2020

IPA PROVIDER MANUAL

A MANUAL FOR MONTEFIORE'S IPA'S
MIPA & HVIPA

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I. INTRODUCTION TO THE PROVIDER MANUAL

Montefiore is committed to delivering quality care to its members by providing easily accessible, comprehensive services. The provider network is an integral part in realizing this goal. The provider manual and its appendices serve as a reference guide and tool to assist providers in navigating the policies and procedures of the Integrated Provider Associations (IPA). We update the provider manual periodically to reflect the IPAs' most current policies and procedures.

Please take the time to read the provider manual to ensure you are fully aware of all current policies and procures. If any of the information in the provider manual is unclear, please call CMO Quality & Network Management at 914-377-4477. A downloadable copy of the provider manual is available on Montefiore's website www.cmocares.org.

II. THE MONTEFIORE CARE MANAGEMENT COMPANY (CMO)

CMO, The Montefiore Care Management Company of Montefiore Medical Center (CMO), is a robust healthcare management company that provides technologically advanced services and interventions to help federal and state healthcare programs and commercial insurers serving Bronx, Westchester and Hudson Valley members achieve optimal health. For more than 20 years, CMO's focus has been on many population health initiatives, all of which support the triple aim, which is to reduce the cost of care, enhance patient satisfaction and improve overall population health. CMO is committed to achieving its mission by:

- Maintaining a network of high quality clinical providers and care managers
- Delivering high quality, cost-effective health care
- Providing a superior customer experience to members and providers
- Continuously evaluating contracted programs, plans and other contracts to ensure they support our goals

CMO works with large networks of physicians and ancillary providers who provide care to more than 225,000 individuals covered by a variety of private sector and government-sponsored health insurance programs. We use proven interventions supported by information technology to be able to assess and manage a patient throughout the care continuum. Our involvement spans hospital care, rehabilitation, outpatient care, professional services, ancillary support, community-based programs, home care, remote patient monitoring and other services that may be required to return a member to optimum health. Our programs intend to meet the needs of members with complex illnesses, and to maintain the physical and mental wellbeing of our healthy members.

CMO also supports its network by providing patient education, provider support, quality and network management, credentialing services, community health programs, data analysis and reporting, financial services, and contact center services.

In addition, CMO operates the Patient Access Center (PAC) /Customer Service Department and manages innovative programs such as Montefiore Medical House Calls, CMO Care Continuity™, Montefiore MyChart Patient Portal, and other health education and promotion programs and services. CMO is central to Montefiore's position as an integrated health care delivery system.

III. INTEGRATED PROVIDER ASSOCIATIONS

The IPAs are comprised of two entities: the Montefiore Integrated Provider Association (MIPA) servicing the Bronx, and the Hudson Valley Integrated Provider Association (HVIPA) servicing Westchester and the Hudson Valley. CMO manages both IPAs, which manage networks of primary care physicians, specialists, care management agencies, behavioral health organizations, community-based organization and other providers. The IPAs have a physician-hospital partnership, contracting with managed care organizations to accept and manage risk under value-based arrangements.

IPA participation gives providers access to enhanced contracts, administrative support, patient engagement, monetary value, provider support and regulatory change navigation.

IV. IPA BOARD OF DIRECTORS

The IPA Board of Directors establishes and directs the policies that govern the IPAs.

The MIPA Board of Directors consists of at least 19 members, as follows:

- Five hospital directors, appointed by MMC
- Seven employed physicians nominated and elected by MMC's clinical chairpersons
- Seven voluntary physicians nominated by committee of voluntary physicians and elected by MIPA voluntary physicians

The HVIPA Board of Directors consists of at least 7 but no more than 19 members, as follows:

- A hospital director from each participating hospital entity
- An FQHC director from each participating FQHC
- One or more behavioral health directors
- One or more physician directors

For more information each IPA's Board of Directors, please refer to their current bylaws.

V. STANDING COMMITTEES OF THE BOARD

Each IPA establishes a quality, finance and credentialing committee. The Board of Directors (the Board) appoints each committee annually.

Quality Improvement Committee

The Quality Improvement Committee reviews and monitors issues related to appropriateness and quality of care provided by practitioner members, hospital members and any professionals contracted with either or both IPAs. The committee offers recommendations to the Board on matters involving, but not limited to, practice guidelines, access and availability of health care services, and preventive care.

Finance Committee

The Finance Committee is responsible for both IPA's finance management. The committee offers recommendations to the Board concerning the annual operating and capital budgets; monthly financial reports; provider reimbursement; insurance coverage for the corporation; and changes related to investment objectives, policies and guidelines of corporation funds.

Credentials Committee

The credentials committee considers applications of providers requesting to become members of the IPAs and addresses membership issues, including suspension or removal of providers from the either or both IPA network. It also makes recommendations to the board regarding acceptance or rejection of such applicants.

VI. PROVIDER ONBOARDING PROCESS

After a provider expresses interest in joining either or both IPAs, they work directly with CMO staff to satisfy participation requirements. To become a participating provider with either or both IPAs, providers will select a track to join; undergo a readiness assessment to evaluate preparedness and improve workflows, fill gaps, meet program requirements and provide education; and receive a training and orientation session.

A list of participation tracks and the contracted plan information are found in section VII.

VII. IPA TRACK SELECTIONS: PAYMENT MODEL & PROGRAMS

The IPAs' contracts cover participation in several different kinds of payment models and programs.

Risk Payment Model Track

In a risk-payment model contract, the insurer pays a monthly per member fee (known as capitation) to the IPAs. The IPAs pay fee-for-service claims to the provider with potential withholds or other adjustments based on financial performance. The following health plans can use this model:

- Employer/individual ("commercial") market HMO products
- Medicaid Managed Care HMO products (including mainstream plan, MLTC)
- Medicare Managed Care (Medicare Advantage)
- Employer/individual/exchange ("commercial") market products (i.e. PPOs, self-insured plans)

Shared Savings Payment Model Track

In a shared savings payment model the payor is a private insurer whose member attribution is determined by their utilization of participants in either or both IPAs. The insurer pays the claims with the potential for a share of any savings against the agreed-upon annual total cost of care benchmark. The following types of health plans can use this model:

- Employer/individual ("commercial") market HMO products
- Medicaid Managed Care HMO products (including mainstream plans, MLTC and FIDA)
- Medicare Managed Care (Medicare Advantage)
- Employer/individual/exchange ("commercial") market products (i.e. PPOs, self-insured plans)

Risk Payment Model	
Emblem Health HIP Commercial	*Prime Network:* • **HIP Access I** • **HIP Prime HMO** • **HIP Child Health Plus (CHP)**
Emblem Health HIP Medicaid	*Enhanced Care Prime Network:* • **EmblemHealth Enhanced Care (MMC)** • **EmblemHealth Enhanced Care Plus (HARP)**
All Claims and UM are managed by CMO The Montefiore logo will appear on all member ID cards	

Government/Medicare Shared Savings Model
There are no Government/Medicare Shared Savings Contracts currently

Health Plan Shared Savings Payment Model **Note:** Active MIPA and HVIPA providers must opt in to participate in these contracts	
Aetna • Commercial • Medicare	
Affinity	
Empire Commercial	Negotiated Fee Schedule (see Provider Contract for details)
Fidelis	
HealthFirst • Medicaid • Medicare	
Oscar • Commercial • Medicare	Negotiated Fee Schedule (see Provider Contract for details)
All Claims and UM are managed by the Health Plan	

VIII. PROVIDER RESPONSIBILITIES AND EXPECTATIONS

Staying Informed

The IPAs regularly send communications by email or postal mail to express important messages related to health plan contract updates, new programs and initiatives, annual compliance training, contractual updates, and other notifications related to the IPAs.

Most communications require a response making it imperative to read all the materials thoroughly to ensure imposed deadlines are met timely and critical information related to IPA participation is understood.

Current Provider Information/Demographics

Providers are responsible for informing the IPAs when changes to their practice occur. To ensure up-to-date information is on file, it is critical that providers update demographic information timely.

This information is necessary to accurately process referrals and claims, and update both the CMO and health plan provider databases. Failure to advise CMO of changes could result in misdirected PCP capitation payments, inaccurately paid or denied claims, and/or medical management issues.

To ensure the IPAs have the most current demographic information the CMO must also be immediately notified, in writing, when there is a change in any of (but not limited to) the following:

- Practice Address
- Billing Address
- Tax ID
- Add/remove providers from practice
- Participation/employment status (termination, relocation, retirement, voluntary, etc.)

To update demographic or provider status information, please refer to forms located in the appendix and follow their instructions. Please note that for all billing updates, a W9 form must accompany the demographic profile update form. Please send completed forms to CMOProviderSupport@montefiore.org.

Medical Record Review

The IPAs periodically conduct medical record reviews to comply with CMS requirements, evaluate practices, identify opportunities for improvement and ensure quality. Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. The IPAs require providers to comply with professional standards and safeguard confidentiality when sharing medical record information with other providers.

Medical records should be up-to-date, well documented and retained in perpetuity unless otherwise noted by the IPAs.

Site Visits

Site visits ensure that IPA provider offices are physically accessible to members, have adequate examination rooms and waiting areas, offer sufficient appointment availability, and maintain acceptable medical record keeping practices.

CMO Staff conducts site visits on an as needed basis, or when a practice is deficient and every six months thereafter until rectified. Deficiencies can be identified through phone calls, letters, complaints received by Customer Service, member satisfaction surveys, or other reporting means. If the IPAs find practice deficiencies during a site visit, CMO staff will send a written notice to the practice within three days with instructions for corrective action. The practice is required to submit a Corrective Action Plan within 30 days.

If the Corrective Action Plan meets the standards to satisfy the deficiency, the IPAs notify the practice and CMO staff conducts a follow-up site visit; additional site visits will occur every six months thereafter until corrected.

If the Corrective Action Plan does not meet the standards or not implemented, CMO staff notifies the Credentialing Committee for review and recommendation. The Credentialing Committee may recommend alternative actions or motion to terminate the provider's IPA participation. The Credentialing Committee brings all recommendations the Board for decision.

Providers may appeal deficiency determinations in writing to the Credentialing Committee.

Information Technology Infrastructure

IPA providers are required to meet at least the minimum standard of IT infrastructure. Failure to comply with this standard will result in review, and possible IPA termination. The requirements include a Certified Electronic Health Record (CEHR) and a Health Information Exchange (HIE):

Certified Electronic Health Record (EHR) Connectivity

An EHR is an electronic version of a patient's medical record. EHRs make patient information available instantly in a secured environment to users with authorized access.

Benefits to using EHRs include:

- Electronic access to patients' full medical history giving providers broader scope of patient needs
- Optimize provider/practice workflows
- Enable providers across more than one healthcare organization to securely share patient information making coordination of care easier and faster

CMS requires providers to use a 2015 or later certified EHR system to meet Stage 3 requirements of the promoting interoperability program previously known as Meaningful Use (MU). The IPAs requires providers to contract and connect with an EHR to participate in value-based programs, including MACRA and APC. If a practice currently uses an EHR but is not sure if it meets the Stage 3 promoting interoperability requirements, contact the EHR vendor for assistance.

Health Information Exchange Organization (HIE) Connectivity

All IPA providers are required to join a Regional Health Information Organization (RHIO). RHIOs are data hubs that electronically collect healthcare information pursuant to healthcare information exchange regulations. Participation with a RHIO enables providers to access healthcare information across the care continuum, which can result in better care for patients, improved communication, regulatory compliance, and enhanced workflows.

When you participate in a RHIO, you will:

- Have better care coordination
- Improve communication in transitions of care
- Be meaningful use compliant
- Find opportunities to streamline workflows

The IPAs works closely with HealtheConnections (services the Hudson Valley) and BronxRHIO (services the Bronx and lower Westchester), two RHIOs that offer a range of services to providers. Each RHIO is a provider organization established and governed by many healthcare organizations and securely exchange clinical information, allowing medical records to travel electronically with a patient, no matter where they go. By being part of a RHIO, you will have access to this shared information.

Contact the Quality & Network Management Department for more information on how to join a RHIO.

Providers Requesting Termination from IPA

- All terminations must be submitted in writing to the CMO, Provider Information Department.
- As stipulated in the Participating Practitioner Agreement, the termination provisions allow a provider to resign, without cause with ninety (90) days prior written notice.
- Upon receipt of the written notice to terminate from the IPA, and/or hospital affiliation, appropriate action to terminate will commence.
- Terminating providers will receive an acknowledgement letter from the CMO with the effective date of termination, according to the terms in the Participating Practitioner Agreement.
- The terminating provider will be removed from the CMO's electronic provider directory and will not be included in future provider directories. If a current IPA participating provider makes referrals to you or contacts you regarding patient care matters, explain that you will no longer participate with the IPA as of the effective date stated on your acknowledgement letter from the CMO.
- During the 90-day period you are required to provide post-termination services to members under your care as per the Participating Practitioner Agreement.
- To advise the CMO of intentions to terminate, providers may complete the *Resignation Request Form* and submit the form to Provider Information by fax or mail. Reminder: 90 day notice is required.

Terminating from Contracted Health Plan(s)

- All terminations must be submitted with 90 days' notice in writing to the CMO Quality & Network Management department for IPA contracted plans for which the CMO is delegated credentialing.
- Appropriate action to terminate participation with all contracted health plans will commence.
- The CMO will notify all IPA health plans of your termination.
- If the provider was credentialed into a health plan via CMO credentialing, then the provider will be terminated from the health plan through the CMO. Providers who wish to continue participation with these health plans must contact the health plan directly in addition to notifying the CMO.
- If the provider was participating with the health plan prior to joining the IPA, the provider's health plan participation will revert to a direct health plan contract. Providers should contact each plan to confirm participation status following IPA termination.
- If you have an assigned panel of members, the members will be notified and reassigned as per each health plan's existing policy.

Member Eligibility

The IPAs urge all providers to verify member eligibility prior to rending services, except in the case of a medical emergency.

Health plan members are entitled to as many visits to their primary care provider's (PCP) office as they need, but PCPs should verify they are the member's PCP. If the PCP's name or site does not appear on the card, the PCP should have the member call their insurance carrier immediately. The PCP's office will not receive payment for members not assigned to their panel.

Members must submit all PCP change requests directly to their health plan. CMO cannot make any PCP changes. In addition, when a provider terminates or resigns from a health plan, the members' health plan will notify them directly of the change.

Primary Care Physician (PCP) Responsibilities

PCPs are responsible for the following:

- Coordinating referrals to participating specialists (referrals are not required for in-network IPA specialists, with a few procedural exceptions. View appendix for more information)
- Coordinating referrals to out-of-network specialists, laboratories and diagnostic imaging facilities are subject to prior approval
- Collecting appropriate co-payment as direct on member's ID card
- Transferring medical records to new PCPs
- Complying with requests for medical information from CMO, member's health plan and/or other providers
- Requesting all medical information necessary to provide patient care from other treating providers
- Coordinating with behavioral health providers, If enrollee is using behavioral health clinic

Specialty Care Physician (SCP) Responsibilities

SCPS are responsible for the following:

- Preauthorization of all appropriate services
- Referral of the member for diagnostic testing or to another SCP for the same diagnosis
- Collecting appropriate co-pay (co-pay is listed on Member's ID card)
- Providing a complete report of services rendered to the referring PCP and advise the PCP of any ongoing treatments
- Complying with requests for medical information from other providers
- Requesting all medical information necessary to provide patient care from other treating providers

IX. CMO DEPARTMENTS

QUALITY AND NETWORK MANAGEMENT

The Quality & Network Management Department (QNM) is the communication link between MMC, Montefiore's IPA provider networks and contracted health plans. QNM engages with providers to offer support related to their IPA participation and ensure adherence to quality standards, facilitate education and process improvement strategies, and implement various clinical tools and initiatives.

Some of the department's functions include:

- Develop and deliver orientation and training to newly credentialed providers
- Support all MIPA contracted programs
- Align reporting strategies
- Develop and implement patient engagement strategy
- Review quality and utilization data
- Implement clinical and peer-to-peer tools that improve conditions management and support population health goals
- Coordinate HIE connectivity
- Hierarchical Conditions Category (HCC) Coding guidance (more information can be found in Appendix)

If you have any questions regarding the Quality & Network Management initiatives, please contact the department at CMOProviderSupport@montefiore.org.

CREDENTIALING AND PROVIDER INFORMATION

The Credentialing Department ensures all providers are properly credentialed and re-credentialed to the applicable IPA and meet the standards for professional qualifications in accordance with IPA bylaws and the National Committee for Quality Assurance (NCQA). CMO is delegated for credentialing by the IPA risk partners and other managed care payers in the market. The credentialing process requires providers to complete an IPA application, which is used to verify provider's clinical history and is presented to the Credentialing Committee for review. The Credentialing Committee reviews each provider's credentialing and re-credentialing application and makes recommendations to the applicable IPA Board of Directors.

Currently, CMO credentials the following provider types:

- Physicians (MD, DO)
- Dentists (DDS, DMD)
- Psychologists (PhD, PsyD)
- Podiatrists (DPM)
- Nurse Practitioners
- Licensed Independent Practitioners including Behavioral Health and Allied Health
- Other organizational providers (ancillary vendors)

CMO's credentialing process takes approximately 45 days from receipt of a complete application and all required supporting documents.

Re-credentialing

Re-credentialing is required for every IPA provider to comply with the health plans' policies, credentialing standards and the bylaws of each IPA organization. Re-credentialing ensures that providers' credentials are current and in good standing, therefore, the IPAs re-credential providers every 24 months. Providers are required to comply with the re-credentialing requirements, which include completing an application and related forms/documents, and a site and medical record review. CMO Credentialing Office mails re-credentialing packages to providers seven months prior to the re-credentialing due date. Failure to respond to re-credentialing requests may result in termination from the IPA and/or Montefiore Medical staff.

The Credentialing Office complies with the standards of the National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Network Standards, New York State Department of Health regulations and delegation agreements with each health plan.

Delegated Credentialing

In addition to managing IPA risk contracts, the CMO is delegated the function of credentialing Montefiore providers into a full range of contracted health plans and products. The specific health plan list is on the internal Montefiore intranet under the Professional Services Department page. The CMO does not provide medical management or claims processing services for members of these health plans and products. Questions about these services should be directed to the plan.

Healthplan Specific Credentialing Services:

Emblem Health - HIP (Commercial, Medicare, Medicaid, CHP) and GHI

Montefiore Employed Providers

- Providers employed by Montefiore Medical Center are required to complete the IPA Participating Practitioner Agreement to be in HIP's provider network
- Employed providers are automatically enrolled in all of HIP's Commercial, Medicare, Medicaid, Child Health Plus and Family Health Plus products, including HIP's non-IPA products (not managed by the CMO)

Voluntary and Non-MMC Affiliated – HIP Only

- Providers not employed by Montefiore Medical Center have the option to be credentialed into HIP's non-IPA products. Providers electing to participate in non-IPA products must also fill out a HIP Physician Service Agreement in addition to the IPA Participating Practitioner Agreement
- Completed agreements are returned to CMO for submission to HIP
- The HIP Physician Service Agreement is mailed to provider's office

Request for Open/Closed Panels

PCPs wishing to close or re-open their member panels must submit a letter to the Quality & Network Management Department, indicating the reason for the change. The IPA Credentialing Committee reviews all requests, which need approval *prior* to changing a provider's panel status.

NETWORK CARE MANAGEMENT

The Network Care Management Department works closely with patients and providers. This ensures patients receive the care they need and that providers are upholding the standards set forth by the IPA's. They develop comprehensive policies designed to ensure that all services are medically necessary and rendered in an appropriate setting. This involves prospective, concurrent and retrospective reviews, case management, disease management, and discharge planning. The department also administers standard and expedited appeals.

Some of the functions this department performs include:

- Transition of care
- Care coordination

MEDICAL MANAGEMENT

Purpose and Scope

The purpose of the Medical Management Department is to ensure that health care provided to members of contracted health plans is coordinated appropriately, effectively and efficiently. The functions of the department include but are not limited to:

- Fostering and supporting the role of the Primary Care Physician (PCP)
- Establishing a referral process that ensures appropriateness while preserving access
- Preauthorizing elective inpatient admissions and certain outpatient services
- Providing for continuity of care through discharge planning
- Case management and disease management activities

All IPA participating providers follow CMO Medical Management Guidelines.

- Referrals issued to and from IPA providers must follow CMO referral guidelines
- Referrals issued to non-IPA health plan participating providers must follow the health plan's referral guidelines for claims to be processed. This process can be done one of two ways:
    1. Submit an electronic referral directly to the health plan.
    2. Submit a CMO Referral Form to CMO. CMO will forward the referral information to the health plan.

Please refer to the University Behavioral Associates (UBA) section for information on obtaining authorizations for UBA services.

Ensuring Appropriate Service and Coverage
It is the policy of CMO that:

- All Utilization Management (UM) decisions made by CMO are based on the member's eligibility, the benefits covered under the member's certificate of coverage, the appropriateness of the care and the services requested.
- CMO does not reward UM decision makers for issuing denials of coverage or service and encourages the use of medically necessary and appropriate care and services to prevent and/or treat medical conditions.
- CMO does not compensate UM decision makers for non-certification of service or offer incentives to encourage non-certification or under-utilization of health care services.

Confidentiality
Member information obtained while performing medical management activities is handled in a confidential manner. Uses and disclosures of confidential information are consistent with the Health Insurance Portability and Accountability Act (HIPAA) requirements and CMO policies and procedures.

Referral and Authorization
Issuing Referrals
A referral should be made when, in the provider's professional opinion, it is believed to be medically appropriate and necessary. IPA providers are expected to work collaboratively to improve clinical quality and reduce the overall cost of care by effectively managing patients. Providers are expected to refer patients to IPA network providers for services. If a specific service is not available from another IPA provider, it is expected that the referral be made to a provider within the patient's health plan participating network. Only after exhausting IPA and health plan referral sources should you request an authorization to use an out of network provider.

The provider has the right to request an office visit by the patient for an examination and diagnosis before issuing a referral but may issue a referral without a visit if appropriate. Referrals requiring pre-certification (prior authorization) are listed below, as is the process for obtaining them.

Referral Process Responsibilities
PCP Responsibilities

- Determines appropriateness of patient's referral for consultation to a specialty care physician (SCP)
- Specifies the reason for the consultation request
- Provide information and/or results regarding any tests and/or procedures performed
- Follows up with the SCP as necessary to assure "continuity of care" for the patient.
- Provides a copy of the referral to the patient

SCP Responsibilities

- Orders diagnostic tests necessary to complete the requested consultation
- Complies with CMO requirements for authorization (pre-certification)
- Determines if additional treatment is necessary and communicates the treatment plan to PCP
- If the PCP agrees with the plan, the SCP coordinates the treatment, including arranging surgery and/or inpatient hospitalization
- If the SCP determines that the referral to another SCP for a cognitive consult may be appropriate, the SCP should inform the PCP, who will coordinate further care
- Provides a follow-up written report to the PCP which outlines:
  - Evaluation
  - Findings
  - Recommended treatment
- For an extended course of treatment, the SCP provides a progress report to the PCP at agreed intervals

Authorization (Pre-certification)

Depending on the reason for a referral, a referral may require authorization (pre-certification). Requests for these services should be sent in advance to the CMO, and where possible, services should not be rendered until a determination is made. (Note: the payment of all services is subject to the terms and conditions of the member's health plan contract. The authorization or issuance of a referral is not a guarantee of payment.) Please visit the www.CMOcares.org website under the Provider Services Center for the most updated list.

Services Requiring Authorization

- Inpatient Admissions (Elective/Emergent)
  - Elective admissions require prior-authorization at least 5 days prior to admission
  - Emergent admissions require 24-hour notification
- Surgery
- New Technology, Cancer Clinical Trials, Investigational or Experimental Procedures
- Durable Medical Equipment (DME)
- Home Health Care- including Home Infusion Therapy
- Hospice
- Infertility workup and treatment
- In-Vitro (IVF) is only covered with the benefit
- Plastic-Cosmetic Surgery, including, but not limited to:
  - Mohs Micrographic Surgery
  - Septoplasty
  - Ligation and stripping of varicose veins
- Hyperbaric 02 Treatments
- Radiology
  - MRI, MRA, PET
- Transportation for all non-emergency services
- Ambulance, Ambulette, Taxi, Air
- All referrals to out-of-network providers

Process for Obtaining Authorization

The Medical Management Department at CMO should be notified at least 72 hours in advance when services require authorization (see Precertification List). If a requested service requires precertification, approval will be determined based on medical necessity. Payment for services also depends on whether the member was eligible at the time of service and if the requested procedure(s) are covered under the member's benefit.

Methods for Generating Referrals

Referrals must be sent to the CMO electronically via Epic Tapestry Link, or on a paper referral form via fax or mail until you obtain access to Tapestry.

Epic Tapestry Link gives users the ability to view claims' status, generate referrals/authorizations, and check member eligibility, depending on your individual role. If you are a new user interested in registering for Epic Tapestry, please contact Quality & Network Management at 914.377.4477

PATIENT ACCESS CENTER /CUSTOMER SERVICE

For IPA contracts with delegated customer service activities, the Patient Access Center/Customer Service Department assists members and providers. This includes providing information regarding covered benefits, primary care and specialist provider selection, and member responsibilities.

Customer Service representatives are available to assist members with any issues or questions. Assistance is available in both English and Spanish. Customer Service can also assist members who speak other languages by accessing Montefiore's Translation Service. Customer Service can be reached at 914-377-4400 or 800-666-8326 Monday through Friday between the hours of 8am and 6pm.

Speech or Hearing-Impaired Members

CMO Customer Service staff can assist speech or hearing-impaired members through the text transmitted telecommunications equipment (TTY). The line may be accessed by dialing the AT&T or Verizon Relay Line. Members must have a TTY line in order to use these services.

If a member has other special needs, such as for wheelchair-accessible facilities, or sign language translators, the member and/or member's designee should contact Customer Service at 914-377-4400. However, if the member and/or member's designee is already working with a health care provider such provider will assist in coordinating the necessary services.

Montefiore Medical Center employed providers may call the Montefiore Language Bank at718-920-4943 or 718-904-2395 for assistance.

In addition, Customer Service collects member feedback regarding the care they receive in Montefiore facilities, their satisfaction with the rendering provider, and IPA in general. They also field member complaints and collaborate to resolve issues.

Complaints, Grievances, and Appeals

The Customer Services Department is responsible for overseeing the process for resolving claims complaints, appeals and grievances for all IPA providers. This process includes acknowledgement, investigation and timely response to these issues. Any verbal or written complaint, grievance or appeal will adhere to CMO policies to ensure compliance with all state and federal laws and regulations, NCQA guidelines and contractual obligations.

Definitions

Inquiry: a question, concern, comment, suggestion, or request for information or assistance.

Complaint: an expression of dissatisfaction that cannot be resolved at the time of interaction.

Administrative Appeal/Grievance: A request to change a decision involving (a) the denial or discontinuation of coverage of services not involving a medical necessity decision; or (b) the denial of whole or partial payment of a claim, also referred to as a "grievance" for the Medicare line of business.

Filing Inquiries and Complaints

A provider acting on behalf of a member or other designee can register inquiries and complaints over the phone by calling Customer Service at 888-666-8326 or 914-377-4400 Monday-Friday 8:00 am – 6:00 pm, or in writing at:

CMO Appeals
200 Corporate Boulevard South
Yonkers, NY 10701

All inquiries receive the same appropriate, timely, and thorough review and response regardless of the method of submission or content of inquiry. Inquiries received from non- IPA members are redirected to the appropriate health plan.

If an IPA Provider has a complaint, CMO will accept, investigate, and resolve the complaint within 48 hours. All pertinent information is reviewed to assist in the resolution process.

Filing an Administrative Appeal

Administrative appeals are considered first level appeals to overturn decisions related to claim payments or determinations that a service is not covered under a member's benefit contract for reasons other than medical necessity.

Medicare appeals are the responsibility of the member's health plan. Requests for Medicare member administrative appeals must be made in writing. However, they may be accepted verbally if there are extenuating circumstances that prevent the member from filing an appeal in writing.

Filing a Grievance

Medicare grievances typically involve issues such as quality of care, access to care, communication issues with the provider, provider billing practices, balance billing, refusal to release member medical records, enrollment issues, and any other issues of dissatisfaction which do not involve an adverse determination.

The member or a designated representative can register member grievances over the phone or in writing. In cases where CMO is not delegated for Medicare grievances, a copy of the grievance is forwarded to the appropriate health plan within 48 hours of receipt. The health plan is responsible for handling the grievance. Grievances received from non-IPA members are sent to the appropriate health plan.

POPULATION HEALTH ANALYTICS

The Population Health Analytics (PHA) Department provides information support, data analysis and decision support to internal MMC and CMO management teams for operational analyses, strategic planning, and to external health plans and government regulatory agencies. The department also operates as internal management consultants to other CMO service areas to provide problem resolution and project management.

FINANCE

The Finance Department ensures that all appropriate financial controls and balances are in place for CMO operations. The department manages cash flow through its banking and investment strategies and reviews and recommends operational enhancements to existing systems to maximize revenues and control expenses.

CLAIMS/OPERATIONS

The Claims/Operations Department is responsible for the timely and accurate processing of all medical/professional and facility claims submitted to CMO on behalf of members enrolled with its contracted health plans. The department is comprised of 3 main areas:

Claims/Special Handling Unit (SHU)

The Claims unit adjudicates and pays medical/professional and facility claims for eligible contracted health plan members according to the reimbursement methodology stipulated in the provider's contract and in the member's benefits.

The SHU Unit reviews claim issues relating to denials of service, payment issues, including application of copayments, incorrect benefit selection, or other issues with adjudication and will adjust claims as needed when errors in processing are identified. The unit also identifies questionable claims activity and collaborates with other departments to resolve issues affecting claims payment.

Coordination of Benefits

The Coordination of Benefits (COB) unit ensures appropriate payments are made when a member is covered under more than one health plan. Through electronic enrollment transactions received from contracted health plans, COB information is captured on the member's enrollment record and on electronic claim submissions, so the proper application of primary and secondary payments can be made by CMO.

Quality Audit and Support Services

The Quality Audit unit audits both UB and HCFA claims to determine financial and non-financial processing accuracy to meet CMO and contracted health plan goals. They regularly conduct audits to identify error trends and develop corrective action plans through policies and procedures, training, system updates, and more.

Support Services provides the technical claims training for Claims/Operations and other CMO and Montefiore departments that need training on the TriZetto QNXT System, including Member, Provider, Contracts, Fee Schedules and Configuration portals. The unit also maintains CMO Claims Department policies and procedures on the Montefiore intranet site and distributes policy updates as needed. The unit participates in system upgrade project teams and manages the Change Healthcare ClaimsXten and Cotiviti auditing software rules development and modifications, as needed to meet CMO business requirements.

Claims Processing

- All IPA providers must submit claims for eligible members to CMO electronically.
- The current fee schedule and capitation rates apply to all IPA participating providers.
- Most Specialty Care Providers (SCP) are reimbursed on a fee-for-service basis according to the IPA fee schedule, although some are reimbursed under capitation agreements.
- IPA participating inpatient and outpatient facility charges must be submitted to CMO for processing.
- All claims for EmblemHealth members managed by CMO must be submitted to CMO for processing, regardless of the provider's participation status.
- Claims for non-IPA members (members who are not managed by CMO) should be submitted to the health plan for processing according to health plan's claim submission guidelines.

BILLING AND CLAIMS

Claims Submission

Claims must be submitted electronically or if need be, they can be mailed to Montefiore Care Management (CMO) on the standard CMS 1500 and/or UB04 forms. The claims payment process is contingent on CMO's receipt of complete and legible claims.

Claims Submission Address:
CMO Montefiore Care Management
Attn: Claims Department
200 Corporate Blvd. South, Suite 200
Yonkers, NY 10701

Encounter Information / Direct Electronic Submission

All IPA participating providers are to submit accurate and complete encounter reports on CMS/HCFA forms to CMO within the contracted 180-day timely filing limit. All Montefiore Medical Center employed providers are to submit encounter data electronically, per established protocol, via direct interface with CMO hospitals' billing systems.

Electronic Claims Submission

CMO has initiated an Electronic Claims Submission Program (ECSP) through Change Healthcare (formerly Emdeon). Providers who do not access the direct interface billing system may submit claims electronically via Change Healthcare. Providers can electronically submit claims to CMO and receive confirmation of receipt by CMO.

Submitting claims electronically offers the following benefits:

- Efficient claims payment
- Automated feedback to providers
- Greater reliability
- Reduced paperwork

To submit electronic claims, providers must either directly subscribe to Change Healthcare or be a customer of an online service/vendor, which subscribes to Change Healthcare. Providers should confirm their billing information, Tax ID and CMO Provider ID with CMO prior to making arrangements for electronic billing. In addition, providers should also ensure that CMO's Payor ID - 13174 is active in their vendor's system. This information is necessary for the successful submission of electronic claims to CMO. For questions regarding electronic claims submission, please contact CMO Quality & Network Management at 914- 377-4477.

Clean / Non-Clean Claims

A "clean claim" is a claim that is submitted for payment consideration that has no defect or impropriety, including lack of required substantiating documentation or circumstances requiring special treatment, which prevents payment from being made on the claim within thirty (30) days of receipt for electronically submitted claims and forty-five (45) days of receipt for non-electronic submissions.

A "non-clean" claim is a claim that is submitted for payment consideration that is not reasonably clear due to:

- A good faith dispute regarding the eligibility of a person for coverage,
- The liability of another insurer or corporation or organization for all or part of the claim,
- The amount of the claim,
- The benefits covered under a contract or agreement,
- The way services were accessed or provided, or
- When there is a reasonable basis supported by the superintendent that such claim or bill was submitted fraudulently.

All claims must, at least, include the following information to be considered clean:

- Patient name and insurance ID #
- Provider information, including Federal Tax ID # and NPI #
- Date of service
- Place of service
- Diagnosis code(s)
- Procedure code(s)
- Individual charge for each service
- Provider signature
- Name and address of facility where services were rendered
- Provider's Billing address

If any of these elements are missing or incorrect, the claim will not be considered clean and will be returned to the provider for correction.

Prompt Payment Guidelines

CMO processes clean and non-clean claims within the prompt pay time frames established by Federal and New York State requirements, and contractual obligations.

Interest calculations for CMS 1500 and/or UB04 claims are processed by the claims system. The system will automatically add the appropriate interest payment to the claim when processed outside the prompt pay time frames.

Time Frame for Claims Submission

- To be considered "timely", a claim(s) must be received by CMO within 180 days of date of service.
- If claims are submitted after the timely filing limit of 180 days from date of service, they will be denied.

Prohibition of Balance Billing

Participating providers are not permitted to bill, charge or collect any compensation or reimbursement from the member, or person acting on behalf of the member, for any services provided under the member's health benefit plan. Providers should make members aware of any member financial responsibility prior to rendering services.

If a member is covered under Medicaid Managed Care, the provider is to bill the local Medicaid agency for services not covered under the member's HMO plan. Providers should refer to their Medicaid Manuals for specific information.

Co-payments, deductibles and coinsurance shall not be charged to any Medicare member for influenza or pneumococcal vaccines or for other services similarly specified in federal or state law.

Payment Determination Appeals

IPA providers must accept CMO's fee schedules and reimbursement as payment in full. Appeals will only be considered due to medical necessity or processing errors.

Coordination of Benefits (COB)

COB is the process by which the order of payment of insurance coverage from more than one insurance plan is determined. Through COB policies, CMO can determine which insurance has primary payment responsibility for a claim and who is responsible for processing the balance of any remaining covered expenses, up to the maximum benefit.

Capturing COB Data

COB and Other Party Liability information is received from IPA contracted health plans on a regular basis. In addition, CMO receives COB data from Montefiore Medical Center databases, Professional Services, CMO Finance, Medical Management and the Patient Access Center.

If there is secondary liability, the provider must submit the primary insurance carrier's explanation of benefits (EOB) together with a paper claim to CMO for processing, unless they are able to submit the COB payment information electronically on the claim submission.

Explanation of Benefits

The Explanation of Benefits (EOB) is the statement sent to the provider in response to a claim(s) submitted to the health plan for services rendered to a member. CMO's EOB lists the services rendered, date(s) of service(s), amount(s) billed and payment(s) for service(s), along with remit reason codes and message descriptions.

The EOB Remit Reason Codes can be found on the website www.CMOcares.org under Provider Services Center.

ClaimsXten

Change Healthcare's ClaimsXten product is a rules-based claim auditing software program that reviews claim submissions to identify inappropriate or questionable coding scenarios. Based on CMS (Centers for Medicare and Medicaid Services) and industry-standard coding guidelines, including the Correct Coding Initiatives (CCI) edits, the program fires a set of coding and payment rules against CMO's claim files and makes coding change recommendations when inappropriate coding is identified.

When ClaimsXten denial edits fire, the denial reasons are populated on the Explanation of Benefits (EOB) with the description of the denial to assist providers in understanding what occurred in the processing of their claim(s).

The EOB Remit Reason Codes can be found on the website www.CMOcares.org under Provider Services Center.

Cotiviti

Cotiviti is a secondary rules-based claim auditing software program that reviews claim submissions to identify inappropriate or questionable coding scenarios. CMO uses different versions of Cotiviti editing:

- Prospective editing – Similar to ClaimsXten, edits are applied during the daily processing of claims and remit reason codes are added to the claim line(s) and appear on the EOB to assist providers in understanding what occurred in the processing of their claim(s).

- Retrospective editing – Historical/Paid claims data is reviewed and where appropriate, inappropriate coding scenarios are recommended for recoupment based on edit rules CMO has selected for review. Providers receive an "Overpayment Recovery Letter" notifying them of the reason for the recovery(ies) and have 30 days to either refute the recoveries or agree with the determinations and elect to either refund the monies to CMO or have the claims adjusted systemically. At the end of this timeframe, if no response is received, systemic recovery is commenced. (CMO adds an additional 3 – 5 days to this timeframe to allow for mailing delays.) Remit codes are added to the claims and EOB to assist providers in understanding what occurred in the editing of their claims.

- Clinical Chart Validation (CCV) editing – Post-payment review of inpatient hospital claims is performed to ensure that DRG assignment is clinically appropriate. Facilities receive "Request for Medical Records" letters from Cotiviti and once reviewed, will receive a response letter from Cotiviti that indicates either 1) there is no change to their coding; or 2) a DRG change is recommended based on the clinical chart review. Facilities have 45 plus days to respond to these DRG change letters. (CMO adds an additional 30 days to this time frame to allow for appeals and mailing delays.)

If no response is received to the first Medial Record request letter, a second Medical Record request letter is sent. Once the timeframe for responding has expired, a file is sent to CMO from Cotiviti with a Medical Record request denial status, which could result in a recoupment of the original claim payment. (CMO adds an additional 30 days to this time frame to allow for appeals and mailing delays.)

Effective January 2020, Montefiore Health System facilities have been removed from the CCV editing process.

Provider Billing Audits

On an ongoing basis, CMO will audit the billing history of providers submitting claims to CMO for processing. Claims profiles for each clinical specialty will be established based on this billing history. CMO Provider Relations Department will notify each provider whose billing experience falls outside the established specialty profiles in writing.

Provider Reimbursement

All IPA participating providers must accept the fee schedule and reimbursement as payment in full. The IPA Board of Directors will continue to evaluate the fee schedule and the IPA's financial position and make modifications as conditions require. A provider may not balance bill a member for in-network covered services. Furthermore, a member may not be held financially liable for a provider's failure to obtain prior approval for services. Appeals will only be considered due to medical necessity or processing errors.

- Primary Care Providers (PCPs) receive a per-member-per-month (PMPM) capitation rate for each member in their panels OR a fee-for-service (FFS) rate, based on contractual agreement.
- Specialty Care Physicians (SCPs) are reimbursed on a fee-for-service (FFS) basis, unless contracted under a Specialty Capitation agreement.

Services Included in Primary Care Capitation

The per-member capitation rate may be based on age, sex, co-payment or benefit plan of the member. Capitation is paid regardless of frequency of services performed or intensity of services provided.

The following services are included in Primary Care Capitation:

- Office Care
- Preventive Medicine
- Hospital Care

- Hospital Observation Services
- Nursing Facility Services
- Special Services (after hours, weekends, etc.)
- Therapeutic Injections
- Venipuncture/Handling
- Diagnostic Procedures (EKG's, Rhythm strips)

For a list of CPT codes included under Primary Care Capitation please visit www.CMOcares.org under the Provider Services Center.

COMPLIANCE

Fraud, Waste & Abuse

Montefiore is committed to compliance with all federal and state laws regarding the prevention and detection of fraud, waste and abuse for claims submitted to government funded healthcare programs, and to provide protection for those who report, in good faith, actual or suspected wrongdoing.

Montefiore is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to the NY state funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste: The over-utilization, careless or needless expenditure of funds resulting from deficient practices, systems, controls or decisions.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Montefiore Compliance Policy

Montefiore Health Systems and its IPA's maintain a strict policy of zero tolerance toward fraud, waste, and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

Reporting of Fraudulent, Wasteful and Abusive Activities

As part of our commitment to this zero-tolerance policy, Montefiore wants to ensure that our providers, vendors, associates, consultants, and any individuals doing business with Montefiore understand that we expect them to bring any alleged inappropriate activity which involves Montefiore to our attention. Individuals may anonymously and confidentially report a potential violation of our compliance policies or any applicable regulation by contacting our Compliance Program:

Montefiore Health System Compliance Hotline at: (800) 662-8595	**Access the hotline on the web at: www.montefiore.alertline.com**

UNIVERSITY BEHAVIORAL ASSOCIATES (UBA)

University Behavioral Associates (UBA) is the behavioral health management services organization for the CMO. UBA is responsible for behavioral care referrals and utilization management for individuals with the following health plans and Montefiore PCP: Emblem, Healthfirst and Oscar.

Plans Managed by UBA

- HIP/ EMBLEM (Commercial, Medicaid, Child Health Plus, HARP)
- Heathfirst (Commercial, Medicare, Medicaid, Child Health Plus)
- Oscar (Medicare as of 1/1/20)

BEHAVIORAL HEALTH

Referral Management for Mental Health AND Substance Abuse Services

UBA triages all incoming requests for behavioral care services. The referral process includes emergent, urgent and routine levels of behavioral care service. Members are referred to qualified behavioral care providers based upon the presenting problem. Adult and child psychiatric emergency evaluations are generally directed by UBA clinicians to Montefiore Medical Center. The Montefiore Behavioral Health Program includes inpatient and outpatient mental health and substance abuse services. For services not available at Montefiore, UBA clinical staff arranges for acute services through contracted UBA network facilities in the region. Acute treatment for chemical addictions is arranged in these network facilities as is the inpatient treatment of children.

Access to care does not require a written referral from the member's PCP. UBA can be contacted directly by the member or the member's PCP to arrange for an appropriate provider referral and authorization. The UBA telephone number is 800- 401-4822.

UBA will arrange urgent or emergent care for members. A licensed UBA staff behavioral care clinician is on-call 24 hours a day 7 days per week.

Telephonic Psychiatric Consultations

UBA offers telephonic psychiatric consultations to participating IPA providers. This service is available to assist the physician with the care of members who do not require referrals for psychiatric treatment or for whom the provider is unsure of the need for a psychiatric referral.

Providers with questions regarding pharmacologic management, diagnosis and other treatment considerations are encouraged to call Dr. John Navas at 1-347-504-2716 Monday through Friday 9 AM – 5 PM.

X. MEDICAL NECESSITY REVIEW PROCESS

When a referral or requested service does not meet the clinical screening criteria, the case is referred to a Medical Director for evaluation.

The CMO has physicians representing diverse specialties who serve as Clinical Peer Reviewers. When necessary, Clinical Peer Reviewers with appropriate specialties review cases involving potentially adverse determinations.

The Medical Director reviews the information provided by the practitioner proposing care and makes an initial determination regarding authorization.

Providers, and members or their designees receive determination notifications according to health plan medical policies, NCQA standards and IPA regulations.

In any case resulting in adverse determination (i.e., denial), instructions for initiating the reconsideration and appeal process are included with the determination notification.

Review Criteria

During the review and case management process, Medical and Behavioral Care Management clinical staff use criteria approved by the CMO Medical Management Committee and the Behavioral Care Utilization Management/Quality Improvement Committee to assist in the determination of clinical appropriateness. The guidelines used include:

- Health Plan Medical Policies
- Medicare coverage guidelines
- Medicaid coverage guidelines
- MCG Guidelines
    - Inpatient and Surgical Care
    - General Recovery Care
    - Ambulatory Care
    - Recovery Facility Care
    - Home Care
    - Behavioral Health Care

Medical necessity review takes into consideration the needs of the individual patients and characteristics of the local delivery system, and with the advice of practicing physicians who are members of the IPA or with external peer reviewers. Providers and members may request to review the entire Medical Management criteria set used in the clinical review process. Providers may schedule an appointment to conduct such a review by contacting the Medical Management Director either in writing or by telephone.

Determining Benefit Coverage and Medical Necessity

Decisions regarding benefit coverage and medical necessity are made using information such as: member benefits; State and Federal regulatory requirements; the collection and review of clinical information provided by the PCP and/or specialist; inpatient and outpatient medical chart review; physician peer-to-peer discussion; and comparison to clinical decision criteria used during the utilization review process.

In all cases where the provider's treatment plan does not meet the definition of medical necessity according to health plan guidelines and decision criteria, the case is referred to a CMO Medical Director for evaluation and final determination. The health care provider can speak directly to the CMO Medical Director at any time by calling 914-377-4756.

Appeals

A provider or designee acting on behalf of the member can appeal a denial by following the instructions included in the denial letter. In cases where a final adverse determination is made, and a particular service did not meet medical necessity criteria or is experimental/ investigational in nature, the notice of final adverse determination contains instructions that address the submission of both expedited and standard external appeals.

XI. EMERGENT AND URGENT CARE

The CMO will cover emergency and urgently needed services whether they are received in-network or out-of-network and in accordance with the prudent layperson standard for determining emergency and urgently needed services, regardless of final diagnosis; or whenever a CMO or health plan provider or CMO or health plan representative instructs the member to seek emergency services.

The CMO does not require preauthorization for emergency and urgently needed services, whether provided within the CMO and health plan's networks or out of such networks.

The definition of an emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by acute symptoms of enough severity, including severe pain that a prudent layperson would identify as needing immediate attention. Prior authorization is not necessary for coverage for emergency services.

Urgently needed services are covered services that are not emergency services as defined above that are provided when:

- the member is temporarily absent from the CMO's or health plan's service area; *or*
- when, under unusual and extraordinary circumstances, the member is within the CMO's or health plan's service area but the CMO or health plan's provider network is temporarily unavailable or inaccessible; *and*
- when the services are medically necessary and immediately required:
    - as a result of an unforeseen illness, injury or condition; *and*
    - it was not reasonable to obtain the services through the CMO or health plan network, given the circumstances.

Emergent Services

In a situation where a provider believes a service that would generally require an authorization is needed on an urgent/emergent basis, the service should be provided and CMO must be contacted by the next business day.

Referrals that require authorization must be sent to the CMO electronically (via Epic Tapestry Link) or on a paper CMO Referral Form via fax until you are set up on Tapestry.

Approval letters are sent to the referring provider and referred to provider, and for non-Medicare Advantage members, mailed to the patient. Providers with Epic Tapestry Link access can view the status of previously submitted referrals in the "Authorization History Tab" of the Epic Tapestry Link Authorization modules. Approval letters are not sent to these providers.

If a service is denied, denial letters are sent to the referring provider, referred to provider, and patient by fax or mail. These letters will include instructions for appeal rights and the filing of an appeal.

In addition, members who have medical emergencies should call 911 or go directly to the nearest hospital emergency unit for treatment. CMO does not require preauthorization for emergency services, regardless of whether services are obtained from in-network or out-of-network providers.

After the member has been seen in a hospital emergency unit and stabilized, if the member is not admitted to the hospital, all subsequent post-stabilization care should be performed at the member's primary care office or coordinated from the PCP's office.

Members should also be advised of the following:

- The proper procedure to access emergency care services (referenced in the Member Handbook provided by their plan, or provided on the member's identification card)
- The member should contact his/her PCP for medical issues. The PCP will triage care.
- Emergency services are not restricted if the member is experiencing a medical or behavioral emergency.
- The member may use a prudent layperson's definition of an emergency as noted in state/federal regulations.
- If the emergency leads to a hospital admission, the member, member's representative, or provider should inform CMO of admission within 24 hours.

Definitions:

Emergency is defined by New York State regulation as 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, who possesses an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (1) placing the person's health in serious jeopardy; (2) serious impairment of bodily functions; (3) serious dysfunction of any bodily organ or part.

Prudent Layperson is defined by New York State regulation as an individual with average knowledge of health and medicine who could reasonably expect that the absence of immediate medical attention could result in the following:

- serious jeopardy to the health of the person
- in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
- in the case of a pregnant woman, serious jeopardy to the health of the unborn child
- serious impairment of the person's bodily functions
- serious dysfunction of any bodily organ or part of the person
- serious disfigurement of the person.

Out of Area Non- Emergent Care

Members should verify whether their benefit plan covers out-of-area non-emergent or routine care. Providers may call CMO Customer Service at 914-377-4400 to verify covered services.

XII. QUALITY ASSURANCE MANAGEMENT

Quality Management focuses on the delivery of high quality healthcare and services for all IPA members. Through the implementation of policies and standards, CMO ensures:

- Clinical guidelines and service standards by which performance is measured
- Objective and systematic monitoring and evaluation of the quality and appropriateness of services and medical care
- Assessment of the medical qualifications of participating providers
- Pursuit of opportunities to improve health care and member services
- Assurance of patient safety and confidentiality of member medical information
- Adequate access to health care services provided by network providers
- Resolution of identified quality issues

Confidentiality

Uses and disclosures of confidential member information must be compliant with HIPAA and any other applicable federal or state requirements. As required by law or contract, providers must keep medical, financial or administrative records available for administrative and quality assurance purposes, or compliance with state and federal law.

Health Plan Employer Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures established by NCQA, which provides information about health plans including effectiveness of care, access to care, use of medical services, and financial status. The measures are key criteria that employers, consultants, regulators, CMS, and prospective members use to evaluate health plans. Measures may include, but are not limited to childhood immunization rates, preventative visits within established timeframes, prenatal and postpartum care, cancer screenings, and diabetes management. CMO assists in the collection of required HEDIS information as requested by the health plans.

XIII. ACCESS AND AVAILABILITY STANDARDS

IPA providers must comply with access to care standards to ensure that members obtain necessary care. All IPA physicians and specialists are required to be available either directly or through medical coverage arrangements 24 hours per day, 7 days per week. In addition, all participating PCPs and specialists must arrange to have an answering service receive calls off-hours. The answering service must have the ability to reach the physician or another physician who may be covering. If requested by a member, a physician must be reachable within 30 minutes.

CMO conducts periodic audits to ensure all IPA providers meet the following access standards:

APPOINTMENT ACCESS STANDARDS:

Type of Service	Timeframe
Emergency Care (Emergent)	Immediately upon request
Urgent Care	Within 24 hours
Routine (non-urgent) and Preventive	Within 4 weeks
Routine GYN Visit	Within 4 weeks
Adult Baseline and Routine Physicals	Within 12 weeks of enrollment
Sick Visits (Non-Urgent)	Within 48-72 hours, as clinically indicated
Specialist Referral (Non-Urgent)	Within 4-6 weeks
Initial Prenatal Exam	During first trimester, within 3 weeks of request; second trimester, within 2 weeks, during third trimester, within 1 week of request
Newborn Visit	Within 2 weeks of hospital discharge
Follow-Up Visit for Breast- Fed Infants	Within 48-72 hours of hospital discharge
Postpartum Visit	Within 21-56 days following delivery
Pediatrician Conference	Within 10 days, as clinically indicated
Well Child Visit	Within 4 weeks
Initial Family Planning	Within 2 weeks
Provider On-Call Coverage	24 hours a day
Any Other Condition	Up to medical judgment of the practitioner.

APPOINTMENT ACCESS STANDARDS:
UBA ACCESS STANDARDS FOR BEHAVIORAL CARE (MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)

Type of Service	Timeframe
Life-threatening Emergency	Immediately
Follow-Up for Emergency/ Hospital Discharge	Within 5 days, as clinically indicated but no later than 7 days post discharge
Non-life-threatening Emergency	Within 6 hours
Urgent Care	Within 24 hours
Routine Office Visit	Within 10 business days
Provider on call coverage	24 hours a day, 365 days per year

Transition of Care

CMO complies with all regulations governing the transition of care when a member's provider disaffiliates from the IPA or health plan network or when a new member if already receiving ongoing treatment from a non-participating provider for certain conditions. The following information pertains to Commercial and Medicaid members. For Medicare members, the member's health plan is responsible for notifying the member of a provider's disaffiliation and coordinating transition of care issues.

If a new enrollee whose current health care provider is not a member of the plan's provider network enrolls in the plan, the plan shall permit the new member to continue an ongoing course of treatment with the current health care provider during a transitional period:

- If the enrollee is being treated for a life-threatening disease or condition or a degenerative and disabling condition, the member may continue to receive ongoing treatment for 60 days from the effective date of enrollment.

- If the enrollee is pregnant and in her second trimester on the effective date of enrollment, she may continue to see her provider for the remainder or her prenatal care, delivery and post-partum care (as it relates to the delivery)

If a member's provider disaffiliates from the network, the plan shall permit the new member to continue an ongoing course of treatment with the current health care provider during a transitional period:

- If the member is in ongoing treatment, the member may continue to see the provider for up to 90 days from the date of notice.

- If the member is pregnant and in her second trimester, she may continue to see her provider for the remainder of her prenatal care, delivery and post-partum care (as it relates to the delivery).

In general, transitional care will be authorized by CMO if the provider agrees to accept applicable CMO reimbursement rates, adhere to CMO and health plan quality assurance requirements, policies and procedures and provides CMO with necessary medical information. Transition periods are reviewed and approved by the CMO Medical Director. Providers are notified of the determination, including the date when the transition period ends, within two days of the decision both verbally and in writing.

Continuity and Coordination of Care

Continuity and coordination of care ensures ongoing communication, monitoring, and oversight by the primary care physician across the patient's health care continuum. Notes by specialty service providers, behavioral health practitioners and ancillary providers help the primary care physician maintain a medical record that comprises a complete picture of health care delivered to each patient and prevent avoidable complications.

Activities that facilitate continuity and coordination of care include:

- Complete and thorough patient history
- Documentation of review and follow-up of diagnostic testing, and documentation of referrals.
- Inquiry during the patient interview of other health problems being addressed by other providers
- Complete medications list
- Use of a problem list that is updated as necessary to reflect the patient's current condition
- Documentation of review of acute and chronic episodes require in- or outpatient care.

XIV. CULTURAL COMPETENCE

Effective communication is a critical part of rendering appropriate clinical care. Services should include information, which allow patients to make informed choices about treatment options, and assistance with making appointments.

IPA providers are required to provide services in a culturally competent manner to all members including those who:

- Are blind or have visual impairments
- Are deaf or hard of hearing
- Are mobility impaired
- Have other physical or mental impairments or disabilities, including cognitive impairments
- Have limited proficiency with the English language
- Have diverse cultural and ethnic backgrounds
- Have socio-economic issues

If the provider needs assistance in finding a cultural competent specialist, contact Customer Services or the member's health plan. When referring a member to a specialist, consider the member's needs in these areas.

Providers and staff should assist members with special needs or disabilities upon request. Some resources available to Montefiore Medical Staff are:

- Translators: Montefiore Medical Center employed providers may call the Montefiore Language Bank at 718-920-4943 for assistance.
- For deaf or hard-of-hearing members:
    - Staff may assist deaf or hard-of-hearing members by arranging for text transmitted telecommunication equipment as needed. Providers may call the NY State Relay service at 1-800-421-1220. The TTY linkage can be established through the AT&T or Verizon Relay Lines. Members must have a TTY line in order to use these services.
    - Sign language interpreting is available. Providers should call Customer Service in advance to schedule an appointment with a staff sign language interpreter at 718-920-4943.

XV. PROFESSIONAL ADVICE TO MEMBERS

CMO and the IPAs do not restrict or prohibit any health care provider from discussing with a member their designee any information the provider deems appropriate regarding the member's health condition or plan of care, including but not limited to the following:

- A course of treatment for a condition, including the availability of other therapies, consultations or tests, regardless of coverage
- The risks, benefits and consequences of treatment or non-treatment
- The right to refuse treatment
- The right to express preferences about future treatment decisions (including advance directives such as DNR and health proxies)
- The terms of a member's health plan coverage for in-network versus out-of-network care

- In addition to the above, CMO and the IPAs do not restrict or prohibit any health care provider from advocating on the member's behalf to CMO, the member's health plan or any other entity.

XVI. MEMBER INFORMATION

PCP Selection

When a member enrolls in a Health Maintenance Organization (HMO), he or she selects a participating Primary Care Physician (PCP), generally from a provider directory received from the health plan. If a member has not selected a PCP, the member should be advised to do so right away.

PCPs include internists (generally care for adults); pediatricians (care for children) and family practitioners (care for adults and children). Members are responsible to make initial contact with the PCP's office. It is suggested the member call his/her PCP soon after enrollment in a health care plan to make an appointment for a routine/baseline examination. The PCP is responsible for coordinating all of the members' health care needs including specialty care, medical tests, laboratory procedures, hospital services (as appropriate) and other health care services. PCPs must be available or have physician coverage 24 hours a day, 7 days a week. Members are entitled to as many visits to the PCP's office as needed.

Women do not need to select an OB/GYN at time of enrollment. An OB/GYN is not considered a PCP. Female members may self-refer to any participating OB/GYN for two (2) well woman visits a year, all maternity care, follow-up care for any abnormal findings detected during a well woman visit and acute gynecological conditions.

If the member has a life threatening, disabling or degenerative disease, or a condition that requires prolonged specialized medical care, the member, PCP or specialist may request that the specialist become the member's PCP. Contact the Customer Service Department at 914-377-4400, for assistance with this process.

Member Identification Cards

Upon enrolling in an IPA health plan and selecting an IPA PCP, each member will receive an identification card from the member's health plan. This card is for identification only and **does not establish eligibility** for coverage. Members should present their card when they request any type of health care service.

The following information is usually listed on the member's identification card: member name, member identification number, PCP or site name and/or telephone number, applicable co-payment amounts, prescription plan number, and procedure to access emergency care services.

Point of Service (POS) Care

Members participating in a Point of Service (POS) plan may access out-of-network providers without obtaining a referral from their PCP. Generally, the member's financial responsibility for out-of-network services is greater than in-network services. Often the member must meet an annual deductible and has a coinsurance (rather than a co-payment) percentage for the service/procedure.

APPENDIX A

Below is a list of Montefiore CMO departments and their contact information, for your reference.

CMO Department	Contact Information
Customer Service	Tel: 914-377-4400 Fax: 914-375-2174
Member Eligibility	914-377-4400, option 1
Claims, Authorizations, Referrals and Member Benefits	914-377-4400, option 2
Mental Health	914-377-4400, option 5
Credentialing	Phone: 914-377-4690 Fax: 914-377-4791 Email: CMOCredentialing@montefiore.org
Epic Tapestry (Technical Issues)	718-920-4554
EpicCare Link (Access)	914-377-4477
Epic Healthy Planet (Access)	914-377-4477
Montefiore Help Desk	718-920-4554
Quality & Network Management	914-377-4477
Montefiore Diamond Care	1-855-556-6683

APPENDIX B

Demographic Update Form Sample:

Changes to provider demographics must be submitted to the IPA within 10 days. Failure to provide adequate notification will result in corrective action and/or exclusion from IPA participation.

DEMORAPHIC PROFILE UPDATE

Date: _____

Change(s) :

__ Practice Address Nos. _____ __ Billing Address Nos. _____ * W9 required for all Non-Monte TINs

Employment Status: _____ to _____

Participating as: _____ Effective date of change: _____

PROVIDER DATA **RECORD STATUS:** _____

Last Name: _____ First Name: _____ Middle initial: _____

Degree: _____ DOB: _____ Sex: _____

Email: _____

SPECIALTIES	DESCRIPTION	ELIGIBLE OR CERTIFIED	EMPLOYMENT
Specialty 1:			MMC: _____ MNR: _____ MMV: _____
Specialty 2:			Renew date:

PRIMARY PRACTICE ADDRESS **PRIVATE ADDRESS:** _____ **PANELED SITE:** _____

Practice Name: _____

Address: _____

Phone No: _____ Fax No. _____

Office hours: _____ Open _____ Closed panel: _____

BILLING ADDRESS

Address: _____

Phone No: _____ Fax No. _____ Tax ID: _____

SECOND PRACTICE ADDRESS **PANELED SITE:** _____

Practice Name: _____

Address: _____

Phone No: _____ Fax No. _____

Office hours: _____ Open _____ Closed panel: _____

SECOND BILLING ADDRESS

Address: _____

Phone No: _____ Fax No. _____ Tax ID: _____

THIRD PRACTICE ADDRESS **PANELED SITE:** _____

Practice Name: _____

Address: _____

Phone No: _____ Fax No. _____

Office hours: _____ Open _____ Closed panel: _____

THIRD BILLING ADDRESS

Address: _____

Phone No: _____ Fax No. _____ Tax ID: _____

APPENDIX C

MEDICAID BEHAVIORAL HEALTH

Overview

It is very important for all IPA providers to be aware of their patients' mental health and substance use disorders. PCPs should screen their patients for depression and other potential issues and take these diagnoses into consideration when developing treatment plans. We recommend using self-administered screening and diagnostic tools such as the Patient Health Questionnaire. The screens are quick and user-friendly, and improve the recognition rate of depression and anxiety and facilitate diagnosis and treatment. To access the latest version of these tools and more, please visit **http://www.phqscreeners.com**. If possible, identify and coordinate care with your patient's behavioral health providers.

Provider Manual

This Provider Manual, with Appendix and Glossary, will serve as reference and training material for the provider. The Provider Manual will be updated as the program changes/amendments are made, and distributed to providers annually. Electronic copies of the Manual are available on the Montefiore website, www.cmocares.org; additional paper copies are furnished upon request.

COVERED POPULATIONS

HARP Eligibility Requirements

To be eligible for HARP, members must:

- Be a New York City Medicaid beneficiary 21 years of age and over
- Have a serious mental illness or substance use disorder diagnosis
- Be eligible for enrollment in a MMC plan
- Not be Medicaid-Medicare enrolled ("duals")
- Not be either participating or enrolled in a program with the Office for People with Developmental
- Disabilities (OPWDD)
- Not be in a nursing home for long term care

Enrollment Process

1. Individuals identified for passive enrollment into EmblemHealth Enhanced Care Plus will be contacted by the NYSDOH Enrollment Broker (Maximus). They will be given 30 days to opt out of EmblemHealth Enhanced Care Plus or choose to enroll in another HARP.
2. Once enrolled in EmblemHealth Enhanced Care Plus, members will be given 90 days to opt out before they are locked into EmblemHealth Enhanced Care Plus until the next open enrollment period.

Member Rights

All members have the right to:

- Obtain complete current information concerning a diagnosis, treatment and prognosis in terms the member can be expected to understand. When it is not advisable to give such information to the enrollee, the information is to be made available to an appropriate person acting on the enrollee's behalf;
- Receive information as necessary to give informed consent prior to the start of any procedure or treatment;
- All members have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

BEHAVIORAL HEALTH APPOINTMENT AVAILABILITY STANDARDS

APPOINTMENT AVAILABILITY STANDARDS						
Service Type	**Emergency**	**Urgent**	**Non-Urgent MH/SUD**	**BH Specialist**	**Follow-up to emergency or hospital discharge**	**Follow-up to jail/prison discharge**
MH Outpatient Clinic/PROS Clinic		Within 24 hours	Within 1 week		Within 5 days of request	Within 5 days of request
ACT		Within 24 hours for AOT		n/a	Within 5 days of request	
PROS		Timeframe to be determined	Within 2 weeks		Within 5 days of request	Timeframe to be determined
Continuing Day Treatment				2-4 weeks		Timeframe to be determined
IPRT				2-4 weeks		
Partial Hospitalization					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
OASAS Outpatient Clinic	Upon presentation	Within 24 hours	Within 1 week of request		Within 5 days of request	Timeframe to be determined
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hours				

Opioid Treatment Program		Within 24 hours			Within 5 days of request	
Rehabilitation services for residential SUD treatment supports				2-4 weeks	Within 5 days of request	
Rehabilitation and Habilitation	n/a	n/a	Within 2 weeks of request		Within 5 days	
Crisis Intervention/Respite	Immediately	Within 24 hours for short term respite	n/a		Immediately	
Education and Employment Support Services	n/a	n/a	Within 2 weeks of request		n/a	
Peer Supports	n/a	Within 24 hours for symptom management	Within 1 week of request		Within 5 days	

Level of Care

Please click here for complete level of care guidelines governing the Medicaid Behavioral Health Requirements. The LOCATDR 3 tool can be found by clicking here.

Authorization and Referral

Emergency, including CPEP, is not subject to prior approval. Crisis Intervention and OMH/ OASAS specific non-urgent ambulatory services are not subject to prior approval. Members may self-refer for specialist services for unlimited behavioral health and substance abuse assessments except for ACT, inpatient psychiatric hospitalization, partial hospitalization, and HCBS services.

For a list of services requiring authorization, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Clinical Practice Guidelines

For a description of the behavioral health clinical practice guidelines including guidelines related to identifying and referring enrollees with behavioral health conditions and ensuring delivery to providers in settings where enrollees are most likely present.

For additional information on Appointment Availability Standards, Clinical Practice Guidelines, please click here.

Provider Responsibilities

Role of the PCP

- Deliver primary care services to members;
- If enrollee is using behavioral health clinic that also provides primary care services, the enrollee may select the lead provider to be PCP;
- Monitor member's need for care management, including any triggers for referrals to health homes;
- For additional requirements for the role of the PCP, including procedures regarding health home care management services, please refer to: http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Claims and Billing Procedures

No Balance Billing

Providers may not balance bill members for covered services rendered. This means that participating providers may not bill, charge, or seek reimbursement or deposit from the member for covered services except for applicable member expenses, and non-covered services. Participating providers are required to comply with provisions CMO code of conduct including, without limitation cooperation with claims and billing procedures.

For additional information on billing procedures, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Emergent and Urgent Care

The definition of an emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson would identify as needing immediate attention. Prior authorization is not necessary for coverage for emergency services.

- Emergent Care: An "emergency medical condition" or "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Urgently needed services are covered services that are not emergency services as defined above that are provided when:

- the member is temporarily absent from the CMO's or health plan's service area; *or*
- when, under unusual and extraordinary circumstances, the member is within the CMO's or health plan's service area but the CMO or health plan's provider network is temporarily unavailable or inaccessible *and,*
- when the services are medically necessary and immediately required:
    - as a result of an unforeseen illness, injury or condition;
    - *and* it was not reasonable to obtain the services through the CMO or health plan network, given the circumstances.

Note: Emergency services are not subject to prior approval.

Emergency Behavioral Health Calls
University Behavioral Associates (UBA) has appropriate protocols in place to handle emergency calls if received per state regulations for Medicaid members.

UBA has identified protocols for prompt referral of individuals with FEP to programs and services.

For additional information on emergency services, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Covered and Non-Covered Services
For a list of covered and non-covered services, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Access to Specialty Care
The member's PCP is responsible for identifying specialist providers within the network of the member's MCO for each instance when such services are determined to be necessary.

For Access to Specialty Care guidelines, please refer to section, or click the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Transitional Care
For New Enrollee
If an enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days. If the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of post-partum care related to delivery.

When a Provider Leaves the Network
Members and/or providers may request approval to continue an on-going course fo treatment for a transitional period of up to 90 days. The transitional period begins on the date the provider's contractual obligation to provide services to MCO terminates and ends no later than 90 days, or if health care professional is providing obstetric care and the member has entered her second trimester of pregnancy at the time of the provider's termination, the transitional period includes post-partum care directly related to the delivery. Provider must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care;
- Adhere to organization's quality assurance program and provide medical information related to the enrollee's care;
- Adhere to the MCO's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the organization.

For additional information on transitional care, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Provider Training
All Providers in the physical health network are required to participate in an initial provider orientation and training session related to the integration of the expanded benefits of the Qualified Health Plan and the Health and Recovery Plans (HARP). Providers will be trained on the expanded benefits of the HARP plan, procedures and policies, keeps them up-to-date on vital benefits and program-related information, and addresses all Provider customer service issues.

Confidentiality of behavioral health and substance use information is of utmost importance. Providers learn policies and procedures developed to assure confidentiality of MH/SU related information.

Follow-up training will be available to all providers who need additional assistance.

Training Refusal
All providers are required to complete an orientation and training session. If a provider refuses the mandatory orientation and training, the following steps will be taken:

1. The provider will be called by the Director to explain the importance of the orientation and training.
2. Provider Relations staff will ask the provider to sign a "Montefiore CMO Refusal of Training Acknowledgement Form."
3. Provider Relations staff will remind the provider they are contractually bound to all of the policies and rules outlined in the Montefiore CMO Provider Manual.
4. Provider Relations staff will bring all refusals to the attention of the Quality Committee in case any issues occur in the future with that provider.

Utilization Review and Appeals and Grievances
For authorization requirements see pages 18-19

For additional information, and for information on how to appeal a Utilization Review Decision, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Quality Assurance
For credentialing and re-credentialing requirements, please see page 13.
For medical record requirements, please see page 08.

For additional information on Quality Assurance and the Quality Management Committee, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Healthcare Provider Performance Evaluations
The plan will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery. Details on the MCO's procedures to review performance can be found by clicking the following link:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

Provider Termination

Refer to page 10-11 in this manual. For additional information, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

HARP and Home and Community Based Services (HCBS)

For a comprehensive description of the HARP program and details, including recovery principles, provider policies, HCBS assessments, HCBS appointment availability, education and training, billing guidance and more, please refer to the link below:
http://www.emblemhealth.com/provider-manual-pdfs/EH_Provider_Manual.pdf

APPENDIX D

NEW YORK STATE CHILDREN'S HEALTH AND BEHAVIORAL HEALTH (BH) SERVICES

New Behavioral Health Services from the Children's Medicaid Transformation

Since January 1, 2019, New York State has been actively transforming the Children's Medicaid Health and Behavioral Health System in accordance with Medicaid Redesign Team recommendations. New York has received CMS approval providing authority to enroll more high needs children into Medicaid Managed Care plans and provide more services for these children through the Medicaid managed care delivery system. Through collaboration among NY State agencies including the Department of Health (DOH), Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Children and Family Services (OFCS), Office for People with Developmental Disabilities (OPWDD) and stakeholders, New York has thus far implemented Health Homes Serving Children, implemented the first four of six new Medicaid State Plan Children and Family Support Services, consolidated the State's six children 1915c waivers into an aligned array of Home and Community Based Services, and aligned the behavioral health benefit for Medicaid managed care enrollees under 21 years of age.

Effective January 1, 2019 children and adolescents under age 21 covered by Medicaid with mental health or substance use needs became eligible for new Children and Family Treatment Support Services (CFTSS) as part of their Medicaid benefit. These new services were the first of a number of new services (see below) that will be phased in over the remainder of 2019 and into 2020. Some of the services are new and emphasize identifying mental health or substance use needs earlier, providing support in the home and community, and overall reduction in the need for emergency room visits, hospital stays and other out of home placements.

Phase I

Effective 1/1/19: The new CFTSS services are Other Licensed Practitioner Therapy Services; Psychosocial Rehabilitation Services; and Community Psychiatric Supports and Treatment.

- **Other Licensed Practitioner Therapy Services**, including assessments for mental health and/or substance use needs; identification of strengths and abilities through individual and group therapies; and provision of these services where individuals and families are most comfortable

- **Psychosocial Rehabilitation Services and Community Psychiatric Supports and Treatment**, including helping individuals and families incorporate therapy goals into everyday life and receive extra support managing medication; assisting patients and families to build relationships and communicate better with family, friends and others; and teaching self-care and how to use coping skills to better manage emotions

Phase II

Effective 7/1/19: The new CFTSS service is called Family Peer Support Services:

- **Family Peer Support Services**, offers six areas of services. Outreach and information about available resources; engagement, bridging and placement transition support; self-advocacy, self-efficacy and empowerment; community connections and natural supports enhancement; parent skill development; and promoting effective family-driven practice

Other changes effective 7/1/19 include:

1. **Behavioral Health** services already in Medicaid managed care for adults 21 and older is now available to individuals 18 to 20. These services include Assertive Community Treatment (ACT), Personalized Recovery-Oriented Services (PROS), Partial Hospitalization, Continuing Day Treatment (CDT), and the Comprehensive Psychiatric Emergency Program (CPEP).

2. **Substance Use** services already in Medicaid managed care for adults 21 and older is now available to individuals 18 to 20. These services include OASAS Outpatient and Opioid Treatment Program (OTP) services; OASAS Outpatient Rehabilitation services, and OASAS Residential services.

3. **OMH licensed Seriously Emotionally Disturbed (SED)** designated clinics became a part of Medicaid managed care.

4. **Children with SSI benefits** became eligible for all Children's Medicaid Transformation programs.

Phase III

Effective 10/1/19, the Home and Community Based Services, formerly provided under the auspices of the 1915 (c) Children's Consolidated Waiver Services, will be added to the Medicaid managed care benefit package. Children/youth participating in the Children's Waiver will enroll in Medicaid managed care plans unless they qualify for another exemption or exclusion from enrollment (e.g., have comprehensive third-party health insurance).

These services will include the following:

- **Community Habilitation** is assistance with learning social and daily living skills and health related tasks.

- **Day Habilitation** is assistance in learning social and daily living skills in an agency setting.

- **Caregiver/Family Support and Services** where caregivers and families can get training, education and support to make informed and empowered choices for children with developmental, medical, mental health, and/or substance use needs.

- **Community Self Advocacy Training and Support** where children, youth and their families can get help and support in understanding developmental, medical, mental health, and/or substance use needs and how to advocate so that these services are obtained and utilized.

- **Pre-vocational Services** so youth aged 14 and older can learn skills to help get ready for paid work, or volunteer work that matches their interests.

- **Supported Employment** for youth aged 14 and older who are ready for a job can now get help to stay in a steady job that pays wages

- **Respite Services** offers two basic types. Planned respite services provide short term relief for families/caregivers and support the child's mental health, substance use and/or health care goals. Crisis respite is short term relief from a mental health, substance use and/or health care crisis event that without this support the child would need a higher level of care.

- **Palliative Care** is for children and youth with chronic or life-threatening illnesses. These services include: massage, art, music and play therapy; pain and symptom management to relieve and/or control suffering; and bereavement counseling

- **Environmental Modifications** involve changes to a child or youth's home to help with their health needs.

- **Vehicle Modifications** involve changes to a child or youth's vehicle to help with their health needs.

- **Adaptive and Assistive Equipment** include technological aids or other devices needed to support children/youth health, welfare, and safety.

- **Non-Medical Transportation** to services or activities that support goals (available as a fee-for-service benefit through the State).

Please note additional services coming next year:

Effective 1/1/20 **Youth Peer Support and Training** and **Crisis Intervention** will become available as State Plan, Children and Family Treatment and Support Services to fee-for-service and Medicaid managed care enrollees.

Effective 2/1/20 children placed with **Voluntary Foster Care Agencies** will enroll in Medicaid managed care, and the services provided by licensed Voluntary Foster Care Agencies will be added to the Medicaid Managed Care benefit package.

If you have patients who are under 21 and covered by Medicaid who would benefit from the services listed above, you or the patient/guardian can contact the Medicaid Managed Care Plan (**or CMO if patient is CMO managed)** with which the patient is affiliated – contact information can be found on the patient's Managed Medicaid health plan card.

Links to the three major health plans that Montefiore patients utilize are listed below:

Healthfirst

www.Healthfirst.org/bh
www.hfprovidermanual.org

Emblem Health

www.emblemhealth.com/Providers/Provider-Resources/Learn-Online
www.Emblemhealth.com/Providers/Provider-Manual

Empire

https://mediproviders.empireblue.com/Documents/NYNY_CAID_ProviderManual.pdf

APPENDIX E

IPA's Expectations of Provider - Legal Notice

Under all programs administered by IPA, both IPA and Provider shall have the goal of (and will take steps to attain)[1] the so-called "**triple aim**:"

1) Enhanced delivery of quality care;
2) Improve the health of patients/covered members; and
3) Lowering the costs of rendering care.

The IPA does not intend for providers and IPA to merely meet minimum standards; instead the IPA aspires for providers and IPA to achieve best practices whenever feasible.

In addition to the obligation to comply with requirements specifically set forth in the participation agreement, providers have signed with the IPA and other portions of this manual, provider's actions while participating with the IPA are expected to include, but are not limited to:

A. Participate in and facilitate care coordination for patients to a reasonable extent (excluding instances where the patient has affirmatively refused to cooperate).

B. Take advantage of available tools for care coordination, such as provider's own electronic medical records, linkages via electronic medical records to other providers caring for the same patient, utilizing electronic databases such as RHIOs which offer data or updates regarding provider's patients, etc.

C. Address and improve the quality of care rendered to patients and the resulting health outcomes.

D. Address and improve the data collected regarding quality of care rendered by Provider practice and rendered to provider's patients (including accurate coding of services for capture in quality metrics), etc.

E. Cooperate with IPA (and IPA's agent- CMO The Care Management Company, LLC) in the care coordination process and the quality improvement process.

F. Not deliver care significantly outside of provider's licensure, board certification or specialty category as on file with IPA. However, such services are permitted so long as provider can document to the IPA that provider's services outside of provider's board certification or specialty category are in fact within provider's competence as a result of training or other expertise and are comparable to the services of a more typical provider of that particular service.

[1] FYI This is a quote from Section 9.1 of the template participating provider agreement, which contains this requirement.

G. Not serve (or cease serving) as a designated primary care physician for a patient in cases where designation of provider is likely (in contrast to other providers participating with the IPA) to compromise efforts to attain the triple aim, such as unusually long travel time for a patient to visit provider's office, or cases where provider is not capable of or willing to provide unusual care or unusual attention required by particular patients, etc.

H. When a referral is necessary, facilitate continuity of care by referring cases to other providers who contract with the IPA, when such in-network providers have the appropriate expertise and/or geographic availability to serve the patient and facilitate ongoing coordination with the provider and the IPA, as contracted with out of-network providers which do not contract with the IPA.

I. Abide by CMS or health plan requirements in specified coverage programs where patients have the right to obtain covered services from providers not participating with the IPA (such as the CMS NextGen ACO program for Medicare Part A/B beneficiaries, who are not subject to typical managed care plan constraints, such as prior approval to utilize out of network providers).

J. Be reasonably conscious of the cost of health care services so that the services delivered (or billed) by provider, or delivered pursuant to referral by provider, are consistent with the goal of lowering the costs of rendering care, so long as such efforts do not compromise the quality of care and do not deprive the patient of medically necessary services.

In any instance where the IPA becomes concerned that a provider's actions (or inaction) might be significantly compromising the attainment of the triple aim for patients served by the IPA as described above, the IPA may investigate the provider's actions, sanction the provider (including but not limited to provider referrals, precluding designations of provider as a PCP by additional patients, directing patients to select a different PCP, recovering payments made under questionable or obviously incorrect circumstances, etc.), or end a provider's participating agreement with IPA.