must immediately notify the member/representative of the decision by phone and provide written notification within three (3) business days of the decision, including instructions on how to file a grievance appeal.

The resolution time period may be extended up to fourteen (14) calendar days if:

- The member or the member's authorized representative, or a provider acting on the member's behalf requests the extension
- Partners Health Plan demonstrates that there is a need for additional information and provides documentation that the delay is in the member's best interest

If PHP requests an extension, the member will be immediately notified in writing of the reason for the delay. Once a decision is reached, PHP will provide the member/representative with written notification within three (3) business days. The notification will include instructions on how to file an expedited grievance appeal if he or she disagrees with PHP's decision to grant an extension.

Grievance Acknowledgment

Partners Health Plan acknowledges all grievances types. Same-day grievances are acknowledged verbally and all other grievances are acknowledged in writing within fifteen (15) business days following receipt unless a determination is reached before the written acknowledgement is sent, in which case it will be acknowledged verbally. The written acknowledgment will include:

- The date that the grievance was received
- Member's name and address
- Type of grievance
- Additional information requested
- Name and contact information of the staff member processing the grievance

If a member/representative requests an expedited grievance and PHP decides not to expedite it, the acknowledgement will indicate that the grievance will be handled on a standard basis.

Grievance Appeals

Members and/or their authorized representatives have the right to file a grievance appeal within sixty (60) business days after receiving a Notice of Grievance Decision. The grievance appeal must be submitted to PHP in writing either in a letter or on a standard form that PHP will provide to the member and/or his or her authorized representative. Following receipt, PHP staff will determine whether the grievance appeal is standard or expedited; a member, the member's authorized representative, or a provider acting on the member's behalf can also request an expedited review of the grievance appeal.

PHP will send a written acknowledgment of the grievance appeal within 15 business days following receipt. The acknowledgement will include the name, address, and telephone number of the individual designated to respond to the appeal as well as a request for any additional information we may need in order to render a decision. Appeals pertaining to a clinical matter will be assigned to qualified health care professionals with the appropriate credentials (at least one of which will be a clinical peer reviewer) who were not involved in the initial determination; non-clinical appeals will be made by qualified personnel at a higher level than the person(s) who made the original determination. If we succeed in resolving the issue before the written acknowledgment is sent, we will send one notice with the Acknowledgement and the Decision. PHP will process the appeal as quickly as the member's condition requires, but no more than:

- **Standard Grievance Appeal Timeframe**: Thirty (30) business days following receipt of all necessary information in most instances.
- **Expedited Grievance Appeal Timeframe**: Two (2) business days following receipt of all necessary information if a delay would significantly increase the risk to a member's health.

PHP will mail a written Notice of Decision to the member and his or her authorized representative and the provider (if applicable) within three (3) business days of the decision. The notice will include the reason for the determination, including the clinical rationale if the grievance appeal was clinical in nature (e.g., a quality of care issue). Members cannot further appeal PHP's determination of a grievance appeal.

Grievance Documentation

PHP will maintain a file on each grievance and associated grievance appeal that we receive. The documentation will include the following information:

- A copy of the grievance/grievance appeal and the date it was initially filed
- A copy of the member's acknowledgment letter of the grievance/grievance appeal (if any), including the date it was received
- Copies of member or provider requests for expedited grievances/grievance appeals, and PHP's associated decision
- Copies of the documentation justifying any extensions

- Copies of PHP's determination of the grievance/grievance appeal, including the date and employee titles of the reviewing personnel (including the credentials of any clinical reviewers)

Appeals Processes

Appeals of an Action

In contrast to a "grievance appeal," an "appeal" is a request for a review of an action taken by PHP. Members or their authorized representative (or a provider acting on behalf of the member with written consent) may submit an appeal orally or in writing within sixty (60) business days of the postmarked date of PHP's Notice of Action; if the appeal is submitted orally, it must be followed up in writing. If the appeal involves 1) the termination, suspension, or reduction of a previously authorized course of treatment; 2) services ordered by an authorized provider; 3) services for which the period covered by the original authorization has not expired; or 4) a request by the member/representative to extend authorized benefits due to expire, benefits will continue if the appeal is requested within ten (10) calendar days of PHP's sending the notice of action or the intended effective date of our proposed action. Expedited and standard appeals will be conducted by a clinical peer reviewer, but the clinical peer reviewer will be different from the reviewer that rendered the adverse determination. For Behavioral Health appeals, a physician board certified in general psychiatry will review all inpatient level of care denials for psychiatric treatment. For substance abuse treatment, a physician certified in addiction treatment will review inpatient levels of care.

If PHP requires additional information to conduct a standard internal appeal, then PHP shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.

PHP will send a written acknowledgment of the appeal within 15 calendar days of receipt. Oral appeals will be treated the same as written appeals to establish the earliest possible submission date. If submitted orally, PHP will send a form that summarizes the appeal and requests the member to sign and return it to us along with any changes the member/representative may wish to make to the summary. If we succeed in resolving the issue before the written acknowledgment is sent, we will send one notice with the Acknowledgement and the Decision. Whatever the circumstances, PHP will not treat the member any differently because of the appeal.

If the member or his or her authorized representative requests that services continue while the appeal is being processed, PHP will continue the services until the sooner of:

- Appeal is withdrawn
- The original authorization period has expired
- If the appeal is denied, until 10 days after the appeal decision has been mailed, unless the member has requested a NYS Fair Hearing with continuation of services

Following receipt of the appeal, PHP will make a determination whether a delay in processing poses serious jeopardy to the member's life or health or ability to attain, maintain, or regain maximum function, in which case it must be treated as an expedited appeal. PHP will further

expedite all appeals relating to a concurrent review of a service authorization request (see below).

Members or their authorized representatives may also request an expedited review of the appeal. Requests for an expedited review may be made verbally and do not have to be followed up in writing. If PHP denies the member's request for an expedited review, our staff will make reasonable efforts to issue an oral notice of denial of an expedited review, and we will follow-up with a formal written notice within two (2) calendar days of receipt of the expedited appeal request. The appeal will then be transitioned to our standard appeal processing time and decided as fast as the member's health condition requires, but will not exceed thirty (30) calendar days. If the member or the member's authorized representative objects to the denial for an expedited appeal, he or she may file a grievance (see above).

PHP will process appeals in accordance with the following timeframes:

- **Expedited Appeals**: Within two (2) business days following receipt of necessary information, not to exceed three (3) business days following receipt of the request for an expedited appeal, members or their designated representative, including providers acting on behalf of the member with written consent, may request an extension for up to fourteen (14) calendar days. PHP may also initiate an extension if there is adequate justification of a need for additional information and the extension is in the member's interest. We will thoroughly document the circumstances behind any extension. Written notice of PHP's final adverse determination concerning an expedited UR appeal shall be transmitted to the enrollee within twenty-four (24) hours of rendering the determination. We will make reasonable efforts to provide verbal notice to the 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 Appeals**: No later than 30 calendar days following receipt of the appeal request. Members or their authorized representative, including providers acting on behalf of the member with written consent, may request an extension for up to fourteen (14) calendar days. PHP may also initiate an extension if there is adequate justification of a need for additional information and the extension is in the member's interest. We will thoroughly document the circumstances behind any extension.
- **Request for Out-of-Network Services**: If a member/representative wishes to appeal our denial for an out-of-network service because we decided it was unnecessary and no different from a service that is available in-network, the member should ask his or her provider to send us a written statement explaining how the requested service is different from what we offer within the network and attach two pieces of medical evidence (e.g., published article, scientific study) that show why the requested service is preferable and will not cause the member more harm than an in-network service.
- **Notification**: PHP will make a determination and provide the reasons for our standard appeal decision including our clinical rationale within the 30-day timeframe unless there has been an extension (see below). We will also send a written notice within two (2) business days

following our decision. If we fail to abide by these timeframes, the appeal will be granted and the service authorization request will be approved.

- **Extension**: If we need more information to make either a standard or expedited appeal determination, we will contact the member/representative in writing and explain what we need (if the appeal is being expedited, we will call the member immediately and send a written notice later). The notice will also explain why the extension is in the member's best interest. Extended appeal determinations will be made within 14 days from the time we requested more information. Members/representatives and providers acting on the member's behalf may also request an extension if they wish to provide more information to help us decide the appeal. Extension requests may be made verbally or in writing. The member/representative may also file a complaint if they disagree with PHP's decision to take more time to review the appeal. The complaint may be filed with PHP or directly with the State Department of Health by calling 1-800-206-8125.
- **Service Continuation During an Appeal**: Members may be able to continue receiving a denied service (aid continuing) or a service that is scheduled to be reduced during the appeal process by asking for a Fair Hearing within 10 days of PHP's denial or by the date the change in service is scheduled to occur, as applicable. If the Fair Hearing results in a denial, the member may be liable for the cost of any continued benefit. The Fair Hearing decision is final.
- **External Appeals**: If PHP denies an appeal the member may ask New York State for an external appeal within four (4) months of the appeal determination, which will be decided by qualified reviewers who do not work for PHP or the State. The service must be in PHP's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. An external appeal may be filed for a health care service that was denied, in whole or in part, by PHP as not medically necessary if the service would be otherwise covered. Members do not have to pay for an external appeal. External appeals may also take place if PHP and the member/representative agree to skip the internal appeals process (the request for an external appeal must be made within four months of the agreement). PHP will provide assistance with filing an external appeal, if requested.

  A member, or the Member's designee, in connection with a retrospective adverse determination, the Member's health care provider has the right to request an external appeal.

  An external appeal may also be filed when the following circumstances are met:

  - When the member's coverage of a health service was denied as medically unnecessary due to being investigational or experimental.
  - When a denial of an appeal has been upheld or both PHP and the Member have agreed to waive the internal appeal process
  - To appeal an experimental/investigational or clinical trial, the physician must be a licensed, board-certified or board-eligible physician i) qualified to practice in the area of practice appropriate to treat the patient; and ii) who recommended the patient's treatment. For an appeal involving a rare disease, a physician must meet the above requirements, but need not be the patient's treating physician.

- To appeal to an experimental/investigational denial, the member's attending physician must attest that (i) standard health services or procedures have been ineffective or would be medically inappropriate; or (ii) there does not exist a more beneficial standard health service or procedure covered by the health care plan and the member's physician must have recommended either a health service or procedure (including a pharmaceutical product within the meaning of PHL Section 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.
- To appeal a clinical trial denial for which the member is eligible, the member's physician must attest that i) there exists a clinical trial that is open; ii) the patient is eligible to participate; and iii) the patient has or will likely be accepted. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board; and (2) approved by i) one of the National Institutes of Health (NIH), or an NIH cooperative group or center; or ii) the Food and Drug Administration in the form of an investigational new drug exemption; or iii) the federal Department of Veteran Affairs; or iv) a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants; or v) an institutional review board of a facility which has multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.
- The service recommended by the attending physician would otherwise be covered except for PHP's determination that the service was investigational or experimental.
- The service recommended by the attending physician would otherwise be covered except for PHP's determination that the service was investigational or experimental.

External appeals will be decided within 30 days, unless more information is needed in which case the decision may take up to five (5) additional business days. Notifications will be made to PHP and the member within two (2) days following the decision.

- **Expedited External Appeal:** An expedited external appeal may be requested if the member's provider states that a delay may cause serious harm to the member's health or if the member is in the hospital following an ER visit and PHP is denying the inpatient admission. Expedited external appeals will be decided in 72 hours or less and notifications will be made immediately by phone or fax followed by a written notification.

  If a service request involves an extension of an inpatient substance use disorder treatment at least 24 hours before the member is scheduled for discharge, PHP will continue to cover the inpatient stay if the member/representative requests both an expedited internal appeal and an expedited external appeal at the same time. Coverage will continue until an appeal determination is made. PHP will make a determination within 24 hours and the external appeal decision will be made within 72 hours, if needed. Notification will be made immediately by phone or fax followed by a written notification.
- **Fair Hearing**: Members/representatives may request a Fair Hearing if PHP decides to deny, reduce, or end coverage for a medical service and PHP upholds the decision following an

internal appeal. Members/representatives may also request both a Fair Hearing and an external appeal. If both have been requested, the decision of the Fair Hearing officer is the one that counts. Fair Hearings may also be requested under the following circumstances:

- The member/representative disagrees with PHP's decision regarding care the member was receiving because they believe the decision limits his or her Medicaid benefits or that PHP did not make the decision within a reasonable amount of time.
- The member/representative disagrees with PHP's decision to deny a service request because they believe the decision limits his or her Medicaid benefits.
- The member/representative disagrees with PHP's decision to deny payment for a service the member already received because they believe the decision limits his or her Medicaid benefits.
- The member/representative disagrees with their provider's decision not to order a requested service and believe the doctor's decision limits his or her Medicaid benefits. The complaint must first be filed with PHP. If PHP agrees with the provider, the member/representative may request a State Fair Hearing.
- If a member/representative requests a Fair Hearing regarding a decision PHP made, PHP must send a copy of the "evidence packet" to the member/representative prior to the hearing that includes all the information we used to make the determination. We will also provide a copy to the hearing officer to explain our decision. If there is insufficient time to mail a copy to the member/representative, we will bring a copy to the hearing on the member's behalf.

Filing a State Fair Hearing or a State External Appeal will not negatively affect or impact the PHP member or providers who treat the member. PHP will ensure that punitive action is not taken in retaliation against a member or a provider acting on the member's behalf who requests a standard or expedited appeal or grievance.

A Fair Hearing can be done:

- By phone -- call toll-free 1-800-342-3334
- By fax -- 1-518-473-6735
- By internet -- www.otda.state.ny.us/oah/forms.asp
- By mail -- NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Appeals of a Prior Authorization or Concurrent Review Action

A prior authorization request is a request by the member (or the member's authorized representative or member's provider on behalf of the member) for a new service or a request to change a service included in a member's Care/Life Plan for a new authorization period. A

concurrent review is a request for additional services that are currently authorized in the member's Care/Life Plan (e.g., an increase in the number of hours of an authorized service).

A member or his or her authorized representative may request an expedited review of a prior authorization or concurrent review request, although PHP will automatically expedite an appeal of a concurrent review action. If PHP denies a request for an expedited review of a prior authorization request, we will handle it as a standard review.

The timeframes for standard and expedited reviews of prior authorization and concurrent review requests are as follows:

- **Prior Authorization**:
  - **Expedited**: Three (3) business days from request of service.
  - **Standard**: Within three (3) business days of receipt of necessary information, but no more than 14 days after receiving the request.
- **Concurrent Review**:
  - **Expedited**: Within one (1) business day of receipt of necessary information, but no more than three (3) business days after receiving the request.
  - **Standard**: All concurrent review appeals will be expedited.

Members or their authorized representatives (or providers acting on a member's behalf) may request an extension of up to 14 days either verbally or in writing. PHP may also initiate an extension if we can justify the need for additional information and the extension is in the member's interest. In either case, PHP will fully document the circumstances behind the extension.

PHP's Notice of Decision will include the following information:

- Date and summary of the service request
- The reason for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination
- Procedure for filing an internal appeal and an explanation that an expedited appeal can be requested if a longer timeframe would be injurious to the member's health
- A description of what additional information, if any, PHP must obtain from any source in order to make an appeal decision if an internal appeal will be requested
- An explanation of the member's option to file a Fair Hearing request after the internal appeal process is exhausted, as well as the option to file an External Appeal if the service denial is related to issues of medical necessity or the experimental or investigational nature of the service
- An explanation that the member has the opportunity to present evidence and examine her or his case file during an appeal

- An explanation that the member can access the clinical review criteria relied upon in making the decision, if the action involved medical necessity or if the treatment or service was experimental or investigational
- An explanation that the member may request assistance (for language, hearing, or speech issues) if the member decides to file an appeal as well as instructions for the accessing the assistance

If PHP decides against the member's appeal of a prior authorization or concurrent review request, the member, the member's designated representative, or provider may appeal the decision under the standard appeal process described above.

Appeal Documentation

As applicable, PHP will maintain a comprehensive file on each action and associated appeal, whether standard or expedited. The records will include:

- A copy of the Notice of Action
- A copy of the Appeal, including the date of submittal
- A copy of requests for expedited appeals, and PHP's decision
- A copy of the member's acknowledgment letter of the grievance/grievance appeal (if any), including the date it was received
- All documentation in support of an appeal extension
- PHP's determination of the appeal, including the date and employee titles of the personnel who conducted the review as well as the credentials of any clinically trained personnel who were involved in an appeal involving a clinical determination

SECTION 19: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) GUIDELINES

Partners Health Plan (PHP) strives to ensure that contracted providers conduct business in a manner that safeguards protected patient/participant information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect to demonstrate compliance with the HIPAA privacy regulations.

- **Minimum Necessary Information**: PHP recognizes its responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting PHP. However, privacy regulations allow the transfer or sharing of member information, which may be requested by PHP to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment, or health care operations.
- **Fax Machines**: Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to PHP, verify the receiving fax number is correct, notify the appropriate staff at PHP, and verify the fax was appropriately received.
- **Email**: Unencrypted email should not be used to transfer files containing member information to PHP (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.
- **Standard Mail**: Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at PHP.
- **Voicemail**: PHP's voicemail system is secure and password-protected. When leaving messages for PHP staff, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting PHP, providers should be prepared to verify their name, address, and Tax Identification Number or National Provider Identifier number.

SECTION 20: MARKETING

Providers may not develop or use any materials that market (i.e., promote or encourage potential members to enroll) Partners Health Plan without PHP's prior written approval. An organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to enroll in PHP unless the materials meet SDOH marketing guidelines and are first submitted for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all other comparable Medicaid plans the providers participate in are represented. In other words, providers are allowed to have posters or notifications that show they participate in PHP as long as the provider displays posters or notifications from all comparable plans in which they participate.

General Requirements

PHP's network providers are permitted to assist prospective members and their authorized representatives in objectively assessing their needs and potential options for meeting those needs, but must remain neutral when assisting with enrollment decisions. To this end, PHP's network providers must comply with the following "do's and don'ts":

Allowed	Not Allowed
• Providing the names of health plans with which they contract and/or participate • Making available and/or distributing PHP marketing materials • Referring their patients to other sources of information, such PHP's enrollment representatives, the State Medicaid Office, the Enrollment Broker, etc.	• Offering sales/appointment forms • Accepting enrollment applications • Making phone calls or directing, urging, or attempting to persuade clients to enroll in a specific plan based on the financial or any other interests of the provider • Mailing promotional materials on behalf of PHP • Offering anything of value to induce PHP members to select them as their provider • Offering inducements to persuade clients to enroll in a particular plan or organization • Conducting health screenings as a marketing activity • Accepting compensation directly or indirectly from PHP for prospective member enrollment activities • Distributing materials/applications within an exam room setting

Provider Affiliation Information

PHP's network providers are permitted to publicize new or continuing affiliations with specific health plans such as PHP through general advertising (e.g., radio, websites, mailings).

New Affiliations

New affiliation announcements apply to providers that have entered into a new contractual relationship with PHP. Newly contracted providers may make a one-time announcement that exclusively names PHP within the first 30 days of the agreement if it is conveyed through direct mail, email, or phone. If a provider wishes to use other mediums to make this announcement, the provider must disclose its relationships with other health plans as well.

Any affiliation communication materials that describe PHP in any way (e.g., benefits, formularies) must be pre-approved by SDOH. Materials that only list PHP's name and/or contact information do not require SDOH approval.

SECTION 21: FRAUD, WASTE, AND ABUSE (FWA)

Health care fraud costs taxpayers tens of billions of dollars every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. There are several stages to addressing fraudulent acts, including detection, prevention, investigation, and reporting. In this section, PHP provides information on how to help prevent member and provider fraud by identifying the different types.

Many types of fraud, waste, and abuse have been identified, including:

- **Provider Fraud, Waste, and Abuse**:
  - Billing for services not rendered
  - Billing for services that were not medically necessary
  - Double billing
  - Unbundling services
  - Upcoding services

Providers can prevent fraud, waste, and abuse by ensuring that services rendered are medically necessary, accurately documented in the medical records, and billed according to AMA/PHP guidelines.

- **Member Fraud, Waste, and Abuse**:
  - Benefit sharing
  - Collusion
  - Drug trafficking
  - Forgery
  - Illicit drug seeking
  - Impersonation
  - Misinformation/misrepresentation
  - Subrogation/third-party liability fraud
  - Transportation fraud

One of the most important steps to help prevent member fraud is as simple as reviewing the member's ID card. PHP will not accept responsibility for the costs incurred by providers rendering services to a patient who is not a current PHP member, even if that patient presents a PHP Member ID card. Providers should take measures to ensure the cardholder is the person named on the card and his or her membership in PHP is up-to-date.

Additionally, providers can assist in encouraging members and their caregivers to protect their cards as they would a credit card or cash, carry their member ID card at all times, and report any lost or stolen cards to PHP as soon as possible.

PHP encourages its members, members' representatives, and providers to immediately report any suspected instance of fraud, waste, and abuse. No individual who reports violations or

suspected fraud, waste, or abuse will be retaliated against, and PHP will make every effort to maintain anonymity and confidentiality.

If you have any questions about identifying and/or reporting suspected instances of fraud, waste, and abuse, please contact PHP's Chief Compliance Officer as soon as possible at 1-855-747-5483.

SECTION 22: PROVIDER PERFORMANCE & TERMINATION

Performance Standards and Compliance

Performance Standards

When evaluating a provider's performance and compliance, Partners Health Plan (PHP) reviews a number of clinical and administrative practice dimensions including, but not limited to, the following:

- **Quality of Care**: Measured by data related to the appropriateness of care and outcomes and adherence to evidence-based practice guidelines
- **Efficiency of Care**: Measured by clinical, non-clinical, and financial data related to the cost of care and services
- **Member Satisfaction**: Measured by member/caregiver survey results regarding accessibility, quality of care, member/provider relations, and the comfort of the office setting
- **Administrative Requirements**: Measured by the provider's protocols for keeping records and transmitting information, ADA compliance, encounter reporting, completion of recommended training, etc.

Compliance

The following types of compliance issues are key areas of concern:

- Unnecessary out-of-network referrals and utilization (which require prior authorization)
- Member complaints and grievances filed against the provider
- Underutilization, overutilization, or inappropriate referrals
- Inappropriate prescribing patterns
- Inappropriate billing practices, such as balance billing of members for monies that are not their responsibility
- Member appointment and access to care issues
- Lack of adherence to evidence-based practice guidelines
- Lack of adherence to medical recordkeeping requirements
- Non-supportive actions and/or attitude (e.g., lax reporting practices, etc.)

PHP tracks and trends provider compliance on a calendar year basis and takes corrective actions as appropriate to address identified issues.

Provider Misconduct

If PHP receives information that could potentially result in an adverse action against a participating provider/practitioner, the Chief Medical Officer will conduct a review of the matter in collaboration with care management and provider relations staff. If indicated, a report will be submitted to the Credentialing and Performance Committee (CPC) for review and

recommendation. If the committee elects to suspend, terminate, or not renew a provider's contract, the provider will be sent a written notification specifying the rationale for the action.

Temporary Suspensions

PHP's CMO may summarily suspend or restrict a provider's participation for a period not longer than 30 days to conduct an investigation in any case where he or she determines, in his or her sole discretion, that an Adverse Action may be warranted. The CMO may take this action 1) to conduct an investigation for a period not to exceed 14 days, or 2) if he or she has reason to believe the provider may cause imminent danger to the health and safety of any individual, subject to the subsequent provision of the hearing procedures applicable to a Proposed Termination. Any suspension or restriction will be effective immediately upon notice to the provider.

Corrective Actions

When a provider/practitioner's performance falls below expectations or an intervention is otherwise indicated and informal efforts to address the issue have failed, PHP will require the implementation of a corrective action plan (CAP) and re-audit the provider in six (6) months to ensure that the CAP is progressing properly. QM and/or Provider Relations staff will be responsible for documenting all such corrective actions and related activities, including their resolution, and entering them into providers' confidential QM files. QM staff will further report this information to the Chief Medical Officer and the Quality Oversight Committee and it may also be used in re-credentialing/certification evaluations of the provider.

Provider Termination and Appeals

If PHP denies, suspends, terminates, or opts not to renew a provider's contract, PHP will send a written notification of the reason(s) for the action (e.g., quality issues) including information about the provider's right to appeal the action to a hearing panel comprised of peers of the affected provider. As applicable, PHP will also notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Provider Terminations

PHP will ensure that all participating providers are regularly informed of PHP's protocols for evaluating their performance, including methodologies to collect and analyze provider profiling data. Upon presentation of this information or data, providers will be given the opportunity to discuss any mitigating factors (e.g., the unique nature of the provider's patient population). Under no circumstances will PHP terminate a contract or refuse to renew a contract solely because a provider has:

- Advocated on behalf of a member
- Filed a complaint against PHP
- Appealed a decision by PHP
- Requested a hearing or review

- Provided information or filed a report regarding a member's treatment options or engaged in other activities as described in PHL 4406-c

In addition:

- PHP and/or a network provider must provide at least 60 days written notice prior to terminating a contract without cause.
- If PHP suspends or terminates a contract with a provider/practitioner because of deficiencies in the quality of care, PHP will provide written notice of the action to the appropriate licensing or disciplinary body.

An appeal is not applicable under the following circumstances:

- PHP's decision not to renew a Practitioner's contract
- A determination of fraud is made by a government entity
- A final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice
- The Practitioner is excluded from participation in the Medicaid or Medicare programs
- The Practitioner has ceased to practice, for legal or other reasons

Provider Non-Renewal Appeals

If a provider elects to appeal a decision by PHP to terminate, suspend, or not renew the provider's contract, a written Notice of Appeal should be sent by certified mail to PHP's Vice President of Network Management within 30 days of PHP's Notice of Decision. PHP will in turn mail a confirmation letter and any relevant documents relating to the decision to the provider within seven business days of receipt and schedule a telephonic appeal hearing.

The hearing, which will be held within 30 days after the request for the hearing, will be attended by PHP's Chief Medical Officer, Chief of Care Coordination, and at least one network provider of the same specialty type. Following the completion of the hearing, these individuals will make a final, non-appealable decision and notify the provider in writing within seven business days following the hearing. The decisions will include:

- Reinstatement
- Provisional reinstatement with conditions
- Termination

Providers whose non-renewal status is upheld will be notified of the effective date of their termination, which will be not less than 30 days after the decision is made. Participation in PHP's network will continue uninterrupted for providers whose non-renewal status is overturned.

Notification to Members

PHP will make a good faith effort to provide affected members and their caregivers with written notification of a provider's termination within at least 15 calendar days before the termination effective date, regardless of the reason for the termination. PHP may provide member

notification in less than 15 days as a result of a provider's death or exclusion from federal health programs.

When a termination involves a PCP, all members who are patients of that PCP will be notified of the termination and the member's care manager/coordinator will assist in identifying a new PCP that will meet the member's needs and preferences.

Transitional Care

Except for situations in which PHP terminates a provider's contract without the right to appeal (see above), we will permit members to continue an ongoing course of treatment with the provider during a transitional period of 1) up to ninety (90) days from the date the provider's contractual obligation to provide services to the member terminates, or 2) if the member has entered the second trimester of pregnancy at the time of the provider's termination, for a transitional period that includes the provision of post-partum care directly related to the delivery.

For Behavioral Health services, PHP will allow a member to continue receiving services from their current provider for 24 months, or longer if clinically necessary, from the effective date of the member's enrollment date. PHP will identify an appropriate treatment provider after this period and ensure a seamless transition of services.

PHP will authorize the transitional care described above only if the provider agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of PHP's policies and procedures.

Duty to Report

PHP will report the occurrence of any of the following to SDOH and any other applicable regulatory agency within thirty (30) days:

- The termination of a provider contract for reasons relating to alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare
- The voluntary or involuntary termination of a provider contract to avoid the imposition of disciplinary measures
- The termination of a provider contract in the case of a determination of fraud, or imminent harm of patient health

In addition, PHP must report:

- To SDOH within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a participating provider is guilty of professional misconduct as defined in New York State Education Law.
- To SDOH and OMIG any adverse actions taken for program integrity reasons against participating providers.
- To SDOH regarding any participating provider who is denied credentialing or re-credentialing for program integrity related reasons, such as being on the excluded

Practitioner list and/or having existing fraud, licensing or Office of Professional Medical Conduct issues.

- On a quarterly basis, PHP will report to OMH and OASAS any deficiencies in performance and corrective actions taken by providers licensed by these agencies.
- Any serious health or safety concerns regarding OMH and OASA licensed providers will be reported upon discovery.

Pursuant to 42 CFR 455.106, PHP must require network providers to disclose any health care related criminal conviction(s) at the time of initial contracting, as well as upon any renewal of an agreement. Once a health care criminal conviction of a provider or anyone affiliated with the provider's practice has been disclosed, PHP must forward that information to SDOH within 20 days.

SECTION 23: CLAIMS PROCESSING AND ENCOUNTER REPORTING

General Payment Guidelines

When adjudicating claims, Partners Health Plan (PHP) applies all applicable federal and state statutes, regulations, and agency guidelines including, but not limited to, those payment rules set forth in Title 10 of the New York Code of Rules and Regulations.

PHP's providers are paid according to their contractual reimbursement arrangement with PHP. PHP's reimbursement for covered services provided to eligible members is considered payment in full. Providers **MAY NOT** balance bill PHP's members for the difference between the claims reimbursement and their charges.

Timeliness of Claims Submission

Claims must be submitted on a timely basis to PHP per the provider's contract. Some contracts indicate 90 days, other contracts may indicate 120 days. Claims submitted beyond the contractual timeframe will be denied for untimely filing.

PHP may pay claims that have initially been denied for untimely filing when it is documented that the claim could not be submitted within required timeframes as a result of an unusual circumstance. However, claims for dates of service beyond 365 days will not be considered for payment.

"Clean" Claims

PHP expects its contracted providers to submit "clean" claims, which is defined as a claim that can be processed without obtaining any additional information from the provider who rendered the service. Thus, clean claims have no defect, impropriety (including lack of substantiating documentation), or circumstances requiring special handling that might impact or prevent timely remittance of payment. Claim inquiries or appeals of claim denials must occur within 60 days of the original claim payment or appeal.

If using paper claims, providers should submit original claim forms. Submission of black and white copies delays claim processing time and may be returned as "not able to process."

Duplicate Claims

Submitting duplicate claims increases processing costs, processing times, and the potential for errors. PHP asks for your cooperation in checking claim status by any of these three methods before resubmitting a claim:

- Online via PHP's website portal at www.phpcares.org (available 24 hours a day, 7 days a week)
- Telephonically by contacting PHP's Provider Relations Department at 1-855-747-5483 (available M-F from 9 AM to 5 PM except for state holidays)
- Telephonically via PHP's IVR (Interactive Voice Recognition, available 24/7)

Additional Guidelines

- **National Provider Identifier (NPI)**: Providers must include their National Provider Identifier (NPI) on each claim submission. If you have not obtained a NPI, you can apply through a web-based application process at https://nppes.cms.hhs.gov.
  - **Atypical Services**: Atypical or nontraditional services are usually called "indirect healthcare-related services." Atypical providers do not meet the HIPAA standard definitions of a health care provider and are not required to have a National Provider Identifier (NPI). Per the August 2008 Medicaid Update Newsletter; "atypical providers" can include:
    - ◊ Personal Care Services
    - ◊ Personal Emergency Response Services
    - ◊ Office of Mental Health (OMH) Rehabilitative Services
    - ◊ Non-Emergency Transportation Providers
- **Member's ID Number**: Claims must include the member's ID number and at least two nodes of the participant's DOB must match PHP's records (i.e., month, date, and year of birth). If this criterion is not met, the claim will be processed with a Member Not on File member default ID and pay code value 41.
- **Prior Authorization**: Claims for services that require authorization, or claims associated with denied authorizations, will be denied (pay code 17).
- **Change in Provider Information**: Network providers must inform PHP about any changes in Tax ID, corporate name, and/or addresses as soon as possible. Updates to provider records typically require 30 days.

Electronic Claims Submission

PHP encourages providers to submit their claims electronically. PHP accepts claims from any clearinghouse that can submit to Emdeon (formerly known as WebMD). The benefits of submitting claims electronically include:

- Claims submitted electronically process more quickly
- Reduced administrative costs for provider
- Reduced volume of paper for provider
- Reduced timely filing denials
- Optimization of reimbursement turnaround time

Emdeon currently accepts claims for PHP with Submitter ID #14966.

If you are not sure you are submitting the correct NPI number or you have any additional questions pertaining to electronic claims submission, please contact PHP Provider Relations at 1-855-747-5483.

Lower Volume Electronic Claim Submitters

Lower volume claims submitters may also submit claims electronically via PHP's web portal. PHP has partnered with MD On-Line to offer participating providers a no-cost solution for submitting electronic CMS1500 claims. Once you are registered and signed into PHP's web portal at www.phpcares.org, select "Submit Your Claims Electronically." You will be linked to the MD On-Line website where you can create an account in order to begin submitting claims. If you have any questions about this process, please contact PHP Provider Relations at 1-855-747-5483.

Paper Claims Submission

PHP utilizes Optical Character Recognition (OCR) technology to process CMS1500 and UB04 paper claim forms as expeditiously as possible. However, only legible, red-ink, current versions of these claim forms can be scanned into the OCR equipment.

Please follow these simple instructions to facilitate the processing of your claims:

- Submit original red-ink, current versions of CMS1500 and UB04 claim forms
- Avoid submitting black and white copies
- Report only six lines of service on a single CMS1500 claim form
- Avoid handwriting claims
- Print data within the allotted field size
- Include your National Provider Identifier (NPI)
- Company invoices and spreadsheets will not be processed.

Providers can obtain UB04 and CMS 1500 forms at http://www.health-forms.com.

REMEMBER: All paper claims and encounter forms must be submitted on a CMS1500 or UB04 form and mailed to the address below.

Partners Health Plan
Claims Department
PO Box `6309
Lubbock, TX 79490

Claims Adjudication Processes

Auto Adjudication

Each day PHP runs batch processes against a comprehensive set of edits that are individually configured based on contractual and regulatory requirements. This rules-based system allows for setting multiple edits to test claim validity and to determine if claims are paid or denied appropriately. These edits include, but are not limited to:

- Member eligibility

- Covered/non-covered services
- Required documentation
- Services within the scope of the provider's practice
- Duplication of services
- Prior authorization
- Invalid procedure codes

Based on these and other system edits, claims are systematically processed to either a pay, deny, or pend status.

Manual Pended Claim Resolution

PHP's claims analysts review and manually adjudicate pended claims using a comprehensive set of documented desktop procedures. Examples of pended claims include, but are not limited to:

- Provider requests for outlier claim consideration
- Claims with Explanation of Benefits attached
- Claims where the member has Third Party Liability (i.e., other insurance primary to Medicaid)

For claims requiring review for outlier consideration, claims analysts will pend the claim to the Care Management department to determine whether to pay or deny the claim. The claim is then sent back to claims for processing. Claims analysts will coordinate or investigate claims for member with TPL indicators and either deny the claim for TPL or pay the claim if it meets allowable exceptions. If we pay the claim, we will pursue payment consistent with state and federal rules and regulations.

Claims Adjustments

If a provider needs to make any adjustments to a previously submitted claim, such as adding a revenue code or changing a diagnosis/procedure code, the provider should use bill type XX7 and re-enter the entire claim including all requested changes. Only previously paid claims can be re-submitted for adjustments.

PHP processes adjustments and issues refunds or recovery notices within 45 days following receipt of all needed information regarding a retroactive claims adjustment.

Claims Processing Timeframes

Effective January 1, 2010 New York State Insurance Law was amended to modify the timeframe for payment of claims based on electronic submission versus paper or facsimile submission. As of that date, affected health plans must pay:

- All clean claims submitted electronically within 30 days
- Clean paper or facsimile claims within 45 days

The 30-day timeframe for requesting additional information or for denying the claim was not changed.

Identification of Late and Interest Due Payments

PHP's claims processing system determines the timeliness of claims adjudication and uses the claim's receipt/clean date to calculate the submission window. Discounts and interest penalties are calculated at the time of the check run based on the receipt date of the claim. The system applies interest penalties to all applicable claims in accordance with regulatory and contractual requirements.

Within 48 hours of receiving a "pay status" claim, PHP's Automated Business Fulfillment (ABF) system generates, prints, and mails payments and corresponding remittance advice to providers, including the minimum required information elements as well as HIPAA-compliant remit comments. We also provide electronic remittance advisories to providers that include all fields required for compliance with the HIPAA 835 format.

Coordination of Benefits

Effective January 1, 2010 New York State Insurance Law was amended to specify that the managed care organization cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the managed care organization has a "reasonable basis" to believe that the member has other health insurance coverage that is primary for the claimed benefit. If the MCO requests information from the member regarding other coverage and does not receive it within 45 days, the MCO must adjudicate the claim and it may not be denied on the basis of non-receipt of information about other coverage. This amended section of the law only addresses the denial of claims due to other insurance and leaves unchanged the plan's annual process for determining the existence of alternate insurance among its members.

Claims submitted to Partners Health Plan as a secondary insurer must be submitted as a paper claim and include the primary insurer's Explanation of Benefits (EOB) for reimbursement consideration. PHP will deny claims for members identified with other primary insurance if a paper claim, including a primary EOB, has not been submitted.

Overpayment

PHP periodically reviews payments made to providers to ensure the accuracy of claims payment pursuant to the terms of the provider's contract and/or to review claims activity in accordance with PHP's fraud and abuse prevention program.

In instances where PHP has identified overpayments, written notice will be sent to the provider requesting repayment within 60 days. The notice will include the member's name, service dates, payment amounts, and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding and submit supporting evidence or remit payment. If a provider fails to respond to PHP's notice of overpayment, then PHP will initiate an overpayment recovery process that offsets the overpayment amount against current and future claim remittances until the full amount is recovered.

In the event that a provider identifies any overpayments, it is the provider's responsibility under Section 6402(a) of the ACA to report and refund the overpayment with a written explanation/reason within sixty (60) days following its initial identification.

For any Billing or Reimbursement questions, please call PHP's Provider Relations Department at 1-855-747-5483.

High-Cost Outliers

Claims initially received without medical records that are identified as potentially eligible for a high-cost outlier payment will be paid to the inlier amount. A letter will be generated requesting the member's medical records for further review and determination.

Reimbursement

Provider reimbursement will be limited to the lower of either the submitted charge/fee or the Medicaid fee schedule. For example, if a provider submits a claim with a charged amount of $50 but the fee schedule amount for the procedure code being billed is $60, PHP will reimburse the provider $50 as this is the lower of the submitted charge vs. fee schedule amount.

Medical/Service Claim Review

PHP conducts ongoing reviews of medical/service claims to confirm consistency and accuracy in billing processes. Our goal has always been to be fair and equitable in this endeavor. PHP continues to utilize globally accepted guidelines, including CPT regulations as documented by the AMA, Correct Coding Initiatives (CCI), and Global Surgery Period Guidelines as outlined by the Center for Medicare and Medicaid Services (CMS). Several areas of review are based on the following globally accepted coding principles:

- **Global Surgical Principles**: CMS has defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure—furnished by the physician who performed the surgery—are to be included in the payment of the surgical procedure code. These procedure codes are evaluated based on major and minor service categories with differently defined global day allocations for each.
- **Add-On Principles**: Both CPT and CMS defined codes require the presence of a primary procedure code for appropriate coding. These rules follow the direction set forth in the CPT manual that describes "add-on codes" as "procedures/services that are always performed by the same physician" and "are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes."
- **Assistant Surgeon Principles**: These represent CMS rules based on the need for an assistant surgeon, co-surgeons, and team surgeons for all surgical procedures, as CMS is the only governing body that continues to evaluate the need for this type of service.
- **National Correct Coding Initiative (CCI)**: As defined by CMS:
  - Comprehensive: These procedure codes have been identified as the inappropriate unbundling of comprehensive procedure codes into its component parts (codes).

- Mutually Exclusive: These procedures codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.

- **Duplicates**: These apply to the following areas: Radiology, Date Range Duplicates, Lifetime Duplicates, and E/M Service Range.
- **Unbundled Procedure Principles:** In addition to CCI, there are code pairs that are considered a component of another procedure code, filed on the same date of service by the same provider.
- **Evaluation and Management Crosswalk Principles:** These represent multiple submissions of E/M codes within the same category and/or two different categories by the same provider on the same date of service.
- **Incidental Procedures (IN):** The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status of B (bundled) or P (bundled/excluded) in the CMS National Physician Fee Schedule Relative Value File.
- **Medical Necessity (MN) Based on Appropriate ICD-9 or ICD-10 Codes:** These are Regional and National Medical Necessity guidelines from CMS. Services reported must have the appropriate ICD-9 or ICD-10 codes, as required, submitted on the claim that demonstrates medical necessity.

Anesthesia Billing: Frequently Asked Questions

Many anesthesia providers have asked us the following questions regarding the appropriate way to submit claims for the provision of anesthesia services.

- What interval is used to determine time units?
  - 15-minute intervals are used to determine an anesthesia time unit (i.e., 60 minutes = 4 time units).
  - Anesthesia time during which the anesthesiologist was in personal attendance will be considered for reimbursement.
- Do you reimburse base units in addition to time, and if so should the base units be identified on the claim submission?
  - Anesthesia procedures (CPT 00100-01999) are reimbursed as base plus time units.
  - Base units are maintained in the claims processing system and should not be included on your claim submission.
- Do you separately reimburse for CPT codes 99100 or 99140?
  - No. Procedure codes 99100 (special anesthesia service) and 99140 (emergency anesthesia) are not separately reimbursed.
- What calculation is used to reimburse general anesthesia services?
  - The total minutes billed are converted into time units and added to the base unit. This sum is then multiplied by the contracted conversion factor to determine the appropriate reimbursement. The calculation is as follows:

  - ◊ total time in minutes ÷ 15-minutes per time unit = time units sum (rounded to the nearest whole value, e.g., 70 minutes ÷ 15 = 4.6 time units [rounded up to 5])
  - ◊ (time units sum + base units) x per unit conversion factor

- What procedure codes should be utilized?
  - Bill general anesthesia services using the ASA/CPT codes (00100-01999).
  - DO NOT bill general anesthesia using surgical CPT codes with anesthesia modifiers. Claims submitted in this manner will be denied to resubmit using anesthesia CPT codes.
  - All other services (e.g., injections) should be billed with the appropriate CPT code.
- Should minutes or time units be billed?
  - Please bill the total time in minutes using qualifier MJ.
  - Do NOT utilize qualifier UN. Claims submitted using qualifier UN will be interpreted as total minutes and therefore underpaid.
  - Only the total minutes are to be reported as the days/units (i.e., box 24g of CMS-1500) when billing general anesthesia services. For example, if anesthesia was administered between 9 a.m. and 10 a.m., box 24g should reflect 60 minutes; If anesthesia was administered between 12 noon and 2:12 p.m., box 24g should reflect 132 minutes.
- Where should the start and stop time be placed?
  - This information can be submitted but is not required for claims processing via EDI.
  - It is recommended that this information be included on paper claim submissions, but it is not required.
  - Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the physician is no longer in personal attendance.
  - Personal attendance, or time in attendance, is time spent face-to-face with the patient.
  - Documentation of time in attendance must always be recorded in the patient's record.

If you need additional assistance or have questions that are not covered in this section please contact PHP Provider Services at 1-855-747-5483.

Fraud and Abuse Monitoring

PHP adheres to all state and federal rules, regulations, and guidelines relating to the monitoring and identification of Fraud and Abuse and has implemented policies and procedures for the detection, investigation, and prevention of fraudulent activities.

- **Fraud**: For the purposes of this section, fraud is defined as any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by a managed care organization, contractor, subcontractor, provider, beneficiary, or enrollee or other person(s). A “provider” includes any individual or entity that receives funds in exchange for the provision, or arranging for the provision, of health care services to an enrollee of a health plan.

- **Abuse**: For the purposes of this section, abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the state or federal government or a managed care organization, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by a managed care organization, contractor, subcontractor, provider, beneficiary, or enrollee. It also includes enrollee practices that result in unnecessary cost to the state or federal government, managed care organization, contractor, subcontractor, or provider. For the purposes of this paragraph, a provider includes any individual or entity that receives funds in exchange for providing, or arranging for the provision, of health care services to an enrollee of a health plan.

PHP performs routine audits and edits of providers' claims to identify billing patterns that are aberrant.

Never Events

Effective January 1, 2010 health plans throughout New York State are required to have procedures in place to address inpatient claims that report a Never Event. Under current law, there are thirteen (13) Never Events, including:

1) Surgery performed on wrong body part
2) Surgery performed on wrong patient
3) Wrong surgical procedure done on patient
4) Retention of a foreign object in a patient after surgery or other procedure
5) Patient disability after medication error
6) Patient disability associated with a reaction to ABO incompatible blood or blood products provided by a healthcare facility
7) Patient disability associated with the use of contaminated drugs, devices, and biologics
8) Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
9) Patient disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
10) Patient disability associated with an electric shock while being cared for in a healthcare facility
11) Any incident in which a line designated for oxygen or other gas is contaminated with a toxic substance
12) Patient disability associated with a burn incurred from any source while being cared for in a healthcare facility
13) Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Never Events numbers 4 and 6 listed above will be monitored administratively in a manner similar to the procedure used by CMS. The remaining 11 Never Events will be monitored via

chart review. There is no significant experience across the nation to serve as a template or guide in the development of policies and procedures for handling Never Events, although some data is available via NYPORTS. Hospitals must always submit the Present on Admission (POA) indicator on all claims.

The New York State Department of Health has developed three (3) rate codes that indicate whether a Never Event occurred, including:

Rate Code	Description
2590	Hospital will use this code to identify that a Never Event happened that was so severe that the hospital does not expect any payment on the claim.
2591	Never Event occurred and may have impacted DRG. Full or partial payment is expected. Claim requires MedReview.
2592	Never Event occurred and may have impacted Per Diem payment. Full or partial payment is expected. Claim requires MedReview.

Frequently Asked Questions and Answers

- What is the effect on Prompt Payment Requirements?
  - Rate code 2590 would be denied with no payment as hospital would not expect to receive payment.
  - For rate codes 2591/2592, hospital will submit an original claim which will get paid, then hospital is expected to submit a second follow-up claim with one of these rate codes for the claim to be reviewed and adjusted. Since the original claim would be paid, there is no violation of the Prompt Payment Laws.
- How will the Hospitals be notified?
  - Hospitals will be notified via meetings with various Hospital Associations, direct communications to Hospitals, and Medicaid Update Newsletters.
- Why would a Hospital ever use rate code 2590 and not expect payment on a claim?
  - Failure to identify these situations could position the facility for being sanctioned for fraud and abuse.
- How can the Events affect payment?
  - Event could change the DRG from a lower cost DRG to a higher-cost DRG
  - Event could add to a DRG by turning the DRG into a DRG with complications
  - Event could cause the DRG to become a high-cost outlier

- How will Never Events impact professional claims?
  - It is very possible that professional claims will be affected but this will be examined at a later date.
- Are any facilities excluded from the Never Events legislation?
  - Currently, nursing homes are the only facilities excluded both at a federal and New York State level. However, while excluded by the federal government, critical access hospitals and cancer hospitals are included for New York State.
- What should be done in cases where the Hospital will not release the medical record because there is litigation and the Risk Management department of the facility will not release the data?
  - Hospitals have 30 days to submit the requested chart. Failure to do so will result in the claim being denied.

Claims Appeals

If a provider disagrees with an authorization-related denial or if the provider disagrees with the manner in which a claim was processed, the provider has the right to file an appeal with PHP within 60 days from the date of determination or denial. Out-of-network providers must submit a waiver of liability with their appeal. Appeals must include the following information:

- Claim number
- Authorization number (if applicable)
- Member name and Partners Health Plan number
- Date(s) of service
- Service code(s) billed
- Unit(s) value billed
- Amount billed
- Reason for appeal
- Waiver of Liability (non-contracted providers only)

Appeals must be submitted in writing and mailed to:

Partners Health Plan
Attn: Appeals & Grievances
PO Box 16309
Lubbock, TX 79490

Encounter Reporting

Definition

An encounter is defined as a professional face-to-face contact or transaction between a member and a provider who delivers a procedure or service. Encounters for all incurred services in PHP's benefit package must be reported. In general, the member must be physically present for an encounter to take place, with the exception of covered laboratory services. A provider consultation with another provider about a member in the absence of the member or making a referral to another network provider is not considered an encounter. Encounters can be categorized into four separate types:

- Institutional
- Pharmacy
- Dental
- Professional

Encounter Reporting Policy

Partners Health Plan's (PHP) encounter data reporting policy and procedure is designed to ensure compliance with state and federal requirements governing the content, accuracy, format, and timeliness of encounter data reports. The objectives are to:

- Comply with regulatory requirements
- Accurately capture utilization and provider payment data for quality performance monitoring
- Identify potential opportunities for improvement

State and federal regulatory agencies use the data to:

- Describe the demographic and health status characteristics of the enrolled population
- Report and monitor service utilization
- Evaluate access and continuity of service issues
- Monitor and develop quality and performance indicators
- Calculate capitation rates
- Perform cost effectiveness analysis
- Evaluate various service models and environments

Fee-for-Service Providers

Providers and practitioners that PHP reimburses on a FFS basis (including institutional, pharmacy, dental, and professional providers, whether in-network or out-of-network) must submit valid claims to PHP in order to be paid. Each claim, whether paper or electronic, represents an encounter for reporting purposes.

Capitated Providers

If PHP enters into a full or partially capitated arrangement with a provider or practitioner, our contract will require the submission of all utilization and encounter data to PHP within three

months of the month in which the service(s) were rendered. Providers who fail to meet the timeliness, validity, and adequacy requirements of their encounter reporting requirements will be penalized in accordance with contract specifications.

In addition, PHP will require capitated or partially capitated providers/practitioners to adhere to the following encounter reporting guidelines:

- Reporting of services must be presented on a per member, per visit basis
- Reporting of all services rendered by date must be submitted to PHP
- Encounter data must reflect all the same data elements required under a FFS arrangement
- All encounter data reporting must be in full compliance with HIPAA and all other state and federal reporting requirements

SECTION 24: QUALITY MANAGEMENT

This section describes Partners Health Plan's (PHP) process for communicating with network providers and enlisting their participation in the development of PHP's quality assurance and performance improvement program and other clinically related policies, procedures, and guidelines.

Provider Consultation

Professional Practice and UM Guidelines

PHP will implement a formal mechanism for consulting with network providers in the development and implementation of professional practice and utilization management guidelines that:

- Are based on reasonable evidence or a consensus of professionals in the particular field
- Consider the unique needs of PHP's members
- Are reviewed and updated periodically

The guidelines will be communicated to all network providers and practitioners and, as appropriate, to PHP's members, members' families/caregivers, and other stakeholders.

Provider Participation on PHP Committees

To further ensure provider input in the development and implementation of PHP's provider-related policies, procedures, and guidelines, PHP encourages provider participation on the following committees:

- Member Advisory Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Quality Oversight Committee (includes Behavioral Health)
- Credentialing and Performance Committee
- Compliance Committee

If you are interested in participating on one or more of these committees or would like more information, including committee meeting schedules, please contact our Quality Management staff at 1-855-747-5483.

Policy of Non-Interference with Provider Advice to Members

PHP will not prohibit or otherwise restrict providers from advising or advocating on behalf of members about the following topics:

- The member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to

provide an opportunity for the member and his or her authorized representative to decide among all relevant treatment options

- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the member and his or her authorized representative to refuse treatment and to express preferences about future treatment decisions

Provider Site Visits

PHP's protocols require QM and/or Provider Relations staff to conduct regularly scheduled and ad hoc site visits to provider/practitioner offices to ensure that network providers maintain PHP's standards for accessibility, appearance, and adequacy of equipment as well as for medical/service record documentation and privacy in accordance with all state and federal rules and regulations, professional ethics, and accreditation standards.

PHP uses a standardized tool to evaluate provider/practitioner offices. If staff identifies a deficiency during an on-site visit, we will require the implementation of a corrective action plan (CAP) and re-visit the provider in six (6) months to ensure that the CAP is progressing properly. QM staff will be responsible for documenting all such corrective actions and related activities, including their resolution, and entering them into providers' confidential QM files. QM staff will further report this information to the Chief Medical Officer and the Quality Oversight Committee and it may also be used in provider/practitioner re-credentialing/certification evaluations. The CMO is also responsible for overseeing the preparation and submission of summary reports to the Quality Management Oversight Committee of the Board.

Potential Quality of Care Concerns (PQoC

A "Potential Quality of Care Concern" is a concern raised by anyone internal or external to PHP that requires investigation as to whether or not the competence or professional conduct of an individual network practitioner, organizational provider, or vendor adversely affects, or could adversely affect, the health or welfare of a member. A "Quality of Care Concern" is a determination that the competence or professional conduct of an individual practitioner, organizational provider, or vendor adversely affected or in the future could adversely affect the health or welfare of a member.

Examples of PQoC include, but are not limited to:

- Misdiagnosis or missed diagnosis with serious outcome or disability
- Major injury or unplanned removal of an organ during surgery/invasive procedure
- Complications from surgery, unplanned return to OR, complication with anesthesia, unexpected admission/readmission following surgery, etc.
- A delay in accessing care or service that has a negative effect on a health problem, worsened a condition, or required emergency treatment
- Alleged inadequate or improper examination
- Alleged failure to order diagnostic testing

- Abnormal diagnostic findings allegedly not addressed by practitioner
- Any other circumstances where a member/representative alleges an adverse effect on his or her health or welfare
- An alleged breach of privacy by a participating provider/practitioner

PHP will investigate all PQoC concerns for both par and non-par providers in accordance with all applicable state and federal rules and regulations. QM staff is responsible for documenting all PQoC concerns, investigations, and decisions in the PQoC database, regardless of the ultimate determination. If a PQoC issue is reviewed by the Credentialing and Performance Committee (CPC), documentation will be included in the committee minutes.

All PHP staff members are responsible and accountable for the identification and communication of PQoC concerns to the Chief Medical Officer. PHP's Chief Medical Officer and other appropriate staff members (e.g., Provider Relations, Chief Compliance Officer, Quality Management, and Care Managers) are responsible for investigating and addressing PQoC, as needed and appropriate.

Member Satisfaction Surveys

On an annual basis, PHP will contract with a qualified, state-approved survey vendor to evaluate the level of satisfaction among our members and their families/caregivers with PHP’s program, services, and network providers. Senior management and PHP’s quality oversight committees will closely evaluate the results consistent with PHP’s dedication to continuous quality improvement and implement appropriate interventions to address any identified deficiencies or opportunities for improvement.

Quality Oversight Committees

PHP's Quality Oversight Committees are responsible for ensuring that PHP’s program, services, and activities undergo multiple layers of review, analysis, and evaluation consistent with PHP’s commitment to continuous quality improvement and all applicable state and federal rules and regulations, professional ethics, and accreditation standards. Committees include:

Board of Directors

The Board of Directors has ultimate accountability for PHP’s corporate compliance and quality assurance and performance improvement (QAPI) program and related processes, activities, and systems and will monitor these activities through the Quality Management Oversight Committee (QMOC). This includes responsibility for monitoring and evaluating the care and services members receive through PHP’s contracted health delivery network.

PHP’s Quality Management Oversight Committee (QMOC) is a standing advisory committee of the Board of Directors and has responsibility for the oversight of PHP’s quality management systems and for reviewing all quality management activities and making recommendations for quality improvement to the Board.

Quality Oversight Committee (QOC)

The QOC's primary responsibility is to oversee PHP's quality strategy and make recommendations to the Chief Medical Officer, Chief of Care Coordination, Director of QM, the QMOC, and the governing board. Included in the committee review focus both on the medical and behavioral components. The QOC's specific responsibilities include, but are not limited to, the following:

- **Clinical/LTSS Guidelines and Review Criteria**: PHP's QOC promotes the recognition and use of nationally recognized practice guidelines and reviews services for appropriateness and medical necessity.
- **Quality of Care**: The QOC is responsible for addressing identified clinical, service, regulatory, and safety issues and resolving them according to approved clinical/LTSS/OPWDD guidelines and protocols. The resolution may include corrective action plans for providers or the initiation of a peer review monitoring process.
- **Adequate Staff and Resources**: The QOC continually assesses and evaluates the adequacy of staff and resources to assure that our members receive timely and appropriate care. Committee recommendations to address inadequate resources may include hiring additional staff, contracting with additional network providers, or re-engineering operational processes.
- **Integration and Collaboration**: The QOC plays a key role in facilitating the integration of QM/UM/QI activities throughout the organization, including the provider network. The committee solicits input and information from internal sources (e.g., member and provider grievances and appeals) as well as external sources (e.g., advocacy groups, community-based organizations, governmental agencies, accreditation organizations, etc.).

Pharmacy and Therapeutics Committee

The P&T Committee is chaired by the Chief Medical Officer and comprised of appropriate representatives from our network providers and health plan staff, including the Pharmacy Coordinator. The Committee's mission is to ensure that members have access to a clinically sound and cost-effective formulary by providing constructive feedback to PHP regarding the structure, content, and utilization patterns of our drug benefit. The Committee also reviews potential quality of care issues related to drug prescribing patterns and makes recommendations for corrective actions.

Utilization Management Committee

The UM Committee is chaired by the Chief Medical Officer and responsible for monitoring all UM-related activities including prior authorization, concurrent review, discharge planning, retrospective review, and the under/over-utilization of services. The ultimate goal of the UM Committee is to assure timely member access to high-quality care and services through the evaluation of the relevant aspects of service delivery, clinical and non-clinical practices, and service authorization processes.

Credentialing and Performance Committee

Credentialing activities are conducted on behalf of PHP in accordance with the standards set by the Credentialing and Performance Committee (CPC) and New York State requirements. The CPC has oversight authority for all credentialing and re-credentialing activities, including

individual providers/practitioners who deliver services and supports to our members. The committee is also responsible for overseeing professional peer review activities for those providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of our members and reviewing and evaluating all credentialing and re-credentialing information and processes.

PHP's Credentialing and Performance Committee will advise the Chief Medical Officer on the credentialing and re-credentialing of network providers, including their selection, approval, or denial. Importantly, the Delegation Oversight Subcommittee has responsibility for reviewing credentialing/background checks/fingerprinting reports of delegated providers (e.g., Home Health Agencies that employ direct-service workers).

Compliance Committee

The Compliance Committee is responsible for reviewing and providing input on PHP's P&Ps in an effort to maintain a salutary balance between PHSP program requirements and the needs of network providers, members, contractors, PHP staff, and other stakeholders in accordance with all state and federal rules and regulations.

SECTION 25: MEMBER RESOURCES

This section describes the general functions, operations, and responsibilities of Partners Health Plan's (PHP) Member Services department. The Member Services department's hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m., with the exception of state and federal holidays, and the toll-free Call Center line is staffed by a live person from 8:00 a.m. to 8:00 p.m. on all normal business days.

Member Services Representatives

PHP's Member Services Representatives responsibilities include, but are not limited to, the following:

- Responding to inquiries about PHP's operations, covered services, and responsibilities, including:
  - Eligibility, enrollment, and disenrollment
  - Care management and care coordination
  - Network providers, practitioners, and pharmacies
  - Covered services and how to access them
  - UM requirements, including prior authorization guidelines
  - Grievances and appeals
  - Cultural Competency
  - Members' rights and responsibilities
  - Copayments and coordination of benefits, as applicable
  - Privacy and confidentiality
  - Language translation services and other forms of communications assistance
- Explaining Partners Health Plan's processes for accessing services and assisting members in making appointments and arranging transportation
- Explaining the role of the PCP and providing assistance in selecting one, if needed
- Developing and distributing member and family marketing materials, including the New Member Welcome Packet, the Member and Family Handbook, Provider and Pharmacy Directory, Quarterly Newsletters, informational brochures and posters, and related materials in a language and format they are able to understand
- Connecting members/caregivers with available internal and external resources, including community-based resources
- Providing translation services as needed, including the use of Language Line and NY Relay services
- Handling emergency crisis or urgent calls for assistance
- Adhering to protocols and restrictions regarding protected health information
- Clarifying information in the Member and Family Handbook and PHP website

- Fielding and responding to questions and complaints and advising members and/or their families/caregivers about their right to complain to the NYS Department of Health and/or OPWDD at any time, as applicable
- Advising members and their families/caregivers about the grievance and appeals system and the service authorization process
- Conducting new member and family orientation sessions and other educational activities
- Assisting care management staff with health promotion and wellness initiatives
- Assisting members with the renewal of their Medicaid benefits

Call Center/Nurse Hotline

PHP's dedicated toll-free Call Center is available 24 hours a day, seven days per week at 1-855-747-5483. At a minimum, the Call Center is staffed with a live person on each business day from 8:00 a.m. to 8:00 p.m. Eastern time; at all other times, the Center employs an interactive voice response system or similar technology to meet members' needs. All voicemail inquiries will be promptly responded to on the next business day. Translation services are available for members and/or families/caregivers with limited English proficiency (LEP) and NY Relay and other accommodations are available in accordance with members' individual needs. Call Center staff is trained to respond completely and accurately to member and prospective member inquiries, issues, and problems regarding their services and have access to clinical staff when a member has inquiries or issues that are clinical in nature.

The Call Center staff is trained and knowledgeable about eligibility, covered services, member rights and responsibilities, and grievances and appeals, among other topics. They are also trained to provide information and assistance relating to provider services, community and social service resources, and resolving complaints. Importantly, Call Center staff will not provide actual coverage determinations or decisions on grievances and appeals, but will instead provide information on how the coverage determinations, grievances, and appeals processes work and assist callers to navigate these processes, if requested.

Call Center staff will promptly transfer any member inquiry outside their scope of authority to the appropriate department within PHP, such as provider relations, care management, claims, and member complaints and grievances. Call Center staff never provides clinical advice or information as these inquiries are always responded to by appropriate clinical staff.

Access to After-Hours Clinical Advice

Call Center staff never provides health-related advice to member or their families/caregivers. Calls of this nature are instead "soft-transferred" without losing contact with the caller (during business hours) to an appropriate care manager or clinician who is licensed and trained to understand and assist with members' health care needs. At all other times the IVR system phone tree will automatically transfer calls of a clinical nature to our Nurse Hotline that is manned 24/7 with a trained clinician to provide general health-related information as well as assistance in accessing services, care managers/coordinators, and service authorizations outside of normal business hours. This service is available at all times, 24/7.

Language Translation Services

PHP makes oral interpretation services available free of charge in any language to all members and their families/caregivers that need assistance in understanding oral communications or written materials. Professional interpreters will be used as needed to discuss technical, medical, or treatment information. As needed, the member's circle of support will also provide assistance in communicating about issues and preferences.

PHP utilizes the New York Relay service at 7-1-1 for communicating with members and families/caregivers that are deaf or hearing impaired.

Member and Family Education

PHP has implemented a robust process for educating members and their families/caregivers about PHP's program, including covered services and benefits, member rights and responsibilities, and other relevant information. The objectives are to:

- Encourage appropriate utilization of covered services and supports and compliance with Partners Health Plan requirements
- Promote optimal outcomes by providing information that facilitates access to care and the effective use of services
- Comply with all applicable state and federal rules and regulations governing communications with members, prospective members, and members' families/caregivers

PHP uses a diverse set of communication tools and protocols to ensure that our members and their families/caregivers have timely access to all relevant information consistent with state and federal regulations, HIPAA guidelines, and internal policies and procedures. Care managers/coordinators and other staff communicate with members and their families/caregivers through a variety of methods, including telephonically and via in-person visits, text messaging, email, standard mail, the PHP website, and through PHP's web-based care management application that allows authorized users to access members' Care/Life Plans, case notes, scheduled appointments, assessment results, and other information from any location with Internet access 24/7.

PHP makes all printed member/family materials available in English, Spanish, and other languages spoken by at least five (5) percent of our members or as directed by the state and submits them to the state for review and approval prior to distribution. Upon request, members can also receive materials in additional languages free-of-charge.

SECTION 26: PROVIDER TRAINING AND EDUCATION

Partners Health Plan (PHP) strongly encourages network providers/practitioners to complete training on an array of topics and offers a variety of opportunities to complete the training, including:

- Orientation sessions
- Distribution of written materials through mailings and on the PHP website
- Regularly scheduled and ad hoc site visits
- Webinars
- Online curriculum

New Provider Orientation

PHP encourages all newly contracted providers/practitioners to carefully review orientation materials to promote an understanding of PHP's contractual requirements, covered services, UM processes, member rights and responsibilities, and reimbursement protocols, etc., and to develop an appreciation for the unique needs and challenges of caring for persons with intellectual and other developmental disabilities (I/DD).

To the extent possible, PHP organizes orientation materials by provider type (e.g., PCPs, specialist physicians, therapists, dentists, HCBS providers, etc.) and encourages completion within one month after they join our network. Provider Relations staff may supplement orientation materials by conducting webinars and other forums and cover such topics as:

- Model of Care
- Covered benefits
- Member and provider responsibilities
- The special needs of persons with intellectual and other developmental disabilities, including but not limited to:
  - Specialized communications techniques and cultural sensitivities
  - Evidence-based practices
  - Common chronic conditions and treatment guidelines, including behavioral health conditions
  - Types of services and supports available either through PHP or other community-based resources
  - Types of barriers encountered
  - Person-centered planning and self-determination
  - Role of the Life Plan
- Utilization Management processes, including prior authorization requirements
- Cultural and linguistic competency

- Availability of language translation services, NY Relay (TTY/TDD), and other accommodations to assist members in accordance with their individual needs
- Provider reference materials, such as the website, Newsletters, etc.
- Process for checking eligibility
- The role of the PCP/Medical Home, including:
  - The assessment and Person-Centered Life Planning process
  - Coordination of care and referrals, including referrals for behavioral health services and long-term services and supports
  - Medical record documentation requirements
  - Electronic health records and information sharing
- Appropriate use of the emergency department
- Provider responsibilities for compliance with the Americans with Disabilities Act and Olmstead requirements, including:
  - Waiting room and exam room furniture that is consistent with the needs of persons with IDD
  - Clear signage and directional finding (e.g., color and symbol signage) within provider facilities
  - Accessibility along public transportation routes and availability of parking
- Methods PHP uses to update providers on program and health plan changes
- The role of care managers/coordinators and related activities
- Coordination of physical and behavioral health condition(s) and treatment(s)
- The importance of evidence-based practice guidelines
- Quality metrics tailored to persons with IDD
- Reporting requirements, including encounter data submission requirements
- PHP's medical/service record documentation requirements
- The provider complaint, grievance, and appeals process
- Care management processes, including:
  - Referrals to specialists and out-of-network providers
  - Preferred drug list
  - Evidence-based practice guidelines
- Appointment availability standards, including wait times and after-hours availability
- Pay-for-performance/value-based performance opportunities (as applicable) and supporting tools, such as provider profiles

- Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist members in this process
- Member resources (e.g., Call Center, community resources, transportation services, etc.)
- Claims payment, including the use of electronic claims and availability of electronic funds transfer (EFT)
- Coordination of Benefits
- Strict prohibition against balance billing of PHP members
- Provider responsibility for compliance with state and federal laws
- Procedures for reporting suspected cases of abuse and/or neglect
- Contact information for Provider Relations and other departments

PHP's provider relations staff uses an In-Service Checklist to guide discussions and verify that they address all topics. We also make this information available in this Provider Manual as well as on the PHP website.

Provider Site Visits

PHP Provider Relations and/or QM staff conduct provider/practitioner site visits at least bi-annually, with additional meetings held as necessary with providers with large panel sizes as well as those not meeting their contractual requirements/obligations. During these sessions, our staff will reinforce previously presented information as well as communicate upcoming plan initiatives, new regulatory requirements, or new policies that may affect providers.

Additional Educational Activities

In addition to the initial orientation and site visits, PHP offers additional opportunities for continued education, including:

- Individualized provider instruction on select topics focusing on those areas with a high rate of prevalence in our target population, such as hyperlipidemia, seizure disorder, obesity, and anxiety, among others
- Group Training Webinars on select topics (e.g., claims coding, member benefits)
- Provider Newsletters and Bulletins containing updates and reminders
- Frequently updated online web materials and presentations
- Online instructional forums that focus on identifying opportunities for improvement based on the results of key quality measures.

Documentation of Provider Education

PHP's provider educational processes include strategies to encourage the completion of all required curricula. As indicated above, provider education can be completed via a review of written materials or web-based training. Each educational modality will utilize a specific means

of documenting attendance (e.g., sign-in sheets, web-based confirmation records, provider attestations). PHP will maintain these records for a minimum of seven years.

Additional Provider Resources

PHP is committed to working in partnership with its network providers to ensure our members are able to access high-quality services and supports on a timely basis in accordance with all federal and state rules and regulations, accreditation standards, and professional ethics. To this end, PHP encourages providers to contact our highly trained and dedicated staff immediately with any questions or concerns or to request any professional assistance that may be needed. At PHP, "continuous quality improvement" is much more than a slogan and we sincerely encourage and appreciate any and all comments, criticisms, and helpful advice you or your staff may wish to contribute.

SECTION 27: BEHAVIORAL HEALTH

Individuals with intellectual and other developmental disabilities (I/DD) and co-occurring mental health and/or behavior disorders (i.e., persons with a "dual diagnosis"), along with their families and caregivers, often encounter significant obstacles to receiving needed services in New York and across the country. Research demonstrates the prevalence of behavioral health disorders among persons with I/DD to range between 30 and 40 percent and they can exhibit the full range of psychiatric disorders present in the larger population such as depression, mood disorders, anxiety, and thought disorders in the form of verbal or physical aggression, self-injury, property destruction, impulsive behaviors, elopement, etc. Conversely, these unwanted, disturbing behaviors may also indicate the presence of interpersonal, physical, or environmental problems rather than a mental health disorder.

The causes of the increased vulnerability to behavioral health problems in persons with I/DD are not well understood. Several factors have been suggested, including:

- Stress stemming from negative social conditions such as social rejection, stigmatization, and a general lack of acceptance.
- Limited coping skills associated with language difficulty, inadequate social supports, and a high frequency of central nervous system impairment.
- Behavioral phenotypes associated with certain genetic syndromes, many of which have characteristic behavioral and emotional patterns that may contribute to the increased rate of mental health problems among persons with I/DD.

Although psychiatric disorders have been observed in persons with I/DD for many years, there have been impediments to more widespread professional recognition of dual diagnosis. One obstacle is "Diagnostic Overshadowing" which occurs when a diagnostician overlooks or minimizes the signs of psychiatric disturbance because it is considered less debilitating than the underlying intellectual disability or because it is thought to be a result of intellectual deficits. Professionals who are pressed to assign a "primary" diagnosis may focus on intellectual functioning, ignoring the psychiatric problem.

Basic Primary Behavioral Health Care Principles for Persons with I/DD

Researchers in the field of dually diagnosed adults have developed a brief set of recommendations for primary behavioral health providers:

- Exclude medical causes before diagnosing behavioral problems
- Avoid medications when behavioral interventions control symptoms
- Use smaller doses of medications among persons who are frail or have severe cognitive impairments
- Beware of unrecognized side effects when prescribing psychotropic medications

Experts on the psychosocial treatment of dually diagnosed persons find that environmental management, applied behavior analysis, and individual and family education (teaching about

psychosocial problems and management) represent the most highly recommended forms of intervention across the complete range of intellectual disability and psychiatric or behavioral disturbances.

Perspectives on the use of psychotropic medications to treat persons with I/DD are all but impossible to separate from their historical abuses within large institutional settings. That said, there are occasions when medication may represent the least intrusive and most positive treatment option, particularly for persons with intellectual disability and co-occurring psychotic, bipolar, or major depressive disorders.

Should you have any questions or concerns about behavioral health issues among persons with I/DD, please do not hesitate to contact our Care Management staff at 1-855-747-5483.

Case Management Services

Care Management is a process that plans, assesses and monitors services to meet a member's needs. A member may benefit from more intensive case management activities if there is a potential for recurrence or exacerbation of the member's symptoms.

PHP, in conjunction with the providers can identify members who may benefit from case management by using the following criteria:

- Three or more hospitalizations for inpatient behavioral health treatment within the last 12 months
- Members receiving chemical dependency treatment who has a serious psychiatric condition or history of a serious medical condition
- Members treated in the emergency room with behavioral health symptoms within a 12-month period.

A member meeting the above criteria will be assessed for referral to a Health Home if not already assigned. PHP will coordinate closely with the Health Home to ensure that the member's needs are thoroughly assesses and the resulting care plan includes a full range of necessary behavioral, medical, pharmacy and home and community services.

Partners Health Plan will collaborate with the Health Home and the PCP to establish consistent behavioral health screening for all members with a focus on members with high risk medical conditions such as stroke, HIV, cancer and chronic pain. The screening activities will screen for depression, anxiety and substance abuse disorders.

The care plan implementation includes the referral to appropriate providers or facilities and monitoring services to ensure they are addressing the member's specific health care needs. Both short term and long-term goals will be measured to measure progress of the treatment plan.

The monitoring may include follow ups with the member and providers, coordinating services with the health home, coordinating services with the treating providers. The treatment plan will document any progress and revising the plan as necessary.

Behavioral Health Clinical Policies and Procedures

Partners Quality Management Program reviews all criteria, guidelines and procedures used in the medical management program on an annual basis. The criteria used for decision making to the medical appropriateness of care, appropriate setting of care and the appropriate provider of care.

Partners uses the most current version of OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) to determine medical necessity for substance abuse rehabilitation and other outpatient levels of chemical dependency treatment. PHP uses the current MCG guidelines and OMH Clinical Standards of Care to determine medical necessity for mental health services including:

- Inpatient psychiatric services
- Partial Hospitalization
- Comprehensive psychiatric emergency room

First Episode Psychosis (FEP)

First Episode Psychosis (FEP) refers to the first time an individual experiences psychotic symptoms suggestive of recently emerged schizophrenia. Research supports a variety of treatment for FEP, especially coordinated specialty care. This care involves the following components:

- Individual or group psychotherapy
- Family Support and education
- Medications
- Supported Employment and Supported education
- Case Management

In regions served by PHP, OnTrackNY is the program to provide Coordinated Specialty Care (CSC) for individuals with FEP. OnTrackNY is available through various providers at locations

throughout the state. PHP will assist with linkages to such providers to ensure the best treatment outcomes. More information on OnTrackNY can be found at http://www/ontrackny.org/contact.

ATTACHMENT A: ADA ATTESTATION CHECKLIST

The Americans with Disabilities Act (ADA) Attestation

Provider Name (print): Date:

Provider Signature:

Provider Address:

Specialty:

1) Does the office have at least one wheelchair-accessible path from an entrance to an exam room? Yes No
2) Examination tables and all equipment are accessible to people with disabilities. Yes No
3) If parking is provided, spaces are reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs? Yes No
4) If parking is provided, are there an adequate number of parking spaces provided (8 feet wide for a car and 5 foot access aisle)? Yes No

Total Spaces	Accessible Spaces
1-25	1
26-50	2
51-75	3
76-100	4

5) For a provider with a disability-accessible parking space, is there a path of travel from the disability accessible parking space to the facility entrance that does not require the use of stairs? Yes No

– Is the path of travel stable, firm, and slip resistant? Yes No
– Except for curb cuts, is the path at least 36 inches wide? Yes No

6) Is there a method for persons using wheelchairs or that require other mobility assistance to enter as freely as everyone else? Yes No

– Is that route of travel safe and accessible for everyone, including people with disabilities? Yes No

7) Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following standards:

– 32 inches clear opening: Yes No
– 18 inches of clear wall space on the pull side of the door, next to the handle: Yes No

- The threshold edge is no greater than ¼ inch high or if beveled, no greater than ¾ inches high: Yes No
- The door handle is no higher than 48 inches high and can be operated with a closed fist: Yes No

8) Are there ramps to permit wheelchair access? Yes No

- If yes, complete the following 4 questions:
  - ◊ Are the slopes of the ramp accessible for wheelchair access? Yes No
  - ◊ Are the railings sturdy and high enough for wheelchair access? Yes No
  - ◊ Is the width between railings wide enough to accommodate a wheelchair? Yes No
  - ◊ Are the ramps non-slip and free from any obstruction (cracks)? Yes No

9) If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance? Yes No
10) Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? Yes No
11) Can the accessible entrance be used independently and without assistance? Yes No
12) Are doormats ½ inch high or less with beveled or secured edges? Yes No
13) Are waiting rooms and exam rooms accessible to people with disabilities? Yes No
14) The layout of the interior of the building allows people with disabilities to obtain materials and services without assistance. Yes No
15) The interior doors comply with the criteria set forth above regarding the exterior door. Yes No
16) The accessible routes to all public spaces in the facility are 31 inches wide. Yes No
17) There is a five-foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered. Yes No
18) All buttons or other controls in the hallway are no higher than 42 inches. Yes No
19) Elevators in the facility meet the following standards:

- There are raised and Braille signs on both door jambs on every floor. Yes No
- The call buttons in the hallway are not higher than 42 inches. Yes No
- The controls inside the cab have raised and Braille lettering. Yes No

20) Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances? Yes No
21) Is the public lavatory wheelchair-accessible? Yes No
22) With respect to the public restroom, the accessible route, the exterior door, and the interior stall doors comply with standards set forth above for exterior doors. Yes No

23) There is at least one wheelchair accessible stall in the public restroom that has an area of at least five feet by five feet, clear of the door swing; OR, there is at least one stall that is less accessible but that provides greater access than a typical stall (either 36 by 69 inches, or 48 by 69 inches). Yes No

24) In the accessible stall of the public rest room there are grab bars behind and on the side wall nearest the toilet. Yes No

25) There is one lavatory in the public restroom that meets the following standards:

- 30 inches wide by 48 inches; deep bar space in front. (A maximum of 19 inches of the required depth may be under the lavatory.) Yes No
- The lavatory rim is no higher than 34 inches. Yes No
- There is at least 29 inches from the floor to the bottom of the lavatory apron. Yes No
- The faucet can be operated with a closed fist. Yes No
- The soap dispenser and hand dryers are within reach and usable with one closed fist. Yes No
- The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower. Yes No

I, [First and Last Names, Title, Provider Name], hereby attest that we are a provider that has a physical site at which PHP members might possibly be physically present and that the answers provided are accurate. Also, I do hereby attest that I hold the authority to make these attestations.

Provider Name (print)_______________________________ Date:

Provider Signature _______________________________