Provider Manual

Updated as of April 30, 2021

Version History

Date	Version	Author	Summary of Changes
9/1/2020	1.0	Anna Zhu, Yiqin Jiang	Initial version (10/1/20 Emblem and HealthPlus effective date)
11/30/2020	1.1	Yiqin Jiang	Clarifications on Behavioral Health and Children's Services policies, updates to specialist referral policies
4/30/2021	1.2	Yiqin Jiang	Update to immunization reimbursement policy

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Welcome to SOMOS

Welcome to SOMOS! Thank you for being a part of SOMOS's network of providers. SOMOS's number one priority is to help SOMOS patients lead fuller, healthier lives. SOMOS IPA, LLC arranges for the delivery and provision of health care services to its patients through its network of participating providers. SOMOS IPA partners with its affiliate, SOMOS Your Health, LLC to provide the administrative and management services necessary for the day to day operations of its patients' applicable benefit plans. Collectively, the two entities are known as "SOMOS." SOMOS works to accomplish its goal by collaborating with its participating providers to oversee and deliver health services to SOMOS patients.

SOMOS patients are members attributed to SOMOS PCPs and enrolled with SOMOS's initial Managed Care Organization (MCO) partners, Empire BlueCross BlueShield HealthPlus ("HealthPlus") and EmblemHealth ("Emblem") for the following lines of business: Medicaid (excluding dual-eligible Medicare members), Child Health Plus (CHP), HARP, and Essential Plans (EP). For these plans and lines of business, SOMOS performs the administrative functions described in this manual in partnership with Evolent Health, which is sub-delegated for claims processing, utilization management, care management, transitional care management and population health as well as certain specialist/hospital/ancillary provider credentialing, among other functions.

This Provider Manual is an extension of the Downstream IPA Participation Agreement. The Provider Manual includes necessary information for doing business with SOMOS. SOMOS will periodically update the Provider Manual as operational policies change and will make best efforts to ensure the current version is reasonably available to all participating providers.

Key Contact Information & References

SOMOS Provider Service Center & Help Desk • Claims Processing • Complaints & Grievances • Utilization Management • Care Management • Network Participation • Performance Reporting • Provider Data Management • Credentialing	ProviderRelations@somosipa.com Toll-Free Number: (844) 990-0255 (TTY 711) Hours of Operation: M-F, 8am-5pm EST *Holidays: New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day*
SOMOS Compliance and Ethics Hotline	(855) 233-3135
HealthPlus Fraud, Waste, Abuse	(877) 725-2702 ethicsandcompliance@HealthPlus.com
HealthPlus Member Services *(including member crisis calls)*	(800) 300-8181 (TTY 711)
HealthPlus Provider Manuals	New York Medicaid Provider Manual: https://mediproviders.empireblue.com/Documents/NYNY_CAID_ProviderManual.pdf Essential Plan Provider Manual: https://mediproviders.empireblue.com/Documents/NYNY_EP_ProviderManual.pdf
Emblem Fraud, Waste, Abuse	(888) 456-3728 kofraud@emblemhealth.com
Emblem Member Services	Medicaid/CHP/HARP: (855) 283-2146 (TTY/TDD 711) Essential: (888) 447-7703 (TTY 711)
Emblem Provider Manual	https://emblemhealth.com/providers/manual

Provider Portal

SOMOS's Provider Portal [https://smnyportal.valence.care] allows providers instant access to many helpful tools and resources. Once registered, providers and their office staff can access the following features and more:

- Access to SOMOS's Provider Directory
- Check claims status and history
- Check patient eligibility and view panel roster (for primary care practices only)
- Check a list of outpatient procedures that require prior authorization
- Link to Identifi Practice to submit prior authorization requests electronically
- Link to the latest version of the Provider Manual

To gain user access to the Provider Portal, please contact your practice administrator or email support@evolenthealth.com. Providers can also contact the Provider Service Center or their designated SOMOS Provider Relations contact with any questions pertaining to the Provider Portal. Each Tax Identification Number (TIN) in the SOMOS network will identify an administrator who will be able to assist with generating one-click user registration emails.

Identifi Practice

Identifi Practice, accessed via a Single Sign On link in the Provider Portal, is the online platform for SOMOS providers to submit and view the status of prior authorization requests. Identifi Practice supports the ability to submit DME, Inpatient, and Outpatient/Home authorization requests, specify priority (Urgent, Routine, Retro), add supporting documentation/care notes, view status of requests, edit requests, add reviews to existing requests, and sort and search requests based on specific criteria.

SOMOS at a Glance

Check Eligibility

Visit SOMOS's Provider Portal at https://smnyportal.valence.care to verify eligibility or call the patient's respective MCO.

Prior Authorization

Prior authorization can be obtained by calling (844) 990-0255, faxing (866) 865-9969 (for HealthPlus) or (877) 590-8003 (for Emblem), or electronically from Identifi Practice (accessed via a Single Sign On link in the Provider Portal).

Claims Submission

Submit claims electronically using the SOMOS Payer ID **81508** (for HealthPlus) or **81336** (for Emblem) through Change Healthcare or another approved EDI vendor. Claims should be submitted within the timeframes outlined in this Provider Manual unless otherwise outlined in Downstream IPA Participation Agreement.

The following information should be included on all claims in order to ensure proper processing:

- Provider name
- NPI1 (individual / rendering provider NPI)
- TIN (Tax ID Number)

- NPI2 (group / business / billing NPI)
- Service Location (address and ZIP code)

Verifying Eligibility

Providers should verify eligibility on every date of service, prior to rendering services to the patient. SOMOS will not pay claims for patients not eligible on date of service or not covered by SOMOS.

Eligibility can be verified through the same process that you are using today. Alternatively, you can verify with the Provider Portal [https://smnyportal.valence.care], Identifi Practice (accessed via a Single Sign On link in the Provider Portal), or by calling the patient's respective MCO. You can look up patients by any one of the following:

If using the Provider Portal:

- SOMOS ID number *(For HealthPlus members, only enter the 9-digit numbers from the Member ID)*
- Patient last name and date of birth

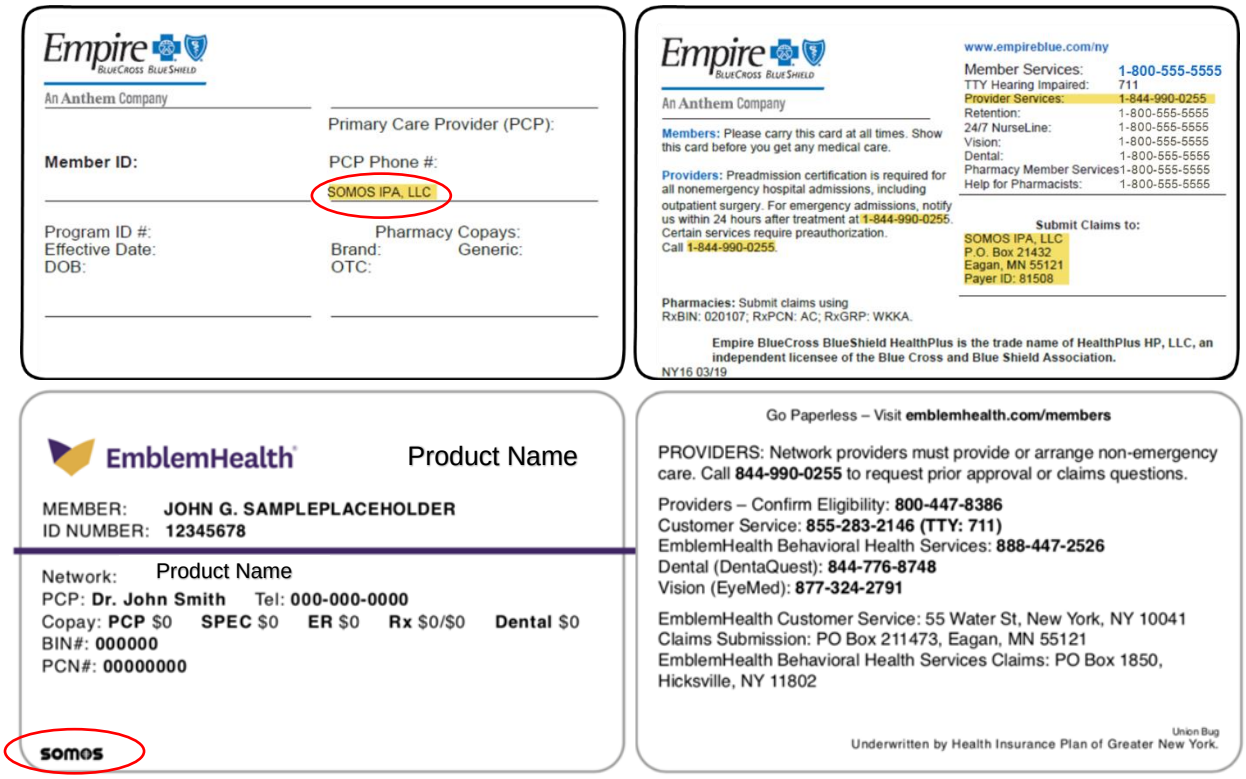
If using Identifi Practice:

- SOMOS ID number *(For HealthPlus members, only enter the 9-digit numbers from the Member ID)*
- Patient first name, last name, and date of birth

Note: Due to processing time with eligibility data feeds, the Provider Portal and Identifi Practice may not be accurate in real-time. Please call the patient's respective MCO for real-time results.

Patients should present their ID card at the time of service. Providers are responsible for ascertaining the current eligibility of the cardholder. Possession of the identification card does not guarantee eligibility or coverage.

SOMOS patients will receive new ID cards issued by the patient's respective MCO with SOMOS-specific information. See below for sample SOMOS ID cards for our partner MCOs.



Sample Emblem SOMOS member ID card. Product Name may be: Enhanced Care, Enhanced Care Plus, CHP, Essential Plan 1, Essential Plan 2, Essential Plan 3, Essential Plan 4

Carved-Out Services (e.g. Pharmacy, Dental, Vision)

SOMOS has contractual arrangements with MCOs whereby a subset of services is “carved-out” and administered by the MCO’s delegate. In these instances, all functions that the MCO has delegated to its vendor must be handled through the applicable vendor. All carved-out services must be provided in accordance with the vendor’s protocols. SOMOS providers must be in-network with the vendor in order to be reimbursed for carved-out services provided to SOMOS patients. SOMOS shall make providers aware of such carve-outs across MCO partners.

HealthPlus Carved-Out Services

For HealthPlus patients, pharmacy, vision, and dental services (for all products), and chiropractic and acupuncture (for EP 1 & 2 only), will continue to be administered through HealthPlus and/or HealthPlus’s applicable vendors. For more information, see Key Contact Information & References for links to HealthPlus’s provider manuals.

Emblem Carved-Out Services

For Emblem patients, pharmacy, dental, vision, behavioral health, radiology, post-acute, chiropractic, and physical therapy/occupational therapy (PT/OT) services will continue to be administered through Emblem’s applicable vendors largely following the same processes that are in place with Emblem today. For example, if you obtain authorizations from any of Emblem's vendors today, you will continue to obtain authorizations through these vendors. For more information, see Key Contact Information & References for the link to Emblem’s provider manual.

Below is a table summarizing any operational changes for SOMOS patients related to claims submission for carved-out services. All other administrative functions remain business as usual.

Important change: **Any claims traditionally submitted to Emblem must now be submitted to SOMOS for processing**.

SOMOS Claims Changes for Emblem Carved-Out Services

Vendor Name	Scope of Services	Changes from Emblem Policy
Beacon	Behavioral Health	None (business as usual)
EviCore	Radiology	*For hospital and specialist radiology services only:* Submit claims to SOMOS Payor ID: 81336 All other radiology services will continue to be handled by EviCore (business as usual)
	Post-Acute Management (DME, SNF, Inpatient Rehab, Homecare and LTAC)	Submit claims to SOMOS Payor ID: 81336
Palladian Health	Chiropractic Services *CHP/EP only*	None (business as usual)
	Physical and Occupational Therapy	*For facility-based PT/OT only:* Submit claims to SOMOS Payor ID: 81336 All other PT/OT services will continue to be handled by Palladian Health (business as usual)

Our Providers

Participating providers are independent contractors of SOMOS and therefore operate independently and are not employees of SOMOS. SOMOS does not direct, control, or endorse health care or treatment rendered or to be rendered by providers. SOMOS encourages providers to communicate with patients to discuss available treatment options, regardless of coverage determinations made or to be made by SOMOS or the patient's respective MCO.

Provider Enrollment

Network participation requires enrollment in the New York State Department of Health (NYSDOH) Medicaid Program, completion of all required credentialing processes, and cooperation with all requirements specified in the Provider Manual as well as all applicable laws and regulations. Providers are required to notify SOMOS of any new providers joining or leaving their organization at least 30 days in advance to ensure that appropriate onboarding and offboarding materials are shared. In the event SOMOS does not receive such provider demographic information within the above timeframe, claims payment and provider participation may be impacted.

Providers that are sanctioned by the NYSDOH Medicaid Program may be excluded from participation in SOMOS's network. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as participating providers.

Provider Demographic Information

Providers are responsible for contacting SOMOS to report any changes in their practice and demographic information. It is essential that SOMOS maintain an accurate provider database in order to ensure proper payment of claims and capitation, comply with regulatory reporting requirements, and to provide the most up-to-date information on provider choices to patients. Any updates to your provider record should be submitted to ProviderRelations@somosipa.com or to your local SOMOS network representative using the applicable SOMOS provider data template at least 30 days before the effective date. Providers must also comply with provider data reconciliations at the request of SOMOS.

Credentialing Criteria

The SOMOS credentialing process is designed to ensure all participating providers can render patient care in accordance to their licensure, certification and accreditation. In order to monitor this, SOMOS conducts a rigorous credentialing process for participating providers based on the Centers for Medicare and Medicaid Services (CMS), NYSDOH, National Committee for Quality Assurance (NCQA), and other guidelines under the direction of the SOMOS Medical Director and Credentialing Committee. All providers must be in good standing with state and federal regulatory licensing bodies and SOMOS will use primary source verification to validate items including but not limited to licensure, malpractice insurance, Drug Enforcement Agency (DEA), Office of the Inspector General (OIG), and other sanctions, prior to approval by SOMOS, their affiliates, or delegates to participate in the network. Providers must also comply with recredentialing standards by submitting all requested information within the specified timeframe. Individual and group practice providers are individually credentialed, while facilities are credentialed as organizations. For non-primary care, non-Corinthian/Excelsior practices, and specialists/hospitals/ancillary providers not par with MCO, call (844) 990-0255 to request credentialing information and application(s). Primary care and Corinthian/Excelsior practices can

contact their local SOMOS representatives to request credentialing information. Providers already credentialed by the MCOs will be re-credentialed by the MCOs.

Credentialing Processes

Providers must submit a complete credentialing application with all required attachments in order to be processed by SOMOS. Within 90 days of receiving a completed credentialing application to participate in the SOMOS network, SOMOS will notify the provider as to: (i) whether credentialing is approved; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. If additional time is necessary due to a lack of documentation, SOMOS will make every effort to obtain such information as soon as possible. SOMOS will not discriminate against any applicant for participation on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein. Once the provider has been approved for credentialing and contracted with SOMOS, the provider will be notified of the date on which the provider may begin to serve SOMOS patients.

Providers must submit an updated recredentialing application every three years and continue to meet established credentialing criteria and quality-of-care standards for continued participation in the SOMOS network. Information from Quality Management, Utilization Management, Appeals & Grievances, as well as reports from regulatory agencies are considered at the time of recredentialing. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

Site Visits

SOMOS may conduct a structured site visit of provider's offices/locations. Site visits include, but are not limited to, an evaluation using the SOMOS site and operation's standards and an evaluation of clinical recordkeeping practices against SOMOS's standards. SOMOS shall provide advanced notice to providers of such site visits. In addition, providers must agree to permit all applicable regulatory agencies to conduct on-site evaluations in accordance with current state and federal laws and regulations.

Medical Records

Providers must keep accurate and complete medical records to enable providers to render the highest-quality healthcare service to patients. To ensure the patient's privacy, medical records should be kept in a secure location.

Medical record is defined as the complete, comprehensive patient records including, but not limited to, x-rays, laboratory tests, results, examinations, and notes, accessible at the site of the patient's participating primary care physician or other provider, that documents all medical services received by the patient, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete and separate medical records for each patient in accordance with the following standards:

- Patient's name, and/or medical record number are on all chart pages

- Personal biographical data is present (i.e., DOB, address, employer, telephone numbers, spouse, next of kin, legal guardianship, primary language, etc.)
- Notation of communication assistance or language translation is prominent
- All entries are legible, maintained in detail, and are dated and signed or dictated by the provider rendering the care
- All providers should be using an Electronic Health Record (EHR) of their choice; SOMOS has a preference for eClinicalWorks and MDLand, because they are used by SOMOS primary care providers, thus allowing for certain efficiencies
- A problem list is maintained and updated for significant illnesses and/or medical conditions and all past and current diagnoses
- Appropriate subjective and objective information pertinent to the patient's presenting complaints is documented in the history and physical and treatment plan is consistent with findings
- Past medical history is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger), medical history relating to prenatal care, birth, surgeries and or childhood illnesses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric patients or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with practice guidelines
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the patient
- Laboratory and other studies ordered as appropriate, with results noted in the medical record; abnormal lab and imaging study results have explicit notations in the record for follow up plans
- Referrals to specialists and ancillary providers are documented with evidence of continuity and coordination of care, including follow up of outcomes and summaries of treatment rendered elsewhere
- For patients 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for patients seen three or more times substance abuse history should be queried)
- Evidence that an advance directive has been offered to adults 18 years of age and older
- Medical records of patients shall be retained for six years after the date of service rendered to patients, and in the case of a minor, for three years after majority or six years after the date of the service, whichever is later
- Access to Medical Records and/or copies of medical records must be made available, without charge, to other participating providers, consultants, or physicians involved with the patient's care and treatment, as well as to regulatory agencies
- The handling of medical records must comply with all Federal and State laws and regulations regarding confidentiality of patient records.

SOMOS may conduct random medical record audits to monitor compliance with the medical record documentation standards noted above. The coordination and quality of care and services provided to patients, including over/under utilization of specialists, as well as the outcome of such services may also be assessed during a medical record audit. SOMOS will provide verbal

or written notice prior to conducting a medical record review. Provider must provide records upon request at no charge.

Telehealth

During certain times, it may be clinically appropriate to use telemedicine (two-way audio and visual) as well as telephonic calls when permitted under a national emergency like the COVID 19 pandemic. Providers may access telemedicine through the “Ignite” platform, which can be accessed by a link provided by SOMOS Provider Relations by emailing ProviderRelations@somosipa.com. The platform is purely for communicating with patients through video/audio and voice-only. Please note that an encounter note must be placed in the medical record for every telehealth visit, including voice-only visits. Telehealth visits can be submitted as claims to SOMOS using the appropriate telehealth CPT Codes and modifiers.

Compliance with Federal Deficit Reduction Act of 2005

SOMOS requires compliance with Section 6032 of the Deficit Reduction Act of 2005, which requires any network provider receiving annual Medicaid payments of at least $5 million (cumulative, from all sources) or $500,000 for an individual provider to:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding the network provider’s policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider’s policies and procedures for detecting and preventing fraud, waste, and abuse.

Confidentiality Policy

SOMOS and its providers are required by federal and state laws to protect a patient’s Protected Health Information (PHI) and report any breach in confidentiality immediately. Providers must have policies and procedures available to protect the confidentiality of patient information and records. These policies must apply to all individuals that access patient information. At a minimum, the policies and procedures specifically address:

- the health plan and any delegates’ appropriate use and disclosure of patient PHI in order to protect patient privacy
- access to confidential information on a "need to know basis" with disclosure of the minimum information needed
- the maintenance and retention of medical records (both original information and documentation used for medical management, care management and quality assessment)
- rights for patients to access their PHI, including requesting restrictions on, amendments to, and accountings of disclosures of their medical information
- protecting the identity of the patient, practitioner, or provider by encrypting all aggregated and individual data reported as a component of the QM process
- protecting the content of all meeting minutes and internal communications (including electronic documents) by clearly identifying these documents as confidential and by

maintaining such documents securely and by shredding such documents if disposal is indicated

To ensure confidentiality of HIV related information, providers should also have policies and procedures to address:

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

Primary Care Providers (PCP)

Every SOMOS patient will select or be assigned a PCP. The PCP is responsible for delivering primary care services, which include: providing health counseling and advice; conducting baseline and periodic health examinations; diagnosing and treating conditions not requiring the services of a specialist; and supervising and arranging inpatient care, consultations with specialists, and with other healthcare providers when medically necessary. In addition, PCPs will be responsible for coordinating the findings of such encounters and interpreting applicable findings to the patient and the patient's family, subject to the confidentiality laws, and maintaining a current medical record for the patient. The PCP must offer Child/Teen Health Plan (C/THP) screening for children and adolescents under 21 and behavioral health screening for all members, as appropriate. The PCP is also responsible for determining the urgency of a consultation with a specialist and shall arrange for all consultation appointments to specialists that participate in the SOMOS network within appropriate time frames.

The PCP must provide timely and adequate access to routine and emergent appointments and are encouraged to offer after-hours in the evenings and/or weekend appointments.

SOMOS PCPs must offer 24/7 coverage to care through arrangements that may include:

- A telephone line access to a live voice 24-hour, 7 days a week; or,
- An answering machine that will immediately page an on-call medical professional. The medical professional should promptly return a call and provide information and instructions for treating emergency or non-emergency condition, make appropriate referrals, and/or provide information regarding accessing other services and handling other medical problems during hours the PCP's office is closed.

Specialty Providers

Specialists are to coordinate patient care with the applicable PCP and report the results of their services to the patient's PCP just as they would for any of their patients. The specialist shall make available all results and notes resulting from their services to the PCP. The PCP is to maintain specialist reports in the patient's central medical record and take steps to ensure that any required follow-up care is scheduled and provided.

Referral Requirements for Specialty Care

For all members, referral forms and approvals are not required for patients to access specialty services within the SOMOS or Emblem provider network. Although the formal referral process is

no longer necessary, members are still required to have their designated PCP introduce specialist care. Providers should continue to document specialist visits in charts and/or EMR records. SOMOS encourages providers to use SOMOS network providers whenever possible. Patients seeking care to out-of-network providers will continue to require prior authorizations and follow the out-of-network process (see the Out-of-Network Providers section of the Provider Manual for more details).

Out-Of-Network Providers

In the event a patient requires healthcare services from a provider that is outside of the SOMOS and the MCO network (true out-of-network providers), for reasons of medical necessity or because a particular service or specialty is not available within the network, providers should submit for a prior authorization review. A determination will be made on whether out-of-network care can be supplied by an in-network provider and whether the requested service(s) are medically necessary.

Continuity of Care/Transitional Care Guidelines

A new patient, whose current provider does not participate in the SOMOS network, may request approval to continue an ongoing course of treatment with that provider for a transitional period of up to 60 days from the effective date of enrollment. If the new patient is within her second or third trimester of pregnancy on the date her enrollment is effective, the transitional period shall include the provision of prenatal care until delivery and the provision of postpartum care directly related to the delivery up until 60 days post-partum.

If a patient's health care provider voluntarily leaves the SOMOS provider network, SOMOS will permit the patient to continue an ongoing course of treatment with the current health care provider during a 90 day transitional period, as long as the provider was terminated for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice.

The transitional period begins on the date the provider's contractual obligation to provide services to SOMOS terminates and ends no later than 90 days, or if health care professional is providing obstetric care and the patient 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. After the transitional period, the patient must choose a participating provider.

For care to be authorized by SOMOS during the transitional period, provider must agree to:

(a) continue to accept reimbursement at rates applicable prior to transitional care
(b) adhere to SOMOS's quality assurance program and provide medical information related to the patient's care
(c) adhere to SOMOS's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by SOMOS

Termination of Downstream IPA Participation Agreements

SOMOS or its participating providers may decide to terminate or elect not to renew a Downstream IPA Participation Agreement. Termination procedures are subject to the provisions of the Downstream IPA Participation Agreement. If there are conflicts between the provisions in this Provider Manual and the Downstream IPA Participation Agreement, the terms of the

Downstream IPA Participation Agreement will apply. SOMOS has the right to notify affected patients in writing of a provider's termination in accordance with all applicable laws and regulations.

Providers who wish to withdraw from the SOMOS network must give written notice of voluntary termination following the terms of their Downstream IPA Participation Agreement with SOMOS and comply with the applicable transitional care requirements for patients following the effective withdrawal date. In addition, providers must supply copies of medical records to the patients' new physician upon request and facilitate the patients' transfer of care at no charge to SOMOS or the patient.

Hearing Processes and Procedures

In the event SOMOS terminates a Downstream IPA Participation Agreement for reasons other than non-renewal or the expiration of the agreement, SOMOS shall provide a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below:

The notice of the proposed contract termination provided SOMOS to the health care professional will include:

(i) the reasons for the proposed action
(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by SOMOS
(iii) a time limit of not less than 30 days within which a health care professional may request a hearing
(iv) a time limit for a hearing date which must be held within 30 days after the date of receipt of a request for a hearing
(v) a summary of the hearing rights

If the health care professional does not request a hearing within 30 calendar days of the date of the notice, the proposed action will be final, not subject to arbitration or review by a court of law, and the provider will have no additional appeal rights.

The hearing panel will be comprised of three or more persons appointed by SOMOS. At least one-third of the total membership on the panel will be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review.

The hearing panel will render a decision on the proposed action in a timely manner. Such decision will include reinstatement of the health care professional by SOMOS, provisional reinstatement subject to conditions set forth by SOMOS, or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

A decision by the hearing panel to terminate a health care professional shall be effective not less than 30 days after the receipt by the health care professional of the hearing panel's decision.

Immediate Terminations

SOMOS reserves the right to suspend or terminate a provider's existing contractual relationship immediately, with written notice to follow, without providing the opportunity for a hearing or a review under the following circumstances:

- Final disciplinary action is taken by a governmental regulatory agency that impairs the provider's ability to practice

- There is a determination of fraud
- There is an imminent harm to patient care
- Sanction and/or exclusion from participation in the Medicaid or Medicare programs, which may require a retroactive termination date.

Behavioral Health & Children's Services

The SOMOS Behavioral Health program manages the needs of patients seeking treatment for mental illness and substance use disorders. SOMOS complies with state Medicaid guidance including incorporating managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. The following are incorporated into SOMOS's guidance for behavioral health services:

- Office of Mental Health's (OMH) Clinic Standards of Care: www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- Office of Addiction Services and Supports' (OASAS) Clinical Guidance: https://oasas.ny.gov/search/clinical_guidance_and_recommendations
- Office of Health Insurance Programs' (OHIP) Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013: www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
- Office of Children and Family Services' (OCFS) Working Together: Health Services for Children/Youth in Foster Care Manual: https://ocfs.ny.gov/main/sppd/health-services/manual.php
- Office of Health Insurance Programs' (OHIP) Principles for Medically Fragile Children (Attachment G): https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_childs_mc_plan_req.pdf

These guidelines are made readily available to all SOMOS providers, in particular to SOMOS PCPs where patients requiring behavioral health services are likely to present. PCPs should screen for behavioral health conditions and patients should be linked to behavioral health providers in their respective MCO's network. Treatment for patients requiring behavioral health services should involve coordination of care with the patient's PCP, other treating providers, and referrals for community support services when necessary. The PCP should actively engage in identifying the need for behavioral health services for their patients and should remain involved in treatment planning for all patients with behavioral health issues.

For information on emergency pharmacy protocols for patients with a behavioral health condition and benefits covered by the patient's MCO, these functions remain with the patient's respective MCO. Please see the below for links to the MCO's provider manuals, which include the lists of covered Adult and Children's Behavioral Health services.

HealthPlus Provider Manuals	New York Medicaid Provider Manual: https://mediproviders.empireblue.com/Documents/NYNY_CAID_ProviderManual.pdf Essential Plan Provider Manual: https://mediproviders.empireblue.com/Documents/NYNY_EP_ProviderManual.pdf
Emblem Provider Manual	https://emblemhealth.com/providers/manual

Behavioral Health Credentialing

State-designation of providers will suffice for SOMOS's credentialing process. When credentialing OMH-licensed, OMH-operated, and OASAS-certified providers, SOMOS will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. For designated home and community-based services (HCBS) providers, SOMOS will accept state-issued HCBS designation in place of the SOMOS credentialing process for HCBS providers and any individual employees, subcontractors or agents. When contracting with state-designated providers, SOMOS will not separately credential individual staff members in their capacity as employees of these programs.

SOMOS shall collect and will accept program integrity related information as part of the credentialing process. SOMOS conducts program integrity reviews to ensure that provider staff are not disbarred from Medicaid or in any other way excluded from participation in the Medicare or Medicaid program. SOMOS requires all licensed and state-designated providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

SOMOS will provide findings to the patient's respective MCO findings of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers. The MCO will then submit to OMH and OASAS a quarterly report encompassing SOMOS's findings. For any serious or significant health and safety concerns, SOMOS will report to the patient's respective MCO immediately upon discovery for the MCO to report to OMH and OASAS.

Behavioral Health Access and Availability

SOMOS expects behavioral health providers to be able to see patients even if there is no scheduled appointment to assess whether the patient needs urgent care and/or triage.

Providers are required to adhere to the following access standards for members 21 years of age and older:

Appointment Type	Access Standard
Emergency Care	Immediately upon presentation
Urgent medical or behavioral	Within 24 hours of request
Non-urgent "sick" visit	Within 48 to 72 hours of request, as clinically indicated
Routine non-urgent, or preventive	Within 2 weeks of request
Specialist referrals (non-urgent)	Within 2 to 4 weeks of request (unless otherwise provided for in this section)
Adult Baseline and routine physicals	Within 12 weeks from enrollment. (Adults >21 years)
Well child care	Within 2 weeks of request
Initial family planning visits	Within 2 weeks of request
Initial PCP office visit for newborns	Within 1 week of hospital discharge

Appointment Type	Access Standard
Pursuant to an emergency hospital discharge or release from incarceration (where SOMOS is informed of such release), mental health or Substance Use Disorder follow-up visits (as included in the Benefit Package)	Within 5 days of request, or as clinically indicated
Non-urgent mental health or Substance Use Disorder visits with a participating provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic	Within 1 week of request
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a Local Department of Social Services (LDSS)	Within 10 days of request
For CPEP, inpatient mental health, inpatient detoxification Substance Use Disorder (SUD) services and crisis intervention services	Immediately upon presentation at a service delivery site
Urgently needed SUD inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential setting and mental health or SUD outpatient clinics, assertive community treatment (ACT) personalized recovery-oriented services (PROS) and opioid treatment programs	Within 24 hours of request
Behavioral health specialist referrals (nonurgent): - CDT, IPRT, and rehabilitation services for residential SUD treatment services - PROS programs other than clinic services	 Within 2 to 4 weeks of request Within 2 weeks of request
Short-term and intensive crisis respite	Within 24 hours of request
Psychosocial rehabilitation, community psychiatric support and treatment, habilitation services, family support and training	Within 2 weeks of request (unless appointment is following an emergency or hospital discharge or release from incarceration, in which case the standard is five days of request)
Education and employment support services	Within 2 weeks of request
Peer support services	Within 1 week of request (unless appointment is following an emergency or hospital discharge, in which case the standard is five days; or, if peer support services are needed urgently for symptom management, the standard is 24 hours)

Providers are required to adhere to the following access standards for members under 21 years of age:

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2–4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 1 week of request	Within 1 week of request	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 business days of request		Within 5 business days of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Patients with appointments shall not routinely be made to wait longer than one hour.

Behavioral Health Utilization Management

For all behavioral health and HCBS services, SOMOS utilization management protocols, medical necessity criteria guidelines, and admission and service authorization criteria shall follow state guidance. For all substance use services, state approved Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3 will be used. All utilization review by SOMOS requires that the plan of care is developed in a person-centered manner, is compliant with federal regulations and state guidance, and meets individual needs. Enrollee's self-identified treatment goals will be reviewed as part of the review process. Upon initial identification of items on the plan of care that are not person centered, Care Team Member will outreach to the Health Home to discuss enhancing the plan of care to be align with person center requirements. If trends are identified that health homes are not consistently providing person-centered plans of care, they will be brough to attention of the quality team for further review. Upon review, SOMOS will partner with HealthPlus to discuss outlier status and plan to address. Behavioral Health Utilization Managers will review enrollee's stated preference provided within the clinical documentation from the facility and will document in Identifi as a component of the quality oversight process for Care Management.

As SOMOS's sub-delegate for utilization management, Evolent Health's utilization review processes are described here. The utilization management process includes but is not limited to the following program components: prior authorization, concurrent review, retrospective (post-service) review, and discharge planning. The clinical decision process begins when a request for authorization of service or clinical information is received. The process is complete when the requesting provider and patient have been notified of the determination and any required letters have been processed and received.

The primary function of the UM staff is to facilitate efficient resource utilization, and review and verify medical appropriateness and necessity for patients. Utilization review will be undertaken in the following circumstances, according to the lists of services below that require or do not require prior authorization:

- pre-certification / prior authorization of services (for those services with authorization is required, as listed below)
- out-of-network services
- transition of care
- admission and concurrent review
- retrospective review
- discharge planning

UM staff consists of licensed physicians, nurses, case workers, and other licensed healthcare professionals, as well as clinical operations staff and non-clinical intake staff. Only licensed physicians have the authority to deny authorization requests.

Providers must use the LOCADTR 3 assessment tool for prior authorization, continuing care decisions, and level of care determination for substance use disorder (SUD) services, in accordance with Office of Addiction Services and Supports (OASAS) guidelines. SOMOS care managers will assist providers with linking patients to lower levels of care when a patient is ready for discharge. If a patient is ready for discharge and an alternate level has been identified, the provider is expected to discharge the member. In the event the discharge does not happen, a denial may be issued after the doctor reviews.

HCBS providers are expected to contact SOMOS for authorization of HCBS services, with the exception of the first 3 Adult BH HCBS visits, which do not require prior authorization. SOMOS uses state-approved medical necessity criteria to authorize HCBS services. Authorization requests must be accompanied by required documentation, including service plans and medical records of the patient. s

The following services require prior authorization:

- All inpatient services
- Community day treatment
- PROS
- ACT
- Partial hospitalization
- Intensive outpatient

The following services do not require prior authorization:

- Emergency services, including comprehensive psychiatric emergency program (CPEP)

- Crisis intervention and OMH/OASAS specific non-urgent ambulatory services
- Initial assessments and outpatient clinic services
- Outpatient mental health (OMH)
- Substance use disorder (SUD) services, including inpatient, detox, or residential
- First 3 Adult BH HCBS visits
- For opioid treatment (methadone maintenance) only notification is required

Prior authorization can be obtained by calling (844) 990-0255, faxing (866) 865-9969 (for HealthPlus), or electronically from Identifi Practice (accessed via a Single Sign On link in the Provider Portal [https://smnyportal.valence.care]). Copies of the authorization forms can be found on the Provider Portal and in the Appendix. The Behavioral Health Authorization Request Form is to only be used for patients with HealthPlus, since Emblem's behavioral health services are carved-out to Beacon.

The following table provides additional guidance incorporating OMH Clinical Standards of Care and OASAS Clinical Guidance:

Service	PA	Concurrent review authorization	Additional Guidance
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family/collateral and group psychotherapy	No	Yes	MMCOs/ Health and Recovery Plans (HARPs) must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: The 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; b) off-site clinic services; or c) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations: https://omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf).
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	No	
Outpatient mental health office and clinic services: off-site clinic services	Yes	Yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	Yes	N/A	

Service	PA	Concurrent review authorization	Additional Guidance
Personalized recovery-oriented services (PROS) preadmission status	No	No	Begins with initial visit and ends when an initial service recommendation (ISR) is submitted to the plan. Providers bill the monthly preadmission rate but add-ons are not allowed. Preadmission is open-ended with no time limit.
PROS admission: individualized recovery planning	Yes	No	Admission begins when ISR is approved by the plan. The initial individualized recovery plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: • Clinical treatment; • Intensive rehabilitation (IR); or • Ongoing rehabilitation and supports (ORS) Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.
PROS active rehabilitation	Yes	Yes	Begins when the IRP is approved by the plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for clinic treatment and base/community rehabilitation and support (CRS).
Mental health continuing day treatment (CDT)	Yes	Yes	
Mental health intensive outpatient (Note: not state plan)	Yes	Yes	
Mental health partial hospitalization	Yes	Yes	
Assertive community treatment (ACT)	Yes	Yes	New ACT referrals must be made through local single point of access (SPOA) agencies. The plan will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Service	PA	Concurrent review authorization	Additional Guidance
OASAS-certified part 822 clinic services, including off-site clinic services (residential, inpatient, outpatient, detox, rehab, IOP)	No	Yes	See OASAS guidance regarding use of LOCADTR tool to inform all level of care (LOC) determinations for all levels of substance abuse covered (including residential, inpatient, outpatient, detox, rehab, IOP). OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice, but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization (30-50 visits per year are within an average expected frequency for OASAS clinic visits). The contractor will allow enrollees to make unlimited self-referrals for SUD assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. The following services do not require prior authorization: • Emergency services, including comprehensive psychiatric emergency program (CPEP) • Crisis intervention and OMH/OASAS specific non-urgent ambulatory services • Initial assessments and outpatient clinic services • Outpatient mental health (OMH) • Substance use disorder (SUD) services, including inpatient, detox, or residential • First 3 Adult BH HCBS visits • For opioid treatment (methadone maintenance) only notification is required
Medically supervised outpatient substance withdrawal	No	Yes	Notification through a completed LOCADTR report for admissions to this service may be required within a reasonable time frame.
OASAS-certified part 822 opioid treatment program (OTP) services	No	Yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice, but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization (150-200 visits per year are within

			an average expected frequency for opioid treatment clinic visits). The contractor will allow enrollees to make unlimited self-referrals for SUD assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
OASAS-certified part 822 outpatient rehabilitation	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for SUD assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.

SOMOS, through its sub-delegate Evolent Health, maintains a Behavioral Health Utilization Management (BH UM) Subcommittee that is chaired by the Lead BH Medical Director. The BH UM Subcommittee meets a minimum of four times a year and more frequent if necessary. Membership is comprised of the Medical Directors, UM Leadership, CM Leadership, Quality and Accreditation, Compliance, Analytics and Reporting and Auditors. The BH UM Subcommittee reviews information for all ages and oversight of the committee activities is provided by the SOMOS UM Oversight Committee. The BH UM Subcommittee's intervention strategies will have measurable outcomes and will be recorded in the meeting minutes.

The BH UM Subcommittee shall:

- Review and analyze data in the following areas:
    - Utilization data sets (UM metrics, under- and over-utilization of BH services, member demographics, cost data, etc.) and recommend any appropriate action for all ages, including medically fragile children
    - Admission and readmission rates/trends and ALOS at all BH facilities, including mental health inpatient, SUD inpatient and residential levels of care facilities
    - Follow-up after discharge, including for discharges from mental health inpatient, SUD inpatient and residential levels of care facilities
    - Inpatient and outpatient civil commitments
    - ED utilization and crisis services use
    - BH prior authorizations/denials/ notices of action
    - SUD initiation and engagement rates
    - FEP initiation and engagement rates
    - Psychotropic medication utilization (with separate analysis for children in foster care)
    - Addiction medication utilization
    - Transitional issues for youth ages 18 to 23 years, focusing on the continuity of care and service utilization
    - Other metrics determined by the State

- Track, trend, and report BH metrics, including denials, related to the populations and services in the Children's Standards
- Review of BH-specific quality improvement initiatives (QIAs), performance improvement projects and focused studies.
- Review and approve studies, standards, clinical guidelines, and trends in utilization patterns
- Review and recommend approval, revision, or denial of medical review criteria
- Identify opportunities to improve the care and services provided to members, and recommend solutions to the Chief Medical Officer (CMO)
- Review and approve the utilization management program description, work plan and evaluation on an annual basis. Reference the program description for a detailed overview of program scope, responsibilities, metrics and goals.
- Provide oversight of inter-rater reliability review (IRR) process and opportunities for improvement
- Monitor Quality of Care, service and/or patient safety issues
- Review, approve, deny or recommend utilization management policies for development
- (For children eligible for HCBS) Separately report, monitor and recommend appropriate action on: use of crisis diversion and crisis intervention services; prior authorizations/denials/notices of action; HCBS utilization; HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and enrollment in Health Home.
- Ensure interventions have measurable outcomes and are included in UM/clinical management committee meeting minutes. Analyses should be conducted separately for individuals under 21 years of age.

Behavioral Health Quality Management

The partner MCO will maintain a BH QM Subcommittee which is responsible for carrying out the planned quality activities under federal and state guidelines related to individuals with behavioral health conditions who access behavioral health benefits and/or HCBS. The committee's functions are expanded to meet the quality requirements and standards for the populations, benefits and services for children as described in the Children's System Transformation Requirements and Standards Document. Providers, peer specialists, members, family members, youth and family peer support specialists, and child-serving providers are part of the MCO's BH QM Subcommittee and guide and provide feedback on the committee's activities. For more information on the responsibilities of the MCO's BH QM Subcommittee, please refer to the MCO's provider manuals (links found in the Key Contact Information & References section).

SOMOS follows behavioral health guidelines recommended by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). When developing or updating our behavioral health clinical practice guidelines, SOMOS uses the following sources:

- Substance and Mental Health Services Administration (SAMHSA)
- National Institute of Mental Health (NIMH)
- American Society of Addiction Medicine
- National Institute on Drug Abuse
- National Alliance of Mental Illness
- United States Department of Health and Human Services

Providers are expected to adopt and offer services that are person-centered and recovery-focused, and to follow the evidenced-based practice for First Episode Psychosis for patients who experience their first break and patients suffering from Substance Use Disorders. In addition, to ensure effective telephonic triage processes and handoffs, SOMOS recommends that all providers follow seamless telephonic triage processes. This includes but is not limited to:

- Asking patients calling by phone if the matter they are calling about is an emergency, and directing them to the proper resources
- Listen to the patient
- Remain calm
- Ask the patient concise questions about their medical condition
- Repeat information back to the patient
- Do not place caller on hold
- Warm transfer patients to clinicians

For patients requiring access to a toll-free telephone number 24 hours a day, 7 days a week for emergency behavioral health calls, patients should contact their respective MCO's Member Services department, where emergency mental health calls will be triaged via telephone by a trained mental health professional. See Key Contact Information & References for MCO-specific contacts and references for Member Services. If Empire HealthPlus member services receives a crisis call, they will continue to follow their established process for crisis calls where the member is live transferred to a BH clinician. The BH Clinician (Crisis Team) will inform the Empire HealthPlus BH Manager of Case Management on the crisis call. The BH Manager will contact SOMOS/ Evolent to inform them of the crisis call and to ensure they follow up and support the member. If the result of the crisis call concluded with the member being hospitalized, this information will be shared with SOMOS/Evolent so the necessary coordination with the hospital can occur.

SOMOS disseminates and monitors fidelity to clinical practice guidelines through the ongoing care management process and peer-to-peer engagement with providers. Through this process, care managers:

- Assess whether a patient's care meets clinical practice guidelines and then address concerns with providers
- Discuss specific guidelines with providers and Health Homes
- Host periodic, topic-specific provider webinars to address identified trends
- Maintain on-going contact with patients, their families, caregivers, treating providers, and Health Homes to monitor progress and refine the plan of care
- Deliver and monitor interventions to meet care plan goals and share patient progress toward achieving those goals

Additional trainings on the following topics will be offered by SOMOS as needed through webinar (or in-person trainings when requested):

- Special Populations: I/DD, TAY, Children Age 0-5, etc.
- Cultural Competencies
- Evidence Based Practices (EBPs) for Children
- HCBS Eligibility and Operational Requirements and POC Development and Review
- Medical Necessity Criteria and Service Authorization Requirements
- BH and Medical Integration: Primary Care, Early Identification, and Screening

- Billing, Coding, Data Interface, Documentation Requirements, Provider Profiling Programs and Utilization Management Requirements for Behavioral Health and Children's Services
- Denials and Appeals Process
- Voluntary Foster Care Agencies (VFCA)

Providers, including HCBS providers, are expected to attend either an offered training or another acceptable training on these topics. Trainings can be delivered by SOMOS on these guidelines when requested by the provider. An initial orientation and training will be offered to all providers in the SOMOS network. SOMOS will conduct annual site visits at select providers' offices to provide education and training.

Providers are required to develop policies and procedures that include the following to assure confidentiality of behavioral health and substance use information:

(a) initial and annual in-service education of staff, contractors
(b) identification of staff allowed access and limits of access
(c) procedure to limit access to trained staff (including contractors)
(d) protocol for secure storage (including electronic storage)
(e) procedures for handling requests for BH/SUD information protocols to protect persons with behavioral health and/or substance use disorder from discrimination
(f) procedures for patients who present for unscheduled nonurgent care, with the aim of promoting enrollee access to appropriate care

Behavioral Health Care Management

Providers can refer patients who may benefit from case management to SOMOS. Patients who have multiple admissions for a BH condition, including substance use disorders and mental health conditions, homelessness, are restricted, have had their first break (FEP), are transitioning from foster care or aging out of the children's system (TAY) are some of the patients who are offered case management services. Additionally, consenting patients meeting eligibility criteria will be referred to a Health Home for additional care coordination. If a patient is in need of case management and is enrolled in a Health Home, SOMOS will link the patient to the Health Home or will work with the provider to ensure this happens. If the provider is unable to link a patient to these supports directly, the provider is expected to reach out to SOMOS to ensure patient needs are met.

A Health Home is a care management service model whereby all of a patient's caregivers communicate with one another so that all needs are addressed in a comprehensive manner. This is done primarily through a dedicated "care manager" who oversees and provides access to all of the services the patient needs. The Health Home services are provided through a network of organizations – providers, health plans and community-based organizations – and when all the services are considered collectively, they become a virtual "Health Home". New York state's Health Home program for Medicaid requires patients to have one or more of the following in order to be eligible to be enrolled in a Health Home:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25 or other chronic conditions)
- One qualifying chronic condition (e.g., HIV/AIDS) and the risk of developing another
- One serious mental illness

The SOMOS Health Home At-Risk Project seeks to address the complex needs of individuals who do not meet New York State eligibility requirements for Health Home participation but do meet federal eligibility participation criteria. The goal of the program is to link community primary care services and community-based organizations for high-risk individuals who do not qualify for Health Homes (HH) under current NYS Health Home standards. Such patients show patterns of repeated hospital and emergency department (ED) utilization that often reflect the effects of social determinants of health, medical, and behavioral health needs not being met – including substance abuse issues. In the absence of a formal health home to provide supportive services, this project brings an array of integrated care management support services to address these needs. The SOMOS Health Home project addresses the high-risk population that have:

- Have one chronic condition and are at risk for a second or
- Have one serious and persistent mental health condition

Patients for SOMOS Health Home project are identified through diagnosis codes recorded in the problem list within the PCP's electronic health record (EHR) or disease registries within meaningful use management platforms. Alternatively, these patients may be identified through claims data from NYS feeds to SOMOS or from data exchange with Medicaid Managed Care Organizations (MMCOs). Policies and procedures for the care management plan for Health Home At-Risk patients include developing person-centered plans of care for each individual with involvement from family members and other supports and identifying medical, behavioral health, and social service needs and network supports.

Patients may additionally be referred to home and community-based services (HCBS). For adults, on completion of the state-mandated assessment, the Health Home is expected to give patients a choice of at least three providers for the HCBS service. Once linked to the service, the HCBS provider contacts SOMOS for authorization. Additionally, for Health and Recovery Plan (HARP) patients, the Health Home completes the Community Mental Health Assessment (InterRai) and offers the patient choices of in-network HCBS providers if the assessment indicates a need for HCBS. Assessments must be conducted by a Health Home or other state designated entity in compliance with conflict free case management requirements.

For children who may be referred to HCBS, the assessment is used to determine whether the patient is eligible for HCBS services and for which type of HCBS. SOMOS has a dedicated team of care managers that are properly trained to review assessments, HCBS eligibility determinations, and plans of care for children. SOMOS will review the assessment and care plan with the Health Home, ensure it is comprehensive, authorize HCBS services, and inform the HCBS provider, the patient and the Health Home. The HCBS provider will work with SOMOS and Health Home to ensure that the patient's plan of care for HCBS is person-centered.

Health Homes are expected to incorporate the HCBS plan of care within the patient's overall plan of care. The plan of care is expected to be strength-based and recovery-focused and is expected to take patient's wishes and choices into consideration. HCBS and Health Home plans of care will be reviewed to ensure that the plan is person-centered and that the patient is progressing with identified goals, and if not, that barriers are being addressed and goals are modified as needed.

HCBS providers are expected to monitor and report to SOMOS the hours of service used by the patient to make sure services provided are utilized appropriately. If SOMOS identifies service utilization patterns that deviate from the approved plan of care, SOMOS will conduct outreach to review the deviations and discuss adjustments to either the service delivery or the plan of care.

In order to meet the state requirements for HARP adults receiving HCBS services, participating Health Homes and HCBS providers must report on various metrics to SOMOS. SOMOS will then coordinate with the patient's respective MCO to report these metrics to the state. As part of the reporting requirements, Health Homes and/or HCBS providers will be asked to submit care plans for review, as well as patient analytical data to evaluate the patient's level of care, adequacy of service plans, provider qualifications, patient's health and safety, financial accountability and compliance, and more.

In order to meet the state requirements for children receiving HCBS services, participating Health Homes and HCBS providers must report on various metrics to SOMOS. SOMOS will then coordinate with the patient's respective MCO to report these metrics to the state. As part of the reporting requirements, Health Homes and/or HCBS providers will be asked to submit care plans for review, as well as patient analytical data to evaluate the patient's level of care, adequacy of service plans, provider qualifications, patient's health and safety, financial accountability and compliance, and more.

HCBS are managed in compliance with the CMS HCBS Final Rule and all applicable state guidance.

Children and Youth Services

In order to promote behavioral health/medical integration for children, including at-risk populations, SOMOS will support provider access to rapid consultations from child and adolescent psychiatrists and referral and linkage support for child and adolescent patients. Such examples of support include establishing a provider consultation phone where providers can discuss the prescribing of medications with a psychiatrist, webinar trainings focused on delivering psychiatric care in a primary care setting. Through SOMOS's provider trainings, providers are given access to tools and guidance for best practices in delivering behavioral health in their practices. The Clinical Practice Guidelines are posted on the provider portal. Additionally, providers are trained on how to create an integrated practice through the BH integration portions of the quality management framework. When a provider does not show adherence to clinical practice guidelines (not doing appropriate screenings etc.), tools and guidance on better integration will be communicated to the provider by the SOMOS practice liaison as part of the CAP conversation.

SOMOS ensures access to providers with expertise in caring for medically fragile children (including children with co-occurring developmental disabilities) so these patients can receive services from appropriate providers. Participating providers should refer to appropriate community and facility providers in the patient's respective MCO's network to meet the needs of the child or seek authorization for out-of-network providers when participating providers cannot meet the child's needs.

When the MCO's network does not include an available provider with the appropriate training and experience to meet the needs of the patient or medically necessary services are not available in the network, providers should submit for an authorization review by calling (844) 990-0255 and requesting a referral to an out-of-network provider.

SOMOS authorizes these services in accordance with established time frames in the Medicaid Managed Care Model Contract and OHIP's Principles for Medically Fragile Children, under

EPSDT, HCBS, and CFCO (upon implementation) rules, as well as with consideration for extended discharge planning.

Effective January 1, 2019, existing New York State Medicaid State Plan services and HCBS covered under fee-for-service (FFS) transitioned to managed care to more fully integrate children and youth's access to physical and behavioral health care. For episodes of care that were ongoing during this transition period, for continuity of care purposes, children will continue with their existing care providers, including medical, behavioral health, and HCBS providers, for a continuous episode of care for the first 24 months of the transition. In addition, children were not required to change Health Homes or their Health Home Care Management Agency at the time of the transition, and SOMOS will pay on a single case basis for children enrolled in a Health Home out-of-network of the patient's respective MCO.

For children transitioning from a 1915(c) waiver, SOMOS will continue to authorize covered HCBS and long-term services and supports (LTSS) in accordance with the most recent plan of care (POC) for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed. During the initial 180 days of the transition, SOMOS will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for FFS children in receipt of HCBS at the time of enrollment, SOMOS will continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed.

To facilitate a smooth transition of HCBS and LTSS authorizations, for children in receipt of HCBS, based on state guidance, SOMOS will begin accepting POCs:

- 60 days prior to the mandatory enrollment of children receiving HCBS and inclusion of children's HCBS in the managed care benefit package for:
    1) patients enrolled with SOMOS's partner MCOs
    2) a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with SOMOS and the family has demonstrated the selection process for a SOMOS partner MCO and a SOMOS PCP has been completed; and
- 60 days prior to the mandatory enrollment of children residing in a Voluntary Foster Care Agency (VFCA) for a child in the care of a LDSS/licensed VFCA, where election of a SOMOS partner MCO and a SOMOS PCP has been confirmed by the LDSS/VFCA.

SOMOS will continue to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when SOMOS is notified by another plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with SOMOS and the family has demonstrated the selection process for a SOMOS partner MCO and a SOMOS PCP has been

completed, or for a child in the care of a LDSS/licensed VFCA, election of a SOMOS partner MCO and a SOMOS PCP has been confirmed by the LDSS/VFCA.

Foster Care Health Services

For SOMOS patients in foster care, a series of assessments serves as the basis for developing a comprehensive plan of care and providers a complete picture of the foster care child's health needs. Initial health assessments must be completed within the time frames listed in the following table:

Initial Health Services Time Frames				
Time Frame	**Activity**	**Mandated Activity**	**Mandated Time Frame**	**Who Performs**
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child Welfare Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X		Mental health practitioner
30 days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	X	X	Health Practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Child Welfare Caseworker or designated staff

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Who Performs
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child Welfare Caseworker or health staff

If a SOMOS patient in foster care is placed in another county and SOMOS operates in the new county, the child can transition to a new PCP and other health care providers without disrupting the care plan in place. If the patient is placed outside SOMOS's service area, SOMOS will permit the patient access to providers with expertise in treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.

In the case of a long-term foster care placement outside of the patient's respective MCO's service area, and solely at the direction of the LDSS or VFCA, SOMOS will coordinate with the LDSS or VFCA for a smooth transition of enrollment.

Behavioral Health Billing, Documentation, and Reimbursement

For providers of mental health and Substance Use Disorder services where an ongoing course of care was approved, SOMOS will reimburse such services as follows:

- For continued services provided by a participating provider, SOMOS will reimburse such services at the contract rate, which may include provision for an alternate level of care rate, unless a payment rate is otherwise specified by the state or is required by law.

- If such care is provided by a Non-Participating Provider, payment will be at no less than the Medicaid fee-for-service rate.
- Services provided to an individual determined to be appropriate for admission to and awaiting transfer to a State-operated psychiatric hospital or other hospital licensed under Article 31 of the Mental Hygiene Law that is certified by Medicare and Medicaid shall not be reimbursed at an alternate level of care rate.

Providers who historically delivered care management services under one of the 1915(c) waivers being eliminated and will provide them under a Health Home after the transition may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as is practical to the interim rates (and as reconciled) established under the former waivers. These rates will be in place immediately prior to the provider's transition to the Health Home.

SOMOS will reimburse OMH-licensed and OASAS-certified behavioral health providers including ambulatory service providers, CPEP and Emergency Observation Bed programs, and Residential Addiction Services at no less than the Medicaid Fee-For-Service (FFS) rates for at least 24 months after the effective date of the transition.

SOMOS will execute single case agreements (SCAs) with out-of-network providers to meet the clinical needs of children in these instances when in-network services are not available. For all SCAs, SOMOS will reimburse providers for services at no less than the FFS fee schedule for the first 24 months of the transition.

Once VFCA settings are transitioned to Medicaid Managed Care, SOMOS will reimburse VFCAs in the SOMOS network for all medically necessary services for which the VFCA is licensed to provide that are provided to SOMOS patients, including reimbursement for any services paid through a state-determined Preventive Residential Supports and Services rate (currently in development).

Reimbursement at no less than the FFS fee schedule for 24 months (or as long as NYS Medicaid mandates — whichever is longer) also applies to the following services/providers:

- New EPSDT SPA services, including:
  - OLP
  - Crisis Intervention
  - CPST
  - PSR
  - Family peer support services and youth peer support and training
  - Preventive residential supports
- OASAS clinics (Article 32-certified programs)
- All OMH licensed ambulatory programs (Article 31-licensed programs)
- Hospital-based and free-standing clinics dually (Article 28-licensed and certified programs)

For patients placed in OASAS certified residential program, SOMOS will contract with the OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis to ensure access to and continuity of care for patients placed outside our service area. SOMOS will pay all HCBS according to the FFS fee schedule as long as SOMOS

is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates).

Any HCBS providers in the SOMOS network will submit claims to SOMOS with all the required fields and the appropriate HCBS codes and other rate codes. Claims from SOMOS providers that are submitted to the patient's respective MCO will be rejected with guidance to resubmit the claim to SOMOS. Training on HCBS claims submission is available to providers. For additional resources on behavioral health billing and documentation, see the following:

- https://www.ctacny.org/sites/default/files/trainings-pdf/revenu-codes-updated-12-21-15_1.pdf
- https://www.ctacny.org/resources

Claims for behavioral health services shall be submitted following the same processes as claims for physical health services (see Claims Submission & Processing section for more details). SOMOS strongly encourages all providers to submit claims electronically. For providers interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

SOMOS HealthPlus Electronic Payer ID: **81508**

If you choose to utilize paper claims, these should be on standard CMS forms (CMS 1500/UB-04), machine/computer generated and printed, and submitted to SOMOS at the following address:

For HealthPlus:
SOMOS IPA, LLC
P.O. Box 21432
Eagan, MN 55121

Facility claims must be submitted with the following:

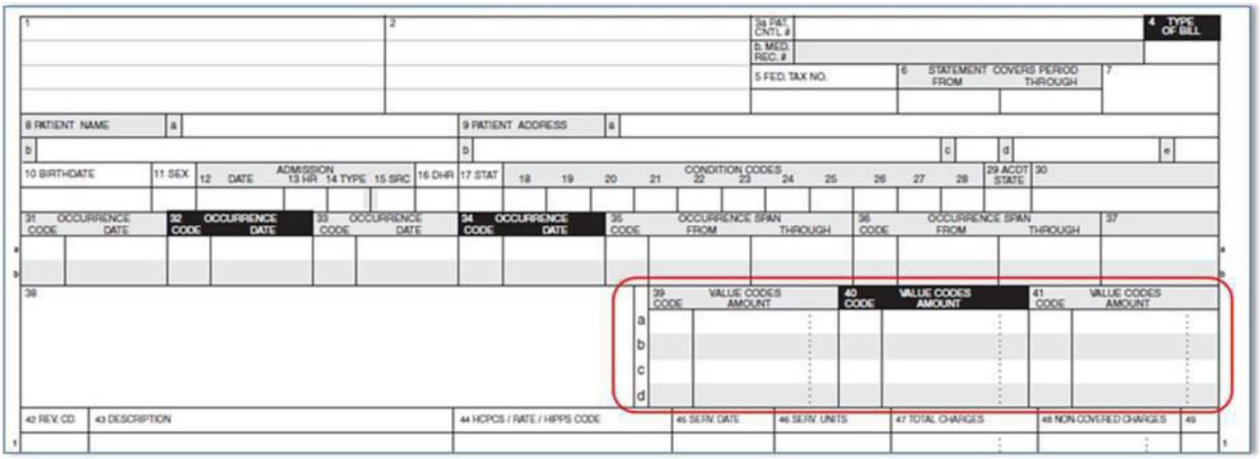
- Form type for Medicare and Medicaid: UB-04 submission
- Valid value code, if applicable
- Valid rate code, if applicable
- Valid revenue code
- Valid CPT code
- Valid diagnosis code that falls within the mental health category
- Bill type must be 731 for initial claims or 737 for corrected claims

Individual/group practice claims must be submitted with the following:

- Form type for Medicare and Medicaid: UB-1500 submission
- Valid CPT code

Placement of value and rate codes:

- Value code is 24 (39a.)
- Rate code should be placed before the dotted line



Claims must be submitted within 120 days from the date of service/discharge; or other mutually agreed upon deadline set forth in the Downstream IPA Participation Agreement and must include all necessary information as outlined in this section and in the Claims Submission & Processing section.

Providers will receive a notice if a claim is rejected or denied. A rejected claim is a claim that does not enter the adjudication system due to missing or incorrect information. A denied claim is a claim that goes through the adjudication process but is denied for payment. For claims inquiries, providers may call the Provider Service Center at (844) 990-0255, which has specially trained call agents to handle claim inquiries in an efficient and timely manner.

SOMOS will offer electronic payment to its provider network. SOMOS is working with InstaMed to deliver claim payments via electronic remittance advice (ERA) and EFT. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN (Reassociation Trace Number), in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions. To expedite payment, you can sign up for InstaMed Payer Payments by visiting https://register.instamed.com/eraeft or calling (866) 945-7990 and electing the “all provider payments” option. If you are currently enrolled with InstaMed, you will be able to add the SOMOS payer IDs to your InstaMed profile upon the effective dates of the SOMOS relationship with the partner MCOs.

Behavioral Health Denials, Grievances, and Appeals

All denial, grievance, and appeal decisions are conducted by a peer (the credential of the licensed clinician making the determination must be at least equal to that of the recommending clinician) and the reviewer must have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition, all decisions are subject to specific behavioral health requirements including the following:

- A physician board-certified in general psychiatry at the plan must review all inpatient level of care denials for psychiatric treatment

    - A physician board-certified in child psychiatry must review all inpatient denials for psychiatric treatment and denials for behavioral health medications for patients under 21 years of age
- A physician certified in addiction treatment must review all inpatient level of care/continuing stay denials for SUD treatment
- Any appeal of a denied behavioral health medication for a child should be reviewed by a board-certified child psychiatrist
- A physician reviews all denials for services for a medically fragile child, taking the needs of the family/caregiver into consideration

For mental health and Substance Use Disorder services, SOMOS will not deny coverage of an ongoing course of care based upon a determination that an alternate level of care is appropriate unless SOMOS has identified an appropriate provider of such alternate level of care and approved coverage for such care. If SOMOS has determined that such alternate level of care is appropriate but has not identified an appropriate provider of such care, SOMOS will continue to approve coverage of and continue to reimburse for services provided by the current provider.

Providers follow the same appeals process for HARP patients as for all Medicaid patients within SOMOS. Member complaints, grievances, and appeals (including providers appealing on behalf of a member) are to be handled directly by the patient's respective MCO.

Access to Care Standards

Appointment Accessibility Standards

SOMOS follows the accessibility requirements set forth by applicable regulatory and accrediting agencies.

Providers must offer hours of operation no less than those hours offered to other insured patients in their practice.

Below is a table detailing the type of service and the scheduling timeframes that should be followed by all providers:

Appointment Type	Access Standard
Emergency Care	Immediately upon presentation
Urgent medical or behavioral	Within 24 hours of request
Non-urgent “sick” visit	Within 48 to 72 hours of request, as clinically indicated
Routine non-urgent, or preventive	Within 2 weeks of request
Specialist referrals (non-urgent)	Within 2 to 4 weeks of request (unless otherwise provided for in this section)
Initial prenatal visit	Within 3 weeks during first trimester, within 2 weeks during the second trimester and within 1 week during the third trimester.
Adult Baseline and routine physicals	Within 12 weeks from enrollment. (Adults >21 years)
Well child care	Within 2 weeks of request
Initial family planning visits	Within 2 weeks of request
Initial PCP office visit for newborns	Within 1 week of hospital discharge
Pursuant to an emergency hospital discharge or release from incarceration (where SOMOS is informed of such release), mental health or Substance Use Disorder follow-up visits (as included in the Benefit Package)	Within 5 days of request, or as clinically indicated
Non-urgent mental health or Substance Use Disorder visits with a participating provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic	Within 1 week of request
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work when requested by a Local Department of Social Services (LDSS)	Within 10 days of request

Patients with appointments shall not routinely be made to wait longer than one hour.

Providers are required to:

- Identify special patient needs while scheduling an appointment (e.g., wheelchair, interpretive linguistic needs, non-compliant individuals, cognitive impairments, etc.)
- Identify and attempt to reschedule missed appointments
- Answer patient telephone inquiries the same day for non-symptomatic concerns
- Provide after-hours telephone care for non-emergent, symptomatic issues within 30 minutes of a patient's call. After-hours calls must be documented in a written format and later transferred to the patient's medical record
- Utilize telehealth when clinically appropriate
- After-hour care with emergency appointment slots
- Schedule continuous availability to provide covered services within normal working hours
- Provide in-network coverage in the event of a provider's absence
- Ensure access to language assistance, including Braille for the visually impaired, bilingual staff and interpreter services to those with limited English proficiency, as well as access to TDD/TTY lines during all hours of operation
- Document every encounter whether face to face or via telehealth or telephone in the Patient's Medical record in the EHR

24-Hour Access for Patients

SOMOS providers shall provide coverage for their respective practices 24 hours a day, 7 days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable:

- After-hours coverage must be accessible using the medical office's published daytime telephone number.
- The selected method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the practitioner or covering medical professional for a clinical decision.
- If applicable, the practitioner or covering medical professional must return the call within 30 minutes of the initial contact.
- The covering provider must provide clinical information to the patient's PCP so that it can be entered into the patient's medical record

Cultural Competency

SOMOS is committed to having all network providers fully recognize and care for the culturally diverse needs of the patients they serve and ensure that language, cultural differences, or disabilities do not pose a barrier to communication. SOMOS providers, vendors and their staff have an obligation to deliver culturally competent health care and services by possessing attitudes, skills, and policies that enable effective work in cross-cultural settings. Provider offices should have their own cultural sensitivity and competency training to ensure providers meet goals that include but are not limited to:

- Being educated about the linguistic needs and cultural differences of patients
- Having an understanding of the population that SOMOS serves
- Being responsive and sensitive to the patient's needs
- Offering education, tools, and subject matter expertise to patients that may help them improve their health literacy

Accommodations for Patients with Disabilities

All providers are required to comply with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 in providing physical accessibility standards in their physical locations. The Americans with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability. Provider locations where SOMOS patients receive covered services should comply with the ADA standards. If this is not possible, provider locations must provide adequate or reasonable physical access, and other accommodations and equipment, to allow people with both physical and mental disabilities to receive care there.

It is unlawful to discriminate against persons with disabilities or to discriminate against a person based on that person's association with a person with a disability. Accommodations for people with disabilities include:

- Physical accessibility
- Effective communication
- Policy modification
- Accessible medical equipment

To successfully meet the demands for 'disability awareness,' providers should capture information about accommodations that may be required in the patient's medical record, and when making referrals to other providers, communicate with the receiving provider regarding any necessary accommodations that may be required.

Advance Directives

SOMOS providers delivering care to SOMOS patients must ensure adult patients 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives, including for behavioral health.

For patients who have executed advance directives, the practitioner should discuss potential medical emergencies with the patient and designated family member or significant other, if named in the advance directive and, if available. All advance directives information should be stored in the medical record and shared with other providers caring for the patient.

Nondiscrimination Policy

SOMOS complies with Section 1557, nondiscrimination law in the Affordable Care Act (ACA). SOMOS does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of gender, gender identity, age, disability, race, color, religion, or national origin in providing aid, benefits or services to patients. If you or your patient believes that SOMOS has discriminated in any way on the basis of gender, gender identity, age, disability, race, color, religion, or national origin, you can file a grievance via the Provider Service Center at (844) 990-0255. The Provider Service Center team will facilitate the initial intake for Provider Grievances and Appeals, then hand off to the Grievance Coordinator/team.

Claims Submission & Processing

Submitting a Claim

SOMOS maintains claims processing procedures designed to comply with the requirements of client plans, government-sponsored health benefit programs, and applicable state and/or federal laws, rules, and/or regulations.

SOMOS strongly encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

SOMOS HealthPlus Electronic Payer ID: **81508**
SOMOS Emblem Electronic Payer ID: **81336**

If you choose to utilize paper claims, these should be on standard CMS forms (CMS 1500/UB-04) and submitted to SOMOS at the following address:

For HealthPlus:
SOMOS IPA, LLC
P.O. Box 21432
Eagan, MN 55121

For Emblem:
SOMOS IPA, LLC
P.O. Box 211473
Eagan, MN 55121

Electronic Claim Filing Requirements

Electronic Data Interchange (EDI) allows for faster, more efficient, and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

The following sections describe the procedures for electronic submission for hospital and medical claims, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Hardware/Software Requirements

Providers may submit claims electronically as long as their software has the capability to send EDI claims to Change Healthcare (formerly Emdeon) through either direct submission or through another clearinghouse/vendor who already has EDI capabilities.

Change Healthcare has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare forwards the accepted information to carriers in an agreed upon format.

After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or Change Healthcare to initiate electronic submissions to SOMOS.

Paper Claim Requirements

Paper claims must be submitted on standard CMS forms (CMS 1500/UB-04) and must be on machine/computer generated printed forms.

Certain claims are excluded from electronic billing. At this time, the following claims must be submitted on a paper claim:

- Letters of Agreement (LOA) or Single Case Agreements;
- Sterilization claims accompanied by appropriate consent forms; and
- Providers billing on a UB-04/CMS-1450 form that are contracted with vendors that are not transmitting through Change Healthcare.

Claim Submission Guidelines

SOMOS is required by state and federal regulations to capture specific data regarding services rendered to its patients. The provider must adhere to all billing requirements in order to ensure timely processing of claims. When required data elements are missing or invalid, claims will be rejected by SOMOS for correction and resubmission. The provider who performed the service to the SOMOS patient must submit the claim for a billable service.

Claims filed with SOMOS are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms
- Verification that all diagnosis and procedure codes are valid for the date of service
- Verification of the referral for specialist or non-primary care physician claims
- Verification of patient eligibility for services under SOMOS during the time period in which services were provided
- Verification that the services were provided by a participating provider or that the “out- of-network” provider has received authorization to provide services to the eligible patient

- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that SOMOS is the “payer of last resort” on all claims submitted to SOMOS
- Verification that an authorization has been given for services that require prior authorization by SOMOS

In addition, SOMOS utilizes claim edit applications following industry standard bundling guidelines. Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with the appropriate disposition code on the remittance advice.

Submitting Member Encounters

SOMOS and/or respective MCO partners are required to submit encounter data to NYSDOH. Provider assistance is an essential component of this requirement. NYSDOH requires complete, accurate, and timely encounter data in order to effectively assess the availability, quality, and costs of services rendered to Medicaid members, and to perform risk adjustment. The data provided affects NYSDOH funding of the Medicaid Program, including SOMOS. Data regarding encounters is also used to fulfill the CMS required reporting in support of the Federal funding of State Medicaid plans.

According to SOMOS policy, providers **must** report all member encounters by claims submission either electronically or by mail to SOMOS. This includes any encounters via telehealth.

Claim Form Requirements

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04/CMS 1450 claim form must be completed for all facility claims.

A clean claim is defined as a claim for reimbursement submitted to SOMOS by a health care practitioner, pharmacy or pharmacist, hospital or person entitled to reimbursement that contains the required data elements and any attachments requested by SOMOS. If the following information is missing from the claim, the claim is not clean and may be delayed or returned to the provider for additional information:

- Patient’s name
- Patient’s Medicaid ID number
- Patient’s date of birth
- Provider name according to contract
- Provider tax ID number and state Medicaid ID number
- NPI of billing provider when applicable
- Taxonomy code
- Date of service
- Place of service
- ICD-10 diagnosis code/revenue codes
- Procedures, services or supplies rendered, CPT-4 codes/HCPCS codes/Revenue Codes
- Days or units
- Modifiers as applicable
- Coordination of benefits (COB) and/or other insurance information
- The precertification number or copy of the precertification

- Name of referring provider
- Name of ordering provider
- Name of prescribing provider
- Present on Admission (POA) Indicator
- Any other state-required data

Using unlisted or miscellaneous codes will delay claims payment and should be avoided to the extent possible. The claim may be denied if unlisted or miscellaneous codes are used without supporting documentation accompanying the claim detailing the services rendered.

All providers are required to supply the 11-digit NDC (National Drug Code) when billing for injections and other drug items on the CMS-1500 and UB-04 claim forms as well as on the 837 electronic transactions. Line items on a claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC, including the N4 qualifier
- Unit of measure qualifier (F2, GR, ML, UN, MG)
- NDC Units dispensed (must be greater than 0)

Timely Filing Requirements

The original clean claim must be submitted within 120 days from the date of service/discharge; or other mutually agreed upon deadline set forth in the Downstream IPA Participation Agreement and must include all necessary information as outlined in the following sections. SOMOS will not be liable for benefits if SOMOS does not receive completed clean claims within this time period. In addition, all codes used in billing must be supported by appropriate medical record documentation.

Claims Status Review

Providers may view claims status using any of the following methods:

- Online – Check claims status by logging into SOMOS Provider Portal [https://smnyportal.valence.care]. Claims status information in the Provider Portal are updated nightly.
- Real-Time – Depending on your clearinghouse or practice management system, real-time claims status information is available to participating providers
- Telephone – You may also check claims status by calling SOMOS at (844) 990-0255

Contact your clearinghouse to access:

- Change Healthcare Products for claims status transactions; or
- All other clearinghouses: Ask your clearinghouse to access transactions through Change Healthcare

Timely Processing of Claims

SOMOS is required to meet the claims payment timeliness standards established by state law and abides by the guidelines set forth by the New York Department of Financial Services (DFS), which stipulate that all undisputed claims not requiring additional information must be processed and paid or denied within 30 calendar days for claims submitted electronically and 45 calendar days for claims submitted by mail, unless otherwise set forth by the provider contract. During the claims adjudication process, SOMOS may request additional information within these timelines from the provider, in order to better determine financial liability and whether the services on the claim should be reimbursed. SOMOS shall issue interest payments in accordance to applicable laws and regulations. If obligation to pay is not reasonably clear, SOMOS shall notify the provider in writing within 30 calendar days of receiving the claim that it is not obligated to pay the claim, stating the specific reasons why SOMOS is not liable, or requesting additional information needed to determine liability to pay the claim or make the payment.

Electronic Fund Transfers (EFTs)

SOMOS will offer electronic payment to its provider network. SOMOS is working with InstaMed to deliver claim payments via electronic remittance advice (ERA) and EFT. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN (Reassociation Trace Number), in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

Additional benefits of ERA/EFT include:

- Accelerates access to funds with direct deposit into your existing bank account
- Reduces administrative costs by eliminating paper checks and remittances
- Avoids disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse

To expedite payment, you can sign up for InstaMed Payer Payments by visiting https://register.instamed.com/eraeft or calling (866) 945-7990 and electing the “all provider payments” option. If you are currently enrolled with InstaMed, you will be able to add the SOMOS payer IDs to your InstaMed profile upon the effective dates of the SOMOS relationship with the partner MCOs.

Rejected Claims and Resubmissions

Rejected claims are defined as claims with invalid or missing data elements that are returned to the provider or EDI source without registration in the claims processing system. In addition, claims from providers who do not have an active New York Medicaid Provider ID or an NPI (unless the provider is an atypical provider as defined by the state of New York) listed in the state’s system of record will be rejected. Providers should make sure their information is up to date with the state to avoid rejection.

Since rejected claims are not registered in the claims processing system, the provider must re-submit a rejected claim as a new claim, abiding by timely filing guidelines for new claims. Denied claims are different than rejected claims and are registered in the claims processing system, but they do not meet requirements for payment under SOMOS guidelines.

Claim Corrections

Providers who believe or have been notified that they have submitted an incorrect or incomplete claim when the claim has already been registered in the claims processing system may submit a corrected claim. Corrected claims submission must be submitted within 90 days of the original date on the EOP.

Corrected claims can be sent electronically and should be marked as a second submission or a corrected claim. All corrected claims should have the corrected claim indicator on the claim and the original claim number that you are correcting.

Corrected paper claims should be sent to:

For HealthPlus:
SOMOS IPA, LLC
P.O. Box 21432
Eagan, MN 55121

For Emblem:
SOMOS IPA, LLC
P.O. Box 211473
Eagan, MN 55121

Corrected paper claims are scanned during reprocessing. Please use machine/computer generated printed forms.

Claim Payment Dispute Process

To initiate a post-service appeal or in the event a provider disagrees with the outcome of a finalized claim due to claim payment issues or other administrative issues, the provider may be able to initiate the claim payment dispute process. Such requests must be submitted by calling (844) 990-0255 or mailed to:

For HealthPlus:
SOMOS IPA, LLC
P.O. Box 21432
Eagan, MN 55121

For Emblem:
SOMOS IPA, LLC
P.O. Box 211473
Eagan, MN 55121

A claim payment dispute may be submitted for multiple reasons, including:

- Contractual payment issues
- Disagreements over reduced or zero-paid claims
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Claim data issues

- Claims that are denied for no authorization when an authorization was obtained, if the authorized services match the claim details
- Timely filing issues

Providers will not be penalized for filing a claim payment dispute, and no action is required by the patient. The following information must be included when submitting a claim payment dispute:

- Provider/facility name, address, phone number, email, and either NPI or TIN
- Patient's name and his or her SOMOS or Medicaid ID number
- A listing of disputed claims, including the claim numbers and the dates of services
- All supporting statements and documentation

The SOMOS claim payment dispute process consists of two steps:

1) **Claim Payment Reconsideration:** A claim reconsideration is the initial step to investigate the outcome of a finalized claim. Requests must be received within 45 calendar days from the date on the explanation of payment (EOP) unless otherwise stated in the Downstream IPA Participation Agreement. In the reconsideration request, please include all relevant information that may not have been reviewed during the initial determination. SOMOS will make every effort to respond with a determination to the reconsideration request within 30 calendar days from the receipt date by sending a determination letter to the provider. If the decision results in a claim adjustment, the payment and EOP will be sent separately.

2) **Claim Payment Appeal:** Once a reconsideration request determination has been made and the provider disagrees with the determination, the provider may submit a Claim Payment Appeal within 60 days of the reconsideration determination. Please note, SOMOS cannot process a Claim Payment Appeal without a Claim Payment Reconsideration on file. Any supporting information not included with the reconsideration request and all other related documents must be included with the appeal. SOMOS will make every effort to respond to standard appeals within 30 calendar days from the appeal receipt date. Provider will receive written notification of the outcome of whether the determination is upheld or overturned. If the decision results in a claim adjustment, the payment and EOP will be sent separately.

Other Claim-Related Issues

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, they are defined briefly here:

- **Claim Inquiry:** A question about a claim or claim payment is called an inquiry. Claim inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the Claim Payment Dispute. For example, once a provider receives an answer to a claim inquiry, the provider may opt to begin the Claim Payment Dispute process as described above.

- **Claim Correspondence:** A claim correspondence is when more information is requested from the provider to finalize a claim. The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received from the claim correspondence, SOMOS will use it to finalize the Claim.

- **Clinical / Medical Necessity Appeal:** An appeal regarding a clinical decision denial, such as an authorization or claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the appeal process outlined under Adverse Clinical Determination in the Utilization Management section of this manual.

Claim Overpayments

If provider identifies an overpayment, provider shall return such overpayment to SOMOS within 45 days after the date on which the overpayment was identified. Claim details will need to be provided, such as reason for refund, claim number, member number, date(s) of service, etc.

If SOMOS recognizes the need for a refund due to an overpaid claim, SOMOS will send a written refund request to provider. The notice will detail the patient's name, member number, claim number, date(s) of service, provider's patient account number, total charges, reason for overpayment, and amount of overpayment/balance. If SOMOS does not receive the refund within 45 days, SOMOS may offset such amounts against future payment that would otherwise be owed to provider beginning 45 days after the notice is issued. Refund of duplicate claims do not require prior notice.

SOMOS must make any refund requests within 24 months from the date of payment of the affected claim. However, such time limit shall not apply where state law explicitly permits, including but not limited to, certain instances relating to a reasonable belief of fraud or other intentional misconduct, or abusive billing or where required by a state or federal government program.

These adjustments will also be reported on the Remittance Advice.

Claim Payments Audits

SOMOS has the right to access to confidential medical records, utilization review sheets and/or itemized bills related to claims for the purpose of claims payment, assessing quality of care, and performing utilization management functions. SOMOS conducts claims audits to ensure that billing is in accordance with Current Procedural Terminology (CPT) guidelines, SOMOS's policies, and provider contract terms, assessing areas including, but not limited to:

- Billing with incorrect coding — CPT, ICD-10, modifiers, bundling/unbundling services
- DRG validation
- Duplicate billing/services
- Prior authorizations not received/denied
- Historical claims review
- Coordination of benefits
- Insurance liability and recovery

Claim audits may be performed on a pre-payment or post-payment basis, subject to the terms of the Downstream IPA Participation Agreement. Pre-payment claim reviews may occur for providers or patients for whom there is a basis to suggest inappropriate billing or services, and entail requests for additional information and review of submitted documentation prior to claim adjudication to determine whether the claim is supported. Post-payment reviews may be conducted when there is a basis to suggest inappropriate billing or services for providers or

patients after claims have previously been processed and paid. A post-payment review may involve review of treatment records and investigations with patient and provider interviews. If the claim is not substantiated through these review processes, the claim may be denied.

Balance Billing

Participating providers may not balance bill patients for the difference between the billed charges and reimbursement paid by SOMOS for covered services rendered. This means that the participating provider may not invoice, charge, or seek reimbursement or a deposit from the patient, NYSDOH, LDSS, or persons acting on a patient's behalf for covered services except for applicable patient expenses (i.e. applicable co-payments or co-insurance or permitted deductibles), and non-covered services. If providers do not comply with rules laid out in their contracts, in this manual, or by state/federal regulators, (e.g. timely filing, surprise bills, pre-authorization checks, etc.), providers cannot hold patients liable for payment.

Capitation

Providers reimbursed on a capitated basis shall not receive additional reimbursement for covered services unless otherwise permitted in their provider agreement or applicable regulation. Monthly capitation payments will be based on patients attributed to capitated providers as of the 15th of the applicable month.

Reimbursement for Immunizations

Unless otherwise outlined in provider's agreement, reimbursement for drugs (vaccines and immune globulins) furnished by practitioners to their patients shall be based on the acquisition cost to the practitioner for the particular drug dose administered to the patient. Providers shall limit applicable billed amounts to the actual invoice cost of the drug dosage administered and SOMOS shall reimburse provider for such costs. Providers shall maintain auditable records of the actual itemized invoice cost of the drug, including the number of doses of the drug represented on the invoice. SOMOS reserves the right to request such invoices for purposes of auditing providers billed amounts to ensure alignment with invoice costs. In the event SOMOS determines that the billed amounts exceed the invoice costs, SOMOS may initiate overpayment procedures as outlined in the Provider Manual or applicable provider agreement. This policy does not apply to primary care providers that are paid on a capitated basis.

SOMOS's vaccine reimbursement policy outlined herein is intended to be consistent with NYS DOH guidance and is subject to change from time to time to ensure consistency with NYS DOH guidance.

Claims Questions

If you have questions on claims, you may contact the Provider Service Center at (844) 990-0255. You may also reach out to your local SOMOS Provider Relations representative for assistance at [ProviderRelations@somosipa.com].

Utilization Management

Utilization Management is the evaluation of the medical necessity, quality, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits. SOMOS defines “medically necessary” as health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.

The utilization management (UM) process includes but is not limited to the following program components: prior authorization, concurrent review, retrospective (post-service) review, and discharge planning. The clinical decision process begins when a request for authorization of service or clinical information is received. The process is complete when the requesting provider and patient have been notified of the determination and any required letters have been processed and received.

The primary function of the UM staff is to facilitate efficient resource utilization, and review and verify medical appropriateness and necessity for patients. Utilization review will be undertaken in the following circumstances:

- pre-certification / prior authorization of services
- out-of-network services
- transition of care
- admission and concurrent review
- retrospective review
- discharge planning

UM staff consists of licensed physicians, nurses, case workers, and other licensed healthcare professionals, as well as clinical operations staff and non-clinical intake staff. Only licensed physicians have the authority to deny authorization requests.

Clinical Criteria

SOMOS has adopted utilization review criteria developed by Milliman Care Guidelines (MCG). MCG appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. MCG criteria covers medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. MCG is utilized as a screening guide and is not intended to be a substitute for provider judgment.

UM staff reviews clinical information against established criteria (MCG*)* to determine medical necessity and appropriateness for requested medical services. These would include medical coverage guidelines, internal medical policies and community standards to each case. The patient’s specific benefit package is also taken into consideration.

When applying criteria to a request for services the following information is taken into consideration: age, comorbidities, complications, progress of treatment, psychosocial situation,

home environment, as well as the availability and ability of the local health care system to provide for the patient's medical needs. Information is obtained from the patient's medical record, treating providers, and/or the patient or patient representative. If the documentation supplied is insufficient or requires clarification, the review staff may contact the treating provider for additional clinical information.

When setting or place of service is part of a review, services performed in a higher-cost setting will not be deemed medically necessary if they can be safely provided in a lower-cost setting. For example, if a surgery or other procedure could have been performed on an outpatient basis, an inpatient admission for the surgery would not be approved.

UM decision-making is based only on appropriateness of care and service, existence of coverage, and available criteria. SOMOS does not reward providers or other individuals conducting utilization review for issuing denials of coverage or services, and SOMOS does not encourage decisions that result in under-utilization.

SOMOS may partner with outside vendors to administer utilization management functions for certain services and/or patients. SOMOS shall communicate such arrangements to providers and ensure providers have the necessary information to appropriately treat patients and fulfill their contractual duties under their Downstream IPA Participation Agreement.

Prior Authorization Requirements

A prior authorization is the prospective process in which medical necessity criteria is reviewed to determine that the services requested are medically necessary and appropriate for the level of medical severity and illness.

Prior authorization can be obtained by calling (844) 990-0255, faxing (866) 865-9969 (for HealthPlus) or (877) 590-8003 (for Emblem), or electronically from Identifi Practice (accessed via a Single Sign On link in the Provider Portal [https://smnyportal.valence.care]). Copies of the authorization forms can be found on the Provider Portal and in the Appendix. The Medical Authorization Request Form can be used for both HealthPlus and Emblem. The Behavioral Health Authorization Request Form is to only be used for patients with HealthPlus, since Emblem's behavioral health services are carved-out to Beacon.

All providers are required to obtain prior authorization from SOMOS's UM department for inpatient services, selected outpatient services and procedures, including certain ancillary services, and for all services performed by out-of-network providers. The prior authorization list of the patient's respective MCO will be followed unless otherwise indicated on the list of procedures requiring prior authorization posted on the Provider Portal. Prior authorization may be requested by the patient's PCP or by the specialist. When an authorization request is received, the information will be reviewed, and the patient's eligibility verified. However, since a patient's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

If prior authorization is not obtained, services may be subject to retrospective review. Some services that may be a part of an ongoing course of treatment may also be subject to concurrent review. Failure to submit a request for authorization may result in a denial and obtaining a prior authorization is not a guarantee of payment.

Notification Requirements

Some covered services require precertification prior to services being rendered, while other covered services require notification prior to being rendered. A notification is a communication from the provider informing SOMOS the intent to render covered medical services to SOMOS patients. Emergent and urgent services require a notification within 24 hours, or the next business day, following admission and may be submitted via phone, fax, or the Provider Portal. To expedite determination, medical records should be submitted with the notification.

Concurrent Review

Concurrent or continued stay review is conducted during the patient's ongoing course of treatment or stay in a facility and includes review for extending a previously approved admission. Hospitals and other facilities must notify SOMOS and the patient's PCP at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays. Concurrent review may be done by phone or on-site and requires cooperation with all inquiries and requests for clinical information, documents, or discussions including diagnoses, care plan, and discharge planning needs. Lack of sufficient clinical documentation to show need for acute care services may result in payment denial.

The following information may be requested and must be documented if the information is reasonably made available to facility:

- Applicable clinical information for concurrent review
- Discharge date
- Aftercare date
- Date and other relevant information regarding first post-discharge appointment
- Medication status and plan
- Familial, occupational and social support systems available to the patient.
- Community resources/self-help groups recommended (note purpose)
- Family illness education, work or school coordination, or other preparation done to support successful community reintegration.

Retrospective Review

Retrospective or post-service review is conducted after the health care service has been provided to the patient and includes review of medical records and other care information to make a claim determination.

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

(1) the relevant medical information presented to SOMOS or its utilization review agent upon retrospective review is materially different from the information that was presented during the pre-authorization review; and

(2) the relevant medical information presented to SOMOS or its utilization review agent upon retrospective review existed at the time of the pre-authorization but was withheld from or not made available to SOMOS or utilization review agent; and

(3) SOMOS or its utilization review agent was not aware of the existence of the information at the time of the pre-authorization review; and

(4) had SOMOS or its review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same specific standards, criteria or procedures as used during the pre-authorization review.

Utilization Management (UM) Determination Time Frames

TYPE OF DETERMINATION	DETERMINATION
Pre-Service (Prospective) Non-urgent	Decision/notification within 3 business days after all information is received not to exceed 14 calendar days after all information is received
Pre-Service (Prospective) Expedited	As fast as the patient's condition requires and within 72 hours of receipt of an expedited authorization request
Concurrent / Extension of Care	Decision/notification within 1 calendar day after all information is received not to exceed 72 hours
Concurrent / Extension of Care Expedited (all inpatient)	Decision/notification within 1 calendar day after all information is received not to exceed 72 hours
Retrospective	30 calendar days from receipt of all necessary information

Note: *Failure to follow authorization, certification, and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the patient be held harmless from any financial responsibility.*

Treatment and Discharge Planning

As appropriate, providers may develop individualized treatment plans that utilize assessment data, address the patient's current problems related to the behavioral health diagnosis, and actively include the patient and significant others, as appropriate, in the treatment planning process. SOMOS will review the treatment plans with the providers to ensure that they include all elements required by the Downstream IPA Participation Agreement, applicable government program, and at a minimum:

- Specific measurable goals and objectives
- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the patient and significant others as appropriate

Providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Discharge planning is an integral part of treatment and begins with the initial review. As a patient is transitioned from inpatient and/or higher levels of care, staff will review/discuss with the provider the discharge plan for the patient.

Adverse Clinical Determination/Peer Review

Requests that do not appear to meet medical necessity criteria or present quality of care issues are referred to a peer reviewer for additional review. Only a licensed physician peer reviewer can clinically deny a request for services. A healthcare professional providing care to an enrollee is prohibited from serving as a clinical peer reviewer for health care provided to that enrollee. All written or electronic adverse determination notices include:

a) The reasons for the determination, including the clinical rationale, if any;
b) Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals; and
c) Notice of the availability, upon request of the patient or the patient's designee, of the clinical review criteria relied upon to make the determination
d) What, if any, additional necessary information must be provided to, or obtained by, SOMOS in order to render a decision on the appeal
e) A description of action to be taken
f) A statement that SOMOS will not retaliate or take discriminatory action if appeal is filed.
g) The process and timeframe for filing/reviewing appeals, including patient's right to request an expedited review
h) The patient's right to contact NYSDOH, with 1-800 number, regarding his/her complaint
i) A Fair Hearing notice review including aid to continue rights; a Fair Hearing may not be initiated unless an appeal has been filed
j) Statement that notice is available in other languages and formats for special needs and how to access these formats.

Reconsiderations

For initial pre-service or concurrent medical necessity denials, providers may request a reconsideration. Reconsiderations can be filed within 60 calendar days of the initial adverse determination. Reconsiderations will be completed within one business day by the Medical Director who made the initial decision to deny the precertification or the extension of service. To request a reconsideration please call the SOMOS Utilization Management Department at 844-990-0255. If a pre-service or concurrent medical necessity denial is past the reconsideration timeframe, or denial was issued after the reconsideration, a provider may be entitled to file a pre-service appeal on behalf of a member by outreaching to the MCO's Member Services in accordance with the respective MCO's guidelines. Appeals will be addressed within 30 calendar days from receipt of the appeal request, and expedited appeals will be responded to within 72 hours from receipt of the appeal request.

Appeals

For any adverse determination following a post-service or retrospective medical necessity denial, providers may file an appeal. The appeal will be subject to the appeal rights specified by SOMOS's policies and procedures and stated in the adverse determination notice.

Appeals should include an explanation for why the decision is being appealed and why you

believe the decision should be overturned, as well as any necessary information to review the appeal, such as the medical record. Providers must initiate the appeal within 60 calendar days of the date on the initial adverse determination notice. Appeals will be addressed within 30 calendar days from receipt of the appeal request. To initiate an appeal of the adverse determination, submit your request via mail to:

For HealthPlus:
SOMOS IPA, LLC
P.O. Box 21432
Eagan, MN 55121

For Emblem:
SOMOS IPA, LLC
P.O. Box 211473
Eagan, MN 55121

Quality Management

SOMOS is committed to ensuring that the quality of care provided to its patients continuously improves. Quality goals include:

- Providing high quality, accessible, and affordable health care and service to the patient through a qualified network of providers and providers who are systematically selected and retained through the credentialing and performance appraisal process
- Maintaining a health plan model that empowers the provider to make decisions, and enables the provider to proactively manage health care
- Meeting and exceeding all the highest clinical and customer quality standards and reporting requirements, specifically the utilization and quality measures of SOMOS, HEDIS, QARR, and other applicable programs
- Coordinating preventive care, wellness efforts and chronic care management, ensuring efforts are patient-centric
- Conducting operations in a manner that protects the confidentiality, safety, and dignity of all patients

SOMOS operates a comprehensive Quality Management program with methods and procedures to control the utilization of services (per Article 49 of the PHL and 42 CFR Part 456). The purpose of the Quality Management program is to objectively monitor and systematically evaluate the care and service provided to patients. The scope and content of the program reflects the demographic and epidemiological needs of the population served; the program will be amended as needed to address the specific monitoring requirements for the benefits and services we manage and the populations we serve. Providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are kept on file in written form. To request a copy, providers can contact ProviderRelations@somosipa.com.

The Quality Management program objectives are aligned with the needs of the population served and is continually re-evaluated based on ongoing evaluation across the continuum of care and service. This includes demographic distribution as well as a review of utilization data, or the information needed to perform utilization reviews (per 42 CFR §§ 456.111 and 456.211) — inpatient, emergent/urgent care and office visits by type, cost and volume.

Among the priorities of SOMOS Quality Management program is reducing disparities affecting cultural groups and increasing access to health and behavioral health care. The QM program addresses cultural competency concerns as part of reporting and evaluation processes to ensure that our providers deliver care in accordance with linguistic, cultural, and social needs of our patients.

Quality of Care

All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in our credentialing program. Review standards are based on medical community standards, external regulatory and accrediting agencies' requirements, and contractual compliance.

The SOMOS Quality Management Program aims to ensure that SOMOS participating providers deliver the highest quality care to patients, while aligning their efforts with the requirements of the NYSDOH Quality Reporting Requirement (QARR) program, NYDSOH Clinical Advisory Group

(CAG), as well as the priorities of New York State's Value-Based Payment initiative. In line with the aforementioned standards, SOMOS relies on various reports to profile and evaluate providers, including but not limited to Healthcare Effectiveness Data and Information Set (HEDIS) measures, CAHPS reports, among others.

Quality Assessment Objectives

Quality Assurance Reporting Requirements (QARR) data for SOMOS providers is submitted to NYSDOH by the SOMOS MCO partners, collected through encounter (claims) data and medical records. SOMOS's responsibility is to supply the medical record data to the MCO on behalf of SOMOS providers as a supplement to the claims-based reporting within the QARR dataset.

Examples of measures reported for QARR include:

- Well-child visits: 0-15 months, 3 to 6 years
- Comprehensive diabetes care
- Breast cancer screening
- Cervical cancer screening

Please note that the more information can be extracted from the encounter and medical record data, the less likely it will be for a medical record review to be deemed necessary. Providers are expected to maintain thorough billing and coding practices to support this effort.

The Quality Management department uses provider-profiling methodology, rationale and processes for classifying physician performance. The method applies to the following key measures: access and availability to care, member complaints, ER utilization and PCP turnover rates.

The principal features of the methodology are:

- Clearly defined goals and objectives for the profiling activity have been developed, including the communication of a profiling summary to providers and the provision of provider/office manager education, based on findings and corrective action plans with timetables and measurable benchmarks of success, as indicated.
- Descriptions and rationale for each measure have been developed, and supporting clinical documentation included, when appropriate.
- The measures selected for the profile meet criteria for valid and reliable measurement and when analyzed as a whole, will be used as a tool to target opportunities for improvement. Additionally, a summary of these results will be shared with the involved physicians to promote continuous quality improvement activities. If assessed performance is below the established metrics, providers will be asked to collaborate in the creation of corrective action plans toward meeting expected levels of improvement in a given timeframe. In the event that improvement targets are not met as specified, SOMOS will move forward in creation of alternate plans to ensure improvement for the provider.
- Quality profiles examine a broad range of practice measures and have some adjustments for risk, and similar cohorts are analyzed across practices to fairly compare each provider.
- Profiles incorporate findings from multiple sources, including claims, QARR, medical record review data, utilization management and pharmacy data, member satisfaction surveys, enrollment and PCP assignment data, member complaints and provider-

supplied information, such as office hours, walk-in policies, and state-issued reports such as OMH and OASAS BH quality reports, etc.

All indices included in the provider-profiling summary will be presented in a standardized reporting format accessible to providers upon request. Formal assessment of provider performance will be evaluated on a periodic basis using the previously stated criteria and an appropriate group of health care professionals using similar treatment modalities and serving a comparable patient population. Providers will have the opportunity to engage in dialogue regarding the report findings, discuss the unique nature of their practices and work cooperatively and collaboratively with SOMOS to assess opportunities to improve performance and/or identify practice areas which are working well.

Quality Management Committee

SOMOS quality assessment and improvement efforts are monitored by the Quality Management (QM) committee with input from BH QM Subcommittee, Credentialing Committee, HARP Subcommittee, and the MCO's Advisory Committees. The committees allow the QM Program to solicit feedback and recommendations from key stakeholders, in addition to an ongoing dialogue with the providers.

The QM Committee is led by the SOMOS Chief Medical Officer (CMO) and reports to the Board of Directors. The SOMOS CMO maintains records documenting attendance by committee members as well as committee findings, recommendations, and actions. Committee members include SOMOS leadership and support staff, as well as adult and pediatric clinicians, including behavioral health specialists and family peer support specialists. Additional stakeholders can be invited for perspective at the quarterly QM Committee meetings.

The Quality Management committee's responsibilities are to:

- Review and approve all quality initiatives, tracking progress and program metrics
- Establish annual goals for each quality program
- Determine progress on quality metrics by physician/clinic, creating targeted interventions for physicians/clinics that are underperforming
- Oversee external quality committees
- Collaborate with stakeholders to collect quality performance data on at least an annual basis, reviewing data to ensure consistent and accurate data collection
- Review quality indicators, utilizing NCQA standards and committee expertise to update indicators annually
- Review and approve utilization management criteria, provider credentialing activities, delegated activities, and delegation oversight
- Review feedback collected from providers, and implement necessary changes
- Assist in the selection and evaluation of preventative health standards/guidelines and pharmacy initiatives
- Documentation of QM activities (focused discussions, tracking, trending, analysis, and follow-up) related to PH services for medically fragile children/complex conditions as separate items in the agenda and committee minutes
- Documentation of all BH QM sub-committee activities (focused discussions, tracking, trending, analysis, and follow-up) related to BH services and HCBS for children as separate items in the QM committee agenda and minutes

SOMOS also maintains an active HARP Quality Management (HARP QM) Subcommittee, the activities of which are monitored by and reported to the Quality Management Committee. The HARP QM Subcommittee is chaired by the Utilization Management (UM) Director and includes SOMOS clinical leadership and adult behavioral health providers. The subcommittee is expanded to include, in an advisory capacity, additional stakeholders such as SUD treatment providers to guide and provide feedback on the committees' activities. Participant attendance is documented at each committee meeting.

The HARP QM Subcommittee's responsibilities are to:

- Report on recovery measures, employment, housing, criminal justice status, etc.
- Conduct an annual consumer perception survey (supplementary to CAHPS)
- Track and report on compliance with HCBS assurances and sub-assurances
- Review reports from MCO on compliance with protocols for expedited and standard appeals regarding plan of care denials for HCBS
- Review reports from MCO on compliance with protocols for the identification and prompt referral of individuals with FEP to programs and services

Preventive Health Resources

SOMOS works with network physicians and patients to encourage the use of preventive services and programs to assist with changing lifestyle risks, such as smoking, in accordance with the recommendations of the US Preventive Services Taskforce and other applicable resources. SOMOS may provide health management and education resources to help patients improve their knowledge about chronic conditions and their treatment and learn behaviors for better self-management, prevention, and early detection of illness.

Care Management

Care Management services are provided to SOMOS patients who have chosen/been assigned to a SOMOS PCP. The suite of clinical programs and performance management framework will drive care coordination resulting in increased quality, improved efficiency, increased member/provider satisfaction, and improved clinical outcomes. Programs and services include, but are not limited to, transitions of care, behavioral health, pregnancy care, complex care, and care coordination. To refer your patients to Care Management, please call 855-225-3211, email SOMOSCareManagement@evolenthealth.com, or fax 1-646-940-9886. When referring patients for care management, please send the member's name, date of birth, referral reason, and any conditions or relevant clinical information.

Potential Quality of Care Issues Reporting and Management

Potential quality of care concerns initiated by a patient or provider are tracked and investigated by the patient's respective MCO and shared with SOMOS. Given the strict requirements for monitoring and follow-up on potential quality of care concerns, these must be handled directly with provider or member services with the patient's MCO. For reporting potentially quality of care issues, contact the patient's MCO directly or educate the patient on the process for completing this themselves.

Fraud, Waste, and Abuse

Please refer to the patient's respective MCO for policies on Fraud, Waste, and Abuse. Key Contact Information & References for MCO-specific contacts and references for Fraud, Waste, and Abuse.

Member Services

Please refer to the patient's respective MCO's Member Services department for the following information:

- Member Enrollment (including Newborn Enrollment)
- Member Benefits
- Member Rights & Responsibilities
- Covered and Non-Covered Services
- Translator and Interpreter Services
- Terminating Care of a Member
- Member Complaints and Appeals (including provider appeals on member's behalf)

See Key Contact Information & References for MCO-specific contacts and references for Member Services.

APPENDIX

UB-04 CLAIM FORM

CMS-1500 CLAIM FORM

PRIOR AUTHORIZATION REQUEST FORM